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DETERMINING THE HIV PREVENTION NEEDS OF MEN
WHO HAVE SEX WITH MEN IN MONTANA

by

Ryan Kathleen Campbell

B.A. University of Montana, 2000

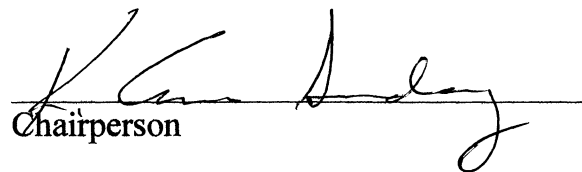
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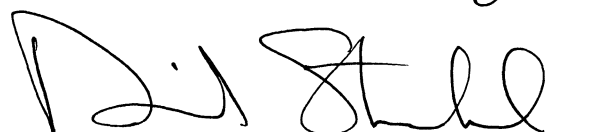
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Thesis Abstract

Campbell, Ryan, M.S., May 2002

Health and Human Performance

Determining the HIV Prevention Needs of Men Who Have Sex With Men In Montana

Committee Chair: K. Ann Sondag, Ph.D. *KAS*

The purpose of this study was to conduct an HIV prevention needs assessment of Men who have Sex with Men (MSM) in Montana. In addition, barriers to providing HIV prevention information and services were explored. Generational differences among Montana MSM were researched. A combination of qualitative and quantitative data was utilized as the basis of methodology. A survey, the Gay/Bisexual Men's Health Survey, developed by FDH & Associates, was distributed to MSM throughout the state of Montana. A number of key informant interviews and focus group sessions were conducted for further insight onto MSM needs.

A combination of descriptive statistics, chi square tests and discriminant analyses were run on survey data; Key informant interviews and focus group sessions were qualitatively analyzed. Statistical importance and reliability was found between oral sex and age, HIV status and age, and Internet use and age. Results indicated most MSM believe that HIV prevention is important and are in need of more comprehensive, confidential, empathetic, social, and individual health services. Major factors influencing risk behaviors were identified as: isolation, homophobia, stereotyping, drug and alcohol use and abuse, HIV testing issues, and safe sex issues. Participants also provided suggested strategies for HIV prevention. The three prevailing themes that emerged from this research were the identification of the above factors, the interconnectedness of the factors, and the discovery of the internal and external components that are characteristic of each factor.

The results of this study may assist the Montana Department of Health and Human Services in understanding the needs of MSM regarding HIV prevention. Development of a social marketing campaign directed towards the general population, and the development of educational materials and services, will improve MSMs' prevention practices in Montana. Ultimately, improving HIV prevention efforts to meet the expressed needs and concerns among MSM will help reduce the number of men who suffer from HIV and AIDS.

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To Dr. Annie Sondag, my thesis chairperson, for her expert advice, humor, strength, and guidance. You are an inspiration. I am grateful to have had the opportunity to work with such an amazing teacher. I will never be able to fully communicate my gratitude.

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To all my friends and family—your endless encouragement has been amazing! I am full of sincere thanks.

To my mother, who has always listened and supported me throughout my life. Your perfect guidance is a blessing. My passion for health promotion is founded in your teachings of love. Love for myself. Love for others. Love for our world.

This writing is dedicated to my honored love, friend, and mentor, my partner, Jeffrey. I thank you for your unconditional support and understanding.

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CHAPTER 1

Introduction of the Study

Purpose of the Study

The purpose of this study is to collect information about the HIV Prevention needs of Men Who Have Sex With Men (MSM) living in Montana. Determination of the demographic and contextual factors which contribute to HIV infection and identification of the perceived HIV prevention needs and service preferences are also included in this study's focus. Reviewing available services and services currently utilized by MSM will assist prevention specialists in determining the gaps between needs and services. A statewide needs assessment will provide Montana's HIV/AIDS State Planning Group (SPG) information that can be used to design programs and services to better accommodate MSM needs.

Research Questions

The research questions examined in this study will focus on MSM in the state of Montana.

1. What are the current behaviors of the MSM population regarding HIV prevention?
 - A. What are the sexual behaviors of MSM?
 - B. What are the substance use behaviors of MSM?
 - C. What are the HIV testing behaviors of MSM?
2. What are the mental/emotional health needs of MSM?
3. What are the social needs of MSM?
4. What are the current resources and services utilized by MSM?

5. What are the barriers to receiving these services?
6. What are the identified gaps between needs and services of MSM?
7. What are the differences in HIV related risk behaviors between MSM under age 25 and those 25 and older?

Statement of the Problem

The Montana Department of Public Health and Human Services (DPHHS), would like to improve the quality of HIV prevention services available to MSM living in Montana. The needs of this population in Montana have not been comprehensively identified. To determine what these needs are, a statewide assessment will be utilized. This study will identify the perceived needs of the MSM population living in Montana, which will provide valuable insight concerning the prevention of HIV/AIDS within this specific at-risk population. Determining the needs of MSM in Montana will improve the quality and availability of HIV related services.

Delimitations

The delimitations of the study are as follows:

1. The study is delimited to MSM over 18 years of age, living in Montana.
2. Data will be collected via survey, focus groups, and key informant interviews.
3. Data will be restricted to participants' self report on surveys, during focus groups and interviews.
4. Participants in the study will be volunteers.

Limitations

The limitations of the study are as follows:

1. Response is limited to the voluntary action of participants completing the survey.
2. Focus group and interview data is limited by what the participants are willing and able to share.
3. Data is limited to the honesty and accuracy of the participants when filling out the survey and participating in the focus groups and interviews.
4. Data is limited to those individuals who are contacted by the researcher and key informants.

Definition of Terms

Men Who Have Sex With Men: men who report sexual contact with other men (homosexual contact) and men who report sexual contact with both men and women (bisexual contact) (Center For Disease Control, Surveillance Report, 2001, p. 1).

Gap Analysis: is the difference between needs and the services available.

Met Needs: are the needs currently being addressed through existing services that are available to, appropriate for, and accessible to the target population (HRSA, 11-5).

Need: is the difference between the present situation and a more desirable one (Gilmore & Campbell, 1996, p. 4).

Needs Assessment: is a planned process that identifies the reported needs of an individual or group (Gilmore & Campbell, 1996, p. 5), and identifies the health needs of the target population to decide whether or not these needs are being met (McKenzie & Smeltzer, 1997, p. 39).

Perceived Needs: are those needs envisioned and reported by the participants in a needs assessment process (Gilmore & Campbell, 1996, p. 5).

Unmet Needs: refers to service needs of those individuals not currently in care as well as those in care whose needs are only partially met or not being met (HRSA, 11-5).

Rural: A population less than 10,000 people (The U.S. Department of Public Health and Human Services, 2001).

Human Immunodeficiency Virus (HIV): A virus that is passed from one person to another through blood-to-blood body fluids and sexual contact (sexual body fluids,

i.e. semen). The virus has also been found in other body fluids such as cerebrospinal fluid (surrounding the brain and spinal cord), synovial fluid (surrounding the bone joints), and amniotic fluid that surrounds the fetus. People with HIV have what is called an HIV infection. Most people will develop AIDS as a result of their HIV infection (Center for Disease Control, Divisions of HIV/AIDS Prevention, What is HIV?, p. 1).

Acquired Immune Deficiency Syndrome (AIDS): An HIV infected person receives a diagnosis of AIDS after developing one of the Center for Disease Control defined AIDS indicator illnesses. An HIV positive person who has not had any serious illnesses also can receive an AIDS diagnosis on the basis of certain blood tests (CD4+ counts). A positive HIV test result does not mean that person has AIDS. A diagnosis of AIDS is made by a physician using certain clinical criteria. Infection with HIV can weaken the immune system to the point that it has difficulty fighting off certain infections. Many infections that cause problems or may be life-threatening for people with AIDS are usually controlled by a healthy immune system. The immune system of a person with AIDS is weakened to the point that medical intervention may be necessary to prevent or treat serious illness. Today there are medical treatments that can slow down the rate at which HIV weakens the immune system. There are other treatments that can prevent or cure some of the illnesses associated with AIDS. As with other diseases, early detection offers more options for treatment and preventative care (Center for Disease Control, Divisions of HIV/AIDS Prevention, What is AIDS? What Causes AIDS?, p. 1).

CHAPTER II

Review of Literature

Epidemiological Information

In the United States, AIDS (Acquired Immune Deficiency Syndrome) remains primarily an epidemic affecting Men Who Have Sex With Men (MSM) (Center for Disease Control, HIV and AIDS, 2001). Men Who Have Sex With Men include men who report sexual contact with other men (homosexual contact) and men who report sexual contact with both men and women (bisexual contact). The first AIDS cases were reported in the United States in June 1981. Since then, the number of cases and deaths among persons with AIDS increased rapidly during the 1980's followed by substantial declines in new cases and deaths in the late 1990's. The greatest impact of the epidemic is among men who have sex with men and among racial/ethnic minorities, with increases in the number of cases among women and of cases attributed to heterosexual transmission (Center for Disease Control, HIV/AIDS Update, 2001). Men who have sex with men who also use drugs intravenously are at the greatest HIV/AIDS risk (HIV/AIDS Update, 2001). Human Immunodeficiency Virus (HIV) has caused approximately 22 million deaths worldwide (Center for Disease Control, HIV/AIDS Update, 2001). As of December 31, 2000, there had been 774,467 persons reported with AIDS in the United States; 448,060 of these had died, 3,542 persons had unknown vital status. The number of persons living with AIDS (322,865) is the highest ever reported. Of these, 79% were men, and 41% of the 79% were infected through male-to-male sexual contact (Center for Disease Control, HIV and AIDS, 2001). The CDC estimates that approximately 40,000 people per year in America become infected with HIV (Center for Disease Control, HIV Prevention

Strategic Plan, 2001). Numerous persons have avoided infection through prevention efforts, and many lives have been prolonged through advances in treatment, such as successful drug therapies.

Prevention Programs

A new generation of MSM has replaced those who benefited from early prevention strategies, and minority MSM have emerged as the population most affected by HIV. Socioeconomic factors, such as high rates of homophobia, high rates of poverty and unemployment, lack of access to health care, and physical isolation, are associated with high rates of HIV risk behaviors among minority MSM and are barriers to accessing HIV testing, diagnosis, and treatment (Center for Disease Control, HIV and AIDS, 2001). Racial/ethnic minority MSM have had large increases in AIDS rates, whereas AIDS rates have decreased slightly for white MSM. AIDS rates also have continued to rise among MSM in small cities and rural areas (Centers for Disease Control and Prevention, HIV/AIDS Trends Among U.S. Men, 1997).

The Center for Disease Control (Notice To Readers, 2001) believes those who are unaware of their HIV status--and consequently not receiving prevention and care services--are contributing significantly to new HIV infections (Center for Disease Control, Notice to Readers, 2001). New strategies are needed to maintain and accelerate progress in HIV/AIDS prevention that sustains and reinvigorates communities most severely affected during the early years of the epidemic, particularly MSM, and to meet the needs of an increasingly diverse epidemic.

A Shift in Epidemic

At the 2001 Center for Disease Control National HIV Prevention Conference it was confirmed that more and more American's aren't protecting themselves from HIV when they have sex, especially young MSM. "We really are at a very critical point in this epidemic where we can either move forward with HIV prevention or risk a resurgence of AIDS," (Helene D. Gayle, MD, MPH, director of the Center for Disease Control's HIV prevention division, 2001 CDC HIV Prevention Conference). One of the greatest successes in public-health history is the profound change in sexual behavior among gay men. Twenty years later, most of these men are still practicing safe sex. Unfortunately, what worked to change their behavior isn't working to change the behavior of younger gay men, (WebMD, Daniel DeNoon, Risky Sex on the Rise, September 25, 2001). "Young men who have sex with men belong to a generation that has not received the intensive interventions of the 1980s. It is not the same epidemic," (Cynthia Gomez, PhD, Center for AIDS Prevention Studies, University of California, San Francisco, CDC HIV Prevention Conference 2001). Since the first cases of AIDS were reported in 1981, the HIV epidemic has taken a devastating toll on MSM. Although the number of lives lost is staggering, the potential toll of the epidemic on MSM was substantially mitigated by grassroots efforts within the gay community that led to significant declines in risk behavior in the 1980s (Shilts, 1987; Revenson & Schiaffino, 2000). In the mid 1990s, the advent of highly active antiretroviral therapy led to dramatic declines in AIDS and HIV-related mortality, (HIV/AIDS Surveillance Report, Center for Disease Control, 1999; Fleming et al., 2000) leading some to foresee an end to the epidemic (Sullivan, 1996).

Sadly, the epidemic continues and could possibly peak again, due to generational differences of the target population of MSM. Although drug therapy treatments have extended the lives of many, treatment is costly, lifelong, and difficult to maintain. It has multiple side effects and can lead to drug-resistant strains of HIV that can be transmitted to others (Boden et al., 1999; Volberding, 1999; Carr & Cooper, 2000).

Considerable research has focused on subgroups of MSM that may be at increased risk for HIV infection. For example, research in the United States has found that younger MSM are more likely than older MSM to engage in risky sexual practices (Mansergh & Marks, 1998). In addition to the demographic, psychosocial, and situational factors that have repeatedly been associated with HIV risk (discussed further in this writing), several newly emerging factors may partially account for recent trends toward increased sexual risk taking. Of these, the association between beliefs about highly active antiretroviral therapy and increased sexual risk taking has received the most attention (Kelly et al., 1998; Kalichman et al., 1998; Venable et al., 2000; Remien et al., 1998). Some researchers have speculated that pharmaceutical advertisements that minimize the negative aspects of HIV infection and antiretroviral therapy with unrealistically upbeat, young, fit portrayals of HIV seropositive persons may also lead to increased risk behavior (Suarez & Miller, 2001). Another possible reason for the shift in the epidemic can be explained as an “AIDS burnout.” A 4-city study indicates that “AIDS burnout” which results from years of exposure to prevention messages and long-term efforts to maintain safer sex practices, is an independent predictor of unprotected anal intercourse among MSM (Ostrow et al.,

2000). Therefore, it can be assumed that the MSM that had lived through the 1980's peak of the AIDS epidemic were introduced to prevention messages that sincerely affected their sexual behaviors, and thus the messages "sunk in" and were learned. Possibly for a younger generation, the same messages are not as effective due to the years of exposure.

Young MSM

Adolescence and young adulthood are often characterized by experimentation and exploration of sexuality and drug using. Many young MSM struggle with individual, interpersonal and societal stressors that may interfere with their ability to protect themselves. One study suggests that for some young MSM, individual factors can lead to unsafe sex, such as: feeling invulnerable to HIV; having high levels of optimism about HIV medications; believing that unsafe sex is more pleasurable than safer sex; being depressed or sad; having conflicting allegiance with either one's racial or sexual identity; and using alcohol and other drugs (Choi et al., 1999). Protecting one's health may not be a top concern of young MSM. Interpersonal motivations may be more pressing—wanting to fit in, to find companionship and intimacy. But, the primary behavior that puts young MSM at risk for HIV is unprotected anal intercourse. A CDC report (HIV/AIDS Trends Among U.S. Men, 1997) states that 45 percent of 13-19 year olds and 54 percent of 20-24 year olds who were HIV-positive were exposed to HIV through unprotected sex with other men. Another study of young gay and bisexual men in Boston (Seage et al., 1997) found that 40 percent of respondents aged 23 and younger reported they had unprotected

anal sex in the past six months. The study also found that this age group was significantly more likely to have had risky sex than older respondents. A collective acceptability of unprotected anal intercourse among young MSM appears to perpetuate risky behaviors; in one study, a lack of social norm regarding safer sex was the strongest predictor of unprotective anal intercourse among MSM aged 17 to 23 years of age (Lemp et al., 1994). Another study found that young MSM have a more difficult time than older MSM in communicating or negotiating safer sex with a sexual partner. The same study also identified that those young MSM in a relationship are more likely to have unsafe sex than a single young MSM (Kegeles et al., 1999).

A study by Kalichman, Nachimson, Cherry, and Williams (1998) found that men who practiced unprotected anal intercourse as the receptive partner were younger, less well educated, and more likely to believe that it is safe to have unprotected anal intercourse as the receptive partner with an HIV-positive man who has an undetectable viral load. These young men also believed that new treatments for HIV “protected” them from infection and their worries about unsafe sex were relieved (Kalichman et al., 1998). A study of 6,000 men entering gay bars in 16 small American cities revealed the following factors to be strongly predictive of risk: a large number of different male partners; having weak intentions to use condoms at next intercourse; believing that safer sex is not an expected norm within one’s peer reference group; being of younger age; and having less education (Kelly et al., 1995). Another study examined behavioral, relationship, and serostatus variables that potentially contribute to HIV infection risk in three age groups of MSM. The

prevalence of unprotected insertive and receptive anal intercourse with primary partners was substantially higher among men younger than 25 years of age than among men aged 25 to 30, or over age 30. These findings suggest that young MSM may be at elevated risk for contracting HIV by virtue of their sexual risk behavior with primary partners (Crepaz et al., 2001). In a study that examined HIV prevalence and associated risks in young MSM, researchers found that among young MSM, HIV prevalence was high, underscoring the need to evaluate and intensify prevention efforts for young MSM (Valleroy et al., 2000).

Reports of unprotected intercourse that do not present the context in which the intercourse occurred may be misleading. For example, an HIV-negative seroconcordant couple that are monogamous have less relative risk during unprotected intercourse than individuals in relationships where monogamy and serostatus have not been established. Unfortunately, evidence indicates that many young MSM are not monogamous and continue to engage in unprotected sex with a number of partners. One study of young MSM in rural Australia reported that 51 percent of the sample had engaged in unprotected intercourse with more than one partner in the previous six months, and 42 percent had engaged in unprotected intercourse with three or more partners in the preceding year (Roberts, 1997).

Many factors combine to put young MSM at increased risk for contracting HIV. Young MSM have to contend with homophobia in response to their sexual preference while also learning how to communicate in intimate relationships and developing the strong sense of identity necessary to be a healthy young adult. Several issues surround MSM, particularly young MSM, that have been shown to be related

to risk behavior: discrimination and identity issues, substance abuse, interpersonal dynamics, isolation and depression, and a misperception of risks (Kalichman et al., 1998).

Rural MSM and HIV/AIDS

Just as young MSM deal with the pressures of a homophobic society, rural MSM deal with similar issues. Some gay men spend their entire lives living in small towns or rural areas. Many more grow up there and migrate to large cities, with some returning to the communities they grew up in when they become symptomatic with AIDS (Shernoff, 1996). Gay men living in rural areas face different obstacles than those living in large urban centers with well-defined gay communities. As Heckman et al. (1996b) noted:

The growing incidence of AIDS and new HIV cases has led to the realization that many rural communities are inadequately prepared to address many of the problems associated with HIV/AIDS including increasing numbers of openly gay men returning to the communities where they grew up. For example, the escalating number of HIV/AIDS cases has resulted in increased demands on rural health care facilities, many of which were financially unstable even before the emergence of AIDS...because many rural communities have not encountered large numbers of persons living with AIDS, little consideration has been given to establishing sources of social support for individuals and families affected by HIV/AIDS, and organized public health HIV prevention efforts are essentially nonexistent in rural areas. Finally as HIV/AIDS becomes more prevalent in rural communities, the stigma and prejudice associated with the disease continues to grow in rural America. (p. 37).

Heckman et al. (1996a) reported that rural clients with HIV/AIDS have great difficulty gaining access to social support. One study participant indicated that “in addition to the person living with HIV/AIDS lacking a similar other to confide in, community residents often believe that persons living with AIDS should move away to the city, thus removing the problem of AIDS from their rural community. This

apathy and resistance among community members greatly impeded clients' efforts to obtain social and emotional support, exacerbating the problems of loneliness and isolation." Another participant in their study noted, "a person with AIDS in a rural area can't talk to just anyone about their condition, because if the wrong people find out you're infected, your life will be more hell than it already is." Heckman et al. (1996b) documented that unlike many of their urban counterparts, rural persons living with AIDS rarely have close friends to whom they can turn, nor do they have a gay community in which they can seek support and social companionship. The repercussions of such findings when applied to young, rural MSM could be even more devastating.

Heckman et al. (1996b) found that barriers to rural gay health care include the following: stigma, lack of trained providers, social and geographic isolation, lack of supports, financial barriers, homophobia, and barriers to family care. These barriers shape who survives AIDS and have unique bearing on how gays in rural areas access care, how they are treated, and their health outcomes. If rural Americans living with HIV must hide their sexual orientation and deny their own identities, then their lives are threatened. Homophobia kills--whether it is socially enforced by the growing stigmatization of AIDS as the epidemic advances or is internalized (Smith et al., 1990). Persons who are forced to conceal their sexual orientation, via both oppression and internalized psychological dimensions, have an accelerated course of HIV diseases (Cole et al., 1996). The barriers to health care social services in rural areas are problems of resources and also are barriers to the availability of specialty services. For gay men, problems are compounded by the reality that rural areas are more

conservative, ingrown, traditional, religious and less tolerant of diversity

Montana MSM and HIV/AIDS

The state of Montana holds 94 million acres, 57.5 million acres of which is utilized for agricultural purposes, and is the fourth largest state in America. Estimated by the 2000 Census, the state's population is 902,195. The U.S. Bureau of Census (2000) also estimates 90.6 % of Montana's population is Caucasian, 6.2 % Native American, and another 3.2 % as Other (including Black, Asian, and Hawaiian, and a mix of ethnicity of two or more races). Therefore, the state is generally homogeneous. As of March 31, 2001, cases of HIV/AIDS reported to the Montana Department of Public Health & Human Services since 1985 include 519 adult/adolescent--278 (61 %) of which are categorized as MSM. Fifty-six of the 519 cases are categorized as MSM that are intravenous drug users. Montana has suffered a total of 236 adult/adolescent (45 % of 519) deaths related to HIV/AIDS. Montana HIV/AIDS cases reported in 2001 total 86. This number includes 14 AIDS cases. People living with AIDS/HIV in Montana include 390 cases and 133 cases of which were diagnosed in other states. These individuals have moved to, or have returned to Montana. Of the 523 total persons living with HIV/AIDS in Montana, 451 report AIDS status and the remainder hold an HIV positive status. Montana has four pediatric cases of HIV/AIDS, five cases of 13-15 year olds, 118 of 20-29 year olds, 225 cases of 30-39 year olds with HIV/AIDS, 92 40-49 year olds, and 47 cases of persons with HIV/AIDS over 49 years of age. There are 459 men living in the state of Montana with HIV/AIDS, with 88 % of HIV/AIDS diagnosed men being white and 35 % being Native American or part Native American (Montana State Health

Department, 2001).

MSM AND HIV/AIDS PREVENTION ISSUES

Substance Abuse

Whether as a reaction to the stress of discrimination and violence or as a way to cope with the challenges of isolation, many MSM turn to alcohol and other drugs--often in conjunction with unsafe sex (Smith and Langenbahn, 1997). Having sex under the influence of drugs has been associated with positive HIV serostatus (Hein et al. 1995 and Hays, et al. 1997). The influence of substances may also play into another factor found in unsafe encounters--failure to communicate directly about safer sex or HIV status. Substance use may limit precautionary behaviors by impairing judgment or acting as a disinhibitor. A recent study in Wisconsin indicated that there were two main predictors of unsafe sexual activity: substance use before sex and the perceived reinforcement value of engaging in a high risk sexual behavior practice--meaning that the subjects were found to be excited by the idea of behaving sexually with someone with an unknown sexual disease status (Kelly and Kalichman, 1998). The effects of substance abuse are also mentioned in the following sections: Isolation and Depression, and Self Esteem.

Communication and Interpersonal Dynamics

Many studies suggest that MSM are unlikely to negotiate about condom use before initiating sexual involvement (Molitor, Facer and Ruiz, 1999; Dufour et al., 2000). Those with poor communication skills with their partners are more likely to have unprotected anal intercourse (Hays et al., 1990; Molitor, Facer, and Ruiz, 1999).

Perhaps this lack of communication is also part of the increased risk for MSM who meet sexual partners at public sex venues. There is evidence that open dialogue about sexual matters can turn recognized risks into mutual safer sex interactions. Gold and Skinner (1992) asked MSM to recall two recent sexual encounters: one in which they had been tempted to engage in unprotected anal intercourse, but did not, and one where unprotective anal intercourse occurred. Sexual communication was found to have occurred more often during the safer encounter. The authors concluded that “even mentioning the possibility of having safe sex helps to make its occurrence more likely by serving as a reminder of the threat from AIDS and thus provoking a more reflective approach” (p. 1028) (Gold and Skinner, 1992). Similarly, noncommunication with partners about risk reduction has been linked to unprotective anal intercourse among young adult MSM (Hays et al., 1990; Molitor, Facer, and Ruiz, 1999).

