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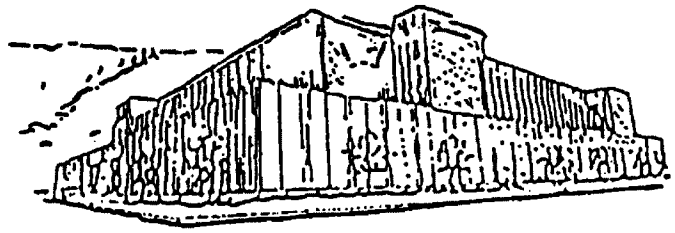
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**HIV/AIDS PREVENTION NEEDS
OF MONTANA'S HIGH-RISK GROUPS:
A QUALITATIVE RESEARCH SYNTHESIS**

By

Sarah M. Keup

B.S., University of Minnesota, 1996

Presented in partial fulfillment of the requirements

for the degree of

Master of Science

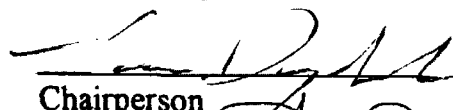
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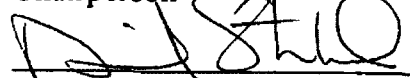
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Thesis Abstract

Keup, Sarah Margaret, May 1999

Health and Human Performance

HIV/AIDS Prevention Needs of Montana's High Risk Groups: A Qualitative Research Synthesis

Committee Chair: L.G. Dybdal, Ph.D.¹⁰

The purpose of this study was to synthesize the existing statewide HIV/AIDS prevention needs assessment data into a comprehensive report. The data was gathered from the entire state of Montana by contacting local agencies, organizations, individuals, and health departments by using the reputational approach. This data was collected and then categorized according to Montana's classification of high-risk populations: men having sex with men, intravenous drug users, youth at risk, Native Americans with high-risk behavior, women with high-risk behavior, HIV+ individuals and their sex partners, incarcerated populations, and people with hidden risk behaviors.

A total of thirty-one HIV/AIDS needs assessments were collected. Each individual needs assessment was first recorded on a data analysis chart, using content analysis. The second step was to synthesize the assessment results for each high-risk group by utilizing the qualitative research synthesis method. The synthesized needs assessment results provide the following: 1) Basic demographic information and description of each assessment; 2) Common behavior, HIV/AIDS knowledge, and attitudes, perceptions, and beliefs about HIV/AIDS for each high-risk group.

The main information gaps that occurred across all collected needs assessments were: 1) lack of demographic information; 2) lack of assessing HIV/AIDS knowledge; 3) time lapse between assessments is too long; 4) lack of annual or biannual needs assessments; 5) lack of thorough examination of all categories (behaviors, knowledge, attitudes, perceptions, beliefs); and 6) lack of examining and determining relationships between the categories. Recommendations were made for each high-risk group and the state of Montana based on those information gaps.

Acknowledgements

“There are no shortcuts in the journey ahead, nor is there a turning back...Development must be allowed to take its proper course.”

- I Ching

The support, encouragement, motivation, and belief in my abilities from Dr. Laura Dybdal and Dr. Annie Sondag helped me realize my true potential during the graduate school journey and in the years that will soon follow. I am so amazed by the experience that the two of you provided to me. At times when I felt incapable of developing myself further, you were both there to reassure me and help me remember that graduate school is a huge learning curve. Thank-you Laura, for your constant encouragement and friendship. You have been there to show me how much farther I could push myself and I am forever grateful. Annie, you have been a role model, mentor, and friend. Your door was always open, as was your heart.

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CHAPTER 1

Introduction to the Study

Acquired Immunodeficiency Syndrome (AIDS) is a condition caused by a deadly virus called HIV (Human Immunodeficiency Virus). HIV essentially attacks the immune system and when that system fails, a person with AIDS may develop a variety of life-threatening illnesses (CDC—HIV infection and AIDS, 1994). AIDS was first reported in 1981 and since that time, over 30 million people have been infected with HIV worldwide. The Centers for Disease Control (CDC) has monitored the HIV/AIDS epidemic since the first reports of infection. Through 1997, more than 232,000 persons were living with AIDS (American Association for World Health [AAWH], 1997). Even with the close monitoring of HIV and AIDS cases, the numbers under-represent the number of people infected with HIV because many people have not been diagnosed or tested.

In the United States, the epidemic has been highest among men who have sex with men, injection drug users, women who have sex with infected men, children born to HIV infected women, and people who received blood transfusions in the early 1980s (CDC, 1994). As of 1997, 641,086 Americans had been reported with AIDS. Estimates indicate that 650,000 to 900,000 Americans are now living with HIV, and at least 40,000 new infections occur each year (CDC—Trends in HIV/AIDS Epidemic, 1998). As of 1996, United States AIDS cases remained highest among men who have sex with men (MSM) and increased most drastically among women, African Americans, people infected heterosexually, and through injection drug use (CDC Surveillance Summaries, 1996).

Even rural states, such as Montana, have HIV infected individuals. Of growing concern is the increased incidence of HIV/AIDS cases in rural areas of the United States. Just as the characteristics of affected populations have shifted from a predominately white homosexual/bisexual population to one now including more minorities, injecting drug users and women, there has also been an increasing proportion of AIDS cases diagnosed in non-metropolitan areas (Fordyce & Thomas, 1997). The number of AIDS cases in rural U.S. increased 80 percent between 1991 and 1995. Rural populations represent 6.7 percent of all AIDS cases in the United States in 1996 and preventing the spread of HIV infection in rural areas is becoming a strong priority (American Association for World Health [AAWH], 1997).

Montana's total population is 879,372 and forty-eight percent of this population is rural. As of December 31, 1997, a total of 373 cases of AIDS had been reported to the Montana Department of Public Health and Human Services (Damrow & Murphy, 1998). The distribution of AIDS cases in Montana by age at diagnosis is highest in individuals aged 20-29 and 30-39. In all regions, males are affected more than females. In terms of reported AIDS cases among various racial/ethnic populations, whites are most affected, making up 88% of the state's total. Native Americans account for 7% of AIDS cases; African Americans for 3%; and Hispanics for 3% (Damrow & Murphy, 1998).

In an effort to decrease the rate of HIV/AIDS cases in Montana, prevention efforts are planned to target high-risk populations. According to Montana's Department of Public Health and Human Services (1998), the following are the eight high-risk populations in Montana: 1) men having sex with men (MSM); 2) injection drug users (IDU); 3) youth at risk; 4) women with high risk behaviors; 5) Native Americans with

high-risk behaviors; 6) HIV-infected individuals and sex partners of HIV-infected individuals; 7) incarcerated populations; and 8) people with hidden risk behaviors.

In comparison to the national rates of HIV/AIDS occurrence in high-risk populations, Montana follows similar patterns. Men having sex with men is the population with the highest numbers of infection in the United States. This is also the main exposure category in Montana. AIDS cases in the United States increased among women, African Americans, and people infected heterosexually and through injection drug use (CDC Surveillance Summaries, 1996). Montana and other rural areas are faced with evidence suggesting an increase in HIV/AIDS incidence (Sowell, et. al, 1997).

Because Montana is a rural state and there has been evidence of increasing incidence of HIV/AIDS in rural areas, it is critical to examine the prevention needs of high-risk populations within the state. Needs assessment data assists health educators and prevention program planners to create comprehensive prevention, education, and awareness programs. A needs assessment is the process of obtaining and analyzing findings through multiple methods of information and data collection to determine, through community participation, the type and extent of unmet needs in a particular population or community (The Academy of Educational Development, 1994). Primary (surveys, focus groups, interviews) and secondary (international, national, state, or local health records) data are included in a needs assessment.

Examining, determining, and evaluating HIV/AIDS prevention needs of Montana's high-risk populations is crucial to controlling the spread of the disease. Across the state of Montana, there are five separate health planning regions. Each region conducts needs assessments for the high-risk populations in order to identify prevention needs. Currently,

a comprehensive report identifying prevention needs statewide does not exist. In an effort to advance prevention programs and meet the prevention needs of high-risk populations, an analysis of existing statewide needs assessment data would provide the State Planning Group (SPG), the Montana Department of Public Health and Human Services, regional planning committees, and local health educators with a comprehensive report.

Being able to fill any information gaps that exist within the current statewide needs assessment data is possible through a content analysis of each individual's needs assessment and a research synthesis of all needs assessments data across each high-risk group.

Content analysis is a research procedure that is used to objectively evaluate the specific attributes of written communication, but can be applied to other message forms in order to generate replicable and valid inferences from data to their setting (Weston & Ruggiero, 1985/1986). Content analysis is also described as a research technique that can combine qualitative and quantitative methods to gather information (Duncan, 1989).

A research synthesis requires the researcher to identify, interpret, and draw conclusions from a set of research studies that have some relation to a particular problem or topic. According to Borg (1993), an ideal research synthesis covers the findings of research conducted by a variety of researchers with different theoretical and practical perspectives and examines various aspects of a problem. One of the main purposes of research integration and synthesis is to direct future research so that it yields a maximum amount of new information (Cooper, 1982).

Statement of the Problem

Montana's identified high risk populations have unmet HIV/AIDS prevention needs. Without further investigation and synthesis of existing statewide HIV/AIDS needs

assessments, those prevention needs will not be fully recognized, thus limiting the future HIV/AIDS needs assessments and HIV/AIDS prevention programming.

Purpose of the Study

The purpose of this study was to synthesize the existing statewide HIV/AIDS needs assessment data into a comprehensive report. This data was then categorized according to Montana's identified high-risk populations. The comprehensive report includes: 1) a description of the assessments which have been conducted with each population; 2) results of individual assessments; 3) a synthesis of HIV/AIDS prevention needs assessment results for each population; 4) information gaps within the current needs assessment data; and 5) recommendations for future needs assessment activities.

Research Questions

1. What are the HIV/AIDS prevention and intervention needs of Montana's high-risk populations (men having sex with men, injection drug users, youth at risk, Native Americans with high risk behavior, women with high risk behavior, HIV-infected individuals and their sex partners, incarcerated populations, and individuals with hidden risk factors), based on existing statewide needs assessment data?
 - a. What are the common behaviors, levels of HIV/AIDS knowledge, and attitudes, perceptions, and beliefs about HIV/AIDS for each high-risk group?
2. What information gaps exist in the current statewide HIV/AIDS needs assessment data?

Need for the Study

Before HIV/AIDS prevention programs are planned and fully implemented, the needs of the populations must be assessed. Assessing the needs of the target populations may be the most critical step in the program planning process. Without such an assessment, HIV/AIDS prevention programs will not reach full potential. In order for statewide HIV/AIDS prevention programs to be designed and implemented effectively, a comprehensive report must be conducted regarding needs assessment data for the identified high-risk groups. Currently, there is no existing comprehensive report in Montana. By providing Montana's Department of Public Health and Human Services (DPHHS) with a comprehensive report, HIV/AIDS prevention needs will be identified for each high-risk group and recommendations for future needs assessment activities and prevention planning will be indicated.

Significance of the Study

This study provides DPHHS, Statewide Planning Group (SPG), planning committees and programmers with a comprehensive profile of existing HIV prevention needs assessment data in the state of Montana. Information from this study will be used by the DPHHS, SPG, regional planning committees, and local health education programmers to develop future HIV/AIDS needs assessments and prevention programs for each high-risk population.

Results of this study can be used to: 1) indicate HIV/AIDS prevention needs for each high risk group; 2) identify any information gaps that exist within the current needs assessment data; 3) provide recommendations for future HIV/AIDS needs assessment

studies; 4) serve as a guide for prevention programs; and 5) ultimately assist in reducing the incidence of HIV/AIDS infection in Montana.

Assumptions

The following assumptions were made while collecting data for this study:

- 1) All needs assessments conducted within the past five years will be available.
- 2) Needs assessment data will be available from all regions of Montana.
- 3) All respondents and participants of the collected needs assessments answered questions honestly and accurately.

Limitations

The following are possible limitations that may exist within this study:

- 1) All needs assessments for each high risk group were not accessible.
- 2) Analysis and interpretation of the collected needs assessments may be influenced by the researcher's personal perceptions and biases.
- 3) The reliability and validity of the instruments used in collecting the needs assessment data may be unknown.

Delimitations

The following delimitations or boundaries were considered for this study:

- 1) Needs assessment data was delimited to the past five years.
- 2) Needs assessment data was delimited to the state of Montana.

3) Needs assessment data was delimited to Montana's high-risk groups.

GLOSSARY

AIDS: Acquired Immunodeficiency Syndrome; characterized by the severe HIV (Human Immunodeficiency Virus) related immunosuppression and associated conditions which include life threatening illnesses (NASTAD Social Marketing Update, 1997).

Content Analysis: A research procedure that is used to objectively evaluate the specific attributes of written communication, but can be applied to other message forms in order to generate replicable and valid inferences from data to their setting (Weston & Ruggiero, 1985/1986).

Epidemiology: The study of the patterns and determinants of health and disease in populations (Odgen et al., 1996).

Epidemic: “Circumstance where a disease spreads rapidly through a community in which that disease is normally not present or is present at low prevalence” (Schochetman & George, 1994, p. 393).

High-Risk Behaviors: Behaviors that allow persons to come into contact with blood, semen, and vaginal fluids of HIV-infected individuals. These behaviors include vaginal and anal intercourse with persons infected with HIV/AIDS, and sharing hyperdermic needles (Rathus & Boughn, 1993).

Human Immunodeficiency Virus (HIV): The causative agent of AIDS. An individual may be infected with HIV for several years before developing any of the symptoms or conditions associated with an AIDS diagnosis. That is, a person may be HIV-infected (or HIV-positive), but not have AIDS (NASTAD Social Marketing Update, 1997).

Incidence: “The number of new cases of a disease that occur in a defined population within a specified time period (Schochetman & George, 1994, p. 394).

Needs Assessment: “Needs assessment is a planned process that identifies the reported needs of an individual or a group” (Gilmore & Campbell, 1996, p. 5).

Prevalence: “The total number of cases of a disease in existence at a specific time and within a well defined area; the percentage of a population affected by a particular disease at a given time” (Schochetman & George, 1994, p. 396).

Research Synthesis: A research method that identifies, interprets, and draws conclusions from a set of research studies that have some relation to a particular problem or topic (Borg, 1993).

CHAPTER II

Review of the Literature

Overview of the HIV/AIDS Epidemic

AIDS (acquired immunodeficiency syndrome) is a condition caused by a virus called HIV (human immunodeficiency virus). The HIV virus essentially attacks the immune system and when that system fails, a person with AIDS can therefore develop a variety of life-threatening illnesses (CDC, 1994). HIV is a virus that cannot survive outside of the body, so individuals cannot be infected from toilet seats, door knobs, tears, sweat or drinking fountains. HIV can be transmitted through certain body fluids, such as blood, semen, vaginal secretions and breast milk. Once the virus is present in the body, it can remain dormant for months or years. During this time, HIV may be causing damage to the immune system without an individual's awareness. HIV-positive individuals may appear and feel healthy and not even know they have the virus, thus increasing the chances of spreading HIV to others (Dobkin, 1995).

Any person can be infected with HIV. The virus has affected men and women, homosexuals and heterosexuals. It is found in all races, nationalities, and age groups. Acquired Immunodeficiency Syndrome (AIDS) was first reported in 1981. Globally, over 30 million people have been infected with HIV. According to the World Health Organization (WHO), over 8,000 people are newly infected every day. Despite education, prevention, and treatment programs, HIV/AIDS remains a global health threat. In the United States, the epidemic has been highest among gay men, injection drug users, women

who have sex with infected men, children born to HIV infected women, and people who received blood transfusions in the early 1980s (CDC, 1994).

HIV/AIDS in the United States

As of December 1997, 641,086 Americans had been reported with AIDS. At least 385,000 of them have died. Estimates indicate that 650,000 to 900,000 Americans are now living with HIV, and at least 40,000 new infections occur each year. AIDS occurrence increased in all regions of the United States through 1994, with the most dramatic increase in the South. In 1996, AIDS incidence dropped in the Midwest (-10%), the West (-12%), and the Northeast (-8%), and leveled in the South (0%). The largest proportion of AIDS cases is among Americans ages 25-44. In 1996, an estimated 57,260 Americans were diagnosed with AIDS. Of these, almost 75% were among people ages 25-44 (CDC—Trends in HIV/AIDS Epidemic, 1998).

As a result of treatment advances, the progression of HIV infection to AIDS and from AIDS to death has been delayed in recent years. In 1996, estimated AIDS incidence dropped for the first time, declining 6%. Deaths among people with AIDS also dropped for the first time in 1996 by 25% (CDC—Trends in HIV/AIDS Epidemic, 1998).

As of 1996, United States AIDS cases remained highest among men who have sex with men (MSM) and increased most drastically among women, African Americans, and people infected heterosexually and through injection drug use (CDC Surveillance Summaries, 1996). In 1994, AIDS cases began to decrease slightly among men, with a more drastic drop of 8% from 1995 to 1996. This decline in incidence among men is a result, in part, of targeted prevention efforts. Among women, AIDS occurrence was

increasing approximately 8% through 1994 before the impact of new treatment services and options. From 1995 to 1996, AIDS incidence among women increased 1% (CDC, 1998).

AIDS rate of occurrence increased among all races through 1994, with the largest increase seen among African Americans. By 1996, African Americans accounted for more AIDS diagnoses annually than whites. In 1995, AIDS incidence dropped slightly among whites (-3%), with a larger drop seen in 1996 (-13%) as treatment began having an even greater effect. For African Americans and Hispanics, AIDS incidence increased through 1995, with a decline in 1996 among Hispanics (-5%) and a leveling among African Americans (0%). The percentage of AIDS cases among Asians and Native Americans remains less than 1% (CDC, 1998).