In the Kelly and Kalichman (1998) study, a regression analysis showed that the reinforcement value of unprotected anal intercourse accounted for variance in predicting levels of condom use that could be accounted for by factors such as knowledge, behavior change intentions, perceived vulnerability, condom attitudes and sexual communication skills. Therefore, helping individuals to think through the risks of unprotected sex could be a key to prevention efforts. Richard Elovich (1999) states,

To do this, professionals must help individuals to think through specific encounters, and to describe in vivid detail both the pleasure and the risks of unprotected anal sex, in terms of who their partner is, what kind of interaction happens (verbal and non verbal), what kind of scenario unfolds and where the sex takes place (since the environment often shapes the choreography). The key to this strategy is accepting that every act of unprotected anal intercourse

involves the possibility of risk (p.5).

Elovich goes on to explain that just like traditional American sex education focuses on the negative side of sex--its risks and dangers--without equal focus on the positive side--pleasure, desire, intimacy and self-esteem are the educational issues that gay men should explore in order to build a balanced sexual health. He believes this inhibits young people from acquiring appropriate sexual knowledge and developing the personal skills necessary for effective decision-making and communication in the areas of sexual activity and relationships (Elovich, 1999).

Misperception of Risk

Several studies have found that MSM are more likely to have unprotected intercourse with steady partners than with less regular partners (Hays et al., 1990). If sex takes place in the context of a monogamous relationship between two HIV negative partners, unprotected intercourse may be safe. Even when the partner's serostatus is unknown, MSM seem to view steady partners as somehow inherently safer than other partners. If the relationship feels safe emotionally, they seem to reason, then it must be safe sexually as well (Ames et al., 1995). However, this may be a false sense of security. The misperceptions of personal HIV risk may take different forms. It may involve the common belief that one can discern a partner's negative HIV status through such perceptible characteristics as a healthy appearance, physical attractiveness, cleanliness, and youthfulness (Ames et al., 1995).

Denying the risk of unprotected sex may also relate to feelings of invulnerability. For example, young MSM, like adolescents in general, report feeling invulnerable, ageless, and immortal (Lowy and Ross, 1994). Misperceptions may also

be an expression of denial, about one's sexual preference and the risk involved in unprotected sex. In particular to rural gays, isolation can lead to cognitive dissonance about what it means to be gay: homophobia which denies the worth of gay people does intrapsychic battle with the self-worth of a gay man. Further, isolation may also deprive a young MSM of healthy role models to counter these negative stereotypes.

Isolation and Depression

MSM experience isolation in many forms. Social isolation is a major concern of the gay population, particularly those with an HIV/AIDS health status. A study of gay/bisexual men identified as risk takers (ages 18-30 years of age) displayed a higher depression score and less social support. These men also have been shown to have more non-consensual sex and to use recreational drugs (Strathdee et al., 1998). Bowen and Barnett's (1997) ethnographic interviews (as cited in Montagne, 2000) with members of the Wyoming gay community identified social isolation and fear of being exposed as gay as major concerns. This could lead to lower social support, which in turn, could enhance loneliness or depression (Martin and Knox, 1997).

Homophobia and Social Support

Homophobia, defined as a unreasonable fear of homosexuals (Smith et al., 1990) can be found in every community. But since less populated areas generally possess more conservative and moralistic values and have had less contact with positive gay role models, it is often difficult to separate these issues. The result of this lack of separation creates a spot light on the limited number of gay and lesbian professionals in a rural community. At the first National Rural AIDS Conference, it was noted that the following circumstances confronting persons living with

HIV/AIDS in rural areas: increased isolation and loneliness; difficulty gaining access to health care services; and increased community perceptions of hatred and prejudice (Heckman, 1996b). Because AIDS was associated with the gay male community so early, separating homophobic reactions from reactions associated with fear of AIDS often is difficult. Homophobia in rural areas has also forced AIDS service organizations to struggle with how they identify themselves--as a gay organization providing services to all persons with AIDS or as an AIDS organization. Such organizations are aware that their identity influences funding, community support and referrals (Rounds, 1998). As a result of homophobia, gays/bisexuals sometimes "blame themselves" or interpret the HIV disease as a punishment--resulting in internalized homophobia. Because several gays/bisexuals and lesbians have felt disconnected from social and health institutions in rural America, some experience bitterness, anger, and distrust of heterosexuals. When such attitudes develop, care and educational outreach efforts are hampered (Smith et al., 1990). A study by Hays and associates (1992) found that gay men who were more satisfied with the social support they received were less likely to show increased depression one year later (Hays et al., 1992). Community support plays a major role in creating a positive gay culture.

Self Esteem

Research done by Martin and Knox (1997) demonstrates that self-esteem instability was associated with higher avoidance coping, higher loneliness, and lower social support. Episodes of self-esteem injury might motivate some gay men to engage in risky sex. Therefore, Martin and Know suggest that HIV prevention strategies with gay men should target the quality of their interpersonal relationships

and community supports (Martin & Knox, 1997). These researchers go on to explain that men who display a momentary low self-esteem most often use avoidance to cope with stress. The feelings of distress associated with fragmentation and low self-esteem states, coupled with feelings of loneliness, might give rise to a variety of coping responses. However, among men who tend to use avoidance to cope with problems, unplanned, impulsive, and risky sex may be one of those responses. According to Hospers & Kok, (as cited in Martin & Knox, 1997) alcohol and drug use is another commonly used avoidance coping strategy; this formulation might also help to explain the association of chemical use with risky sex. These researchers concluded that the quality of interpersonal relationships and community supports should be a focus of HIV prevention strategies.

Conclusion

Many factors put MSM at risk for contracting HIV. Among these factors are substance abuse, communication and interpersonal dynamics, misperception of risk, isolation and depression, homophobia, social support, self-esteem. There is an urgent need to address the rapidly increasing number of HIV and AIDS cases being diagnosed in rural communities (Sowell and Christensen, 1996). Prevention starts with understanding. As Richard Elovich says, "If HIV prevention is going to be relevant in our lives, it has to be broader than HIV. It needs to be about sexual health. Building a culture of sexual health means leaving behind the notion that any part of the gay community is too hard to reach" (Elovich, 1999, p.8).

CHAPTER III

Methodology

The purposes of this study are to identify the HIV prevention needs of MSM living in Montana; to identify the current resources available to meet those needs; and to determine the gaps between needs and services. In addition, the barriers to receiving HIV/AIDS related services and support will be examined. The information gathered from this study will be used as a guide to develop appropriate health services, and prevention programs for this population.

Description of Target Population

The population to be assessed in this study is MSM over the age of 18 who live in Montana. For the purpose of this study, MSM include homosexual men, bisexual men, and men who participate in sexual relations with other men, but who do not identify as homosexuals.

Protection of Human Subjects

The human subject application material and consent forms have been completed in accordance with The University of Montana Institutional Review Board (IRB) (Appendix A).

PROCEDURES

Nature of Selected Samples

Survey:

The survey was distributed to men 18 years of age and older who have sex with other men. The survey was administered by the Gay Men's Task Force (GMTF) during the summer of 2001 and was first distributed at the Montana Pride Celebration

(early June). Gay men attending workshops and retreats conducted by the FDH & Associates and the Montana Gay Men's Task Force during summer months also completed surveys. The survey was also distributed by MSM outreach workers in Missoula, Butte and Billings. David Herrera, director of FDH and Associates had this to say about the survey: "outreach workers primarily distributed surveys at adult bookstores, where some men seek other men for sex (2001)."

Focus Groups:

Three focus groups will be performed. Individuals will be invited to participate on a volunteer basis. Focus group participants will be recruited through the recommendation of indigenous leaders. Indigenous leaders are individuals who have influence in the targeted population. These individuals, who are noted for their participation and involvement with the target population, provide access to the target population through personal invitations to individuals who fit the criteria for participation in the study. In addition, an effort will be made to obtain participation from gay/bisexual men support groups located in different geographical regions of the state.

Two of the three focus groups will be divided into specific age groups; under age 25, and over age 25, and the third focus group will be composed of mixed age participants.

Key Informant Interviews:

Eight to Twelve interviews will be conducted with key informants from across the state. Key informants will be identified by gay or bisexual male leaders within Montana. Interviews will be conducted with men who are representative of various

demographics. Several key informants work with gay men in HIV/AIDS prevention and gay men's health organizations. Other key informants are representing of various criteria such as age, socio-economic status, ethnicity, HIV/AIDS status, educational background, religion, etc. Informants will not only aid in the recruitment of focus group participants, but will also participate in a face-to-face interviews with the researcher concerning MSM needs. Key informants are a valuable resource for information regarding the needs of rural MSM.

Instrumentation

Survey:

A survey instrument was developed by the GMTF to identify the needs of a sub-group of MSM--gay and bisexual men (Appendix B). This organization's 2001 survey gathers information in the following areas: demographics of the population, HIV/AIDS status, high-risk sexual behaviors of the population, and substance use and abuse. This survey, with minor revisions, has been utilized each year since 1993, with the exception of 1994. The GMTF developed the survey as a way to gather information about high-risk behaviors of gay and bisexual men, which in-turn is used to make recommendations to state agencies and health providers of this particular population. The survey aids the GMTF by supporting their mission which is to improve the health and well-being of gay and bisexual men in Montana.

Focus Groups:

Three focus groups will be conducted throughout the state of Montana. Individuals recommended by the key informants, and men from gay and bisexual support groups and organizations will be invited to participate. The focus group

questions were developed based on a literature review, the GMTF survey, as well as other existing surveys dealing with gay and bisexual men or HIV prevention. The focus group interview schedule includes questions that aim to regard the following issues: sexual and drug use behaviors, epidemiological information related to HIV/AIDS, social needs and emotional/mental needs (Appendix C).

Key Informant Interviews:

Key informant, or formal, structured face-to-face interviews will be conducted with gay leaders throughout the state of Montana. The interview process is designed to supplement the information gathered from the survey and the focus groups. Questions for the key informant interviews (Appendix C) are similar to the questions for the focus groups and also reflect the main issues addressed in the survey instrument.

Data Collection

Survey:

Survey data collection was done by an approach and ask-to-participate technique. Task force members and outreach workers explained the purpose of the survey and that all information was voluntary, anonymous and confidential. The surveys were distributed in person and returned to the task force member or outreach worker after they were completed. Surveys took less than five minutes to complete.

Focus Groups:

Three focus groups will be conducted with MSM throughout the state of Montana. Participation in the group is by invitation and is voluntary. Individuals will be invited to participate based upon recommendations of key informants. At the time of invitation, participants will receive general information about the session. In

conjunction with support group or gay/bisexual organizational facilitators, a time and meeting place for the focus groups will be arranged. Upon meeting with support group leaders or gay/bisexual organizational leaders, the focus group facilitators will explain the purpose of the meeting to the participants and will distribute the informed consent papers (Appendix D) and a brief demographic questionnaire (Appendix E). A research assistant will be present to take notes and the focus group sessions will be audio recorded to assure accurate records of the responses.

Key Informant Interviews:

Eight to twelve key informant interviews will be conducted with the identified gay leaders from the state of Montana. Each key informant will be contacted and asked to volunteer for a face-to-face interview. If the key informant agrees to participate, a time and place to conduct the interview will be arranged. The researcher will conduct the interview and take notes. Each session will be audio recorded to assure accurate records of responses. Before the interview, each key informant will be given a consent form to read and sign (Appendix F) and a list of the questions asked during the session (Appendix C). Key informants will also fill out a brief demographic questionnaire (Appendix E). The proceedings will be verbally explained.

Data Analysis

Collected data for this study will come from a survey, three focus groups, and eight to twelve key informant interviews. Quantitative and qualitative analyses will be completed on the focus group and interview data.

Survey Analysis:

Survey responses will be statistically analyzed using a SPSS computer program. Survey analysis will include descriptive statistics to report the perceived needs among the MSM population in Montana. Frequencies will be reported by actual count and sample sizes. Frequencies will also be reported in charts and graphs when appropriate. Wherever deemed necessary a Chi-Square Goodness-of-Fit test, with an alpha of 0.05, will be conducted to determine relationships between age and behaviors.

Focus Groups and Interviews:

Focus group and interview data will be qualitatively analyzed. Immediately following the sessions, the researcher will review the notes and the tapes to make sure they make sense, to identify any areas of ambiguity or uncertainty, and to review the overall quality of the information received from participants. Observational data (such as, where the interview/focus group occurred, number of participants) will also be noted. A context summary sheet (Appendix G) will be utilized in this process. The tapes will be transcribed and the notes from the focus groups and interviews will be compared with the transcripts to check for accuracy. Analysis will involve identifying themes, patterns, perceptions, the general impression and concerns identified by participants. Significant information, unusual and informative findings will also be reported.

CHAPTER IV

Results

The purpose of this study was to conduct an assessment regarding the HIV prevention needs of MSM living in Montana. The assessment included data collection from the following sources: the Gay Men's Task Force Survey, Key Informant Interviews, and Focus Groups. Following are results from analysis of data from each of these sources.

Survey

The Gay Men's Task Force developed and administered the survey. It was distributed to gay and bisexual men at health fairs, retreats and support groups in Butte, Billings, and Missoula during the summer of 2001. A total of 196 completed surveys were included in this analysis.

Participants' Age:

- 18-24 (n=31) 16.3%
- 25-34 (n=49) 25.8%
- 35-44 (n=58) 30.5%
- 45 & older (n=52) 27.4%

Residency in Montana

- Participants currently living in Montana (n=172) 91.0%
- Participants not living in Montana (n=17) 9.0%

Ethnicity

- Caucasian (n=163) 85.8%
- American Indian (n=20) 10.5%
- Hispanic/Latino (n=3) 1.6%
- Asian/Pacific Islander (n=1) 0.5%
- "Other" (n=2) 1.1%

Educational Level

Approximately 98% of the participants had attained an educational level equivalent of a high school degree or higher. Nearly half of the participants were college graduates.

- Eighth Grade or Less (n=1) 0.5%
- Some High School (n=3) 1.6%
- High School degree or GED (n=36) 19.0%
- Some College (n=70) 37.0%
- College Graduates (n=47) 24.9%
- Post Graduate degree (n=33) 17.5%

Question #1: “In the last year, have you engaged in Anal Sex?”

More than three fourths of participants (80.2%, n=150) reported engaging in anal sex within the last year (N=187):

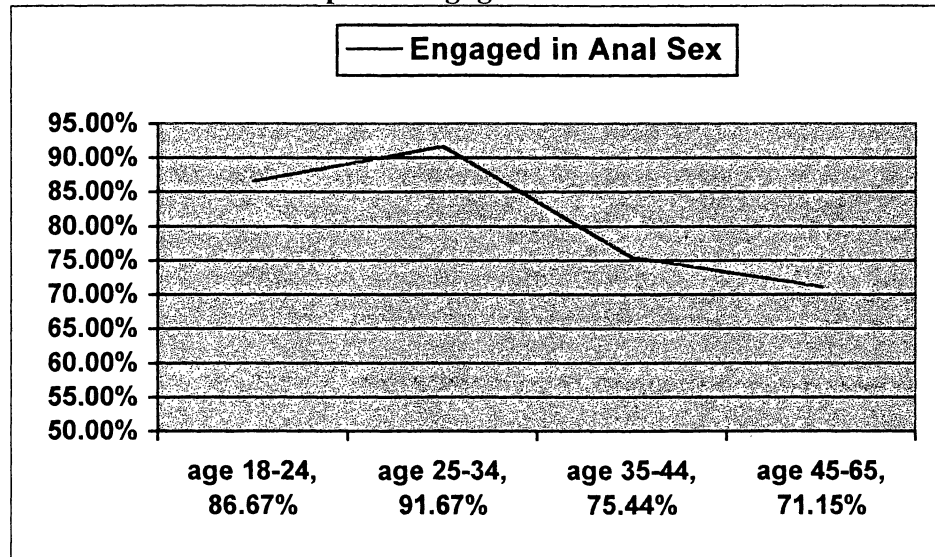
- Yes (n=150) 80.2%
- No (n=37) 19.8%

Chi Square tests of significance revealed reliable differences between the number of participants who reported engaging in anal sex and age. Men in the 18 to 34 year old age group were more likely to report engaging in anal sex than men in the 35 to 65 year old age group.*

- 18 – 24 year olds, (n=26, N=30) 86.67%
- 25 – 34 year olds, (n=44, N=48) 91.67%
- 35 – 44 year olds, (n=43, N=57) 75.44%
- 36 – 65 year olds, (n=37, N=52) 71.15%

*(significance level set at $p \leq .05$; determination of whether or not the difference was meaningful was based on a minimum 10% difference in yes/no response categories).

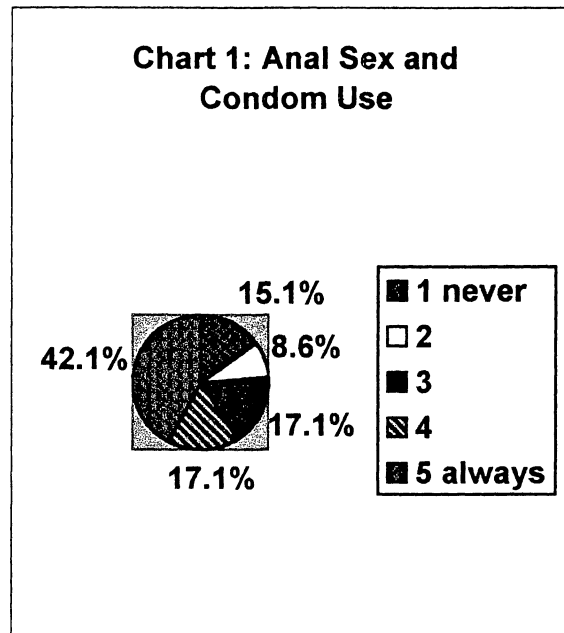
Graph 1: Engaged in Anal Sex



Question #2: “If yes, how often did you use a condom?”

A five-point Likert Scale of “Never,” “2,” “3,” “4,” and “Always” was used for response categories. Nearly 58% of respondents reported that they did not always wear a condom during anal sex. Responses are as follows (N=152).

- 1 never 15.1% (n=23)
- 2 8.6% (n=13)
- 3 17.1% (n=26)
- 4 17.1% (n=26)
- 5 always 42.1% (n=65)



Questions #3 “If you did not use a condom, what are some of the reasons (check all that apply).

There were 97 persons who checked one or more of the following reasons.

Table 1: Reasons for Not Using Condoms

| Reason | % | (n) |
|----------------------------------|-------|--------|
| “He was my regular sex partner.” | 25.3% | (n=43) |
| “We were both HIV negative.” | 17.9% | (n=34) |
| “I am HIV negative.” | 6.8% | (n=13) |
| “He said he was HIV negative.” | 5.3% | (n=10) |
| “He did not want to use one.” | 4.2% | (n=8) |
| “The sex was exciting.” | 11.6% | (n=22) |
| “Other” | 9.5% | (n=18) |

Question #4: Other responses included:

Eighteen participants who responded to this question reported these reasons as to why a condom was not used during anal sex:

- “I choose not to wear one.”
- “Was Top.”
- “Don’t care for condoms.”
- “First Time for both of us.”
- “Out of condoms.”
- “Stupidity.”
- “High.”
- “It didn’t matter.”
- “Both Positive.”
- “Sometimes makes me limp.”
- “Personal choice.”
- “Blow Jobs.”
- “Monogamous Relationships” (four responses)

Question #5: “Have you ever used the “Reality @ Condom” for anal sex?” (N=189)

- Yes (n=18) 9.8%
- No (n=166) 90.2%

Question #6: “If yes, would you use it again?”

- Yes (n=13) 46.4%
- No (n=15) 53.6%

Question #7: “In the last year, have you engaged in vaginal sex?”

- Yes (n=20) 11.2%
- No (n=158) 88.8%

Chi Square tests revealed no reliable differences between the number of participants who engage in vaginal sex and age.

Question #8: “If yes, how often did you use a condom?”

A five-point Likert Scale, where “1” represents “Never” and “5” represents “Always” was used as response categories. Approximately 70% of respondents reported that they did not always use a condom during vaginal sex. Responses are as follows (N=27):

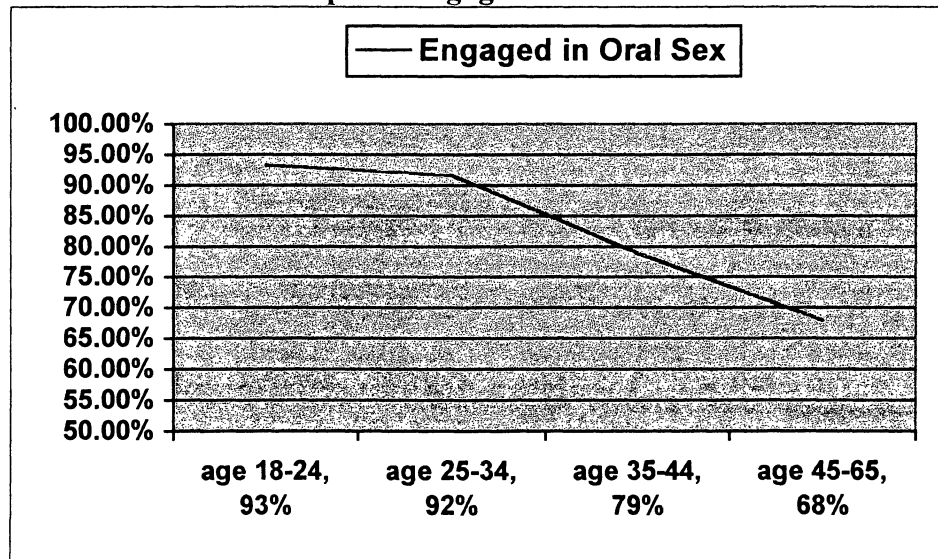
- 1 never (n=13) 48.1%
- 2 (n=1) 3.7%
- 3 (n=2) 7.4%
- 4 (n=3) 11.1%
- 5 always (n=8) 29.6%

Question #9: “In the last year, have you engaged in oral sex?”

- Yes (n=151) 81.6%
- No (n=34) 18.4%

Chi Square tests of significance revealed reliable differences between the number of participants who reported engaging in oral sex and age. Men in the 18 to 34 year old age group were more likely to report engaging in oral sex than men in the 35 to 65 year old age group.*

Graph 2: Engaged in Oral Sex

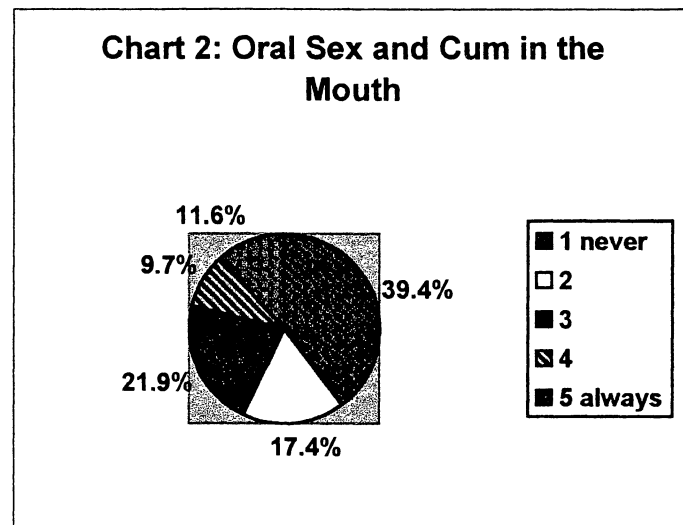


*(significance level set at $p \leq .05$; determination of whether or not the difference was meaningful was based on a minimum 10% difference in yes/no response categories).

Question #10: “If yes, how often did you get cum in your mouth?”

A five-point Likert Scale of “Never,” “2,” “3,” “4,” and “Always” were used as response categories. Responses are as follows (N=155):

- 1 never 39.4%, (n=61)
- 2 17.4%, (n=27)
- 3 21.9%, (n=34)
- 4 9.7%, (n=15)
- 5 always 11.6%, (n=18)



Question #11: “In the last year, have you engaged in mouth to rectum contact?”