AIDS cases in the United States increased among the following groups through 1994: men who have sex with men (MSM), injection drug users (IDU), and heterosexuals. Heterosexual AIDS cases increased most rapidly during this period. The first drop in reported AIDS cases was evident among MSM in 1995 (-2%), with a more significant drop in 1996 (-11%). AIDS cases among IDU was increasing at approximately 5% each year and dropped 5% in 1996. AIDS cases among heterosexuals was increasing by approximately 15% annually before 1996 and slowed to an increase of 7% in 1996 (CDC, 1998). For all three groups, the decrease in AIDS incidence is likely due to treatment efforts. Even though the implementation of new treatment services for individuals with HIV/AIDS has been decreasing AIDS incidence, it does not relate to HIV incidence. In actuality, the number of new HIV infections that occur each year is not

slowing down and in fact, the number of reported HIV cases is under-represented due to infected individuals not being tested and/or diagnosed.

HIV/AIDS in Rural States

Even rural states, such as Montana, have HIV infected individuals. Between 1988 and 1990, the top U.S. counties with the largest increases of HIV were rural, with average populations of 73,000 (Lam & Lui, 1994). The AIDS rate in rural U.S. increased 80 percent between 1991 and 1995. Rural populations have the highest rates of increase in AIDS cases, representing 6.7 percent of all cases in the United States in 1996, with heterosexual contact accounting for most cases in many areas (American Association for World Health [AAWH], 1997).

According to Bell (1991), high-risk sexual behavior among homosexual/bisexual men in smaller cities and rural areas in the South are much higher than rates reported for gay men in larger cities. Fordyce and Thomas (1997) noted that just as the characteristics of affected populations have shifted from a predominately white homosexual/bisexual population to one now including more minorities, injecting drug users and women, there has been an increasing proportion of AIDS cases diagnosed in non-metropolitan areas. AIDS incidence and mortality data suggest a shift in AIDS cases from urban to rural areas and from coastal to interior parts of the United States (Fordyce & Thomas, 1997).

An examination of descriptive epidemiologic studies conducted at the University of Virginia Health Sciences Center identified trends in HIV and/or AIDS-infected individuals in a predominately rural population. Individuals in the study were adult patients with HIV infection or AIDS who were cared for between 1982 and 1993. The frequency of cases in minority and female heterosexual patients increased significantly. Patients who believed

they had acquired the infection in Virginia were more likely to cite a rural area of acquisition and to have had multiple heterosexual partners. They were less likely to have had male homosexual contact than patients who believed they had been infected in other states (Roberts, et. al., 1997).

Most studies performed during the past ten years have focused on people living in large metropolitan areas. Because of possible social stigmas that occur with HIV/AIDS, rural areas have reason for concern. Compared with urban counterparts, rural individuals with HIV reported a lower satisfaction with life, lower perceptions of social support from family and friends, reduced access to medical and mental health care, elevated levels of loneliness, more community stigma, and heightened personal fear (Heckman, et. al., 1998).

High risk behaviors among adolescents living in rural areas have been reported to be as frequent as those of lower socioeconomic minority youth living in urban areas (DuRant, et. al., 1992). DuRant, et. al. (1992) surveyed a sample of 294 youth living in a rural county in Georgia to determine if rural adolescents possess adequate knowledge to make responsible decisions to avoid exposure to HIV. This particular county had significant social problems including high rates of sexually transmitted diseases, sex-for-drugs, poverty, and drug abuse.

DiClemente, et. al. (1993) found that rural adolescents have higher levels of HIV knowledge, particularly about risk-reduction. However, rural adolescents also reported higher rates of high-risk behaviors. Another study examining adolescents in rural southern Indiana indicated that rural teenagers believe that HIV and AIDS do not affect them. Results of the study also indicate that both male and female teenagers would not practice

abstinence to avoid HIV. Both groups also felt it was embarrassing to buy condoms in town because the store workers would most likely know them or their family (Louisville Courier, 1997).

A descriptive study examining HIV/AIDS patients in rural eastern North Carolina identified the most affected population to be female, heterosexual, non-white, and younger compared to those of urban areas (Rumley, 1991). In addition, Sowell, et. al. (1997) reports that a growing number of cases of HIV infection are being diagnosed in rural communities and especially among women.

In regards to drug use and HIV infection, rural addictions and related high-risk behaviors have received limited attention in rural areas of the United States when compared with urban areas. However, prevalence rates of drug and alcohol abuse are similar in rural and urban areas (Leukefeld & Godlaski, 1997).

According to a report of HIV/AIDS among American Indians and Alaskan Natives in the United States from 1981-1997, the most frequently reported mode of HIV exposure among Native Americans and Alaskan Natives was men who have sex with men (MSM). A larger percentage of AIDS cases among this population were associated with MSM who also were injecting drug users (Morbidity and Mortality Weekly Report [MMWR], 1998). Another characteristic of this population, when compared with all persons who have AIDS, a lower proportion of Native Americans and Alaskan Natives resided in metropolitan areas with populations greater than 1,000,000 and a higher proportion resided in rural areas with populations less than 50,000 (MMWR, 1998).

HIV/AIDS in Montana

Montana's total population is 879,372. Forty-eight percent of this population is rural. In comparison, twenty-four percent of the United States population live in rural areas. Because the rate of HIV/AIDS incidence has increased significantly among rural areas in the United States, HIV/AIDS prevention in Montana is essential. As of December 31, 1997, a total of 373 cases of AIDS have been reported to the Montana Department of Public Health and Human Services (Damrow & Murphy, 1998). In 1997, Montana's case rate (AIDS cases per 100,000 population) was 5.2. This number is adjusted to include non-resident cases. The national case rate is 22.3 (Damrow & Murphy, 1998).

Montana is separated into five separate regions for health planning purposes. Reported AIDS cases in Montana continue to follow population patterns throughout the state. The distribution of AIDS cases in Montana by age at diagnosis is highest in individuals aged 20-29 and 30-39. Of the 373 total reported AIDS cases, 177 occurred in the 30-39 age category and 83 occurred in the 20-29 age category. In all regions, males are effected more than females. In fact, the male to female ratio of AIDS cases is 10:1. Compared with national increases in women living in urban areas, cases among Montana's women remain relatively distributed over time. In terms of reported AIDS cases among various racial/ethnic populations, whites are the group most affected, making up 88% of the state's total. Native Americans account for 7%; Blacks for 3%; and Hispanics for 3% (Damrow & Murphy, 1998).

High-Risk Populations

Unfortunately, new advances in treatment services does not slow or stop the spread of HIV infection. However, rate of HIV infection among high risk groups can decline through prevention efforts. High-risk groups have been identified in an effort to prevent the spread of HIV infection through education, outreach, counseling, testing, and other methods. Because each high-risk group has specific prevention needs, it is important to categorize the groups accordingly based on those needs. High-risk groups are chosen because of high or increasing numbers, proportions, or other estimates of the impact of HIV infection and may be defined in many different ways. High-risk groups often reflect a combination of race/ethnicity, gender, age, and risk behavior.

HIV infection can happen to anyone and it's not necessarily who you are, but what you do. High risk behavior will leave any individual susceptible to HIV infection. High risk behavior includes having unprotected anal or vaginal sex with someone who is infected, performing oral sex on an infected individual, or sharing needles with an HIV infected person or injecting any substance with an unsterile needle. This is probably the most direct means of becoming infected (CDC, 1990).

Two other means of transmitting the HIV virus are from mother to child and through blood transfusions. Women infected with HIV can pass the virus to their babies during pregnancy or during birth. The virus can also be passed on during breast feeding. A number of people became infected through blood transfusions prior to 1985, when screening and testing of all blood donations began (CDC, 1994).

In an effort to decrease the rate of HIV/AIDS cases in Montana, prevention efforts are planned to target high-risk populations. According to Montana's Department of

Public Health and Human Services, the following are the eight high-risk populations in Montana: 1) men having sex with men (MSM); 2) injecting drug users (IDU); 3) youth at risk; 4) women with high risk behaviors; 5) Native Americans with high risk behaviors; 6) HIV⁺ individuals and sex partners of HIV⁺ individuals; 7) incarcerated populations; and 8) people with hidden risk behaviors.

Men Having Sex With Men

State totals show that men who have sex with men is the main HIV exposure category reported, accounting for 63% of the cases in Montana men. Men who reported injecting drug use and men reporting a combination of male-to-male sexual contact and injecting drug use make up another 22% of reported cases. Together, male-to-male sexual contact and injecting drug use comprise approximately 85% of the AIDS cases among men in Montana (Damrow & Murphy, 1998). In a 1997 study, 43% of a sample of MSM perceived themselves to be at no or low risk of becoming infected with HIV (Mochi, 1997).

Intravenous Drug Users

Injecting drug use is another exposure category placing both males and females at risk for HIV/AIDS infection. Of the 373 total AIDS cases, forty individuals were infected by injection drug use. Thirty-eight of the forty cases are males; two are females. Injecting drug use is linked, directly and indirectly, to approximately 25% of Montana's AIDS cases (Damrow & Murphy, 1998). According to a study by the Department of Health and

Human Performance at the University of Montana, intravenous drug users in Montana perceived themselves to be at low or no risk of becoming infected (Mochi, 1997).