(N=176):

- Yes (n=70) 39.8%
- No (n=106) 60.2%

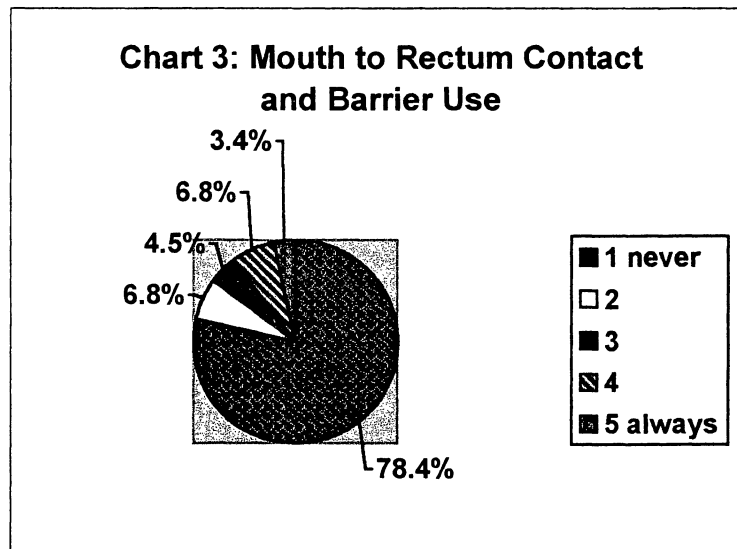
Chi Square tests revealed no reliable differences between the number of participants who engaged in mouth to rectum contact and age.

Question #12: “If yes, how often did you use a barrier?”

A five-point Likert Scale of “Never,” “2,” “3,” “4,” and “Always,” were use as

response categories. Nearly 80% of participants reported that they never use a barrier when engaged in mouth to rectum contact. Responses are as follows (N=88):

- 1 never (n=69) 78.4%
- 2 (n=6) 6.8%
- 3 (n=4) 4.5%
- 4 (n=6) 6.8%
- 5 always (n=3) 3.4%



Questions #13: “In the last year, how many sex partners have you had?”

“How many male partners?” (N=163)

- Mean = 5.95 male partners
- Mode = 1 male partner
- Range 0 to 77 male partners

“How many female partners?” (N=50)

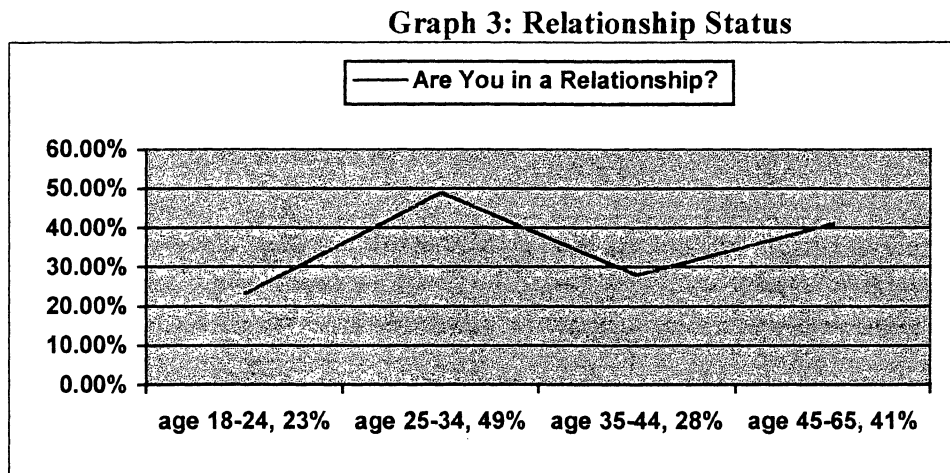
- Mean = 0.84 female partners
- Mode = 0 female partners
- Range = 0 to 8 female partners

Question #14: “Are you in a relationship?” (N=192)

- Yes (n=68) 36.4%
- No (n=119) 63.6%

Chi Square tests of significance revealed reliable differences between the number of participants who reported being in a relationship and age. Men in the 25 to 34 and the 45 to 65 year old age groups were more likely to report being in a relationship than men in the 18 to 24 and 35 to 44 year old age groups.*

- 18 – 24 year olds, (n=7, N=30) 23.33%
- 25 – 34 year olds, (n=24, N=49) 48.98%
- 35 – 44 year olds, (n=16, N=57) 28.07%
- 45 – 65 year olds, (n=21, N=51) 41.18%



*(significance level set at $p \leq .05$; determination of whether or not the difference was meaningful was based on a minimum 10% difference in yes/no response categories)

Question #15: “If yes, how long?”

This follow-up question was recorded in months (N=67).

- Mean = 48.10 months (approximately 4 years)
- Mode = 6 months
- Range = 1 month to 276 months (approximately 23 years).

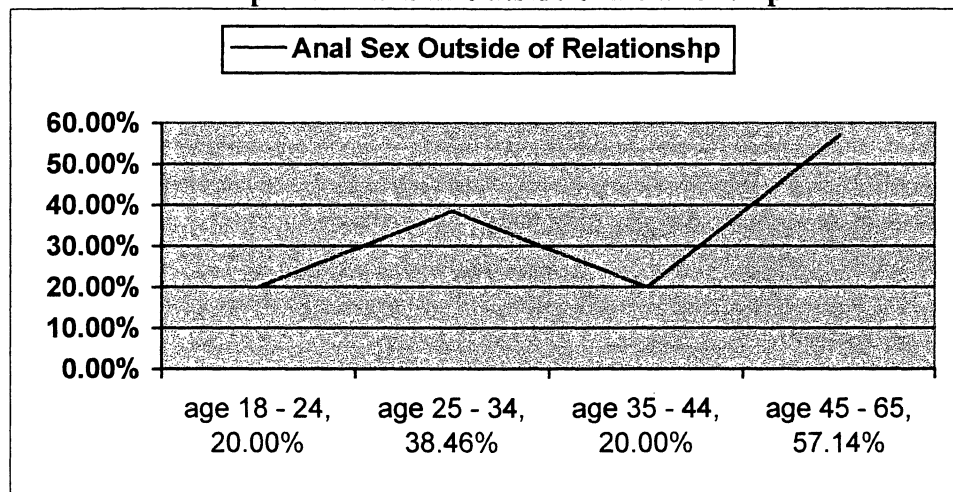
Question #16: “If yes, have you had anal sex outside the relationship?” (N=77).

- Yes (n=28) 36.4%
- No (n=49) 63.6%

Of those who reported having anal sex outside of the relationship, Chi Square tests revealed no reliable differences among the age groups despite substantial differences in percentages. This lack of reliability may be due to the small number of participants in each age group.

- 18 – 24 year olds, (n=2, N=10) 20.0%
- 25 – 34 year olds, (n=10, N=26) 38.4%
- 35 – 44 year olds, (n=4, N=20) 20.0%
- 45 – 65 year olds, (n=12, N=21) 57.14%

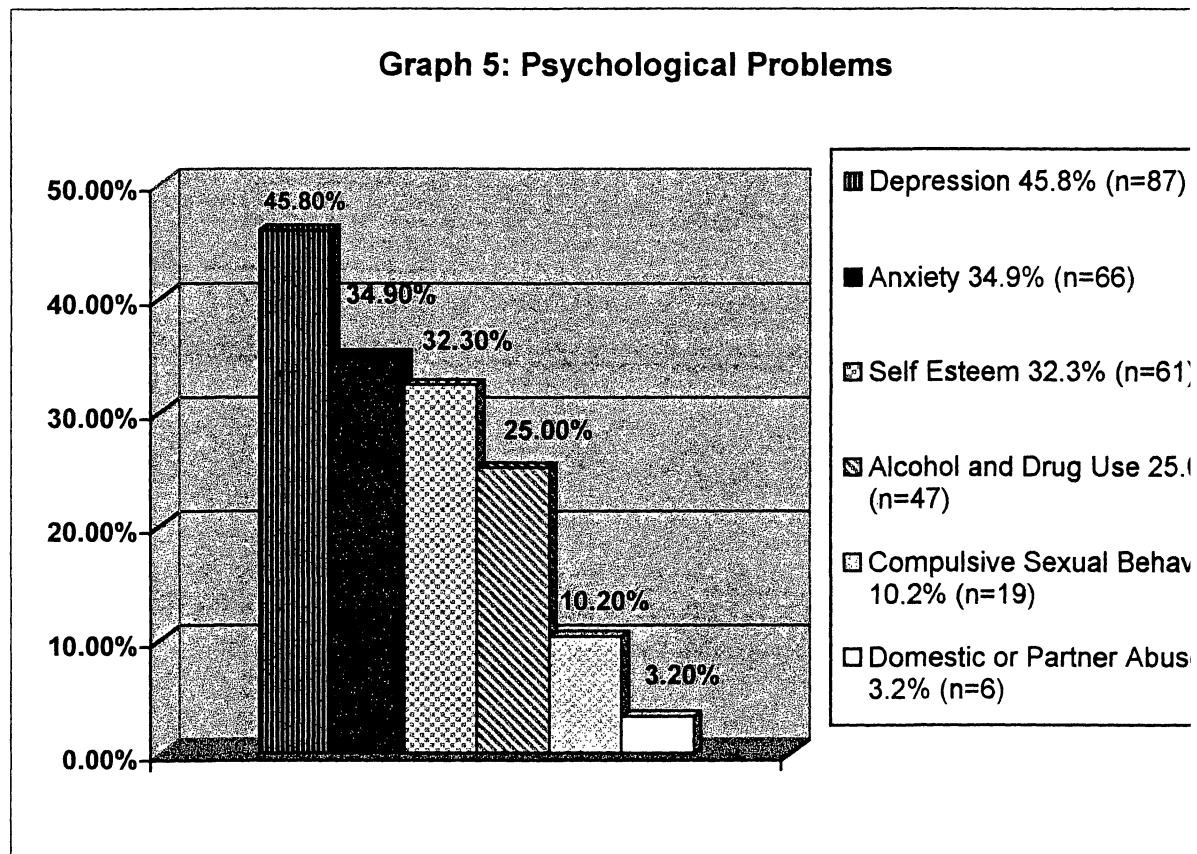
Graph 4: Anal Sex Outside of Relationship



A second question (Question #17) was asked, “If yes, did you use a condom?” (N=35).

- Yes (n=20) 57.1%
- No (n=15) 42.9%

Question #18: “Have you experienced problems in any of the following areas in the last year?”



Chi Square tests of significance ($p \leq .05$) revealed no reliable differences between the number of participants who reported experiencing a range of psychological problems and age.

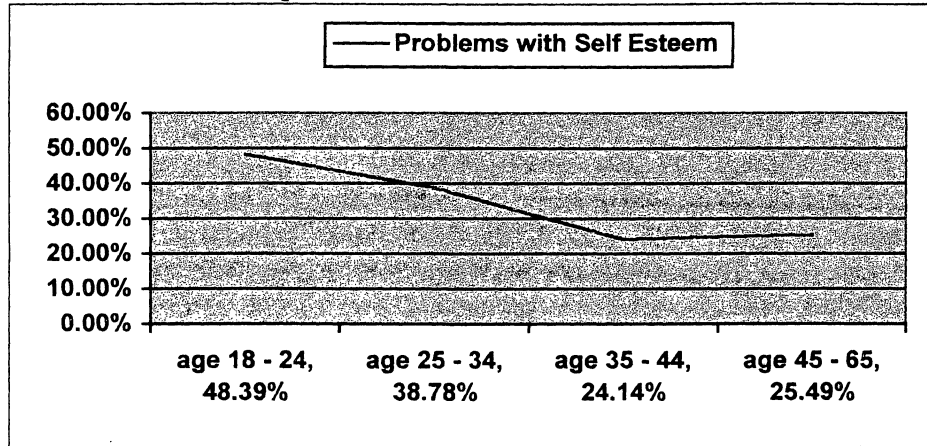
Self Esteem:

Approaching significance ($p = .059$) were differences in the number of men who reported problems with self-esteem related to age. It appears that fewer men between the ages of 18 to 35 report having low self-esteem than those who are 35 years of age or older.

- 18 – 24 year olds, ($n=15$, $N=31$) 48.39%

- 25 – 34 year olds, (n=19, N=49) 38.78%
- 35 – 44 year olds, (n=14, N=58) 24.14%
- 45 – 65 year olds, (n=13, N=51) 25.49%

Graph 6: Problems with Self Esteem



Question #19: “Are you in recovery or treatment for any of the following psychological problems: depression, anxiety, self esteem, alcohol and drug use, compulsive sexual behavior, and/or domestic or partner abuse?”

Participants answered as followed (N=176):

- Yes (n=32) 18.2%
- No (n=144) 81.8%

Question #20: “If yes, for which problem(s) are you in recovery or treatment?”

(N=24)

Answers were as follows: Eight participants mentioned alcohol, and 7 participants mentioned depression. Other responses included, “vigorous exercise-body image,” “bipolar,” “anxiety,” “drug addiction,” and “sex addiction.”

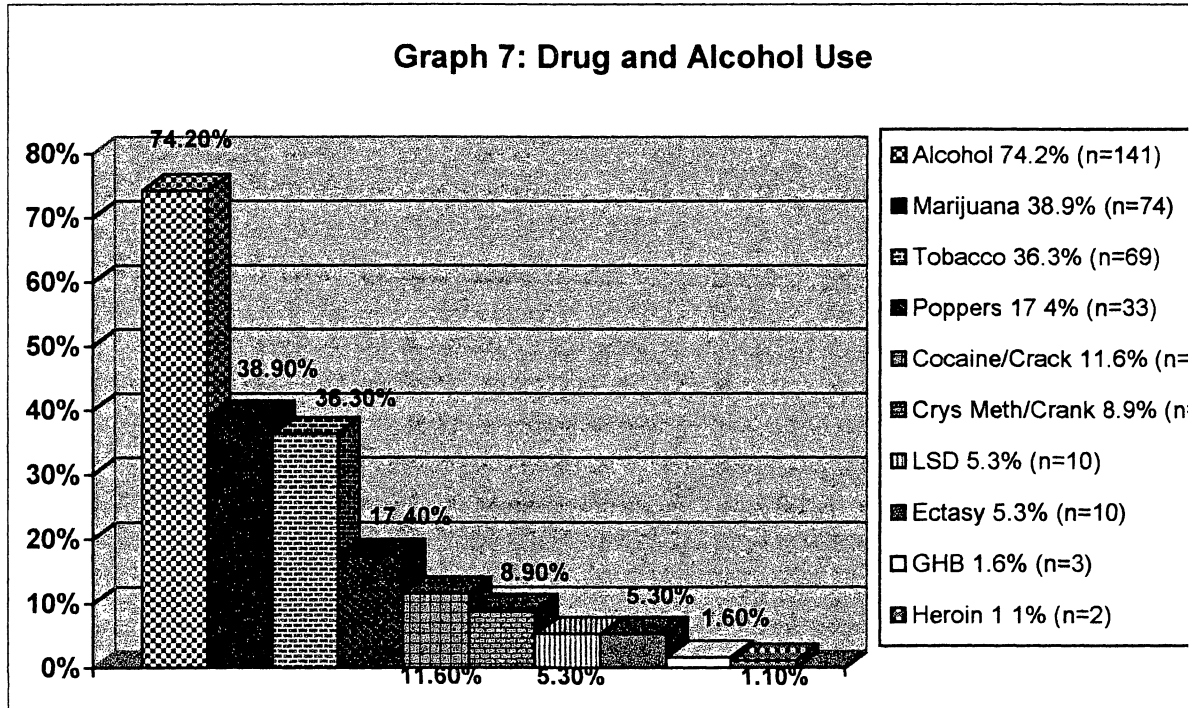
Question #21: “What about alcohol/drug use in the last year?”

Table 2: Alcohol and Drug Use Response

| Response | % | (n) | Total N |
|---|----------|------------|----------------|
| “Used needles to inject drugs?” | 4.3% | (n=8) | (N=187) |
| “Shared needles to inject drugs?” | 1.6% | (n=3) | (N=184) |
| “Have you ever felt you had to cut down your drinking or drug use?” | 30.3% | (n=57) | (N=188) |
| “Have people annoyed you by criticizing your drinking or drug use?” | 14.4% | (n=27) | (N=187) |
| “Have you ever felt bad or guilty about your drinking or drug use?” | 21.6% | (n=41) | (N=186) |
| “Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover? (or drugs)” | 7.6% | (n=14) | (N=185) |

Question #22: “In the last year, have you used any of the following recreational drugs?”

Participants were asked to circle all that apply. (N=190)



Question #23: “In the past year, how often have you had unprotected anal sex after drinking and/or using drugs?”

This question included a Likert Scale of “Never” representing 1, and “Always” representing 5. Nearly 33% of the participants have engaged in unprotected anal sex after drinking or using drugs. Responses are as follows (N=187):

- 1 never (n=125) 66.8%
- 2 (n=29) 15.5%
- 3 (n=23) 12.3%
- 4 (n=5) 2.7%
- 5 always (n=5) 2.7%

Question #24: “Before having sex with a new partner(s), how often do you talk

about safer sex?”

This question included a Likert Scale of “Never” representing 1, and “Always” representing 5. Approximately 31% of the participants always talk about safer sex prior to engaging in sex with a new partner. Responses are as follows (N=177):

- 1 never (n=32) 18.1%
- 2 (n=24) 13.6%
- 3 (n=34) 19.2%
- 4 (n=32) 18.1%
- 5 always (n=55) 31.1%

Question #25: “How comfortable do you feel talking with your partner(s) about safer sex and HIV status?”

This question included a Likert Scale of “Uncomfortable” representing 1 and “Comfortable” representing 5. Responses are as follows:

Safer Sex (N=183)

- 1 uncomfortable (n=10) 5.5%
- 2 (n=6) 3.3%
- 3 (n=31) 16.9%
- 4 (n=26) 14.2%
- 5 comfortable (n=110) 60.1%

HIV Status (N=179)

- 1 uncomfortable (n=12) 6.7%
- 2 (n=6) 3.4%
- 3 (n=32) 17.9%
- 4 (n=21) 11.7%
- 5 comfortable (n=108) 60.3%

Chi Square tests of significance ($p \leq .05$) revealed no reliable differences related to age and the level of comfort in talking with a partner about safer sex or HIV status.

Question #26: “What are your concerns about HIV testing?”

Participants were given a list of concerns and asked to check all that applied to them. Responses are listed below in a table format (N=190):

Table 3: Concerns About HIV Testing

| Concerns | % | (n) |
|-------------------------------------|-------|--------|
| Confidentiality | 47.4% | (n=90) |
| Fear of results | 33.2% | (n=63) |
| Waiting time for results | 20.5% | (n=39) |
| Satisfied with testing | 19.5% | (n=37) |
| Cost of test/money | 13.8% | (n=26) |
| Mistrust of Health Dept. | 12.1 | (n=23) |
| Lack of cultural sensitivity | 10.0% | (n=19) |
| Having blood taken/needles | 9.5% | (n=18) |
| Inconvenient location/times | 8.9% | (n=17) |
| Mistrust of those doing the testing | 8.9% | (n=17) |
| Don't know where to test | 6.8% | (n=13) |
| Don't care to know | 5.3% | (n=10) |

Question #27: “How long ago were you tested for HIV?”

Participants choose one of six optional responses to this question:

- 3 Months (n=39) 20.7%
- 6 Months (n=37) 19.7%
- 1 Year (n=36) 19.1%
- 2 Year (n=15) 8.0%
- Over 2 Years (n=43) 22.9%
- Never Been (n=18) 9.6%

Chi Square tests revealed no reliable differences between age groups and whether or not an individual reported being tested for HIV.

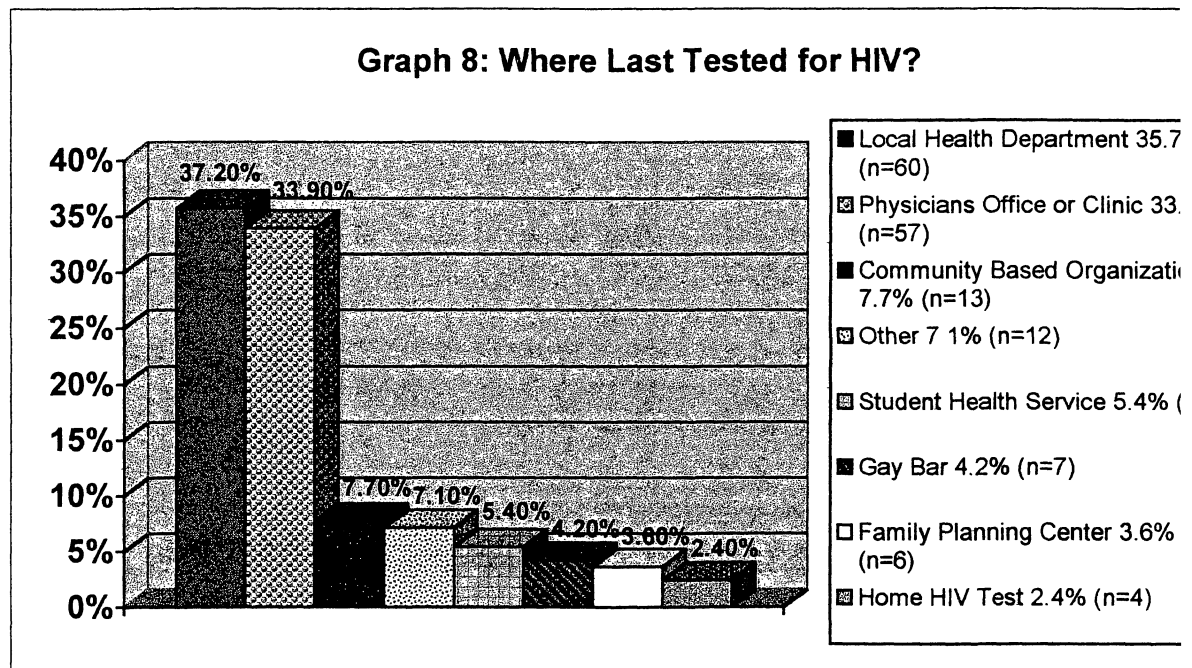
Question #28: “In the last two years, how many times have you been tested for HIV?”

Two-thirds of the participants had been tested for HIV at least once in the past two years. Responses are listed below (N=184).

- 1 Time (n=46) 25.0%
- 2 Times (n=33) 17.9%
- 3 Times (n=16) 8.7%
- 4 Times (n=8) 4.3%
- Over 4 Times (n=19) 10.3%
- None (n=62) 33.7%

Question #29: “Where were you last tested for HIV?”

Eight possibilities of HIV testing locations were listed, and participants were asked to check one response. Responses for HIV testing locations that were listed on the survey were reported as follows (N=168):



Other testing locations named by participants included:

- Out of state health department
- Jail
- AIDS council
- Mexico
- Emergency room

Question #30: “Do you feel at risk for HIV?”

Participants answered as followed (N=174):

- Yes (n=70) 40.2%
- No (n=104) 59.8%

Question #31: “Do you feel comfortable speaking with your health care providers regarding your sexual orientation or behaviors?”

Participants answered as follows (N=186):

- Yes (n=131) 70.4%
- No (n=55) 29.6%

Approaching significance ($p = .053$) were differences in the number of men who reported feeling comfortable talking with their health care providers as it related to age. It appears that more men between the ages of 18 to 24 are comfortable than those who are 25 years of age and older.

- 18 – 24 year olds, (n=25, N=31) 80.65%
- 25 – 34 year olds, (n=32, N=49) 65.31%
- 35 – 44 year olds, (n=39, N=56) 69.64%
- 45 – 65 year olds, (n=35, N=50) 70.00%

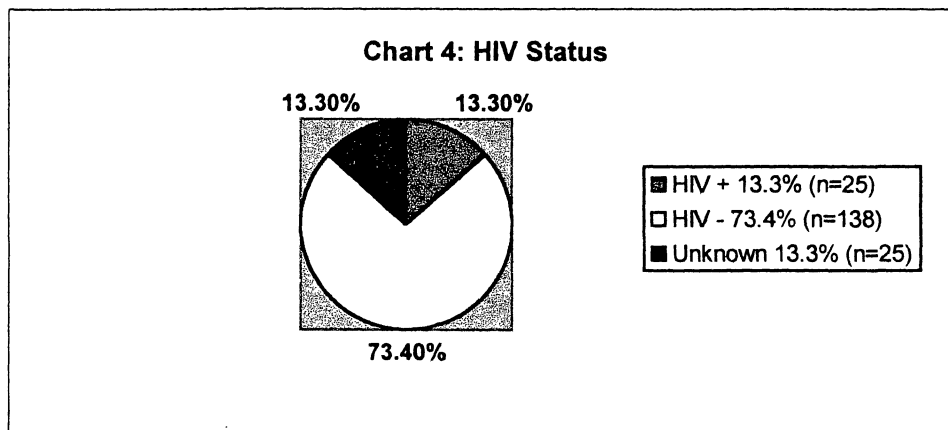
Question #32: “Have you experienced homophobia in the medical or health care setting?”

Participants answered as followed (N=182):

- Yes (n=52) 28.6%
- No (n=130) 71.4%

Question #33: “What is your HIV status?”

Responses are recorded in the following pie chart (N=188):



Chi Square tests of significance revealed reliable differences ($p = .001$) between the number of participants who reported their HIV status and their age. HIV positive status was reported more frequently by 35 – 65 year olds than by 18 – 34 year olds.*

Positive HIV status responses:

- 18 – 24 year olds, (n=1, N=31) 3.2%
- 25 – 34 year olds, (n=4, N=49) 8.16%
- 35 – 44 year olds, (n=9, N=58) 15.52%
- 45 – 65 year olds, (n=11, N=50) 22.00%

*(significance level set at $p \leq .05$; determination of whether or not the difference was meaningful was based on a minimum 10 % difference between HIV status category percents.)

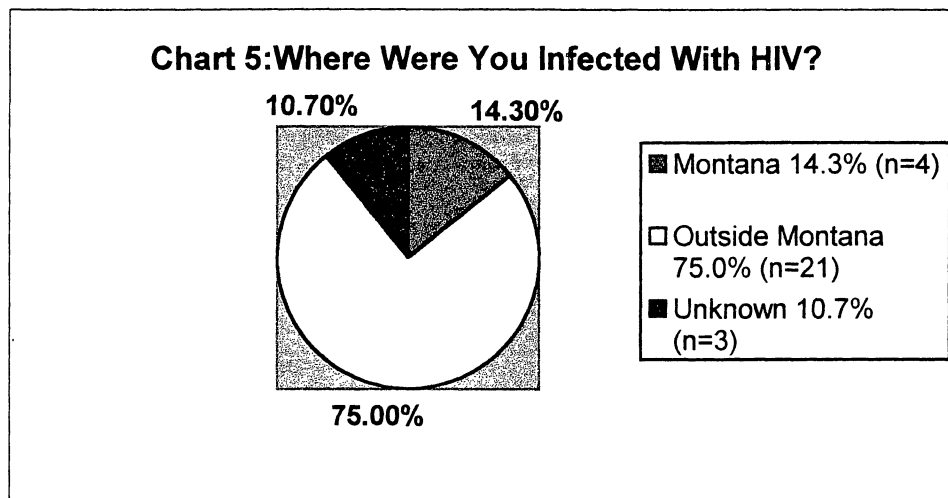
Question #34: “If HIV +, how long?”

- Range = 54 months (4.5 years) to 216 months (18 years)
- Mode = 192 months (16 years)
- Average Time Living with HIV/Mean = 138.12 months (11.5 years)

Question #35: “If HIV Positive, where were you infected?”

This question was designed as a follow-up question to “What is your HIV status.”

(N=28)



Question #36: “What is one thing we can do to educate gay men and help stop HIV/AIDS?”

This question was left open for an optional written response from participants.

Responses are as follows (N=89):

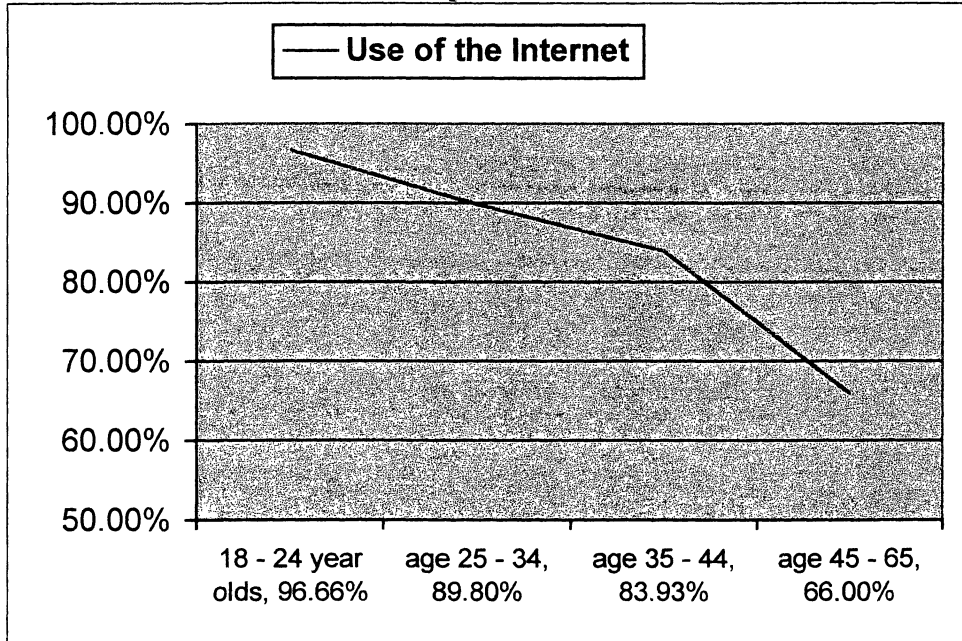
- Proper condom use and increased condom access (n=25)
- Education about HIV/AIDS and its relationship with drug and alcohol use (n=16)
- Increased communication in education (n=14)
- More publicity, specifically newspaper and television advertisements (n=12)
- Specific education for young gay men; comprehensive sexual education; homosexuality education as a unit of study with in the sexual education public school programs (n=11)
- Increase in counseling/outreach/support groups (n=5)
- Increased responsibility and self care (n=2)
- Increased education about gay men’s health (n=2)
- Increase in friendly doctors (n=2)
- More available testing (n=1)
- More funding for HIV/AIDS education (n=1)
- Joining the AIDS March (n=1)
- Finding a “cure” (n=1)

Question #37: “Do you use the internet?”

Participants answered this “yes/no” question as follows (N=185):

- Yes (n=153) 82.7%
- No (n=32) 17.3%

Graph 9: Use of the Internet



Chi Square tests of significance revealed reliable differences ($p = .001$) between the number of participants who reported using the internet and their age. Men in the 18 to 44 year old age groups were more likely to report using the internet than men in the 45 to 65 year old age group.*

- 18 – 24 year olds, (n=29, N=30) 96.67%
- 25 – 34 year olds, (n=44, N=49) 89.80%
- 35 – 44 year olds, (n=47, N=56) 83.93%
- 45 – 65 year olds, (n=33, N=50) 66.00%

*(significance level set at $p \leq .05$; determination of whether or not the difference was meaningful was based on a minimum 10 % difference in yes/no response categories).

Focus Group and Key Informant Interview Results

Several common themes evolved from the transcriptions of recorded focus group sessions and key informant interviews. These themes are presented and explored based on the perceptions of the MSM participants. Each theme emerged by a topic guided question (Appendix C). Each topic guided question asked during the sessions and interviews were reflective of the original research questions (Appendix H). The following sections are organized based on theme development. All data was analyzed as group data. A separate content analysis of focus group and key informant interviews revealed similar themes. Therefore, reported results reflect a combination of data from both sources. Comments from focus group participants are identified by [FG] while key informant comments are identified by [KI]. Only the most representative comments are reported in this results section. All statements, derived from the complete transcriptions and organized by themes, can be found in Appendix L.

Focus Group and Key Informant Demographics

Focus groups were conducted in Missoula, Billings, and Butte. The Missoula focus group consisted of 8 participants between the ages of 18 and 24 (younger MSM). The Billings focus group also consisted of 8 participants, and these men ranged in ages between 18 and 64 (mixed aged MSM). The Butte focus group consisted of 8 participants between 25 and 64 years of age, with the majority of men in the age range of 35 to 64 (older MSM). The key informant interviews were conducted with MSM participants who reside across the state. There were a total of

six interviews with MSM key informants. All demographics can be found in the following chart:

Chart 6: Demographics of Focus Group and Key Informant Participants

| Demographic | Descriptor | Valid Percent |
|--|---|----------------------|
| Age | 18-24 | 43.3% |
| | 25-34 | 6.7% |
| | 35-44 | 26.7% |
| | 45-64 | 23.3% |
| Race/Ethnicity | Caucasian | 86.7% |
| | Hispanic or Latino | 3.3% |
| | American Indian | 10.0% |
| Sexual Orientation | Gay Man | 90.0% |
| | Bisexual Man | 10.0% |
| Does Your Doctor Know You Have Sex with Other Men? | Yes | 50% |
| Highest Level of Education Completed | High School | 13.3% |
| | Graduate/GED | |
| | Some College | 53.3% |
| Employment Status | College Graduate | 26.7% |
| | Full-time | 50% |
| | Part-time | 25% |
| | Unemployed | 17.9% |
| What Type of Community Do You Live in? | Disability | 7.1% |
| | Urban Area (population over 30,000) | 76.7% |
| | Mid-sized Area (population 10,001-29,999) | 13.3% |
| | Rural Area (population less than 10,000) | 10% |
| Where Do You Live (Regions)? | Region 1 | 6.7% |
| | Region 3 | 23.3% |
| | Region 4 | 26.7% |
| | Region 5 South | 43.3% |

Themes Derived From MSM Focus Group and Key Informant Interviews:

Theme 1: Isolation

Isolation was characterized by the general perception of a lack of a support system. Sub-themes included social isolation, spiritual isolation, and geographical isolation.

A. Social Isolation

Social isolation was rooted in the existence of an underdeveloped MSM community. Participants reported the existence of small, fragmented social groups that often did not mingle with one another. Men socialized only amongst a limited social circle, or they reported limited socializing with any other MSM. Another common problem was having limited social settings to meet other men. Several participants complained that there were not enough comfortable environments, other than the bar, where MSM can go to meet other MSM. Although, the bar was seen as a central meeting place for MSM, complaints were frequently voiced about the bar being a place for meeting casual sex partners, rather than a place to meet a long-time partner or a good friend.

- *What gay community? I really don't see much of a gay community. I probably run in the same group they do, which is always showing up the same people. [FG]*
- *I feel that the gay community is really divided and secretive. [FG]*
- *Lots of people are lonely, but I think, even more so in the gay community. They're just not connecting...they're not connecting with other people. And some people don't need to. Some people are just naturally loners. But I think that connecting issue can build community and knowing you'd have a sense of belonging to it. [FG]*
- *I would say for social reasons, there are a lot of biases towards Native Americans and so I just choose not to take any part in anything (community). [KI]*

B. Spiritual Isolation

Several men felt that spirituality was important in their lives, but found no organization or place where they felt comfortable to express this spirituality with others. Other men spoke about feeling spiritually abandoned by their religions and churches because of their sexual identity.

- *I think gay men are spiritual but there's not many avenues to be able to explore their spirituality. So the issues are trying to find answers to questions. [FG]*
- *There are several churches, or a half dozen, that are really affirming. And the problem is that most people don't jump denominations. If they grew up in their church that is very repressive they don't often leave it just because of that. [FG]*
- *There are a couple of churches in Missoula that are openly affirming. I've gone to one of them. It's nice. It's like it's a step, it's a beginning. But I haven't heard them addressing issues or being more open about it just in sermons.....acceptance versus simply, "okay, I guess we're open and affirming, but we're not really going to talk about it." [FG]*
- *I think a lot of gay men feel alienated from spiritual traditions. And sort of have had to craft their own or leave their home communities, their churches, and the places where they feel spiritually grounded. And so it's a sense of isolation from a larger community. [KI]*

C. Geographic Isolation

Geographic Isolation was based on the limited availability of and attendance at social engagements due to the rural nature of the state. Montana has a lot of land and a small population, making it difficult for MSM to connect with other MSM.

- *Geographic obstacles (to accessing HIV prevention treatment services in MT). I mean I traveled 600 miles. [FG]*
- *I would be leaving the area because of the lack of population (to find a gay community). [KI]*
- *In any rural city you really have no support system or no friends. And so the social side of it, having other gay friends helps a lot because*

they know where you're coming from. In rural Montana you don't have that. Or you have, if there is another out gay man in the school or in the community the chances are fairly slim, that either that person will be too old for the person to connect with or they're not just meant to click personality wise or whatever. But in any of the more urban areas, the chances are higher that you'll find a friend that you can connect with. [KI]

- *Montana is such a small town place. Even cities get to be that way after a while, but you don't have any anonymity here. You can't explore other facts of your life nearly as easily, so my experience growing up here, granted it was a long time ago was that what neighbors thought and saw was one of the most important things. [KI]*
- *If you're a single gay man, regardless of what your health status is, there's generally a sense of isolation, not finding a community. That seems to be what I hear most from gay men. And a lot of gay men in Missoula and Billings come from small towns where they felt totally isolated. And the only reason they're here, well one of the principal reasons is because there is more of a community. [KI]*

Theme 2: Homophobia

The vast majority of participants spoke about the effects of homophobia. It was evident that the participants felt that this homophobia was reflective of the community's view of MSM.

- *Homophobia is an issue that affects gay men. I believe it's getting worse with the AIDS scare, you end up feeling like you belong to a leper colony. [KI]*
- *I think there's a certain amount of paranoia that stems from the homophobia or the possibilities of homophobia that there's a fear of being accepted as a human being. [KI]*
- *In reality it's an oppressive society. And it's not just here. But you're constantly told it's right to be straight...there are very few places where you can be gay. Where you can openly show affection if you choose to or not and feel comfortable doing it. And so you're constantly going against the flow. There isn't a gay section where you can just go and be gay. [KI]*
- *I think there's always been an implicit threat that men having sex with men is either illegal or socially not sanctioned. So whether you're gay, straight, bisexual, whatever, the idea of having sex with other men is taboo. It's like the sense that what you're doing, whether you're an out person or not, the sense that what you're doing, who you are inherently, is antisocial or not deemed as socially acceptable.*

That's the biggest problem. [KI]

- *There's really no way, in my mind, there's no way of gauging the truth of fear. If you're experiencing fear, if you're afraid of being bashed, if you're leaving a bar or something. That (the fear) is a reality. [KI] Whether in fact there are people lined up at the outside of the bar with sticks or not. [KI]*

Theme 3: Stereotypes

Several MSM mentioned that trying to follow or break out of the stereotype of a gay man is a challenge. Participants viewed this stereotype as a problem that is fueled by the gay media, and by the ideals of gay men themselves. The following statements reflect this issue.

- *It's just like any social thing where people are drinking or doing other things, your self-image, your body image, especially gay men, it's just as bad as young women who are fed, you should look a certain way. This is what you should attain to have. Certain measurements and most of it are never attainable for the average person. And we are very much fed that, even in national gay magazines. This is what we are fed. This is what we should look like. This is how we should act. This is what we should have. [FG]*
- *They don't help any with all the ads with these healthy people running around, climbing mountains. [FG]*
- *And when you look in the ads in like the national press with the AIDS cocktails and everything, you always see these Jim Buff guys. They're all looking healthy. [FG]*
- *I think the gay community is pretty stereotypical. Most of them, if you don't have the perfect body, you don't have the perfect mind, or the perfect personality, smile, whatever, appearance, they look down upon you. And there's an attitude that goes along with that. [KI]*

Theme 4: Drugs and Alcohol

Drugs and alcohol, it was often stated, were used as a way to escape low self-esteem issues, and thus, as reported, to make it easier for MSM to meet each other

and to engage in sexual activities. MSM commented that using drugs or alcohol helped them accept themselves and to forget their differences and lack of acceptance from the whole of community.

- *I think because sometimes when you meet somebody you figure, well I'm only going to see this person for maybe once, maybe a few times and let's make the best of it and do what drugs we can that might enhance the experience. [FG]*
- *A lot of the guys that I know, a lot of times they're drunk when they have sex and they just don't use anything or they'll use that as an excuse...we're getting way into it so I didn't have time to get a condom or whatever. [FG]*
- *A lot of men won't have sex, even with their boyfriends unless they're drunk. [FG]*
- *It's a guilt factor for a lot of people. They have to get drunk to get over that guilt. [FG]*
- *With the new bar that has opened up, it's sort of the, it's a rave bar. Sort of the dancing disco scene. I guess I should have figured with this new bar. But in a public setting. Or just having all your sense enhanced. A new feeling that maybe appeals to the gay community more. [KI]*
- *Gay men are used to being secretive to survive growing up in your youth. You have to. And drugs and alcohol, that can keep things repressed. They help you not feel your feelings. [KI]*
- *I mean, I think there's always been drug abuse, alcohol abuse in the gay community. And there's no denying that. The primary pickup place is the bar where the liquor flows and the drugs flows. I don't think that has changed any. For a while it felt like after sort of public information on HIV went up, the gay community responded by treatment groups, lots of information. But I think that that's kind of on the wane now. And places like Montana where the information is never really heard, and where drug abuse has always been a factor...I just wonder how, if people really have the right information. [KI]*

Theme 5: HIV Testing Issues

A general lack of confidence in the professionalism of HIV testing sites was an overall theme displayed by the focus group and key informant participants. The major sub-themes are as follows: a lack of confidentiality, an increased fear of testing due to

an uncomfortable atmosphere or a homophobic medical atmosphere, a fear of results, a lack of a support system, and a lack of HIV testing awareness.

A. Lack of Confidentiality and Lack of HIV Testing Sites

Several men shared personal HIV testing stories that gave examples of breached confidentiality. A general lack of trust in confidence of health care professionals is apparent from the focus group and interview data. A lack of testing sites in the more rural areas was a commonly expressed problem as well.

- *I don't even believe in confidentiality because all it takes is one person in the chain to break the chain. [FG]*
- *It's the rural nature of the state. Just eastern Montana, where there's basically nothing (is the greatest obstacle to HIV/AIDS prevention treatment services in MT). [FG]*
- *I think if you're in a small town and even if there was free HIV testing or whatever, I seriously doubt...well, you'd be scared. I mean, you'd have to drive to Billings or drive to Great falls or Missoula or something. Some place where you're not likely to be known.*
- *The fear of people talking. And I speak from rural Montana, there's a tendency that in some of the clinical situations tongues wag and words get out. [KI]*
- *Well from a rural area, small town, other reservations I know, the main thing is confidentiality. Some men are concerned about it. And the ones who are (concerned) are usually the ones who are always labeled as being positive...whether that's true or not. [KI]*
- *As far as I know, the Health Department gives out free tests. But I think they told me there was no confidentiality. [KI]*

B. Fear of Testing Results

Increased fear of testing was the biggest theme that emerged from this data—MSM don't want to know if they have HIV. Several participants were concerned that men who may not identify as gay or bisexual don't have the

knowledge or access to HIV prevention.

- *There are a lot of people that don't want to know. [FG]*
- *They're afraid. Maybe they're afraid of the diagnosis maybe. [FG]*
- *They're really scared to find out. They don't really want to find out. And so they don't get tested, even though they know that it's free or it's anonymous. Even if there's counseling offered afterwards. They still don't want to know...I think a fear factor is an issue in getting tested. [KI]*
- *In the rural areas, or even across the state the stigma, the fear of getting diagnosed, and the fear of what would follow that would be put on you. I think that's an obstacle for getting tested. People don't want to deal with that, and so they won't get tested. [KI]*
- *The most at risk men don't go and test. And I think it's not just those external factors, it's the internal factors too. Being afraid...of finding out. Having to change behaviors or not wanting to be responsible for themselves. [KI]*
- *And I would guess bigger concerns would be that you just don't want to know. That you don't want to deal with it. [KI]*

C. Lack of Awareness

A common theme expressed was the need for more advertised testing. A lack of awareness as to where to get tested was an issue for the participants, especially the younger men. Some men suggested that HIV counseling and testing should be promoted amongst the community at large, especially in rural-small town areas.

- *When AIDS peaked and there was all that publicity, awareness, everything was out there at the time. Get tested here. Get tested there. You could hear it on...all your public service announcements... And then boom. You noticed the decrease as the meds come out and all that. There were less and less deaths and less and less awareness. And I think that's where we're sitting today. The less deaths we have and the less new cases we have, you're seeing a change in the awareness that's being put out there. [FG]*
- *The fact that so many of these people are hidden. They're closeted and nobody knows who they are. And so many of them don't know the first thing about AIDS prevention. And there's really very little way of*

reaching them. How are they going to get testing, if they can't be reached? [FG]

- *I think it's just the lack of information. I don't think most men really know where they can actually get the testing done. In small towns we do have a few different places that will do it. I think it's just the fact that people don't know. [KI]*
- *Access to testing is needed. To know that it's confidential and that there's going to be support on the other side whatever the results are. [KI]*

Theme 6: Safe Sex Issues

Participants identified a lack of condom availability and usage, a lack of communication, and beliefs about safer sex as the major themes in regards to safer sex issues. There was a definite sense of a lack of safe sex promotion, and a sincere concern for sexual education programs not teaching the “reality” of sexual issues or homosexuality. This is an underlying problem seen throughout each of the following themes:

A. Lack of Condom Availability and Usage

Condom use was the number one response when MSM were asked what they do to protect themselves against HIV. Unfortunately, several men commented on how other MSM are not performing safe sex. Following this response, condoms were often “attacked” or the condom campaign efforts were negatively questioned. There was a general need for more access to condoms, especially in the smaller towns. The main issue with condom access is the need for private and free access, and advertisement as to where to find the condoms.

- *I think that people that don't go to places that give them out (condoms) might find a lack of availability. And if you're living in a small town you're going to have a problem. [FG]*
- *There are some people that won't even buy them in a grocery store. They're afraid somebody will see them. And if they're afraid to be seen going into adult bookstores, they're the ones we have to find a way of reaching. It's a privacy issue. [FG]*
- *It's not romantic (to use condoms). [FG]*
- *How about the over 50 that has a wife...how's he going to justify buying condoms? [FG]*
- *The fact that the common knowledge is not that there's medication that you don't have to, I mean, this is kind of like hearsay. But that you don't have to use any kind of protection because there is medicine.*
- *I don't think the condom campaign is very effective. I think there's plenty of condoms out there, but people just don't know where to get them. I don't think the "always use a condom" message is effective at all. [KI]*
- *In checking the Internet, a trend that is returning is bare backing, which means anal sex with no condom. [KI]*
- *They don't want to deal with the inconvenience of getting condoms, keeping condoms around. You know, putting them on and then having to have sex with them. And I don't think there's any, there's never any real information attached. [KI]*

B. Lack of Communication

Many participants noted that during sexual encounters, HIV status communication usually happened during foreplay (if it happened at all), and that communication was limited. It was also suggested a few times during the focus groups that MSM might be lying about their HIV status to sexual partners before engaging in sexual acts.

- *It can be brought up (communication before sexual behaviors), but it's really not taken seriously. From what I hear, a lot of things that some guys do tell me is they say when it is coming up someone may say, do you have a condom, or do you have anything? And then a lot of times what I hear is they may just say no, or no, I don't have one on me. But then again that's just kind of set aside after that and it's not...they go ahead and they engage in sex. [KI]*
- *Most men I know protect themselves against HIV by rejecting anyone*

who's positive without knowing that a third of the people don't know they're positive that they're being sexual with. That's where I think the denial thing comes in too. It's like if I keep away from it...I don't want to know any more than I have to. [KI].

- *They're afraid. They don't want to know. Negative people assume the other person is negative unless they say something. And positive people assume they're positive unless they say so. I think that's breaking down a little bit. And I do think people talk more than they used to. [KI]*

C. Beliefs About Safer Sex

Participants discussed behaviors and perceptions of reducing the risks of HIV transmission through safe sex. The following sub-themes emerged—oral sex and withdrawal beliefs, transmission and cure beliefs, and the rural nature of the state of Montana and how this relates to safer sex attitudes and ideas.

C1. Oral Sex and Withdrawal Beliefs

As far as oral sex is concerned, most participants reported that they know men who do not perform protected oral sex, or oral sex was used as a way to reduce the risks of contracting HIV because it replaces anal sex.

- *The other thing you are fighting is the age-old thing. A hard on has no conscience. [FG]*
- *Or they'll restrict, they'll do only oral sex. [FG]*
- *I don't think the average gay man knows withdrawal is safer than coming inside the person. There are ways of doing harm reduction around not using a condom. [KI]*
- *I know very few people who have protected oral sex. Gay or straight. And actually, I'm surprised at how many people are shocked at the idea that you would even need to have protected oral sex. [KI]*
- *I think people really want badly to believe that there is little or no risk with oral sex. And people also really badly don't want to deal with it. [KI]*

C2. Transmission and Cure Beliefs

Several participants reported that there is a lack of correct information about HIV transmission and that some men are believing false “cure” information.

- *They're young and they figure that a cure or major treatment is right around the corner, so why worry about it. [FG]*
- *I've heard that some people think that AIDS is controllable now and you don't have to worry about it. [FG]*
- *There are all these medical breakthroughs with controlling the HIV virus and you increase the time people can live with it. And also there's the possibility of finding a cure for it. [KI]*
- *I was shocked actually recently to hear from a guy my age that he actually just; he would eat somebody's cum. And I thought, wow, you know, ten years ago, fifteen years ago I was warned that that's not a good thing to do...and his response was, "oh, the virus is actually quite weak. Your pancreatic juices, your stomach juices will kill it." I thought, why even take the risk? That just seemed like unsafe behavior. And I was shocked. He was a guy who was my age, he's been around. Probably had the same access to the same information I've had. So I think there's still some ambiguities about what's safe and what isn't safe. [KI]*

C3. Beliefs About Safer Sex—The Rural Nature of Montana/Low Incidence State

Due to the rural nature of the state of Montana and the low incidence of HIV/AIDS persons found in the state, several men made statements based on the belief that Montana is a safe haven from the HIV virus. Therefore, it is believed that Montana is a safe place to practice unprotected MSM sex.