Youth At Risk

Generally, the percentage of students reporting high-risk behaviors in Montana has remained minimal over the past two years. The U.S. Centers for Disease Control has been administering a national survey called the Youth Risk Behavior Surveillance System, or YRBS. The survey allows monitoring of behaviors that influence health and possibly place youth at risk for significant health and social problems during adolescence (Damrow & Murphy, 1998). Information from the Montana YRBS is primarily information on youth in school. The data presented for high-school students is from a random survey; the information from junior high and Native American students is not.

Data indicate that Montana high-school students are less sexually active than their national counterparts. Forty-six percent of 9th-12th grade students report not having had sexual intercourse. Twenty-two percent of 7th and 8th grade students report not having had sexual intercourse. Seventy three percent of Native American students living on reservations report having sexual intercourse, while 64% of urban Native Americans report having had sexual intercourse.

Condom use or partner condom use is as follows for the four groups of surveyed students: 58% of 7th and 8th grade students; 55% of 9th-12th grade students; 46% of American Indian students on reservations; and 42% of American Indian students in urban areas (Damrow & Murphy, 1998). Other risk behaviors among Montana's Junior high, Senior high and Native American students include multiple sex partners and use of alcohol or drugs prior to sex. Condom use is less frequent among Montana's Native American

students. Alcohol and drug use prior to sex is also higher among the Native American student population (Damrow & Murphy, 1998).

Women with High Risk Behaviors

Among Montana female AIDS cases, heterosexual contact with an HIV-infected or at risk individual is the major exposure category. It is estimated that 80% of female AIDS cases in Montana are due to heterosexual contact. While only nine of the 335 adult male AIDS cases are due to heterosexual contact, 23 of the 34 adult female cases are the result of heterosexual contact (Damrow & Murphy, 1998).

Native Americans with High Risk Behaviors

Montana's Native Americans have not followed the national trend of the HIV epidemic disproportionately affecting minority populations. Native Americans at high risk for HIV/AIDS usually fall into the men having sex with men (MSM) and intravenous drug user (IDU) categories. Because of Montana's large Native American population, high-risk behaviors have been addressed through prevention efforts by tribal educators and urban clinics.

In recent studies conducted by the Department of Health and Human Performance at the University of Montana, Native Americans reported themselves to be at low or no risk for infection (Landry, 1998 and Mochi, 1997).

HIV-infected individuals and sex partners of HIV-infected individuals

Because it is difficult to determine how many individuals are infected with HIV, there is not an exact number of HIV-infected individuals in Montana. Prevention efforts to reach both infected individuals and their sex partners continues to be a priority in order to decrease the spread of HIV.

Incarcerated Populations

In general, there is concern among health educators about the spread of HIV/AIDS in incarcerated populations. Because injection drug use and male homosexuality is evident among this population, it places them at high-risk for HIV/AIDS if they engage in such behaviors.

People with Hidden Risk Behavior

This population has also been defined as the general public. In other words, these individuals perceive themselves to have no risk of becoming infected with HIV/AIDS or know they are at risk, but will not admit to risky behaviors. Whether it be lack of HIV/AIDS knowledge and awareness, or denial of risky behavior, this population may need more education regarding prevention of HIV/AIDS.

Qualitative Research

Qualitative research is a method that involves interpretation and analysis of the data using description, narratives, quotes, and charts and tables (Thomas & Nelson, 1990). As in all types of research methods, the first step to conducting a qualitative research study is defining the problem. The decision of what type of methodology to use is based on what the qualitative researcher wants to know about the problem. Qualitative research methods include the following types of data collection: 1). in-depth, open ended interviews (individual or focus group interviews); 2) direct observation; 3) written documents, including sources such as diaries and questionnaires; and 4) researcher-designed instruments (Thomas & Nelson, 1990).

Data analysis in qualitative research is considerably different from traditional quantitative research. Qualitative research is often done in a manner similar to multiple experiment research, in which discoveries made during the study shape and direct each successive phase of the study. Thus, simultaneous data collection and analysis allows the researcher to direct the data-collection stage more effectively. Analysis then becomes more intensive after the data have been collected (Merriam, 1988).

Another basic difference between quantitative and qualitative data analysis is that qualitative data are generally presented by words, descriptions, and images, whereas quantitative analysis is typically presented through numbers. The general phases of qualitative research analysis include sorting and analysis during data collection, analysis and categorization, and interpretation.

Analysis is the process of making sense out of one's data. Goetz and LeCompte (1984) recommend reading the data again before analysis to ensure completeness and to generate analytic categories. This is the beginning of the stages of organizing, abstracting, integrating, and synthesizing, which ultimately permit the researcher to report what has been seen and heard. An outline may be developed to search for patterns that can be transformed into categories (Thomas & Nelson, 1990). Burns (1989) suggests that the researcher identify the categories or common elements used and the rules used to place data into the categories. It is the categories that provide a clear picture of the phenomenon.

The qualitative researcher faces a formidable task in sorting the data for content analysis. Obviously, there are many types of categories that can be devised with any given set of data, depending on the problem (Thomas & Nelson, 1990). Categories can range in

complexity from relatively simple units of behavior types to concepts or theories (Merriam, 1988). Furthermore, categorization of data is one of the key components of true qualitative research. Instead of using basic description, the researcher may use descriptive data as examples of the concepts that are being advanced. The data need to be studied and categorized so that the researcher can retrieve and analyze information across categories as part of the inductive process.

Content Analysis

Content analysis is a research procedure that is used to objectively evaluate the specific attributes of written communication, but can be applied to other message forms in order to generate replicable and valid inferences from data to their setting (Weston & Ruggiero, 1985/1986). Content analysis is also described as a research technique that can combine qualitative and quantitative methods to gather information (Duncan, 1989). Qualitative content analysis involves examining the collected data manually in order to find constructs, general themes, and patterns (Krueger, 1994).

Kassarjian (1977) identifies objectivity and systemization as characteristics of content analysis. Objectivity provides a scientific standard to the analysis, thereby increasing the reliability and decreasing the subjectivity. Systemization applies consistent rules and guidelines in selecting the categories to be studied in an attempt to decrease bias. Systemization also creates the awareness of the connection between the characteristic of the chosen categories and the hypothesis or research question.

Kassarjian (1977) identifies the following components of content analysis: sampling, units of measurement, and categories of analysis. Sampling defines what and

how much of a phenomenon will be studied. Units of measurement include words or phrases, space-time measurements, and themes. Themes involve examining issues, values, beliefs, and attitudes.

The initial step in content analysis is to define the components of analysis. Secondly, establish the categories to allow the research questions or hypotheses to be answered. By defining the components of analysis and establishing specific categories, the researcher has created systematic guidelines to analyze the collected data. The instrumentation used to analyze data usually involves systematic charting and recording to insure all results are included. The results of a content analysis are usually written narratives/interpretations and sometimes descriptive statistics will be included. Descriptive statistics serve a useful purpose by summarizing all of the data in a form of a few simple numerical expressions, or statistics (Borg, 1993). The most common types of descriptive statistics are: mean, median, mode, frequency counts and percentages, range, and standard deviation (Borg, 1993).

Research Synthesis

In a research synthesis, the reviewer identifies, interprets, and draws conclusions from a set of research studies that have some relation to a particular problem or topic. Research syntheses vary in their scope; that is, the number of studies reviewed; the period of time covered; and the range of the subjects, settings, populations, and disciplines included. According to Borg (1993), an ideal research synthesis covers the findings of research conducted by a variety of researchers with different theoretical and practical perspectives and examines various aspects of a problem. The research reviewed may be

based on various research methodologies. The most common types of research syntheses are meta-analysis, meta-synthesis, integrative reviews, and conceptual-methodological critiques (Borg, 1993).

Meta-analysis has become the most widely used method for quantitatively combining research results from different studies. Meta-analysis involves translating the findings of a set of related studies into effect sizes. The studies are typically experiments that test the effectiveness of a particular program or method (Borg, 1993).

The integrative review is “primarily interested in inferring generalizations about substantive issues from a set of studies directly bearing on those issues” (Jackson, 1980). The reviewer will typically collect a group of studies that investigate the same questions through various procedures (Bangert-Drowns, 1986). The terms integrative review and meta-synthesis are often used interchangeably. One of the main purposes of research integration and synthesis is to direct future research so that it yields a maximum amount of new information (Cooper, 1982).

Qualitative research synthesis is defined as the theories, grand narratives, generalizations, or interpretive translations produced from the integration or comparison of findings from numerous studies (Sandelowski, et.al., 1997). Through qualitative research synthesis, researchers synthesize data from existing studies and provide comprehensive reports based on such components as their study design, techniques of sampling, data collection, and data analysis (Burns, 1989).