- *There's this idea in Montana that you're safe (from HIV/AIDS). It's not up here. [FG]*
- *I've heard someone say, well, you know I'm not worried about safe sex because they're from Montana. [FG]*

- *Some men only have sex with other guys in Montana. They think that's going to protect them. [FG]*
- *I think there is some truth in Montana that we're a rural state, not a lot of people, so there won't be a lot of cases of HIV and AIDS so they (MSM) don't think they would ever get infected. So I think the rural thing plays a part like the chance are very low that it would ever happen to me and so they don't practice safe sex. Another thing that might be too on the reverse side is that they want to get infected with HIV so they don't have to worry about it. [KI]*

Theme 7: Older MSM Perceptions of Younger MSM

Two opposing ideas arose in this theme—a lack of awareness and knowledge about HIV/AIDS, and immortality. The first theme reflects a great concern about the younger MSM generation not having enough education, knowledge, experience, and expertise. Having not lived through the peak of the HIV epidemic, there is a fear that the younger generation will begin a new wave of the epidemic. It was mentioned that the younger generation is still experiencing an “invincibility” stage and that they are not practicing safe sex. In opposition to this idea, it was also mentioned that perhaps the younger generation has learned from the mistakes of the older generation and as a result are more cautious when it comes to practicing safe sex.

A. Awareness and Knowledge

Most men reported that there is a need for accurate education programs. There is a general concern for the younger generation of MSM and a demand to provide awareness to all MSM, especially the young men. Opposing this view, there were also a portion of participants that believed that the younger generation has a wealth of knowledge and that they have learned from the history of the epidemic. The internet was cited as a major provider of information for MSM

(especially for the younger generation).

- *With the Internet, I think kids in a way are much more sophisticated. You've gone from so many things are covered, so much more media. I think that one of the main things you're battling against is that I'm 16, 17, and I'm going to live forever. That whole, and that's always been going on. But I think kids are a bit more sophisticated. They have the ability to get the information on their own if it's provided. [FG]*
- *And of course my concern is the age of sexual awareness is also the age of intense social rebellion against parents, authority figures. So I just think people need to know that they have options other than killing themselves and killing their partners. And that this (AIDS) is a killer. This will in fact take their lives. [KI]*
- *The younger ones (MSM) I've worked with are more well aware. They have, their values are a little bit stronger. They do have a tendency to stick to them more. I believe personally it's just because from growing up, hearing it most of the time. That's just how I view it because for me when HIV was first discovered in like eighty something, I was really young. And I hear it throughout my life. And then it just stuck with me, and a lot of the other guys my age and younger, we've kind of always, we talk about that and we know, we do remember all of that. [KI]*
- *My biggest concern is younger people, high school aged kids, college kids, who I think have really fallen through the cracks. I think in general terms they're healthy or they think they're healthy and they probably don't know as much about what options there are. So that's the community I'm concerned about. I think my generation, people who in some ways have outlived the initial scourge of AIDS and HIV, I think we know what medical care is about, we know how to get information and most people are educated enough. [KI]*

B. Immortality

It was believed by several, mostly older, participants that young MSM are at risk for HIV due to their natural sense of immortality.

- *I think older guys have seen the wave of death that the HIV virus brought. The young kids don't feel that, nothing is going to kill them. [FG]*
- *I think some of it is probably self-denial with younger people. They're young and they figure that a cure or major treatment is right around the corner, so why worry about it. [FG]*
- *And young gay America, they're expecting to live a long time and to*

possibly see the cure, and so they don't really care if they get infected because they think something later down the line will save their lives from it. [KI]

- I was in San Francisco...people died. That's ten, fifteen years ago. Half the guys coming out right now have never seen anyone (die of HIV). Or the drugs (HIV drugs). They (youth) have no idea...they don't know anyone with HIV probably here in Montana or what they go through if they're on drugs, which the majority of the people, I think the majority of people with HIV are on some kind of drug...side effects...and the impact on your physical body. You read the articles and it sounds like, "Well that is not that bad is it?" The invincibility of youth. [KI]*
- Maybe it's because of the thought that there are drugs out there that if they get infected they're going to be fine. I don't know if there are people with a kind of devil-may-care kind of attitude. With my generation I think a lot of us have lost friends and so we're more likely to know how precious life is and how fragile life is. But I think with younger people who have not had that loss, who don't know anyone who has died, who are coming out of the closet and don't have the information to know what safe sex is, I think they're just taking risks. It's all teenagers. It's the younger people. Invincibility. [KI]*

Theme 8: Strategies for Prevention

Each focus group and key informant described an unusual information/message network amongst the MSM. Even though social groups are small and fragmented, these groups still overlap and thus an informational network has formed. This network seems to serve as the primary way MSM educate themselves, learn the latest information about health services, state and local gossip, what events are happening where, etc. There is an obvious need for more education amongst the MSM community, and more education for all children in the school system. Advertising safe sex through various techniques was an emphasized suggestion. Several men made comments about how to increase the support and communication between Montana's MSM.

A. Education

The major strategy found amongst the participant data was to educate the whole community about sexuality and HIV—this is focused as a community issue, not as a gay issue. Sexual education should be truthful and thorough (including homosexuality) and should begin in the school system, which in turn would help strengthen a weak MSM support system. Education should utilize the holistic health model and should continue within the community.

- *I think the abstinence program has hurt sex education in the school districts worse than anything else. Because they say, oh we're teaching sex education. But they're not teaching 60 to 75 percent of the kids that aren't abstaining. [FG]*
- *I think you should be talking to high school kids because it's a whole different world than it was ten years ago. [FG]*
- *I think it's our bureaucracy that prevents people from accessing. We can't get knowledge into the schools. [FG]*
- *I think that prevention is education and I think that without having people reiterate over and over and over again, people don't learn. They hear it. But they don't learn it. [FG]*
- *Even if they don't give out condoms, I think they need to educate a lot of people. Education is probably equally important to just giving out condoms. How to use them, what your risk factor is. [FG]*
- *Even though it's fallen by the wayside, continue the education programs. [FG]*

B. Advertising

Advertising and a safe sex promotion campaign was also a common theme. These campaigns must have a high sustainability and utilize various marketing strategies over time. The general notion of a media marketing campaign that targeted the public and that utilized various outlets such as television, radio, billboards, books, posters and pamphlets was the main theme

of this section. It was also suggested that homosexuality be presented to the public in a more “normal” way through this advertising (and through in-state school education). A few participants interviewed had suggested that the MSM population needs a famous leader to provide public service announcements and to help guide the younger generation. Comments about giving the true facts of HIV through the media were also a suggestion.

- *There needs to be more community advertising. Posters and pamphlets. I think they could use something by a TV (television).. [KI]*
- *The billboard and TV, through the local channels of commercials would be good because anyone would have a TV. So targeting the local television stations and buying airtime for commercials that would be a plus, and the radio too. Through those media it would help with awareness. [KI]*
- *And for the access thing, I guess for the most part, Montana is spread out enough, there are big cities at least that whatever portion of the state you're in you're at least an hour and a half or two hours away from a big city. A marketing campaign or a media campaign I guess would be a really good thing to go about doing. That would be the best bet since we are so rural. [KI]*
- *I would seem to me that all the ways that it's (advertising information about safer sex) coming from now, all these pamphlets that are getting printed and you know, I guess there aren't a lot of commercials on TV any more. There never really were. It should be, maybe it should be entirely an information campaign and not like a behavior changing, don't do this. Less preachy. And I also think the other problem is that sure, there are all these ads and there are all these pamphlets and a lot of messages saying always use a condom. Then you turn on the TV and you watch a sitcom and you know, it's really funny. And then the couple hooks up after the fighting or whatever, and they fall into the bed and it fades to black. Or they struggle under the blankets and it cuts to commercial. But they never show them reaching for a condom. They never say, "Should we have safe sex?" No one ever says, "Oh, I'll only have sex with you if it's safe." There's none of that. Meanwhile the government is buying anti drug plots in sitcoms. [KI]*

C. Information-Networks

Participants strongly suggested that there is a need for more gay male

leaders to work in HIV prevention, and this would then help build a stronger MSM community. Participants provided suggestions on how to utilize communication tools and networking tools to strengthen the MSM population. This sub-theme is separated into the categories of Internet and “other” types of networking.

C1. Internet

The Internet is reported to be a common tool used to connect MSM.

The participants referred to the Internet most often as they discussed the behaviors and knowledge of the younger MSM.

- *With the Internet, I think kids in a way are much more sophisticated. You've gone from so many things are covered, so much more media. I think that one of the main things you're battling against is that I'm 16, 17, and I'm going to live forever. That whole, and that's always been going on. But I think kids are a bit more sophisticated. They have the ability to get the information on their own if it's provided. [FG]*
- *With the Internet and the chat rooms and everything, its one thing. It allows you to be anonymous. And you don't have to go to like the bookstore, the bar to find someone to have sex with. You can go into the chat rooms and find someone of interest and so, they don't, you know. You've got to kind of wonder why the condom use is there. And you figure its, because they certainly aren't available. You can't pick them up on-line. [FG]*

C2. “Other” Networking Techniques

Other networking techniques included support groups, retreats, discussions, educational retreats, and socials. Participants suggested using MSM leaders to organize and maintain networking systems. It was also suggested that attempting to change the political ideals that surround MSM

would help support and unite MSM participants.

- *They could do things like the health retreats or the men's groups or that type of stuff too. Give an outlet for guys to have a chance to meet other guys without having to go to the bar to have that other outlet because I think that will create a healthier person if they have some other outlet, other than just the bar. [FG]*
- *Discussion groups (are needed, as a way for support). [FG]*
- *I think we need more actual peers, gay men to do the testing. [KI]*
- *Hire more out gay men. I think that would be one of the biggest steps to making it a safe place, for gay men to be involved, to be okay with being gay and out. And I think that would increase gay men's participation and gay men's self esteem. My biggest thing is building a community. It helps people that say are in the closet feel better about themselves. [KI]*
- *Political involvement. To me the best way to get rid of those emotional, mental, and spiritual issues, the best way to get rid of the social issues which would possibly even...we wouldn't even need to target MSM any more, would be visibility and equality. [KI]*
- *As long as politicians keep telling gay people that they're a problem then they're subversively contributing to the problem. They're making people feel alienated. They're making them feel like who they are and what they do is wrong. And therefore people will do whatever they want. And even at the expense of their own health....so it's getting the right information out there. [KI]*

A Comparative Look at the Similarities and Differences Between the Focus Group Results and the Key Informant Results

Similarities

Focus group and key informant participants both:

- Shared an underlying theme of a general homophobic society that centralizes all other themes. In addition, the ruralness of the state of Montana also contributes to the heightened non-accepting society and a divided, small, isolated MSM community results.
- Noted that emotional distress is born from this isolation (explained above).
- Looked unfavorably on the bar as a central meeting place for MSM; thus contributing to the sense of a fragmented, unsupported gay community.
- Viewed drugs and alcohol abuse and use as the main reason for risky sexual encounters.
- Expressed that the greatest concern of an HIV testing issue was the breaching of confidentiality.
- Spoke of a lack of public awareness of HIV/AIDS issues
- Emphasized the need to further educate MSM.
- Established that there is a great need for an overall education/awareness strategy that would provide the entire society with an introduction and acclamation to homosexuality.
- Discussed the active network of MSM that shares information amongst one another through an informal chain of communication where men gossip, find out about health services, and educate themselves (whether this education is correct or not).

Differences

- The focus groups dwelled more on the idea that a severe lack of community stemmed from the geographic isolation that the state provides.
- The focus group participants emphasized the use of the Internet as a way to connect with other MSM
- The key informants elaborated on the sense of fear that arises when testing is an issue. These concerns are based in fear of homosexual exposure, and fear of the HIV testing results—a negative problem, especially if there is a reported lack of community and support.
- The key informant interviews focused on depression's link with drugs and alcohol as a low-self esteem outlet.
- The generational differences between the younger and older MSMs are made apparent by the (approximate) twenty-year difference between today and the peak of the HIV/AIDS epidemic in the 1980's. The key informant interviews explained this phenomenon and its affects more so than the focus groups.
- The younger generation of MSM use the internet more often than the older MSM.

CHAPTER V

The purpose of this study was to conduct an HIV/AIDS prevention needs assessment with the MSM population in the state of Montana. Both qualitative and quantitative data were collected. Quantitative data were collected via The Gay/Bisexual Men's Health Survey, while qualitative data were collected via key informant interviews and focus groups with the target population.

Discussion of Results

Survey Results: Key Findings

Anal Sex: Results from the survey revealed important information regarding the prevalence of behaviors that put men at risk for HIV infection. One of these behaviors, anal sex, is of particular concern because it is the behavior that is responsible for most HIV infections in MSM. In the survey, 80% of the participants reported engaging in anal sex. While this information in itself is not cause for alarm. What is noteworthy, is the fact that nearly 58% of respondents reported that while they sometimes or usually wore a condom, they did not always wear a condom when engaging in anal sex.

The reasons given for lack of condom use were varied. The most frequently offered reason for not using a condom was, "He was my regular sex partner" (24%). This response, and the second most common response, "We were both HIV negative" (18%), can be seen as practices that reduce the possibility of HIV transmission. However, the next four most frequent responses do not reflect safer sex or harm reduction practices. Following is a list of those responses: "The sex was exciting" (11%); "I am HIV negative" (7%); "He said he was HIV negative" (5%); and "He did not want to use one" (4%).

Sex Outside of a Relationship: Another issue that is particularly relevant to HIV transmission is the number of men who have anal sex outside of their relationships. Nearly 63% of the men surveyed reported being in a relationship.

Of those men in a relationship, about one-third of them reported engaging in anal sex outside of the relationship. It is important to note the fact that nearly half of the men having sex outside of their relationship reported that they don't always use a condom.

Oral Sex: Oral sex is a common sexual practice that puts men at risk for HIV infection. Approximately 82% of survey participants reported engaging in oral sex. And, while the risk of infection is lower for MSM who engage in oral sex rather than anal sex, the risk still remains. It is therefore, important to note that over half of the participants reported receiving their partner's cum in their mouth during oral sex.

Substance Use: Not surprisingly, participants reported high alcohol use (74.2%), and moderate use of various drugs, mostly reporting tobacco (36.3%) and marijuana (38.9%) use. Nearly 33% of the participants have engaged in unprotected anal sex after drinking or using drugs.

Additional Findings: Other survey findings of importance include reported Internet use and suggested prevention strategies.

Internet Use: Among younger MSM age 18 to 44 Internet use was quite high (90.1%). It was significantly lower (66%) among older men age 45 to 65.

Suggested Prevention Strategies: When asked for suggestions on how to stop HIV/AIDS and what professionals could do to help gay men, participants responded with the following general ideas: education of MSM population and educational programs in the public school systems; promotion of education, testing, and MSM support systems; fostering an increased feeling of self responsibility and self care, and increasing communication amongst the MSM community (including the use of the internet as a networking tool).

Focus Group and Key Informant Results: Key Findings

Three major findings resulted from analysis of the qualitative data of this study. The findings are as follows:

1. The identification of factors that influence behaviors that put MSM at risk for contracting HIV.

Major factors identified include isolation, homophobia, stereotyping, the use of drugs and alcohol, HIV testing, and reluctance to practice safer sex. These factors were not surprising as they were identified in the review of the literature. For example, Heckman et al. (1996b) found that barriers to rural gay health care include the following: stigma, lack of trained providers, social and geographic isolation, lack of supports, financial barriers, homophobia, and barriers to family care. In a recent Wisconsin study, two main predictors of unsafe sexual activity were identified as substance use before sex and the perceived reinforcement value of engaging in a high risk sexual behavior practice (Kelly and Kalichman, 1998). Smith et. al (1990) found homophobia to

be a major issue with gay and bisexual men who have felt disconnected from social support. This study supports the findings found in the literature cited, however, data from this study helps to more clearly describe the influences of the identified factors as they relate to MSM from Montana.

2. The identification of both internal and external components associated with each of the factors that influence MSM risk behaviors.

While issues such as isolation, homophobia, and stereotyping are often perceived as emanating largely from outside the gay community (externally), results from this study revealed that these issues are very likely to emanate from within the gay community as well (internally). For example, homophobia was found to exist both within the gay community and also outside of the gay community. Similarly, an identified factor such as stereotyping also was found to exist both within and outside of the gay community. Following are brief descriptions of the internal and external components of each factor as identified by the participants:

- *Isolation*-- This theme was characterized by the perception of a general lack of a support system. Sub-themes included social isolation, spiritual isolation, and geographical isolation. The internal component of isolation was described as the tendency of MSM to socialize within a limited social circle having little contact with other MSM social circles. Several participants complained of not having environments in which they felt comfortable to socialize or to participate in as a group whole, as in religious gathering places. The external component of

isolation rests in the fact that our state is geographically remote. The general social climate in Montana makes it difficult for MSM to feel accepted.

- *Homophobia*—Homophobia was found to be an extremely salient issue for MSM in Montana. Internalized homophobia was propelled by the lack of self-acceptance as a member of the MSM community. The external component of homophobia was found in MSM's perceptions of the widespread existence of hatred and prejudice throughout the general population.
- *Stereotyping*—Internally, participants viewed the stereotype of a gay man as a problem that is fueled by the gay media and by the ideals of gay men themselves. Externally, the stereotype of MSM can also derive from the misperceptions and misunderstandings of the community at large.
- *Drugs and Alcohol*—Drug and alcohol use/abuse carries both an internal and external component. Internally, substance use can be used as an excuse to engaging in HIV risk behaviors (commonly reported by the research participants). The external component of this identified issue lies in the cultural acceptance that substance use is a socially sanctioned way to “escape” emotional difficulties or can be used as a way of relaxing.

- *HIV Testing*—The sub-themes related to HIV testing issues are as follows: lack of confidentiality, an increased fear of testing, fear of results, a lack of support, and a lack of HIV testing awareness. The internal component is expressed through the unwillingness of individuals to be tested because of their fear of the actual testing procedure, fear of a professional breaking confidence, and fear of finding out results. The external component of HIV testing fears is due to a lack of professionalism on the part of those performing the tests. There is a perception of discrimination against MSM who test, and a negative assumption about the testers from those who are tested.
- *Safer Sex Issues*—A lack of condom availability and use, a lack of communication, and beliefs about safer sex are major themes that participants identified in the research. Internally, a lack of communication between MSM sexual partners is an individually based problem that is reported to happen for the following reasons: not wanting to know the HIV status of the other partner; not knowing how to approach the topic of HIV status, condom use, or sexual history; and the belief that if a person appears healthy, he is healthy. Condom use can also be an “external” problem in that there is a perceived lack of availability and a general belief that sex without a condom is better.

Traditionally, much of the blame for homophobia, stereotyping and other negative influences on MSM has been placed on the heterosexual community. As a result, prevention efforts within the MSM community have focused on attempts to overcome or cope with negative societal attitudes and messages that MSM receive from the heterosexual community. This research, however, reveals that MSM are aware that negativity exists within their own population. The responsibility is shared - while the heterosexual community is responsible for much of the damaging effects to MSM, MSM themselves contribute to the cycle with their own internalized negative influences resulting from these factors. This finding leads to the question, "Can the heterosexual community accept and embrace MSM when MSM are not able to accept and embrace themselves?" Concurrently, "Can the homosexual community accept and embrace themselves at the same time they feel ostracized and often despised by the heterosexual community?" It is apparent that prevention efforts need to address both the internal and external components of the factors that influence HIV risk behaviors of MSM.

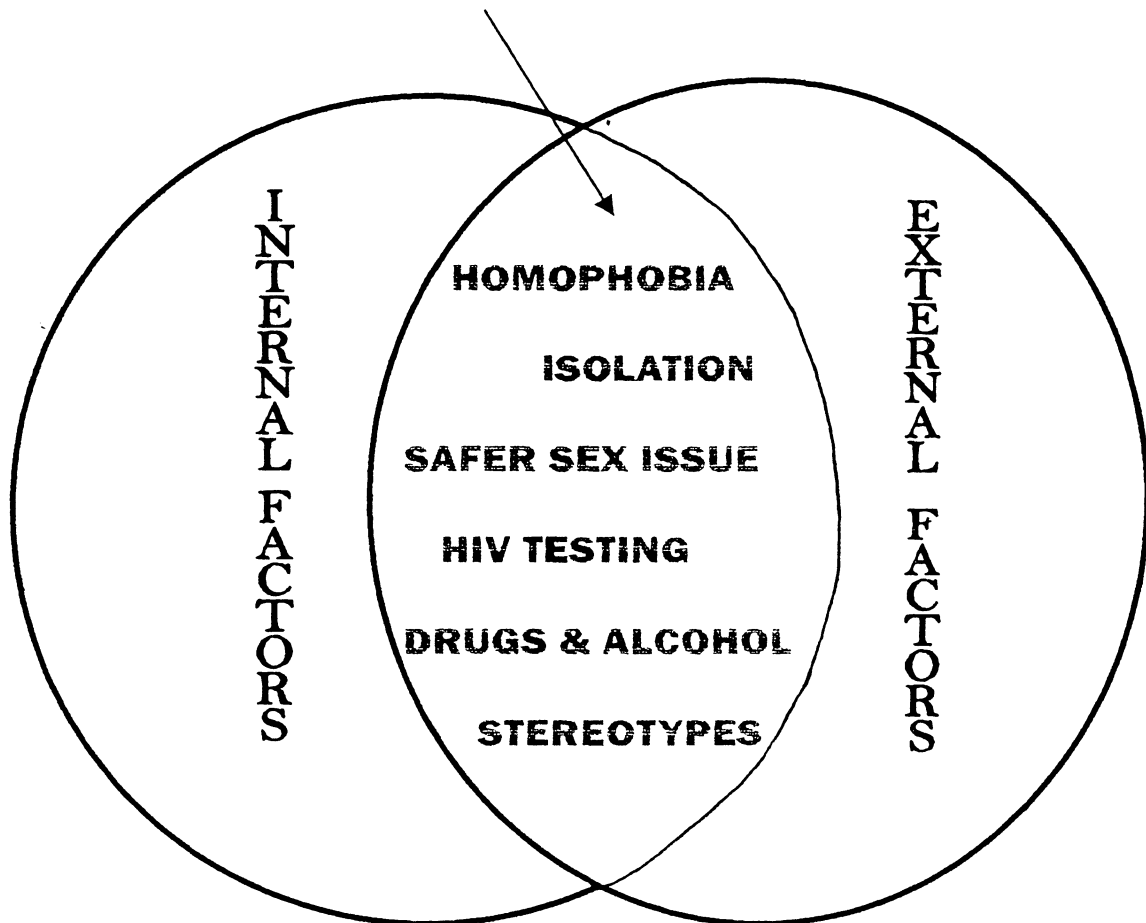
3. The emergence of the interconnectedness of the identified factors that influence behaviors that put MSM at risk for contracting HIV

During data analysis, it became apparent that the identified factors were not exclusive of each other, but were interrelated. For example, homophobia affected perceptions of isolation, stereotypes of gay men, drug use, reluctance to obtain an HIV test and unwillingness to practice safer sex. And each of those

factors, in turn, affected the others. It follows, therefore, that prevention efforts that target one of these factors may indirectly affect the others. HIV prevention should consider all of the identified factors when designing strategies, even if only one factor is emphasized—this accounts for solidly designed prevention efforts.

The following model illustrates the main findings in the study.

INTERCONNECTEDNESS



Recommended Strategies for HIV Prevention

Findings from this study clearly point out the necessity of designing prevention strategies aimed at affecting both the internal and external factors that influence MSM risk taking behavior. Therefore, the following strategies are recommended: a comprehensive social marketing campaign and an education programming intervention targeting both MSM and the public.

Social Marketing— Targeting External Components

External components related to the major factors identified in this study could be targeted through the development of a social marketing campaign directed toward the general population. Social marketing incorporates a five-step process. Careful attention to each step is critical to the success of the campaign.

The first step in the Social Marketing Model consists of knowing and completely understanding the issue to be addressed. For example, in order to successfully market the concept of diversity and acceptance of homosexuality, it is critical to understand all aspects of the issue.

The second step in the Social Marketing Model consists of researching the target population. First, it would be necessary to identify target populations that are particularly influential in Montana. These specific populations, such as public school teachers or clergy, would become the target of campaigns designed to create awareness, correct misperception, and create a more accepting social environment for MSM living in Montana. Understanding not

only the demographic characteristics of the target population, but also their values, beliefs, opinions, attitudes, lifestyles, and readiness to change, is crucial to the success of a Social Marketing Campaign.

The third step in the Social Marketing Model consists of identifying the best channel through which to market the message. A thorough understanding of the target population will determine which avenue will be most effective in gaining the attention of the individuals you are trying to effect. Common avenues include mass media and education materials such as television, radio, billboards, posters, newspapers, flyers and brochures.