According to Jackson (1980), performing such a study may seem easy. However, this is incorrect, because the researcher must examine the biases within the studies, the reasons for any differences in the results, and what the body of research, taken as a whole,

reveals and does not reveal about the topic (Jackson, 1980). According to Cooper (1982), the scientific guidelines for integrating and/or synthesizing research involves five stages: 1) problem formulation; 2) data collection; 3) evaluation of data; 4) data analysis and interpretation; 5) presentation of results. Because there is risk of making false conclusions through integrative research methods, these guidelines assist researchers for the entire process. The formulation of the problem is the initial step that guides the remainder of the study. By asking specific research questions, the researcher clearly identifies the problem. Once the research questions have been asked and the problem has been formulated, data collection may begin. Deciding how the data collection will be performed is the first step in this process, such as literature searches, contacting other researchers, or retrieving information by “tracking” citations from one study to another. Once the data has been collected, the process of data evaluation follows by asking the following questions: where will the studies be obtained?; what procedures should be used to find relevant evidence?; and what criteria will be set to determine inclusion of studies?

In regards to inclusion of studies, Sandelowski, et. al. (1997) states that the issue of whether to include all or only good studies in integrations of research has created some debate among researchers. The conclusion by Sandelowski, et. al (1997) is that there are no solid arguments that can adequately address goodness in research studies.

Furthermore, Jackson (1980) notes that many researchers wish to eliminate studies from their analyses with results that have been seriously biased by methodological inadequacies. This may seem reasonable, but often faces several difficulties. Johnson (1980) goes on to say that first, almost all research studies have at least a few methodological inadequacies. Second, methodological inadequacies do not always cause biased findings. Third, it is

sometimes difficult to determine reliably when methodological inadequacies have caused biased findings and when they haven't.

The analysis and interpretation stage of qualitative synthesis is the process by which the researcher makes inferences from the primary studies (Jackson, 1980). The analytic task of research integration is seldom simple, because usually the methodology and findings of the examined studies vary moderately. After careful examination of each individual study, the researcher must choose qualitative or quantitative methods to perform the analysis. The results from each individual study will be synthesized into a unified statement (or result) about the research problem by using content analysis (Cooper, 1982). By using qualitative methods, the researcher produces narrative or theoretical combinations of studies in the same topical area, using such techniques as translation of key metaphors, concepts, and themes (Sandelowski, et. al., 1997). A useful qualitative technique to capture similarities and differences in numerous studies' results is the Venn diagram, in which circles and the spaces within the circles are used to represent overlapping and unique ideas (Cieutt, Krimerman, & Elder, 1969). Miles and Huberman (1994) suggest a visual data display, which allows researchers to recognize similarities and differences that shaped findings among studies, and the convergence or divergence of the findings themselves. Quantitative approaches typically apply one statistical technique to combine the results from several studies that previously used a variety of statistical techniques.

No matter what method is used, the aim of qualitative research synthesis is to account for all important similarities and differences in language, concepts, images, and other ideas around a target experience. In contrast to quantitative meta-analysis,

qualitative meta-synthesis is not about averaging or reducing findings to a common metric, but rather enlarging the interpretive possibilities of findings and constructing larger narratives or general theories (Sandelowski, et. al., 1997).

Needs Assessments

Assessing the needs of the target population may be the most critical step in the program planning process. Without such an assessment, HIV/AIDS prevention programs may not reach full potential. A needs assessment is the process of obtaining and analyzing findings through multiple methods of information and data collection to determine, through community participation, the type and extent of unmet needs in a particular population or community (The Academy of Educational Development, 1994). The purpose of a needs assessment is to: 1) assess existing community resources for HIV prevention to determine the community's capability to respond to the epidemic; 2) identify unmet HIV prevention needs within defined populations; and 3) prioritize HIV prevention needs by defined high-risk populations.

The following basic steps of the needs assessment process include: 1) determining the present state of health of the target population; 2) analyzing the data collected; 3) prioritizing the identified needs; and 4) validating the prioritized needs.

Needs assessment data can be gathered through a number of different methods. For example, one community may use surveillance strategies, while another community uses focus groups and public meetings. A needs assessment will incorporate information from providers (HIV counselors, health educators, nurses) and consumers (high-risk groups, persons being tested) of services (Academy of Educational Development, 1994).

Needs assessments use epidemiologic and other qualitative and quantitative data as the basis for making informed decisions about the adequacy of services (counseling, testing, education, prevention, etc.) available to a given population. Both primary and secondary data are included in a needs assessment. Primary data are data that are newly collected specifically for a task. Examples of primary data are single and multi-step surveys, community forums, focus groups, observations, and interviews. Secondary data are existing data that are gathered and used in a project. The main sources of secondary data include data collected by governmental agencies at any level (international, national, state, or local), data available from health records, and data that are presented in the literature (McKenzie & Smeltzer, 1997).

CHAPTER III

Methodology

The purpose of this study was to synthesize existing statewide HIV/AIDS prevention needs assessment data into a comprehensive report according to Montana's eight high-risk populations. The information from this study was used to identify the common themes (behavior, HIV/AIDS knowledge, and attitudes, perceptions, and beliefs about HIV/AIDS) across all needs assessment data for each high-risk group, identify information gaps in the existing statewide needs assessment data and assist in the future development of HIV/AIDS prevention programs. This chapter includes a description of the methods and procedures that were applied.

This study utilized a descriptive qualitative research design in an effort to analyze HIV/AIDS needs assessment data across the state of Montana. The purpose of using a qualitative research design was to examine and record the common themes, including risk behaviors, HIV/AIDS knowledge, and attitudes, perceptions, and beliefs about HIV/AIDS across all high-risk groups (men having sex with men, intravenous drug users, youth at risk, Native American with high-risk behaviors, women with high-risk behaviors, HIV-infected individuals and their sex partners, incarcerated populations, and people with hidden risk behaviors) in all regions (health planning regions in Montana).

The initial research phase was a content analysis and consisted of sorting and categorizing the needs assessment data. The first step involved sorting the assessments according to Montana's identified high-risk populations. Secondly, each assessment was analyzed based on the following categories: type of assessment, health planning region,

number of participants, age range, gender, race/ethnic background, sexual orientation, assessment administrator, and assessment outcomes (behaviors, knowledge, attitudes/beliefs/perceptions).

Needs assessment outcomes, such as behaviors, knowledge, attitudes, beliefs, and perceptions are defined by Green (1986) as concepts. When measuring concepts, the researcher is most interested in the properties of concepts. For example, health beliefs include beliefs in seriousness, in susceptibility, and in efficacy of prevention or treatment. The belief in seriousness includes dimensions such as fear, knowledge of risks, and attitudes toward risks for any given disease or health threat.

The second phase of data analysis was a research synthesis. The main purpose of the research synthesis was to examine common themes regarding risk behaviors, HIV/AIDS knowledge, and attitudes, perceptions, and beliefs about HIV/AIDS across all assessments conducted for each high-risk group. The other categories (type of assessment, health planning region, number of participants, age, range, etc.) were also examined and then synthesized to create a comprehensive report.

Description of Target Populations

The populations included in this study involve eight HIV/AIDS high-risk populations within the state of Montana. Because Montana is divided into five health planning regions (1-5), needs assessment data was obtained for each high-risk population in each region. According to the Montana Department of Public Health and Human Services, the HIV/AIDS high risk groups identified in Montana are: 1) men having sex with men; 2) intravenous drug users; 3) youth at risk; 4) women with high risk behaviors;

5) Native Americans with high-risk behaviors; 6) HIV⁺ individuals and sex partners of HIV⁺ individuals; 7) incarcerated populations; and 8) individuals with hidden risk behaviors.

Instrumentation

According to Duncan (1989), part of a content analysis procedure requires that categories of analysis be defined and that coding techniques be developed. For the purpose of this study, the instrument used for the content analysis phase was a data analysis chart to record HIV/AIDS needs assessment data, adapted from Fjeld (1998). Fjeld (1998) conducted a content analysis of health-related information found in consumer disability advertisements by using an analysis chart that included categories such as race, age, sex, health-related information, and main text message.

A separate data analysis chart was created for each needs assessment. The data analysis charts consist of the following categories: high-risk group, the assessment #, type of assessment, health planning region, # of participants, age range, gender, race/ethnic background, sexual orientation, assessment administrator, and assessment results (See Appendix A). These categories were chosen in order to provide comprehensive answers to Chapter One's research questions: what are the HIV/AIDS prevention needs of Montana's high-risk groups, based on existing statewide needs assessment data and what information gaps exist in the current needs assessment data?

Data Collection

The process of collecting existing HIV/AIDS needs assessment data for Montana's high-risk populations was performed as follows:

- 1) The reputational approach was used to collect needs assessment data from agencies, organizations, and individuals who have current needs assessments data. The reputational approach involves identifying individuals reputed to have influence in the targeted population (Nix, et. al, 1977). Contacts who are familiar with HIV prevention in Montana agreed to assist in collecting needs assessments data. With their assistance and from referrals that were made from various agencies, organizations, and individuals, the HIV/AIDS needs assessments data was collected until all sources were exhausted. Current needs assessment data, copies of the instruments used to conduct the needs assessments, and their results were requested from the agencies, organizations, and individuals. Furthermore, a contact person was identified to help obtain follow-up information regarding HIV/AIDS needs assessments data.
- 2) Upon request of current needs assessments data, the following criteria was given to the contacted agencies, organizations, and individuals:
 - a. Needs assessment data will be from the past five years.
 - b. Data will be collected from all regions of Montana.
 - c. Data will be collected from high-risk groups only.
- 3) After all sources had been exhausted in order to collect the HIV/AIDS needs assessments data, the collected needs assessments were sorted according to Montana's identified high-risk populations. Individual assessments for each

high-risk group were read thoroughly to determine which assessments were relevant to the study. The following criteria was used to determine their relevance:

1. Was the needs assessment conducted within the past five years?
2. Was the needs assessment addressing HIV/AIDS prevention needs?