The fourth step in the Social Marketing Model is pilot testing the campaign. This step requires presenting samples of materials and messages to members of the market segments within the target population. Feedback is received from the market segment before final decisions are made regarding materials and marketing strategies.

The final step in the Social Marketing Model is full implementation. This requires organization, coordination and attention to detail. Media activities should be scheduled in advance as much as possible. The process should be continually refined and monitored to assure that the strategies are targeting the correct audience at the best time, with the most “bang for the buck.” The specific objectives of this campaign would be to reduce homophobia and stereotyping, and to decrease the feelings of isolation amongst the MSM population.

Social Marketing—Targeting Internal Components

The internal component of the social marketing campaign would specifically target the MSM population. Therefore, instead of an attitude or idea being marketed, an actual behavior would be the primary marketing product. The same five-step process would be utilized: (1) knowing the health issue, (2) researching the target audience, (3) identifying the best channel for marketing the message, (4) pilot testing, and (5) fully implementing the marketing strategy. For example, in order to encourage HIV counseling and testing amongst MSM, the issues surrounding counseling and testing must be thoroughly understood. Researching the target population's behaviors and perceptions towards HIV testing (as this research has accomplished), and identifying the best channel for the message (perhaps the existing MSM communication network or the Internet) would lead the programmer to pilot test the campaign and then fully implement. The key to success with this internal campaign is to continually redesign the message. One major complaint from the participants of this study is that they are opposed to being exposed to the same marketing. This marketing campaign would need to provide the population with new and innovative marketing strategies. The objective of this part of the campaign would be to encourage HIV counseling and testing and to increase safer sex behaviors amongst the MSM population in Montana.

MSM Social/Education Programs

A. Key Leaders— Targeting Internal Components

Internal components related to major factors identified in the study could

be addressed through educational programming. This programming would specifically target MSM, promoting safer sexual practices and a holistic approach to overall health. The program would be based on observational learning, which is a component of Social Cognitive Theory. The educational program would utilize the four components of observational learning: (1) attentional processes, (2) retentional processes, (3) motor reproductive processes, and (4) acquisitional processes. Individuals who conduct these educational programs should be cognizant of the four sequential processes of observational learning.

The first component, *attentional processes*, refers to the necessity of gaining the attention of your target audience. The observational learning model indicates that greater attention will be paid to the learning process if the person doing the educating is attractive to the observer, the behavior to be learned is not too complex, the behavior is demonstrated for the observer, and if the educator addresses the unique needs of the observer.

The second component, *retentional processes*, refers to the observer's ability to remember the behavior that is being taught. The observational learning model recommends that in order to heighten retention the following factors should be considered: the words and images must be relevant to the observer; few distractions are present when learning is occurring; and there is the immediate opportunity to recall and apply the information learned.

The third process, *motor reproductive process*, consists of the physical task of actually duplicating the observed behavior. If, for example the negotiation of safer sex were being taught, the observational learning model

would require that individuals have an opportunity to role play newly learned negotiation skills. Therefore, this process fosters the acquisition of skills.

The last process, *acquisitional process*, refers to the motivation of the observer to acquire the skills and understanding of the observed behavior and then relate that behavior to other behaviors. For example, if the MSM population was taught to always ask a new sexual partner's HIV status before engaging in sex, then perhaps the individual's concern for their safety and their health will also encourage them to more often wear condoms, or to regularly get HIV tested.

The specific objectives of the educational programming would be to increase HIV testing and counseling, and to promote safer sex.

Communication Network: In addition, it is also recommended that rather than using key MSM educational program leaders in the more remote areas of the state, utilizing a newsletter, newspaper, and/or an Internet site that would act as an outreach source, would be more successful. This would aid in increasing communication within the MSM community and would provide more isolated MSM with better access to support services and education.

B. Sexual Education in the Montana School System— Targeting External Components

Sex education presented in the school systems, which includes teaching tolerance towards diversity in general and sexual orientation specifically, would also be a way to decrease homophobia and to increase external/societal

awareness of HIV/AIDS. Once again, it would be important to base this educational program on the four-processes of the Observational Learning Model. A sexuality presentation could be developed by MSM through an advocate organization that would utilize each of the four processes and could be made available to the public schools, to other MSM gatherings, HIV/AIDS organizations, and to the general public. Not only would this help educate MSM and others in the community, but also the advocate program would provide a social support system for MSM. The bottom-up approach of using MSM in a prevention strategy meets the need for MSM to build strength within the MSM community itself, while at the same time providing outreach education and awareness to the general public, thus aiding in the curtailing of homophobia. Specific objectives of this school-based education would be to promote a diverse understanding of sexual orientations and would provide young people with an awareness of homosexual issues, thus decreasing stereotyping and homophobia.

Methodological Considerations of this Study

There are four major methodological considerations in this study: a limited number of Native American MSM participants; a lack of “closeted” MSM participants; a lack of primary quantitative research; and a female heterosexual primary investigator.

A Limited Number of Native American MSM Participants: Native Americans represent a unique and under-researched sub-population of MSM. More

perspective from this sub-population could have enhanced the research findings, and enabled us to define MSM needs specific to Native Americans.

A lack of “Closeted” MSM Participants: Men who have Sex with Men includes self identified homosexual men, as well as those men who engage in homosexual behaviors, but who do not identify themselves as homosexual. Unfortunately, it is difficult to gain participation from men who don’t identify as gay or who identify as gay, but are closeted. In other words, they are not open about their sexual orientation.

A Lack of Input into Survey Design: The survey utilized for this study was developed and implemented prior to the design of the research study. Therefore, the researcher had little control over the survey. If survey design and implementation were included in the research design, survey questions could have been specifically tailored to reflect research questions.

A Female Heterosexual Primary Investigator: The last major methodological consideration of this study that may have affected data is the use of a primary researcher who was a heterosexual female. Participants may not have felt comfortable speaking about MSM issues with someone other than an MSM community member.

If this study is replicated, these methodological considerations should be taken into account.

Conclusion

The major factors that influence behaviors that put MSM at risk for HIV infection were identified in this study and include: isolation, homophobia, stereotyping, the use of drugs and alcohol, HIV testing, and the reluctance to practice safer sex. The negative effects of these factors on MSM seem to be fueled by the external messages MSM receive from society that become internalized resulting, in a general sense of pessimism, sadness, and helplessness. It would seem, therefore, that efforts aimed at reducing the negative effects of these factors must be two-pronged. Prevention strategies must attempt to target both societal prejudice against MSM and also the internalized prejudice MSM direct toward themselves.

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Appendix A

The University of Montana Institutional Review Board

Application and Consent Forms



The University of
Montana

Office of the Vice President
Research and Development
University Hall 116
(406) 243-6670
(406) 243-6330 Fax

Date: November 19, 2001

To: Ryan Kathleen Campbell and Dr. K. Annie Sondag, HHP

From: J. A. Rudbach, IRB Chair

RE: UM IRB approval of your proposal titled "Determining the HIV Prevention Needs of Men Who Have Sex With Men in Montana".

Your memo, along with the enclosed modified Informed Consent Forms (ICFs) and the modified Procedures satisfactorily address the conditions that the IRB placed on approval of the proposal cited above. Please use the "signed and dated" ICF as a "master" for preparing copies for your study. Approval for this study is granted as of the date of this memo and continues for one year after the date of the Conditional Approval; if the study runs more than one year a continuation must be requested. Also, you are required to notify the IRB if there are any significant changes in the study or if unanticipated or adverse events occur during the study.

Jon A. Rudbach

attachments

For Internal
Use Only

The University of Montana #124-01
INSTITUTIONAL REVIEW BOARD (IRB)
CHECKLIST

RECEIVED

OCT 23 2001

Submit one completed copy of this Checklist, including any required attachments, for each course involving human research. The IRB meets monthly to evaluate proposals, and approval is granted for one academic year. See IRB Guidelines and Procedures for details.

Project Director: Ryan Kathleen Campbell Dept.: HHP Phone 243-4291

Signature: Ryan K. Campbell Date: Oct 22, 2001

Co-Director(s): _____ Dept.: _____ Phone: _____

Project Title: **Determining the HIV Prevention Needs of Men Who Have Sex With Men in Montana**

Project Description: **The purpose of this study is to collect information through focus groups and interviews about HIV prevention needs of men who have sex with men in Montana.**

All investigators on this project must complete the NIH self-study course on protection of human research subjects. Certification: I/We have completed the course - (Use additional page if necessary)

| Signature | Date Completed | Signature | Date |
|--------------------|----------------|-----------|-------|
| <u>R. Campbell</u> | <u>7.01</u> | _____ | _____ |
| <u>A. Sondag</u> | <u>2.01</u> | _____ | _____ |

Students Only:

Faculty Supervisor: Annie Sondag Dept.: HHP Phone: 243-5215

Signature: A. Sondag
(My signature confirms that I have read the IRB Checklist and attachments and agree that it accurately represents the planned research and that I will supervise this research project.)

For IRB Use Only

IRB Determination:

___ Approved Exemption from Review

___ Approved by Administrative Review

☒ Full IRB Determination:

- ___ Approved
- ☒ Conditional Approval (see attached memo)
- ___ Resubmit Proposal (see attached memo)
- ___ Disapproved (see attached memo)

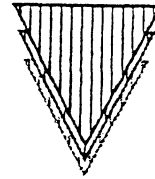
Signature IRB Chair: Janice Rull Date: 11/14/01
(over)



Appendix B

Gay Men's Task Force Survey 2001

GAY MEN'S TASK FORCE SURVEY 2000



Thank you for taking the time to complete this survey. The results will be used to help develop and evaluate health needs for gay and bisexual men in Montana.

IN THE LAST YEAR, Have you engaged in:

YES NO

☐ ☐ *Anal Sex?*

If yes, how often did you use a condom?

Always 5 4 3 2 Never 1

If you did not use a condom, what are some of the reasons. (check all that apply)

- ☐ He was my regular sex partner.
- ☐ We were both HIV negative.
- ☐ I am HIV Negative
- ☐ He said he was HIV negative.
- ☐ He did not want to use one.
- ☐ The sex was so exciting.
- ☐ Other _____

YES NO *Have you ever used the "Reality"*

☐ ☐ *Condom" for anal sex?*

☐ ☐ If yes, would you use it again?

YES NO *Vaginal Sex?*

☐ ☐

If yes, how often did you use a condom?

Always 5 4 3 2 Never 1

YES NO *Oral Sex?*

☐ ☐

If yes, how often did you get cum in your mouth?

Always 5 4 3 2 Never 1

YES NO *Mouth to Rectum Contact?*

☐ ☐

If yes, how often did you use a barrier?

Always 5 4 3 2 Never 1

In the last year, how many sex partners have you had? Male _____ Female _____

YES NO

☐ ☐ *Are you in a Relationship?*

If yes, how long? _____

☐ ☐ If yes, have you had anal sex outside the relationship?

☐ ☐ If yes, did you use a condom?

Have you experienced problems in any of the following areas in the last year? (check all that apply)

- ☐ Depression ☐ Anxiety
- ☐ Compulsive Sexual Behavior ☐ Self Esteem
- ☐ Domestic or Partner abuse ☐ Alcohol/Drugs

YES NO

☐ ☐ Are you in recovery or treatment for any of the above?

If yes, please describe: _____

What about Alcohol / Drug Use in the LAST YEAR?

YES NO

☐ ☐ Used Needles to inject drugs?

☐ ☐ Shared needles to inject drugs?

☐ ☐ Have you ever felt you had to cut down on your drinking or drug use?

☐ ☐ Have people annoyed you by criticizing your drinking or drug use?

☐ ☐ Have you ever felt bad or guilty about your drinking or drug use?

☐ ☐ Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover? (or drugs)

In the last year, have you used any of the following recreational drugs? (circle all that apply)

| | | |
|---------|---------------|--------------------|
| Alcohol | Cocaine/Crack | Tobacco |
| Poppers | GHB | Crystal Meth/Crank |
| Heroin | LSD | Marijuana |
| | | Ecstasy |

1. In the past year, how often have you had unprotected anal sex after drinking and / or using drugs? (circle)

Always Never
5 4 3 2 1

2. Before having sex with a new partner(s), how often do you talk about safer sex? (circle)

Always Never
5 4 3 2 1

3. How comfortable do you feel talking with your partner(s) about safer sex and HIV status? (circle)

Comfortable Uncomfortable
Safer Sex 5 4 3 2 1
HIV Status 5 4 3 2 1

4. What are your concerns about HIV testing?

(check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> Confidentiality | <input type="checkbox"/> Mistrust of Health Dept. |
| <input type="checkbox"/> Cost of test/money | <input type="checkbox"/> Mistrust of those doing testing |
| <input type="checkbox"/> Fear of results | <input type="checkbox"/> Satisfied with testing |
| <input type="checkbox"/> Waiting time for results | <input type="checkbox"/> Lack of cultural sensitivity |
| <input type="checkbox"/> Don't care to know | <input type="checkbox"/> Inconvenient location/times |
| <input type="checkbox"/> Having blood taken/needles | <input type="checkbox"/> Don't know where to test at |

5. How long ago were you last tested for HIV?

- ☐ 3 Months ☐ 6 Months ☐ 1 Year
☐ 2 Years ☐ Over 2 Years ☐ Never Been

6. In the last two years, how many times have you been tested for HIV?

- ☐ 1 time ☐ 2 times ☐ 3 times
☐ 4 times ☐ over 4 times ☐ None

7. Where were you last tested for HIV?

- | | |
|---|---|
| <input type="checkbox"/> Local Health Dept. | <input type="checkbox"/> Physician's Office or Clinic |
| <input type="checkbox"/> Student Health Service | <input type="checkbox"/> Family Planning Center |
| <input type="checkbox"/> Home HIV Test | <input type="checkbox"/> Community Based Org. |
| <input type="checkbox"/> Gay Bar | <input type="checkbox"/> Other _____ |

8. YES NO
☐ ☐ Do you feel you're at risk for HIV?

YES NO

☐ ☐ 9. Do you feel comfortable speaking with your health care providers regarding your sexual orientation or behaviors?

☐ ☐ 10. Have you experienced homophobia in the medical or health care setting?

11. What is your HIV status?

☐ HIV+ ☐ HIV- ☐ Unknown

12. If HIV+, how long? _____ Years _____ Months

13. If HIV Positive, where were you infected?

☐ In Montana ☐ Outside Montana ☐ Unknown

14. What is one thing we can do to educate gay men and help stop HIV/AIDS? _____

15. Do you use the Internet?

☐ Yes ☐ No

16. How old are you?

☐ Under 18 ☐ 18-24 ☐ 25-34
☐ 35-44 ☐ 45-65 ☐ Over 65

17. Are you currently living in Montana?

☐ Yes ☐ No

18. Ethnic Identity? (check only one)

☐ Caucasian ☐ American Indian
☐ African American ☐ Asian/Pacific Islander
☐ Hispanic/Latino ☐ Other

19. What is your Education Level?

☐ Grade 8 or Less ☐ Some High School
☐ High school / GED ☐ Some College
☐ College Graduate ☐ Post Graduate

FOR QUESTIONS OR COMMENTS CALL THE GAY MEN'S TASK

1-888-713-GMTF

WHO

Is The GAY MEN's TASK FORCE?

WHAT

Is The SURVEY FOR?

WHEN

Will The RESULTS
Be AVAILABLE?

WHO IS THE MONTANA GAY MEN's TASK FORCE?

The Montana Gay Men's Task Force (GMTF) is a group of gay men from throughout Montana that meet on a quarterly basis to develop HIV prevention strategies and health education campaigns for gay and bisexual men. The GMTF is funded through a federal grant from the MT Dept. of Public Health and Human Services and administered by FDH & Associates.

Their Mission is to provide sensitive, appropriate and comprehensive health messages and interventions aimed at improving the overall health of gay and bisexual men in Montana. The work of the GMTF is carried out in the spirit of acceptance and appreciation of the diversity of the human experience.

WHAT IS THE SURVEY FOR?

Each year the GMTF conducts a survey of gay and bisexual men in Montana to help gather important information on sexual behaviors, attitudes and health risks. The data is used to make recommendations to state agencies and health providers on the needs of gay and bisexual men in Montana. More importantly it helps us in our mission to improve the health and well-being of Gay / Bi-sexual men in Montana.

WHEN WILL RESULTS BE AVAILABLE?

Results will be published in the fall issue of the GMTF Focus Newsletter. A Final Report will also be available for state agencies and community organizations. Call FDH & Associates at 1-888-713-4683 for more information.

FDH & Associates
P.O. Box 1253
Billings Montana 59103-1253

PLACE
STAMP
HERE

Appendix C

Focus Group and Key Informant Questions

Focus Group and Key Informant Questions

Ice Breaker: How do you feel about the gay community where you live?

1. What are the emotional/mental/spiritual issues that affect men who have sex with men in Montana?
2. What are the social issues that affect men who have sex with men in Montana?
3. What HIV testing issues surround men who have sex with men in Montana?
4. What health related services in Montana are utilized most by men who have sex with men?
5. What are the greatest obstacles to accessing HIV/AIDS prevention treatment services in Montana?
6. What do most men you know do to protect themselves against HIV?
7. What behaviors do you believe men who have sex with men in Montana engage in that put them at risk for HIV?
 - A. Why aren't men you know practicing safe sex?
 - B. What factors contribute to the abuse of drugs and alcohol among men who have sex with men?
 - C. In your opinion, how effective is the current condom campaign?
8. What would be the most important things that people who are involved in HIV prevention in Montana could do to improve the health of men who have sex with men?
9. What other thoughts do you have regarding the needs of men who have sex with men in Montana?

Appendix D

Focus Group Consent Form

INFORMED CONSENT FORM

For Focus Group Participants

TITLE: Determining the HIV Prevention Needs of Men Who Have Sex With Men in Montana

CONTACT PERSON: Ryan Campbell: 406-243-4291; UM, McGill Hall, Missoula, MT 59812

Please read this information carefully before you make a decision about whether to participate in the focus group. If this information sheet contains words that are new to you, please ask the person who gave you this form to explain them to you.

PURPOSE

The purpose of this project is to assess the needs of Men Who Have Sex With Men (MSM) in Montana. Information gathered from this project will be made available to Montana's Department of Health and Human Services (DPHHS). By participating in this focus group you will help provide valuable information, which in turn may be used to prevent the spread of HIV/AIDS throughout Montana's high-risk population of MSM.

PROCEDURES

Participation in this study is **VOLUNTARY**. If you agree to participate you will be asked to take part in a focus group covering various topics (see attached focus group questions) related to MSM. The focus group will take approximately 1 to 2 hours. In addition to reading and signing this consent form, you will be asked to read and sign a confidentiality form (see attached confidentiality form). The session will be audio recorded and transcribed for accuracy of responses. All data will be kept in a locked filing cabinet, in a locked office in the project director's office and the project assistant's office. In no way will the researchers link your name with the transcribed materials or the results of this study. Confidentiality amongst the participants cannot be guaranteed, so please be careful about disclosing personal or private information about yourself. We ask that you try to keep all information general and relative to the focus group questions. Pizza and snacks will be served.

RISKS/DISCOMFORTS

- You may find some of the questions very personal and may make you uncomfortable.
- You may find that participation in this interview may bring up personal questions or issues related to HIV/AIDS.
- You may be concerned about your privacy and confidentiality.
- Investigators have no absolute way to protect the confidentiality of statements made in focus groups. You may be concerned that other participants in the group may disclose your identity, or statements made in the focus group, outside of the session.

METHODS FOR REDUCING RISKS:

- You can withdraw from the project at any time if you feel personal discomfort. If a question makes you uncomfortable, you do not have to answer it.
- You will receive a list of available resources if you would like more information or someone to talk to following the interview. If you would like to talk to someone about the risks and available services particular to MSM in Montana, you may call the Montana HIV/AIDS Hotline or one of the HIV Prevention Sites in your area. A list of these resources, as well as a list of Montana MSM sensitive health organizations, are attached to this sheet.
- Investigators' will not disclose your name or identity. As far as the project is concerned, every precaution is taken to ensure that your name and identity will not be connected to the collected data—all forms held in confidence, and all audiotapes will be destroyed following transcriptions.
- Each focus group member will be asked to sign a confidentiality form before the session begins and will be verbally reminded to maintain confidentiality before and after the session.

BENEFITS

Your help with this project will provide valuable information to DPHHS. By Participating in this project, your answers will help staff offer services and develop programs to meet the needs of MSM living in Montana. By meeting these needs, the quality of your life may improve.

CONFIDENTIALITY

All of the information we collect here today is confidential. We will not identify any of the participants. For example, we will not use your name, or any other identifying information in reports or other materials related to this study.

1. Participants' identities will remain confidential and will not be associated with information from the project in any way.
2. The investigators will not be able to guarantee confidentiality due to possible disclosure of information by focus group participants. But we will do our utmost to encourage confidentiality amongst group members.
3. At the conclusion of the study, any information pertaining to participants' identities will be destroyed.
4. No identifiers will appear on transcription of tapes or on any project reports.
5. Tapes will be destroyed after transcription occurs.
6. Data will be stored in a locked filing cabinet in the researcher's locked office at the University of Montana.
7. All data will be reported as group data: no individual data will be recorded.

COMPENSATION FOR INJURY

Although we believe that the risk of taking part in this project is minimal, the following liability statement is required in all University of Montana consent forms:

In the event that you are injured as a result of this research you should individually seek appropriate medical treatment. If the injury is caused by the negligence of the University or any of its employees, you may be entitled to reimbursement or compensation pursuant the Comprehensive State Insurance Plan established by the department of Administration under the authority of MCA, Title 2, Chapter 9. In the event of a claim of such injury, further information may be obtained from the University's claims Representative or University Legal Counsel.

VOLUNTEER PARTICIPATION/WITHDRAWAL

Your decision to take part in this project is entirely voluntary. You may withdraw from this project for any reason and at any time.

QUESTIONS

If you have any questions about this project now or later, you may contact Annie Sondag: 406-243-5215, Rick Holman: 406-723-5242, Ryan Kathleen Campbell: 406-243-4291.

I have read the above description of this project. I have been informed of the risks and benefits involved, and all of my questions have been answered to my satisfaction.

Furthermore, I have been assured that any future questions I may have will be answered by a member of the project team. I voluntarily agree to take part in this project. I am at least 18 years of old. I understand that I will receive a copy of this consent form.

Signature: _____

Date: _____

THANK YOU VERY MUCH FOR YOUR PARTICIPATION!

HIV/AIDS Sensitive Services

National:

CDC National AIDS Hotline 1-800-342-2437

National Association of People with AIDS 202-898-0414

National Native American AIDS Prevention Center 510-444-2051

Gay Men's Health Crisis, Inc. 1-800-243-7692

AIDS Clinical Trials Information Services 1-800-874-2572

Project Inform National Hotline 1-800-822-7422

Montana:

Yellowstone AIDS Project (Montana) 1-800-675-2437

Montana STD/HIV Information Line (Montana) 1-800-233-6668

Gay Men's Task Force (Montana) 1-800-713-GMTF

For HIV/AIDS Information and Prevention Services in Your Area, Contact:

Yellowstone City-County Health Department
123 S. 27th St.
Billings, MT 59101
406-247-3350

Butte-Silverbow Health Department
25 West Front St.
Butte, MT 59701
406-723-3274

Cascade City-County Health Department
115 4th St. South
Great Falls, Mt 59401
406-454-6950

Lewis & Clark City-County Health Department
1930 9th Ave.
Helena, MT 59901
406-433-2584

Flathead City-County Health Department
723 5th Ave. East
Kalispell, MT 59901
406-758-5750

Missoula AIDS Council
406-543-2296

Missoula City-County Health
Department
Partnership Clinic
323 West Adler
Missoula, MT 59802
406-829-4163

Appendix E

Focus Group and Key Informant Demographic Questionnaire

DEMOGRAPHICS--RESPONDANT QUESTIONNAIRE

Note: All the information collected here will be kept strictly confidential. If you feel uncomfortable answering any question, you can leave it blank.