Based on the above questions, the researcher determined which assessments/past studies would be included in the study. The purpose of this study was to collect all available needs assessment outcome data. Therefore, an assessment was not thrown out of the study based on its research methodology.

- 4) Each assessment was numbered using a separate color marker to distinguish which high-risk group.

Data Analysis

Analysis of the data occurred in two stages. A data analysis chart with specific categories was used to examine and record each individual assessment's contents to: 1) identify HIV/AIDS prevention needs across each high-risk population for all regions; 2) identify any information gaps that exist within the assessment data; and 3) report basic demographic information. Content analysis allowed the researcher to examine each assessment based on the pre-determined categories outlined in the data analysis chart (See Appendix A). The categories included, but were not limited to: health planning region (1-5), administrator of assessment, number of total participants/respondents, number of males/number of females, race/ethnicity, sexual orientation, type of assessment (focus groups, survey, etc.), and outcomes. The outcomes category included one or more of the

following: health risk behaviors, HIV/AIDS knowledge, and attitudes, perceptions, and beliefs about HIV/AIDS. Beneath the analysis chart is an area for “additional comments” that the researcher determined were important information, but did not apply to any of the outcome categories.

For each collected needs assessment, there was a separate data analysis chart to analyze and record the data from each individual assessment. For example, for the men having sex with men population, each individual assessment that was collected for this group was analyzed and recorded on a separate data analysis chart. When all collected assessments for men having sex with men were analyzed and recorded, the data analysis charts were complete for that high-risk group. This process continued until all assessments were analyzed and recorded for each high-risk group.

The next step was to synthesize the results from each individual assessment listed on the data analysis charts. In order to completely answer the research questions (Chapter One), the information from the completed data analysis charts was analyzed for common themes across each high-risk group. A qualitative research synthesis was completed by the following steps:

1. The number of total assessments for each high-risk group was recorded. The type of method used to conduct the assessments, such as interview, focus group, or survey, was also recorded and summarized.
2. The age range across all assessments was recorded, when available.
3. The years the assessments were conducted was reported.
4. The Health Planning region where the assessment took place was reported.

5. Needs assessment data, previously recorded on the data analysis charts, was analyzed to identify common themes and patterns within each high-risk group. To begin this process, the researcher read each of the data analysis charts several times to highlight key results for each category (behavior, knowledge, attitudes, perceptions, and beliefs).

The results of the research synthesis will have the capacity to: 1) identify the prevention needs of each high-risk population; and 2) identify any information gaps that exist in the needs assessment data.

CHAPTER IV

Results

The purpose of this study was to synthesize the existing statewide HIV/AIDS prevention needs assessment data into a comprehensive report. The data was gathered from the entire state of Montana by using the reputational approach until all resources were exhausted. Phone calls were made and letters were sent to local organizations, agencies, individuals, and health departments in order to obtain current needs assessment data. This data was collected and categorized according to Montana's classification of high-risk populations: men having sex with men, intravenous drug users, youth at risk, Native Americans with high-risk behavior, women with high-risk behavior, HIV+ individuals and their sex partners, incarcerated populations, and people with hidden risk behaviors.

Each individual needs assessment was first recorded on a data analysis chart by applying the content analysis research method (See Appendix B). The second step was to synthesize the assessments for each high-risk group by utilizing the methods of qualitative research synthesis. The synthesized needs assessment results provide the following: 1) Basic demographic information; 2) Common risk behavior, HIV/AIDS knowledge, and attitudes, perceptions, and beliefs about HIV/AIDS for each high-risk group. This chapter outlines the results of this study based on the conducted content analysis and research synthesis. Section one provides a brief summary of the demographic information and a description of each assessment for each high-risk group. Section two summarizes the common health behaviors, HIV/AIDS knowledge, and attitudes, perceptions, and beliefs about HIV/AIDS.

Section One: Basic Demographic Information and Description of Each Individual Needs Assessment

A total of thirty-one HIV/AIDS needs assessments were collected from the state of Montana. Included in the following sections are the results of the synthesized demographic information for each high-risk group and a brief description of each assessment. (Please note: these numbers may not represent different individuals, as some individuals may have participated in more than one survey, one individual may be reported in more than one high-risk group, and one needs assessment may be recorded in more than one high-risk group).

Men Having Sex With Men

Six assessments were collected for the high-risk group “men having sex with men.” All six assessments used the survey method. Four of the six assessments were conducted in health planning region three; the fifth was conducted in region five south; the sixth in region four. The collected assessments were conducted from 1993 through 1997 and a total of 603 respondents participated in the needs assessments.

In 1993, Criticare Health Education Services conducted a survey in region three with one-hundred gay men. Eighty-one percent of participants were white; four percent were Native American; three percent were Hispanic and eight percent were of other racial/ethnic backgrounds. The average age of the participants was 32.2 years.

In 1995, FDH & Associates conducted the same survey as Criticare had in 1993 in region three. A total of 133 participants responded to the survey. Eighty-eight percent of those respondents were white; four percent were Native American; three percent were Hispanic; two percent were from other racial/ethnic backgrounds and three percent did

not respond to the question. Ninety-nine percent of participants were over eighteen years of age.

In 1996, FDH & Associates conducted another survey with 161 gay men in region two. Eighty-nine percent of respondents were white and nine percent were Native American. The age of participants ranged from eighteen to over sixty-five. Seventy-five percent reported being HIV-negative; nine percent reported being HIV+.

Also in 1996, Robin Mochi, from the University of Montana, conducted a survey regarding barriers to HIV counseling and testing. A total of sixty-two participants were involved in the survey and all were eighteen years and older. No specific information regarding racial/ethnic background of participants was available.

In 1997, Jeff Feathergill conducted a survey at the Gay/Bi Men's Group in region four. Seven gay men participated in the survey. The age range of participants was 25-53 years. No information was available regarding racial/ethnic backgrounds of participants.

The sixth assessment was a survey conducted by the Gay Men's Task Force members in 1997 in region three. A total of 140 gay and bisexual men responded to the survey. Ninety-three percent of respondents were white; one percent were African American; two percent were Hispanic; two percent were Native American and two percent were from other racial/ethnic backgrounds. All participants were at least eighteen years of age or older.

Intravenous Drug Users

Four assessments were collected for the "intravenous drug user" group. A total of 165 individuals participated in the assessments. In 1995, 117 participants responded to a statewide survey that was conducted in various drug treatment centers across Montana.

Of the 117 participants, 67.5% were male and 32.5% were female. Eighty percent were white; 12.8% were Native American; 4.3% were Hispanic; 0.9% were African American and 1.7% were of other racial/ethnic backgrounds. The age of participants was fourteen years and older. No information was available regarding sexual orientation of the participants.

In 1996, Robin Mochi, from the University of Montana, also surveyed intravenous drug users. A total of thirty-nine individuals responded and seventeen were males; fifteen were females. Age of participants was eighteen years and older. No information regarding sexual orientation or racial/ethnic backgrounds was available.

In August of 1997, an in-depth interview was conducted with a 36-year old female that was receiving her second HIV test in the county jail in region five-north. No information was available regarding this individual's sexual orientation or race/ethnicity. The interviewer's name was also not available.

The fourth assessment was conducted in region four by Dianne Kimball (Butte-Silver Bow Health Department) at the Montana Chemical Dependency Center. This assessment was a focus group with eight participants. No information was available regarding the age, sexual orientation, number of males/females, racial/ethnic background of participants and year of assessment.

Youth At Risk

The "youth-at-risk" group represents seven of the total assessments. All of these assessments are the Montana Youth Risk Behavior Surveys (MTYRBS), which are conducted every two years. They are distributed to 7th-12th grade students in Montana

and analyzed by the Office of Public Instruction. A total of 25,373 students have been surveyed since 1993, using the MTYRBS.

Women with High-Risk Behaviors

One assessment was collected for the “women with high-risk behavior” group. This assessment was conducted statewide in various STD clinics in 1995. The age range of the participants who completed the survey was 14-47. A total of 75 women were participants in this assessment; 97.3% were white and 2.7% were other racial/ethnic backgrounds. No information was available regarding the sexual orientation of participants.

Native Americans with High-Risk Behaviors

The “Native Americans with high-risk behavior” group contains five needs assessments. One of the assessments did not provide a total number of participants. Therefore, of the remaining four assessments, a total of 336 individuals participated.