1. **Gender**
 - ☐ Male
 - ☐ Transgender
2. **Age**
 - ☐ Under 18
 - ☐ 18-24
 - ☐ 25-34
 - ☐ 35-44
 - ☐ 45-64
 - ☐ 65 and older
3. **Race/Ethnicity**
 - ☐ Caucasian
 - ☐ Asian/Pacific Islander
 - ☐ African American
 - ☐ Hispanic or Latino
 - ☐ American Indian
 - ☐ Other
4. **What is your sexual orientation?**
 - ☐ Heterosexual/straight
 - ☐ Gay Man
 - ☐ Bisexual Man
 - ☐ Other (Please specify)

5. **Where do men who have sex with men go to socialize with other men?**

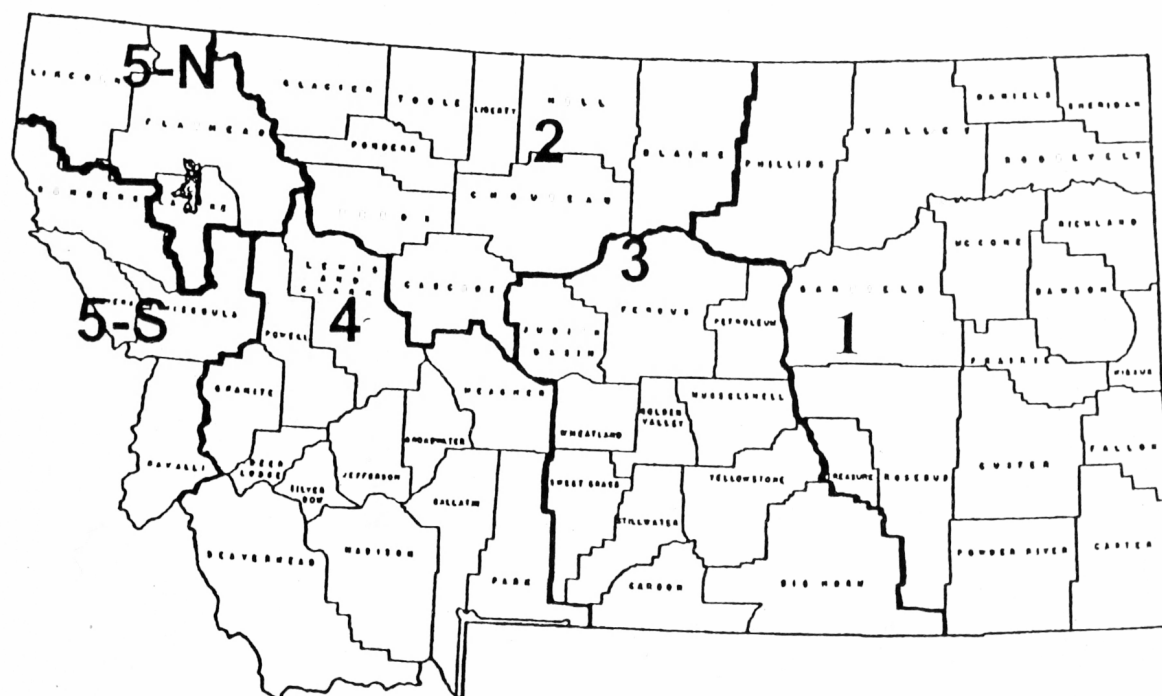
6. **Does your doctor know that you have sex with other men?**
Yes ☐ No ☐
6. **Highest level of education Completed?**
 - ☐ 8th grade or less
 - ☐ Some high school
 - ☐ High school graduate/GED
 - ☐ Some college
 - ☐ College graduate
 - ☐ Other (Please specify)

7. **Current employment status**
 - ☐ Employed full-time
 - ☐ Employed part-time
 - ☐ Unemployed
 - ☐ Disability
 - ☐ Volunteer work
8. **Monthly Income (optional)**

9. **What type of community do you live in?**
 - ☐ Urban area-- population over 30,000 people
 - ☐ Mid-sized area-- population 10,001 - 29,999 people
 - ☐ Rural area -- population Less than 10,000 people
10. **Where do you live? (select a region--see map on other side of page).**

THANK YOU!

Figure 1. Geographic Configuration of Montana's Health Care Planning Regions



Appendix F

Key Informant Consent Form

INFORMED CONSENT FORM

for Key Informants

TITLE: Determining the HIV Prevention Needs of Men Who Have Sex With Men in Montana

CONTACT PERSON: Ryan Campbell: 406-243-4291; UM, McGill Hall, Missoula, MT 59812

Please read this information carefully before you make a decision about whether to participate in the interview. If this information sheet contains any words that are new to you, please ask the person who gave you this form to explain them to you.

PURPOSE

The purpose of this project is to assess the needs of Men Who Have Sex With Men (MSM) in Montana. Information gathered from this project will be made available to Montana's Department of Health and Human Services (DPHHS). By participating in this interview you will help provide valuable information, which in turn will be used to design programs which in turn may be used to prevent the spread of HIV/AIDS throughout Montana's high risk population of MSM.

PROCEDURES

Participation in this study is **VOLUNTARY**. If you agree to participate you will be asked to take part in an interview covering various topics (see attached interview questions) related to MSM. The interview will take approximately 1 hour. The session will be audio recorded and transcribed for accuracy of responses. All data will be kept in a locked filing cabinet, in a locked office in the project director's office and the project assistant's office. In no way will the researchers link your identity with the transcribed materials.

RISKS/DISCOMFORTS

- You may find some of the questions very personal and they may make you uncomfortable.
- You may find that participation in this interview brings up personal questions or issues related to HIV/AIDS.
- You may be concerned about your privacy and confidentiality. Although your names will not be associated with the information collected for this project or with any reports, you may have concerns that your identity as a participant in this study will become known.

METHODS FOR REDUCING RISKS:

- You can withdraw from the project at any time if you feel personal discomfort. If a question makes you uncomfortable, you do not have to answer it.
- You will receive a list of available resources if you would like more information or someone to talk to following the interview. If you would like to talk to someone about the risks and available services particular to MSM in Montana, you may call the Montana HIV/AIDS Hotline or one of the HIV Prevention Sites in your area. A list of these resources, as well as a list of Montana MSM sensitive health organizations are attached to this sheet.
- Your name and identity will not be connected to the data or the project--audio tapes will be destroyed following transcriptions.

BENEFITS

Your help with this project will provide valuable information to DPHHS. By Participating in this

project, your answers will help staff offer services and develop programs to meet the needs of MSM living in Montana.

CONFIDENTIALITY

All of the information we collect here today is confidential. We will not identify any of the participants. For example, we will not use your name, or any other identifying information in reports or other materials related to this study.

1. Participants' identities will remain confidential and will not be associated with information in any way.
2. At the conclusion of the study, any information pertaining to participants' identities will be destroyed.
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I have read the above description of this project. I have been informed of the risks and benefits involved, and all of my questions have been answered to my satisfaction. Furthermore, I have been assured that any future questions I may have will be answered by a member of the project team. I voluntarily agree to take part in this project. I am at least 18 years of old. I understand that I will receive a copy of this consent form.

Signature: _____

Date: _____

THANK YOU VERY MUCH FOR YOUR PARTICIPATION!

HIV/AIDS Sensitive Services

National:

CDC National AIDS Hotline 1-800-342-2437
National Association of People with AIDS 202-898-0414
National Native American AIDS Prevention Center 510-444-2051
Gay Men's Health Crisis, Inc. 1-800-243-7692
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Project Inform National Hotline 1-800-822-7422

Montana:

Yellowstone AIDS Project (Montana) 1-800-675-2437
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For HIV/AIDS Information and Prevention Services in Your Area, Contact:

Yellowstone City-County Health Department
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406-247-3350

Butte-Silverbow Health Department
25 West Front St.
Butte, MT 59701
406-723-3274

Cascade City-County Health Department
115 4th St. South
Great Falls, Mt 59401
406-454-6950

Lewis & Clark City-County Health Department
1930 9th Ave.
Helena, MT 59901
406-433-2584

Flathead City-County Health Department
723 5th Ave. East
Kalispell, MT 59901
406-758-5750

Missoula AIDS Council
406-543-2296

Missoula City-County Health
Department
Partnership Clinic
323 West Adler
Missoula, MT 59802
406-829-4163

Appendix G

Focus Group and Key Informant Context Summary Sheet

Focus Group and Key Informant Context Summary Sheet

Date:

Location:

Number of Participants:

General Impression:

Specific theme/tone to interview:

Additional constructs that emerged not already noted:

Interview time length:

Appendix H

Research Questions and Focus Group/Key Informant Questions as They Relate to One Another

Appendix H: Combination of Focus Group and Key Informant Questions and Research Questions

The focus group and key informant questions are first presented in bold, with the research questions that it reflects, following. The research questions can be viewed in Appendix I.

1. **What are the emotional/mental/spiritual issues that affect men who have sex with men in Montana?**

Question #2: What are the mental/emotional health needs of MSM?

2. **What are the social issues that affect men who have sex with men in Montana?**

Question #3: What are the social needs of MSM?

3. **What HIV testing issues surround men who have sex with men in Montana?**

Question #1C: What are the HIV testing behaviors of MSM?

Question #4: What are the current resources and services utilized by MSM?

Question #5: What are the barriers to receiving these services?

Question #6: What are the identified gaps between needs and services of MSM?

4. **What health related services in Montana are utilized most by men who have sex with men?**

Question #4: What are the current resources and services utilized by MSM?

5. **What are the greatest obstacles to accessing HIV/AIDS prevention treatment services in Montana?**

Question #5: What are the barriers to receiving these services?

Question #6: What are the identified gaps between needs and services of MSM?

6. **What do most men you know do to protect themselves against HIV?**

Question #1: What are the current behaviors of the MSM population regarding HIV prevention?

Question #1A: What are the sexual behaviors of MSM?

Question #1C: What are the HIV testing behaviors of MSM?

7. **What behaviors do you believe men who have sex with men in Montana engage in that put them at risk?**

Question #1: What are the current behaviors of the MSM population regarding HIV prevention?

Question #1A: What are the sexual behaviors of MSM?

Question #1B: What are the substance use behaviors of MSM?

7A. **Why aren't men you know practicing safe sex?**

Question #1: What are the current behaviors of the MSM population regarding HIV prevention?

Question #1A: What are the sexual behaviors of MSM?

Question #1B: What are the substance use behaviors of MSM?

Question #1C: What are the HIV testing behaviors of MSM?

7B. What factors contribute to the abuse of drugs and alcohol among men who have sex with men?

Question #1B: What are the substance use behaviors of MSM?

7C. In your opinion, how effective is the current condom campaign?

Question #4: What are the current resources and services utilized by MSM?

Question #5: What are the barriers to receiving these services?

Question #6: What are the identified gaps between needs and services of MSM?

8. What would be the most important things that people who are involved in HIV prevention in Montana could do to improve the health of men who have sex with men?

Question #6: What are the identified gaps between needs and services of MSM?

9. What other thoughts do you have regarding the needs of men who have sex with men in Montana?

Reflective of all research questions (see appendix I).

Research Question #7: What are the differences in HIV related risk behaviors between MSM under age 25 and those 25 and older? **This research question is reflective throughout all the focus group and key informant questions.**

Appendix I

Focus Group and Key Informant Full Statement Results

Appendix I—Full Key Informant and Focus Group Participant Statements

Theme 1: Isolation

A. Social Isolation

- “Part of the problem is there isn’t an overall umbrella organization anymore that does events like there used to be.” [FG]
- What gay community? I really don’t see much of a gay community. I probably run in the same group they do, which is always showing up the same people. [FG]
- Fragmented would be the word that comes to mind. If you become part of a group it seems like a little pocket. There’s a lot of judgment going on between groups. [FG]
- I feel that the gay community is really divided and secretive. [FG]
- Emotional (issues) would probably be wanting to belong and feel love. [FG]
- I think the idea of loneliness can really cause a lot of emotional and mental strain. [FG]
- Lots of people are lonely, but I think, even more so in the gay community. They’re just not connecting...they’re not connecting with other people. And some people don’t need to. Some people are just naturally loners. But I think that connecting issue can build community and knowing you’d have a sense of belonging to it. [FG]
- I would say for social reasons, there are a lot of biases towards Native Americans and so I just choose not to take any part in anything (community). [KI]
- Other small communities where I know other guys, they kind of have a group they also stick to and there’s a little interaction between each group, maybe between a couple of the people in the group. But other than that it’s usually always kind of their own little groups. [KI]
- I just think there could be more involvement from the gay men themselves. [KI]
- I was thinking, living in Missoula it’s a fairly urban area and there is a gay community, so you’re not totally isolated. But still if you’re new to Missoula or you’re not comfortable being with yourself. You sort of have to be comfortable to take part in organizations. You might feel intimidated to go to the community center. Feel very intimidated to go to the bar. And I know that I felt very intimidated going to the bar, even when I’d been there for two years. Intimidation, self-consciousness. Like I said before, the attitude. The looking down upon people. I think that everyone probably in the gay community will feel self-conscious at some time, and other people deal with it differently. [KI]

B. Spiritual Isolation

- “So many gay people had horrendous experiences with organized religion and they have turned their back on it and you couldn’t get them into a church for love nor money.” [FG]
- I think gay men are spiritual but there’s not many avenues to be able to explore their spirituality. So the issues are trying to find answers to questions. [FG]
- There are not a lot of avenues here in Billings for it. Got lots of churches but they’re not really affirming to gay people. [FG]
- There are several churches, or a half dozen, that are really affirming. And the problem is that most people don’t jump denominations. If they grew up in their church that is very repressive they don’t often leave it just because of that. [FG]
- There are a couple of churches in Missoula that are openly affirming. I’ve gone to one of them. It’s nice. It’s like it’s a step, it’s a beginning. But I haven’t heard them addressing issues or being more open about it just in sermons.....acceptance versus simply, “okay, I guess we’re open and affirming, but we’re not really going to talk about it.” [FG]
- It’s a real struggle still going to the same church that they were raised in but knowing that they’re gay and everything. They’re being pulled two different ways with the beliefs in the church or their feelings and beliefs of themselves. It’s a big struggle. [FG]
- I’ve never been part of an organized religion. I just stayed away from it as much as I can. But my friends are really oppressed when they go to a church or are part of a congregation...or they’re going to burn in hell or end up in purgatory or something like that. [FG]
- A lot of guys I know don’t have any real strong spiritual base, and I feel like that’s something that gay men need to help strengthen a community. I really think it would help. [KI]
- For my friends, some of them, and I think it comes from Montana being a pretty conservative and pretty religious state, some of them struggle a lot with the religious beliefs and being gay. In Missoula, I know some of the churches are very progressive and they do offer support and they are supportive and gay men. Other churches do not. But in Missoula, you’re lucky because you can explore. People can explore and find churches that match their beliefs and offer the support. In rural Montana that wouldn’t happen. And another spiritual side, a lot of my friends, here in Montana and also in Wyoming, it just seems that they turn away and say they’re atheists or they have no belief system or they’re not spiritual. And I think that’s in response to sort of being on the outside of this religious community, spiritual community. And so they just totally shun their beliefs, or so they say they shun them. [KI]

- I think a lot of men don't realize that they have spiritual issues and mostly feel alienated from spiritual groups...some work to get past what most religions in the state say about being gay. [KI]
- I think a lot of gay men feel alienated from spiritual traditions. And sort of have had to craft their own or leave their home communities, their churches, and the places where they feel spiritually grounded. And so it's a sense of isolation from a larger community. [KI]

C. Geographic Isolation

- Wondering who else is out there. Where's the community? If you don't like going to the bar or something, what do you do? [FG]
- I don't really like going out. That the only outlet (the bar) here, and it seems like it's a meat market...and people go there to look for somebody to have sex with that weekend and then next weekend somebody else. [FG]
- The other big factor is where are we supposed to go to meet people? There's just bars. [FG]
- The gay community is kind of fractured. Right now the bar is the central point. Most of the other organizations and gathering places have kind of dissolved. [FG]
- It's the rural nature of the state. Just eastern Montana, where there's basically nothing (is the greatest obstacle to HIV/AIDS prevention treatment services in MT). [FG]
- Geographic obstacles (to accessing HIV prevention treatment services in MT). I mean I traveled 600 miles. [FG]
- I think for those people that are reachable, it's (condom campaign) effective. For those that you can't reach it's not obvious. I mean, you can put them in the bars, but if the people don't go to the bars or they don't go to a bookstore, then it doesn't reach them; especially if they live in a small town. [FG]
- I would be leaving the area because of the lack of population (to find a gay community). [KI]
- I just don't know anymore, I don't know at this point. I've lost communication with all the people (gay men) I've known. [KI]
- I know in a small community, that they don't have a lot of things that Billings may have. Some of the guys don't have phones, cars; they may live further out of town. So sometimes the only thing they do have available there is the chance to use (drugs and alcohol). So a lot of them will take up the opportunity rather than just sit at home. And it's also another way to, for other guys, for them to meet other guys. [KI]
- In any rural city you really have no support system or no friends. And so the social side of it, having other gay friends helps a lot because they know where you're coming from. In rural Montana you don't have that. Or you have, if there is another out gay man in the school or in the

community the chances are fairly slim, that either that person will be too old for the person to connect with or they're not just meant to click personality wise or whatever. But in any of the more urban areas, the chances are higher that you'll find a friend that you can connect with. [KI]

- In a small town where you maybe have one bar, you don't have any choice, and it's fairly obvious that you probably won't be accepted there. [KI]
- Montana is such a small town place. Even cities get to be that way after a while, but you don't have any anonymity here. You can't explore other facts of your life nearly as easily, so my experience growing up here, granted it was a long time ago was that the neighbors thought and saw was one of the most important things. [KI]
- If you're a single gay man, regardless of what your health status is, there's generally a sense of isolation, not finding a community. That seems to be what I hear most from gay men. And a lot of gay men in Missoula and Billings come from small towns where they felt totally isolated. And the only reason they're here, well the one of the principle reasons is because there is more of a community. [KI]

Theme 2: Homophobia

- Montana is so conservative. The state is so conservative that the mentality of homosexuality is, it's really non-existent. There is not really a voice in this. No one really talks about the gay lifestyles. [FG]
- I always wondered if people were afraid of their orientation because there wasn't a community or if there wasn't a community because people were homophobic or whatever. [FG]
- I think one of the big ones here is that Montana doesn't have a million people. I think in bigger places you know, in some ways it's easier to be, well it's easier to be opening big cities because you're just sort of a face there. You're not, you go anywhere in this town, you go to the mall you're going to bump into somebody you know. That's a lot of it I think. Just, I think that's why maybe there's a lot of closeted people here is because there's just that. [FG]
- A lot of society still has a real stereotype of what it is, what we should be like. We're having sex with men and they don't necessarily, if you don't fit that type you get, "oh well, he can't be gay." I think it's a social issue, because people have expectations of what it is to be gay and they're being affected by what is sensationalized by the media. That's their only knowledge of it so there's a real lack of knowing in the general population of the whole diversity within the gay community. [FG]
- They (the community in general) are really stereotypical about gay people. [FG]
- (Closeted) try to hide being gay because they're afraid of their, losing what esteem or whatever place they have in the community [homophobia].

I think that too many of them are too afraid to get involved in anything because someone might see them and I think that fields both emotional and mental (issues/problems). [FG]

- There's a lot of fear. Will I get jumped somewhere and end up dying or whatever? And there's that insecurity. They're really insecure about their sexuality. [FG]
- Homophobia is an issue that affects gay men. I believe it's getting worse with the AIDS scare, you end up feeling like you belong to a leper colony. [KI]
- There's a lack of understanding and a lack of even wanting to understand. [KI]
- I think there's a certain amount of paranoia that stems from the homophobia or the possibilities of homophobia that there's a fear of being accepted as a human being. [KI]
- Missoula is an open place as far as relative to the rest of the state at least. It's probably the easiest place to be gay in my opinion. ...I think there's a long ways to go, but especially in a men's community. [KI]
- Homophobia is a big issue. And a lot of men have not done work to get through that. Recognizing themselves and how they treat each other. And the gay media has really objectified the male body. [KI]
- In reality it's an oppressive society. And it's not just here. But you're constantly told it's right to be straight...there are very few places where you can be gay. Where you can openly show affection if you choose to or not and feel comfortable doing it. And so you're constantly going against the flow. There isn't a gay section where you can just go and be gay. [KI]
- Society is down on you all the time, which is rough emotionally. [KI]
- I think there's always been an implicit threat that men having sex with men is either illegal or socially not sanctioned. So whether you're gay, straight, bisexual, whatever, the idea of having sex with other men is taboo. It's like the sense that what you're doing, whether you're an out person or not, the sense that what you're doing, who you are inherently, is antisocial or not deemed as socially acceptable. That's the biggest problem. [KI]
- There's a fear of being found out be people. [KI]
- And then there's the physical threat too, which is, that's the biggest I think for young people coming out, that's probably the largest, the most important issue. The threat that you will be beaten up and you're going to wind up like Mathew Shepard. [KI]
- There's really no way, in my mind, there's no way of gauging the truth of fear. If you're experiencing fear, if you're afraid of being bashed, if you're leaving a bar or something. That (the fear) is a reality. Whether in fact there are people lined up at the outside of the bar with sticks or not. [KI]
- There's a fear of being found out be people. [KI]
- And then there's the physical threat too, which is, that's the biggest I think for young people coming out, that's probably the largest, the most

important issue. The threat that you will be beaten up and you're going to wind up like Mathew Shepard. [KI]

- There's really no way, in my mind, there's no way of gauging the truth of fear. If you're experiencing fear, if you're afraid of being bashed, if you're leaving a bar or something. That (the fear) is a reality. [KI]
Whether in fact there are people lined up at the outside of the bar with sticks or not. [KI]

Theme 3: Stereotypes

- It's just like any social thing where people are drinking or doing other things, your self-image, your body image, especially gay men, it's just as bad as young women who are fed, you should look a certain way. This is what you should attain to have. Certain measurements and most of it are never attainable for the average person. And we are very much fed that, even in national gay magazines. This is what we are fed. This is what we should look like. This is how we should act. This is what we should have. And that I know contributes. I know it does. [FG]
- A lot of society still has a real stereotype of what it is, what we should be like. We're having sex with men and they don't necessarily, if you don't fit that type you get, "oh well, he can't be gay." I think it's a social issue, because people have expectations of what it is to be gay and they're being affected by what is sensationalized by the media. That's their only knowledge of it so there's a real lack of knowing in the general population of the whole diversity within the gay community. [FG]
- They (the community in general) are really stereotypical about gay people. [FG]
- And when you look in the ads in like the national press with the AIDS cocktails and everything, you always see these Jim Buff guys. They're all looking healthy. [FG]
- (Sarcastically said) God, you're HIV positive. You are buff! [FG]
- They don't help any with all the ads with these healthy people running around, climbing mountains. [FG]
- I think the gay community is pretty stereotypical. Most of them, if you don't have the perfect body, you don't have the perfect mind, or the perfect personality, smile, whatever, appearance, they look down upon you. And there's an attitude that goes along with that. [KI]

Theme 4: Drugs and Alcohol

- I think because sometimes when you meet somebody you figure, well I'm only going to see this person for maybe once, maybe a few times and let's make the best of it and do what drugs we can that might enhance the

experience. And because you don't expect too much out of, or nothing-long term, you want to make, you're willing to use drugs to enhance that temporary experience. [FG]

- If people can become accepting of themselves they don't need to be abusive of drugs and that kind of stuff. They're comfortable. [FG]
- A lot of the guys that I know, a lot of times they're drunk when they have sex and they just don't use anything or they'll use that as an excuse...we're getting way into it so I didn't have time to get a condom or whatever. [FG]
- Drugs can enhance sex. And it lowers people's inhibitions. [FG]
- They (MSM) are more open. I even see that with gay men they won't when they go into the bar they'll sit there and they'll just have, they'll drink until they get...before they even talk to anybody. [FG]
- A lot of men won't have sex, even with their boyfriends unless they're drunk. [FG]
- It's a guilt factor for a lot of people. They have to get drunk to get over that guilt. [FG]
- It's a pick-up line. "Hey, can I buy you a drink?" [FG]
- It's an excuse. "I was drunk." "Oh, I didn't know". "I'm not gay, I just was drunk." [FG]
- A lot of the guys that I know, a lot of times they're drunk when they have sex and they just don't use anything or they'll use that as an excuse...we're getting way into it so I didn't have time to get a condom or whatever. [FG]
- I can see people going down there getting drunk and then disappearing to the bathroom or disappearing at night or whatever. And so it's just leading to the conclusion of hooking up.
- I would say that alcohol is the real common vice that throws monkey wrenches because under the influence of alcohol there's a tendency that people will do things that maybe they would take some responsibility for if they were sober. [KI]
- I think it's just like for a whole community, gay or straight, you lose your inhibitions. And so when you're on a date or you're trying to hook up or you're trying to meet someone new by drinking a lot or by taking drugs you lose your inhibitions and it makes it easier for people to meet each other. [KI]
- And so I'm thinking that it might now be cool to use drugs or to get really drunk at a bar and it might also be used as like something to "fit in." [KI]
- With the new bar that has opened up, it's sort of the, it's a rave bar. Sort of the dancing disco scene. I guess I should have figured with this new bar. And with Ecstasy too, from what I've heard, it makes everything seem like you want to be all touchie-feelie and the pleasure increase or whatever. And I think that might have something to do with it being abused in the gay community. You never really get the chance to be all touchie-feelie with your partner or whatever unless you're in a private

setting. But in a public setting. Or just having all your sense enhanced. A new feeling that maybe appeals to the gay community more. [KI]

- Sometimes it seems to be daunting, why not just drink, do drugs and not worry about it? [KI]
- Gay men are used to being secretive to survive growing up in your youth. You have to. And drugs and alcohol, that can keep things repressed. They help you not feel your feelings. [KI]
- It used to be easy to pick someone up when I used drugs and alcohol. [KI]
- I think gay men have more pressure on them when they have sex with men and they have more pressure and so they have a higher tendency to drink more. [KI]
- I think the other risky behavior is drug abuse and needle use. And I think that's pretty high in Montana. I hear that heroine use is up. I hear that meth use is up. I hear that the younger people are using drugs. And drugs that involve needles, the exchange of body fluid, so that's troubling. [KI]
- I mean, I think there's always been drug abuse, alcohol abuse in the gay community. And there's no denying that. The primary pickup place is the bar where the liquor flows and the drugs flows. I don't think that has changed any. For a while it felt like after sort of public information on HIV went up, the gay community responded by treatment groups, lots of information. But I think that that's kind of on the wane now. And places like Montana where the information is never really heard, and where drug abuse has always been a factor...I just wonder how, if people really have the right information. [KI]

Theme 5: HIV Testing Issues

A. Lack of Confidentiality and Lack of HIV Testing Sites

- I don't even believe in confidentiality because all it takes is one person in the chain to break the chain. [FG]
- For me, I just don't trust the health care profession up here in Montana. If I have to go to a doctor for any reason, I usually go out of state. [FG]
- Confidentiality. The fear of being exposed...I think it's a no-brainer (that this is an HIV testing issue in the state of Montana). [FG]
- The first times that I was tested I was working the medical field and I used the excuse as patient exposure for being tested. Then I came to Billings and the only way that it was easy was me meeting a certain doctor and going to his office. And it's comfortable. I can come talk to him any time. So that's just having people in the community that you know and can trust. [FG]
- I think a lot of (new MSM who have moved into Billings), go to Bozeman or whatever town just because they're afraid that they might run into somebody that might figure out what you're doing there, you're getting

tested. Especially in small towns. You go to the hospital and you say that's what you want to be tested for, every nurse there will go home and tell their husbands about it. [FG]

- It's the rural nature of the state. Just eastern Montana, where there's basically nothing (is the greatest obstacle to HIV/AIDS prevention treatment services in MT). [FG]
- Geographic obstacles (to accessing HIV prevention treatment services in MT). I mean I traveled 600 miles. [FG]
- I think if you're in a small town and even if there was free HIV testing or whatever, I seriously doubt...well, you'd be scared. I mean, you'd have to drive to Billings or drive to Great falls or Missoula or something. Some place where you're not likely to be known.
- Being so rural. In the small towns, you might not necessarily have access to them (HIV Prevention). [KI]
- The area of the state. The hugeness and getting enough people together. Isolation. Distance to travel. The small townness. These are obstacles to accessing prevention treatments. [KI]
- The fear of people talking. And I speak from rural Montana, there's a tendency that in some of the clinical situations tongues wag and words get out. [KI]
- Well from a rural area, small town, other reservations I know, the main thing is confidentiality. Some men are concerned about it. And the ones who are (concerned) are usually the ones who are always labeled as being positive...whether that's true or not. [KI]
- A lot of the guys would rather go somewhere. They would rather get a test from another gay man that they know. Or if they don't have that in their community they would travel the distance just to get a test. [KI]
- Confidentiality (is an issue). You go to another town. I mean people still go out of state to test. [KI]
- As far as I know, the Health Department gives out free tests. But I think they told me there was no confidentiality. [KI]
- I don't trust doctor's competency. I don't think anyone trusts doctors. And for good reason in a lot of cases. [KI]

B. Fear of Testing Results

- There are a lot of people that don't want to know. [FG]
- They say, I couldn't afford the drugs and if I had it I don't want to know. [FG]
- Denial. It's not going to happen to me (HIV/AIDS). Maybe someone else. [FG]
- They're afraid. Maybe they're afraid of the diagnosis maybe. [FG]
- There's the fear of the unknown (result of the test/future/etc.) [KI]

- Only healthcare that deals with their (MSM's) sexuality. There's a tremendous fear. There's a lot of closet situations, and I would say probably that's happening all over rural America, Montana included. [KI]
- They're really scared to find out. They don't really want to find out. And so they don't get tested, even though they know that it's free or it's anonymous. Even there's counseling offered afterwards. They still don't want to know...I think a fear factor is an issue in getting tested. [KI]
- In the rural areas, or even across the state the stigma, the fear of getting diagnosed, and the fear of what would follow that would be put on you. I think that's an obstacle for getting tested. People don't want to deal with that, and so they won't get tested. [KI]
- The most at risk men don't go and test. And I think it's not just those external factors, it's the internal factors too. Being afraid...of finding out. Having to change behaviors or not wanting to be responsible for themselves. [KI]
- Denial of your own risks, the risks around you, what they're actually about. Fear of joining a group, or putting yourself out there. Fear of learning these things. A fear of being. [KI]
- And I would guess bigger concerns would be that you just don't want to know. That you don't want to deal with it. [KI]

C. Lack of Awareness

- I think the larger cities in Montana do pretty well with promoting testing and where it's done. [FG]
- It doesn't seem like there's a lot of publicity for it (HIV testing) though. [FG]
- When AIDS peaked and there was all that publicity, awareness, everything was out there at the time. Get tested here. Get tested there. You could hear it on...all your public service announcements... And then boom. You noticed the decrease as the meds come out and all that. There were less and less deaths and less and less awareness. And I think that's where we're sitting today. The less deaths we have and the less new cases we have, you're seeing a change in the awareness that's being put out there. [FG]
- I think the HIV testing would be the biggest service that they (MSM) use (out of all health related services). [FG]
- The fact that so many of these people are hidden. They're closeted and nobody knows who they are. And so many of them don't know the first thing about AIDS prevention. And there's really very little way of reaching them. How are they going to get testing, if they can't be reached? [FG]
- The greatest obstacle to HIV prevention treatment is the lack of information. [KI]

- I think it's just the lack of information. I don't think most men really know where they can actually get the testing done. In small towns we do have a few different places that will do it. I think it's just the fact that people don't know. [KI]
- Access to testing is needed. To know that it's confidential and that there's going to be support on the other side whatever the results are. [KI]

Theme 6 :Safe Sex Issues

A. Lack of Condom Availability and Usage

- What condom campaign? [FG]
- It's an awareness and knowledge issue for people that don't know where to get them (condoms distributed where?). [FG]
- I think that people that don't go to places that give them out (condoms) might find a lack of availability. And if you're living in a small town you're going to have a problem. [FG]
- There are some people that won't even buy them in a grocery store. They're afraid somebody will see them. And if they're afraid to be seen going into adult bookstores, they're the ones we have to find a way of reaching. It's a privacy issue. [FG]
- It's not comfortable. They don't like using condoms. It doesn't feel good. [FG]
- It's not romantic (to use condoms). [FG]
- Condom use is first and foremost (when MSM protect themselves). [FG]
- How about the over 50 that has a wife...how's he going to justify buying condoms? [FG]
- Bare backing is number one (out of all the behaviors that put MSM at risk for HIV). [KI]
- The fact that the common knowledge is not that there's medication that you don't have to, I mean, this is kind of like hearsay. But that you don't have to use any kind of protection because there is medicine.
- Lack of condom use is a behavior that gay men engage in that put them at risk for HIV. And lots of men are putting themselves at risk. [KI]
- They (MSM) use condoms (to protect themselves), whenever they have sex. But something that I've noticed over the last couple of years too, most gay men like myself are choosing to abstain from having anal sex with anybody just because they know it's dangerous and they don't feel comfortable with it. And so I think abstention I think is growing. I think it's for their own morals, for their own safety. They're thinking more about it and maybe they're actually listening to the information and they've heard since grade school. [KI]
- I'm surprised with anal sex that a lot of people are (wearing condoms). [KI]

- I think the only thing is it's still hard for people, once you are in the sex act. People don't know how to make putting a condom on part of the flow. [KI]
- I don't think the condom campaign is very effective. I think there's plenty of condoms out there, but people just don't know where to get them. I don't think the "always use a condom" message is effective at all. Like the first proof of that is that it's not coming through as even with oral sex. And I think even if that message did come across that way that would make people that much more likely to turn it off. [KI]
- I think people have probably heard about using condoms. You hear protecting, safe sex, you know. They might have seen an ad or TV (Television) and they might have heard somebody in their high school giving a speech or whatever, or they might have talked to their friends about it or whatever. But my fear is personal information is really sketchy, not coming consistently. So probably people I suspect don't know the specifics of how to or how not to get infected. It just doesn't feel like it's enough. And I suspect that there are probably a lot more men having sex with men that we're owning up to. Reasons why they don't use protection...a lot of times they may be using, there's alcohol involved. [KI]
- In checking the Internet, a trend that is returning is bare backing, which means anal sex with no condom. [KI]
- They don't want to deal with the inconvenience of getting condoms, keeping condoms around. You know, putting them on and then having to have sex with them. And I don't think there's any, there's never any real information attached. [KI]

B. Lack of Communication

- Not finding out (before engaging in a sexual act), not talking about it with whoever your partner is. Asking, are you positive? [FG]
- It can be brought up (communication before sexual behaviors), but it's really not taken seriously. From what I hear, a lot of things that some guys do tell me is they say when it is coming up someone may say, do you have a condom, or do you have anything? And then a lot of times what I hear is they may just say no, or no, I don't have one on me. But then again that's just kind of set aside after that and it's not...they go ahead and they engage in sex. [KI]
- Most men I know protect themselves against HIV by rejecting anyone who's positive without knowing that a third of the people don't know they're positive that they're being sexual with. That's where I think the denial thing comes in too. It's like if I keep away from it...I don't want to know any more than I have to. [KI]
- They're afraid. They don't want to know. Negative people assume the other person is negative unless they say something. And positive people

assume they're positive unless they say so. I think that's breaking down a little bit. And I do think people talk more than they used to. [KI]

- What I find dismaying is that people will cut off a conversation with you if they find out you're positive. So to me that means they aren't really aware of their risks. They don't know how to be safe or want to be safe. So they're probably not being safe. So the people that lie to them or the people that don't know they're positive, they're having unsafe sex. [KI]

C. Beliefs About Safer Sex

C1. Oral Sex and Withdrawal Beliefs

- The other thing you are fighting is the age-old thing. A hard on has no conscience. [FG]
- Or they'll restrict, they'll do only oral sex. [FG]
- Or they'll pull out before they cum. [FG]
- I don't think the average gay man knows withdrawal is safer than coming inside the person. There are ways of doing harm reduction around not using a condom. [KI]
- I know very few people who have protected oral sex. Gay or straight. And actually, I'm surprised at how many people are shocked at the idea that you would even need to have protected oral sex. [KI]
- I think people really want badly to believe that there is little or no risk with oral sex. And people also really badly don't want to deal with it. [KI]

C2. Transmission and Cure Beliefs

- They're young and they figure that a cure or major treatment is right around the corner, so why worry about it. [FG]
- I've heard that some people think that AIDS is controllable now and you don't have to worry about it. [FG]
- There are all these medical breakthroughs with controlling the HIV virus and you increase the time people can live with it. And also there's the possibility of finding a cure for it. [KI]
- The idea that it is a manageable disease. Why worry about it (being safe). [FG]
- I think some of it (unsafe sex) is probably self-denial with younger people. [FG]
- Being selective with their partners (is the way MSM protect themselves against HIV). [FG]
- Men don't practice safe sex out of pure laziness or complacency...it won't happen to me. [FG]
- I've heard that some people think that AIDS is controllable now and you don't have to worry about it. [FG]

- As far as men who have sex with men, I think there's still a huge proportion of them who are married to women that have sex with men. [KI]
- I was shocked actually recently to hear from a guy my age that he actually just; he would eat somebody's cum. And I thought, wow, you know, ten years ago, fifteen years ago I was warned that that's not a good thing to do...and his response was, "oh, the virus is actually quite weak. Your pancreatic juices, your stomach juices will kill it." I thought, why even take the risk? That just seemed like unsafe behavior. And I was shocked. He was a guy who was my age, he's been around. Probably had the same access to the same information I've had. So I think there's still some ambiguities about what's safe and what isn't safe. [KI]

C1. Beliefs of Safer Sex—The Rural Nature of Montana

- There's this idea in Montana that you're safe (from HIV/AIDS). It's not up here. [FG]
- I've heard someone say, well, you know I'm not worried about safe sex because they're from Montana. [FG]
- Some men only have sex with other guys in Montana. They think that's going to protect them. [FG]
- The population being so sparsely spread out that I'm not sure how that's working (condom campaign). I would say probably in the more largely populated areas like Billings, Great Falls, Butte, Bozeman, Missoula, that there's a greater chance of, you know, they have bookstores, bars and places where they can put these out. Where in rural Montana it's a real problem because it's kind of like the towns and few and far between.
- A lot of people feel that, I think they still have that view of, we live in a small town and this (HIV) isn't something that comes here.
- I think there is some truth in Montana that we're a rural state, not a lot of people, so there won't be a lot of cases of HIV and AIDS so they (MSM) don't think they would ever get infected. So I think the rural thing plays a part like the chances are very low that it would ever happen to me and so they don't practice safe sex. Another thing that might be too on the reverse side is that they want to get infected with HIV so they don't have to worry about it. [KI]

Theme 7: Older MSM Perceptions of Younger MSM

- How many 17-year olds are going to go in the store and buy condoms? [FG]
- If there's not a community then how are you going to access all the under 21 year olds that don't go to the bar? [FG]

- I think older guys have seen the wave of death that the HIV virus brought. The young kids don't feel that, nothing is going to kill them. [FG]
- The other thing you are fighting is the age-old thing. A hard on has no conscience. [FG]
- I think some of it is probably self-denial with younger people. They're young and they figure that a cure or major treatment is right around the corner, so why worry about it. [FG]
- Everybody feels that it's older guys that use the condoms and younger guys don't. [FG]
- With the Internet, I think kids in a way are much more sophisticated. You've gone from so many things are covered, so much more media. I think that one of the main things you're battling against is that I'm 16, 17, and I'm going to live forever. That whole, and that's always been going on. But I think kids are a bit more sophisticated. They have the ability to get the information on their own if it's provided. (Quote also found in theme 6—Information and Networks). [FG]
- And of course my concern is the age of sexual awareness is also the age of intense social rebellion against parents, authority figures. So I just think people need to know that they have options other than killing themselves and killing their partners. And that this (AIDS) is a killer. This will in fact take their lives. [KI]
- The younger ones (MSM) I've worked with are more well aware. They have, their values are a little bit stronger. They do have a tendency to stick to them more. I believe personally it's just because from growing up, hearing it most of the time. That's just how I view it because for me when HIV was first discovered in like eighty something, I was really young. And I hear it throughout my life. And then it just stuck with me, and a lot of the other guys my age and younger, we've kind of always, we talk about that and we know, we do remember all of that. [KI]
- And young gay America, they're expecting to live a long time and to possibly see the cure, and so they don't really care if they get infected because they think something later down the line will save their lives from it. [KI]
- I was in San Francisco...people died. That's ten, fifteen years ago. Half the guys coming out right now have never seen anyone (die of HIV). Or the drugs (HIV drugs). They (youth) have no idea...they don't know anyone with HIV probably here in Montana or what they go through if they're on drugs, which the majority of the people, I think the majority of people with HIV are on some kind of drug...side effects...and the impact on your physical body. You read the articles and it sounds like, "Well that is not that bad is it?" The invincibility of youth. [KI]
- My biggest concern is younger people, high school aged kids, college kids, who I think have really fallen through the cracks. I think in general terms they're healthy or they think they're healthy and they probably don't know as much about what options there are. So that's the community I'm concerned about. I think my generation, people who in some ways have

outlived the initial scourge of AIDS and HIV, I think we know what medical care is about, we know how to get information and most people are educated enough. [KI]

- Maybe it's because of the thought that there are drugs out there that if they get infected they're going to be fine. I don't know if there are people with a kind of devil-may-care kind of attitude. With my generation I think a lot of us have lost friends and so we're more likely to know how precious life is and how fragile life is. So I hope that people have that sense of awareness, that they could lose their friends or they could lose themselves. But I think with younger people who have not had that loss, who don't know anyone who has died, who are coming out of the closet and don't have the information to know what safe sex is, I think they're just taking risks. It's all teenagers. It's the younger people. Invincibility. [KI]

Theme 8: Strategies for Prevention

A. Education

- I think the abstinence program has hurt sex education in the school districts worse than anything else. Because they say, oh we're teaching sex education. But they're not teaching 60 to 75 percent of the kids that aren't abstaining. [FG]
- I think you should be talking to high school kids because it's a whole different world than it was ten years ago. [FG]
- I think it's our bureaucracy that prevents people from accessing. We can't get knowledge into the schools. [FG]
- I think that prevention is education and I think that without having people reiterate over and over and over again, people don't learn. They hear it. But they don't learn it. [FG]
- I overheard a comment made by some of the school boarders, school board meeting one time off the record, said that they'd like to give out condoms to students but all they had to do is mention the word reproduction and the whole thing is dead. [FG]
- Even if they don't give out condoms, I think they need to educate a lot of people. Education is probably equally important to just giving out condoms. How to use them, what your risk factor is. [FG]
- Even though it's fallen by the wayside, continue the education programs. [FG]
- I think to educate them. It's like an updated version of health class with all the new drugs or whatever. [KI]

B. Advertising

- Getting the message out and saying that there is somebody you can talk to about this stuff. I know that when I was that age, just even comments about gay people and comments, It would...I just perked up immediately. [FG]
- Maybe they need to push it more. Their campaign, advertising, their education. You know, when they, when I was in high school we had to take a class that taught us that. But maybe we need to go beyond just that in schools or at the health centers or hospitals...Just promote it more in different places. I know there's not a lot of bars that hand out condoms or even promote safe sex. They're there to sell beer and alcohol...so maybe they need to at least get more spread out in different places. [FG]
- I think it's the rural/urban divide. In urban places, I've lived in big cities. There's a glut of information. The bars are full of it. Everywhere you go it seems like there, wherever you go as a gay person there's information about it. Whether you take it or not, whether you listen to it or not. Public television ads, that sort of thing. In Montana that's really thin, I mean even in an urban center in Missoula it feels like that is thin. It's just not there. And I know people who work for Missoula AIDS Council who are active in the community center and stuff. It just feels like there isn't enough information out there.
- I was theorizing something I think would be quite effective to reach the masses would be Male Sex for Dummies. It would be done in such a way that it could be mixed male/female environment that they wouldn't have to feel uncomfortable. I think especially in rural areas, as well as probably in larger areas. Anyone that's hiding from their true identity sexually, that they could feel uncomfortable. [KI]
- Magic Johnson recently was on the Tonight Show with Jay Leno. I think if people who are well known, such as Magic Johnson, or that swimmer, that diver...if they would do public service whether it be on a videocassette or television commercials. I think there needs to be more public service announcements done in such a way that it would affect the consciousness of people in general. But I would say for everyone involved, and I think to help the morale of those who are HIV positive. And a resource would be people like Magic Johnson or the various, you know, that life does go on, and it can go on if you wish to continue. [KI]
- There needs to be more community advertising. Posters and pamphlets. I think they could use something by a TV (television) that would maybe, like maybe they have some kind of just generalized meeting. [KI]
- I think gay men know to wear condoms through common sense of learning it through school or learning it, like through health discussions. At the bar, at closing time, if you need a prophylactic they're available at the bar. I think it's just sort of being hit over the head with it again and again through health class, through meeting with your friends. Peer pressure I think. But people who haven't really been active in the (gay) community and maybe...I think they would benefit from a more developed safe sex campaign. They're not really in public places anymore. [KI]

- Sometimes I think the best way to target those people would be put up a giant billboard that's supporting gay health or something. I know that access is a huge issue because we are a rural state. And it would be hard to set up in each of those teeny tiny little places an HIV counselor or a testing site or whatever so I think that it's just a matter of raising those individual's awareness and their community's awareness. [KI]
- The billboard and TV, through the local channels of commercials would be good because anyone would have a TV. So targeting the local television stations and buying airtime for commercials that would be a plus, and the radio too. Through those media it would help with awareness. [KI]
- And for the access thing, I guess for the most part, Montana is spread out enough, there are big cities at least that whatever portion of the state you're in you're at least an hour and a half or two hours away from a big city. A marketing campaign or a media campaign I guess would be a really good thing to go about doing. That would be the best bet since we are so rural. [KI]
- It would seem to me that all the ways that it's (advertising information about safer sex) coming from now, all these pamphlets that are getting printed and you know, I guess there aren't a lot of commercials on TV any more. There never really were. I would say through the same channels. It should be, maybe it should be entirely an information campaign and not like a behavior changing, don't do this. Less preachy. And I also think the other problem is that sure, there are all these ads and there are all these pamphlets and a lot of messages saying always use a condom, always use a condom, and always use a condom. Then you turn on TV and you watch a sitcom and you know, it's really funny. And then the couple hooks up after the fighting or whatever, and you know, and they fall into the bed and it fades to black. Or they struggle under the blankets and it cuts to commercial. But they never discuss, you never show them reaching for a condom. They never say, should we have safe sex? No one ever says, "Oh, I'll only have sex with you if it's safe." There's none of that. Meanwhile the government is buying anti drug plots in sitcoms. [KI]
- I would like to see in every bathroom stall in this campus in this town information about safe sex. I'm not talking a condom machine. I'm talking, like these are resources you can grab a telephone off, you know. These are the places that offer this confidential. I just think the problem is information. And if it's not on the college campus and if it's not in downtown bars, in the bathrooms in downtown bars then I bet you it's not in the high school bathrooms either. And what kid is going to go into a counselor's office in high school to get that information? [KI]

D. Information-Networks

- With the Internet, I think kids in a way are much more sophisticated. You've gone from so many things are covered, so much more media. I think that one of the main things you're battling against is that I'm 16, 17, and I'm going to live forever. That whole, and that's always been going on. But I think kids are a bit more sophisticated. They have the ability to get the information on their own if it's provided. [FG]
- I don't find them (prevention treatment services) to be as well presented or integrated into things up here in Montana. It makes it so hard. [FG]
- A great obstacle to accessing prevention treatment services is a lack of support groups. [FG]
- They could do things like the health retreats or the men's groups or that type of stuff too. Give an outlet for guys to have a chance to meet other guys without having to go to the bar to have that other outlet because I think that will create a healthier person if they have some other outlet, other than just the bar. [FG]
- I think there needs to be more support. Support for gay men and young men...I think there's a lot of people who don't have that kind of support. [FG]
- I think having venues like this not only forms like a sense of community. Well, yeah, that's what it does. Because for me it's a relief, you know, knowing that there are places where you can go that are not only anonymous but also acceptable. [FG]
- Discussion groups (as a way for support). [FG]
- The retreats you go to weekends, you learn, you meet, you form friendships. I've just met so many wonderful people at the retreats. It's amazing. [FG]
- With the Internet and the chat rooms and everything, it's one thing. It allows you to be anonymous. And you don't have to go to like the bookstore, the bar to find someone to have sex with. You can go into the chat rooms and find someone of interest and so, they don't, you know. You've got to kind of wonder why the condom use is there. And you figure it, because they certainly aren't available. You can't pick them up on-line. [FG]
- A lot of guys I know don't have any real strong spiritual base, and I feel like that's something that gay men need to help strengthen a community. I really think it would help. [KI]
- I think there needs to be more (HIV) counseling. More, getting more out to the community as much as they can themselves. I'd have to say just be more aggressive at reaching others, just the general public. And I think with more of that it will bring out more awareness of the MSM population. Maybe some of their needs to other people. [KI]
- I think we need more actual peers, gay men to do the testing. [KI]
- Hire more out gay men. I think that would be one of the biggest steps to making it a safe place, for gay men to be involved, to be okay with being gay and out. And I think that would increase gay men's participation and

gay men's self esteem. My biggest thing is building a community. It helps people that say are in the closet feel better about themselves. [KI]

- It might be nice if there was some sort of directory if this is what you're looking for these are the three places or this is the one place (to access it). [KI]
- Political involvement. To me the best way to get rid of those emotional, mental, and spiritual issues, the best way to get rid of the social issues which would possibly even...we wouldn't even need to target MSM any more, would be visibility and equality. [KI]
- As long as politicians keep telling gay people that they're a problem then they're subversively contributing to the problem. They're making people feel alienated. They're making them feel like who they are and what they do is wrong. And therefore people will do whatever they want. And even at the expense of their own health...so it's getting the right information out there. [KI]