In 1997, a statewide telephone survey was conducted by trained telephone interviewers. From May to July 1997, the Montana Department of Public Health and Human Services conducted the telephone survey of adult American Indians living on or near the seven American Indian Reservations in Montana. Questions for this survey were taken from the Behavior Risk Factor Surveillance System and fifty-seven individuals responded. Forty-one percent of respondents were male and fifty-nine percent were female. The average age of male participants was 45 and average age of females was 41. No information was available regarding sexual orientation of participants. All participants were Native American.

Also in 1997, Robin Mochi conducted a survey regarding barriers to HIV counseling and testing with eighty-two Native American respondents. Thirty respondents were male and forty-eight were female. The age and sexual orientation of participants was not available.

In 1997, the Montana Youth Risk Behavior Survey was conducted with Native American students in urban schools. A total of 151 students, grades nine through twelve, participated. Eighty-five of the participants were male and sixty-five were female. The Office of Public Instruction and various Montana teachers administered the test. No information was available regarding sexual orientation of students.

Focus groups were conducted with homosexual and bisexual Native Americans from different areas across the state of Montana by Jay LaPlante. The sites of the focus groups were the Blackfeet Reservation, Flathead Reservation, Ft. Peck Reservation, and Missoula. It was reported by Jay LaPlante that the average number of participants was seven, with the exception of one group with only three participants. No information was provided regarding total number of participants, number of males, number of females, and year the focus groups were conducted.

The fifth assessment was conducted as a joint effort between the University of Montana and the Flathead Indian Reservation Health Services in 1998. Four focus groups were conducted and a total of forty-six individuals participated. Twenty-two were male and twenty-four were female. The age of participants was eighteen years and up. The focus groups were conducted with students from the Two River alternative school, representatives from the Indian Parent/Teacher Council, various tribal educators, and

members of the tribal jail. No information was available regarding sexual orientation of participants.

HIV-infected individuals and sex partners of HIV-infected individuals

Four assessments were conducted with HIV-infected individuals. Three of these assessments were surveys and the fourth was a telephone survey/interview. A total of 63 respondents participated in the four assessments.

A survey conducted by the City-County Health Department of Great Falls (region two) included eight participants. Seven participants were male and the eighth was female. Three identified themselves as heterosexual; three identified themselves as gay and one identified as bisexual. Six respondents identified themselves as white and two did not respond to the question. No information was available regarding the year of the assessment, the age of participants, or the name of the administrator of the survey.

In 1997, Ron Seibel conducted a survey at the HIV+ Men's Retreat with twenty-six men. Twenty-one were reported as white; one was black and four indicated being from other racial/ethnic backgrounds. The age of participants breaks down as follows: (15-29) = 4%; (20-29) = 4%; (30-39) = 54%; (40-49) = 15%; no response = 23%. Four respondents identified themselves as bisexual; eighteen reported being homosexual. Three participants reported being intravenous drug users.

Also in 1997, David Herrera conducted a survey at the HIV+ Retreat. This survey was developed by the Yellowstone AIDS Project and FDH & Associates. There were nineteen total respondents to the first portion of the assessment, which dealt primarily with needs and services. Eighteen total respondents answered the second portion of the assessment that dealt primarily with behaviors. No information was available regarding

the age of participants, sexual orientation, health planning region where assessment was given, number of males and females, and the race/ethnicity of participants.

In 1998, Claudia Montagne, from the Montana Department of Health and Human Services, conducted a telephone survey and interview with ten individuals. Five of the participants were male and five were female. All participants except for one male were Caucasian. The women were exclusively heterosexual; the men were all homosexual except for one who listed his sexual orientation as "other." The age breakdown is as follows: (18-24) = 1; (25-44) = 8; and (45-65) = 1. One respondent had known about her HIV infection for two years; four respondents had known for four years; one knew for six years; one for eight years; one for ten years; and two for twelve years. From a group of ten men and ten women who volunteered to participate at the Fall 1997 Retreats, the interviewer selected ten participants total, based upon their availability to interview during a two week period in January of 1998.

Incarcerated Populations

One assessment was collected with the "incarcerated population" group. This assessment was a Public health Survey, conducted by Dianne Kimball and the Butte-Silver Bow Health Department (region four) in 1996. A total of fifty-nine individuals participated in this survey, with an age range of 18 years and older. Sixty-three percent of the participants were white; 25% were Native Americans; 2% were Black and 10% were Hispanic. No information was available regarding total number of males/females and sexual orientation of participants.

People with Hidden Risk Behavior

Three assessments were conducted with the “people with hidden risk behavior” group. One of these assessments does not indicate how many total individuals participated. Based on the remaining two assessments, there was a total of 658 participants from this high-risk group.

In 1994, the Center for Population Research at the University of Montana conducted a survey with 590 college students. Males respondents totaled 270 and female respondents totaled 320. Ninety-seven percent reported being white; eleven individuals reported being Asian; four reported being African American; ten reported being Hispanic; and seventeen reported being Native American. The students were grouped by the following ages: 17-19 years; 20-24; 25 and older. No information was available regarding sexual orientation of the participants.

A focus group was conducted at Flathead Community College by Timothy Fanwand and Sharon Randolph in 1996. No information was available regarding total number of participants, age, sexual orientation, number of males and females, or race/ethnic background.

Another focus group was conducted by the Lake County Health Department at Salish Kootenai College in 1996. A total of sixty-eight individuals participated; fifteen were male and forty-three were female. Thirty-three identified themselves as Native American; fifteen reported white; three reported “other” and seventeen did not respond. The age range of participants was 16-60. No information was available regarding sexual orientation of the participants.

Section Two: Common Themes Across Each High-Risk Group

HIV/AIDS needs assessment data were analyzed for general themes and patterns that occurred within each high-risk group. Numerous themes emerged within each group regarding common health behaviors, levels of HIV/AIDS knowledge, and attitudes, perceptions, beliefs about HIV/AIDS. This section describes those themes within each high-risk group.

Men Having Sex With Men

Common Behavior Themes

Many common behavior themes emerged that place “men having sex with men” at particular risk for HIV/AIDS. The most common and significant reported behaviors were anal and oral sex, with five of the six assessments indicating that respondents participate in these behaviors. In addition to these behaviors, having unprotected anal and/or oral sex was reported by the vast majority of respondents in five of the six assessments. Alcohol and/or drug use was reported as a precursor to unsafe sex in the assessment conducted in 1997 by the Gay Men’s Task Force members. Another common behavior theme was having sex (either anal or oral) with multiple sex partners. Four of the assessments indicated at least forty-percent of the respondents have sex with more than one partner. Five of the six assessments asked respondents if they had ever been tested for HIV. The percent of respondents report having ever been tested for HIV ranged from 61%-89%.

Common Knowledge Themes

Two of the needs assessments surveyed levels of knowledge for this group. One assessment asked for self-assessed HIV/AIDS knowledge. Seventy-nine percent of the

100 respondents in the 1993 Criticare Survey reported they were receiving adequate information about AIDS and sixty-six percent reported they knew “a lot” about the HIV/AIDS epidemic. A second survey, conducted with a sample size of seven males at the 1997 Gay/Bi Men’s Group, indicated high levels of knowledge regarding the following: unprotected anal sex being the main route of HIV transmission, unprotected oral intercourse as a route of HIV transmission, an HIV negative test result doesn’t mean that unprotected sex is okay, use of oil based lubricants with condoms is not safe, and unsafe sexual behavior occurs while under the influence of alcohol/drugs.

Common Attitude, Perception, and Belief Themes

Many common attitude, perception, and belief themes were acknowledged while analyzing the data. In regards to sexual activity practices, the majority of the respondents in the FDH and Associates 1996 survey noted that unsafe sex occurred because: 1) respondents felt safe in a relationship; 2) believed that it interferes with intimacy; and 3) alcohol/drug use influenced unsafe sex practices. The assessment conducted by David Herrera and local Criticare staff in 1993 indicated that respondents reporting unprotected anal intercourse were significantly more likely to report that they intended to use condoms in the future and to practice safer sex after drinking.

In the 1997 survey, conducted by the Gay Men’s Task Force members, forty-one percent of the 140 respondents believed their sex practices over the last year were “less safe”, but that they intended to practice safer sex. In the same 1997 survey, forty-nine percent of respondents believed unprotected oral sex to be a low-risk sexual behavior. A final theme emerging from the 1997 survey was the majority of respondents reported feeling comfortable talking with sexual partners about safer sex practices and HIV status.

Many assessments examined the concerns and barriers related to HIV testing. The most prevalent reasons for either not getting tested for HIV or being concerned about the HIV test were: the waiting time for results, fear of the results, confidentiality, cost of the test, lack of trust in the health department, and fear of people finding out. In every assessment that examined the respondents' perceptions of their personal risk for the HIV virus, the vast majority of respondents reported feeling at low or no risk for HIV.

The majority of the assessments also asked respondents about their attitudes, perceptions, and beliefs regarding support they receive from "others." Respondents reported a perception of very little support from "others." The greatest needs reported by gay men were: desire for more social and support group meetings, friendships, information/resources on HIV/AIDS, dating and relationship skills, and more accessibility to meeting other gay/bi people or groups. Of equal importance are the support sources and areas of information that men perceive will encourage safer sex practices. The most commonly identified sources of support and information that would encourage safe sex practices were: support from friends and lovers, literature on safer sex, literature on HIV/AIDS, Gay Men's Task Force, the gay community, family, clinics/doctors, and counselors.

A final observation of the researcher was the significant amount of input from the respondents regarding their beliefs in ways to prevent HIV. The most common beliefs across four of the assessments were: increased communication, more HIV/AIDS education, safer sex, and condom distribution. In addition, the assessments indicated the belief that social stigma, fear of HIV/AIDS, and myths and stereotypes about the gay community need to be decreased in order to prevent HIV.

Intravenous Drug Users

Common Behavior Themes

The most common behavior among this high-risk group is the use of injection drugs. Certain behaviors that are related to injection drug use place users at higher risk for HIV. For instance, in three of the four assessments, questions regarding the behavior of sharing needles revealed that over seventy percent of the participants do share needles. The individual being asked questions in the in-depth interview indicated that sharing needles often occurs when people are high, because “you’ll do whatever it takes.” In the focus group conducted at the Montana Chemical Dependency Center, all eight participants stated they know people who share needles. Seven of the eight participants also stated they would do drugs even if the needle wasn’t clean when using it.

In addition, those respondents who share needles are not always cleaning their “works” with bleach. Forty-seven percent of respondents of the statewide survey, conducted in drug treatment centers, stated they do use bleach when cleaning works. Seventy-one percent of the same respondents (total of 117) reported sharing needles at one point in time. The survey also reported that fifty-six percent of respondents have changed drug/needle use to protect themselves from HIV infection.

Three of the four assessments asked questions about sexual behaviors that may place this group at higher risk. The statewide survey indicated that seventy-three percent of respondents have changed their sex lives to protect themselves from HIV infection. Thirty percent (of 24 respondents) usually practiced safe sex, according to the survey conducted in region five-south. The individual’s response from the in-depth interview was that condoms were only used “sometimes.”

Common Knowledge Themes

Six of the eight focus group participants felt that intravenous drug users do have adequate HIV knowledge. The in-depth interviewee indicated that IDUs have a lack of knowledge about getting Hepatitis C from intravenous drug use and unsafe sex.

The statewide survey asked the most in-depth questions to determine HIV knowledge, with all numbers representing a sample of 117. In regards to protective actions against HIV infection, sixty-eight percent reported that stopping injection drug use will protect; forty-four percent reported that use of a sterile needle and syringe every time injecting drugs will also protect. Sharing needles only with people you know was seen as a protective action by three percent of participants.

Knowledge of sexual behaviors that place a person at risk for HIV infection is as follows (based on 117 respondents). Ninety-four percent reported that having multiple sex partners places a person at risk. Having unprotected sex with another injecting drug user was seen as a risk behavior by ninety-one percent. Having unprotected oral, anal, or vaginal sex was reported as risk behavior by ninety-four percent. Eighty-six percent indicated that having sex with someone who is HIV positive places people at risk. Having sex while either self or partner was intoxicated and having sex while using drugs other than injection drugs were seen as risk behaviors by seventy percent.

The following figures represent the percent of the respondents (N=117) who felt the indicated behaviors are protection against HIV infection. Eighty-six percent report using a new condom, correctly, for each time you have sex is protection against HIV. Using spermicide each time you have sex was seen as protective by twenty-five percent.

Withdrawing prior to “cumming” was seen as protective action by thirteen percent.

Refraining from anal sex was seen as a protective action by forty-four percent.

Knowledge of modes of transmission of HIV infection was also assessed by the statewide survey. The exchange of HIV infected semen or blood during sex or injecting drug use was seen as a mode of transmission by ninety-two percent of respondents.

Sharing eating and drinking utensil of a person with HIV was seen as a mode by 2.6%.

Donating blood was seen as a mode by 4.3% and having a blood transfusion was seen as a mode by 18%.

Common Attitude, Perception, and Belief Themes

The statewide survey indicated that 34.5% of 117 respondents said “yes”, they considered themselves at risk for exposure to AIDS. Forty-six percent of 24 respondents in the survey conducted by Robin Mochi reported they had no or low risk of HIV infection. The in-depth interview revealed that concern about HIV/AIDS is not as obvious as concern about Hepatitis C. The focus group participants from the Montana Chemical Dependency Center indicated that the level of awareness about HIV/AIDS needs to be increased among the injection drug user population. The participants also felt that influencing people with a fear of AIDS will not work.

In the survey conducted by Robin Mochi, internal and external barriers to HIV counseling and testing were examined. The results of this study indicated the following internal barriers: perceived low or no risk, didn’t care, feared people finding out, uninformed about AIDS in Montana, lacked trust of health department, uneducated about HIV, and too scared of results. External barriers included: usual practice of safe sex, always practice safe sex, and practice only oral sex.

A final attitude and belief theme was the support of a needle exchange program. Three of the four assessments indicated an overwhelming interest in a needle exchange program. The majority of respondents in the focus group felt a local needle exchange program would provide access to syringes, bleach kits, and HIV/AIDS prevention information. Five of the participants felt that needle exchange would help decrease the number of people sharing needles. One of these participants stated that when she was fully into her drug addiction, she would use dirty needles from the garbage to take drugs if she didn't have access to clean needles. She also stated, "they need to be right out there. You shouldn't have to ask, that can deter people as well." Participants from the focus group and the in-depth interview stressed the need to have a safe place for needle exchange, such as family services, rescue mission, or porno shops.

Youth At-Risk

All of the Youth At-Risk surveys are the Montana Youth Risk Behavior Surveys. These surveys assess behaviors of seventh through twelfth grade students, therefore, no common knowledge, attitude, perception, and belief themes regarding HIV/AIDS exist. All results below include male and female responses combined.

Common Behavior Themes

Of the seventh and eighth grade students who completed the MTYRBS, approximately one-fourth report they have had sexual intercourse. A small percent of these students reported having sexual intercourse with four or more people during their life. Over fifty-percent (approximately 58%) of the sexually active students reported wearing a condom during their last sexual intercourse, meaning approximately 42% of students reported not using a condom the last time they had sexual intercourse. Close to

one-third of students reported using alcohol or drugs before sex. Males were more likely to report having had sexual intercourse than females.

The remaining assessments surveyed 9th-12th grade students across Montana, including the Native American Students in urban schools. Overall, over fifty percent of students reported ever having sexual intercourse. On average, eighteen percent of students reported having sexual intercourse with four or more people during their life. An average of fifty-three percent of students reported wearing a condom during their last sexual intercourse and an average of thirty-three percent of all respondents reported using alcohol or drugs before sex.

Women With High-Risk Behavior

One assessment from the “women with high-risk behavior” group was collected. The assessment was a survey conducted across the state of Montana in various Sexually Transmitted Disease (STD) clinics. The data was analyzed, interpreted, and reported by Krista Brumley. The results are summarized below, based on the sample size of 75 females, unless otherwise indicated.

Common Behaviors

Fifty-nine percent of respondents reported having only one sexual partner in the past twelve months; thirty-two percent reported having two to four partners and seven percent reported having five to nine partners. In regards to anal sex, thirty-nine percent reported ever having anal sex and fifty-nine reported never having anal sex. Twenty-four percent reported having sex with someone other than a steady partner. Fifty-nine percent of those having sex with someone other than a steady partner reported “sometimes” using a condom during sexual activities. Eighty-five percent (of 69 respondents) reported

having a steady partner and sixty percent of those respondents reported never using a condom with the steady partner. The majority, ninety-three percent, reported having sex with men only. Thirty-six percent of the respondents reported every having a sexually transmitted disease.

Eleven percent of individuals reported having sex with an individual who has used or uses intravenous needles, while another eleven percent reported not knowing. Seventy-eight percent reported using alcohol and/or drugs before or during sex “rarely” or “sometimes.” The following is an age breakdown for respondents who stopped having sex when using drugs or alcohol: adolescents = 0%; young adults = 10%; adults = 10%; and those over 35 years = 80%.

The respondents were asked questions about whether their behavior had changed because of knowledge of HIV/AIDS. The following are results to those questions: 95.5% did not stop having sex; 82.5% stopped having sex with partners they didn’t know well; 86% have fewer sex partners; 62.6% stopped having sex with a particular person; 79.7% have sex with only one person; 59.3% use condoms more often; 62.1% started using condoms; 70.8% changed use of drugs; 70.8% stopped having sex when they use drugs or alcohol; 50% did not change behavior at all.

Common Knowledge Themes

No questions on the survey assessed level of HIV/AIDS knowledge.

Common Attitude, Perception, and Belief Themes

Several questions were asked regarding attitudes toward condoms and sex. Fifty-six percent (of 73 respondents) said they would tell a partner what they do or do not like to do during sex. Eighty-seven percent stated it was “not true” that a partner would

become angry or upset if asked to use a condom. Eighty-three percent stated it was “not true” that a partner would think they were cheating if they asked for a condom to be used during sex.

Reasons for using condoms were for birth control and to protect against sexually transmitted diseases (STDs) and HIV/AIDS. Reasons for not using condoms were: use of oral contraceptives, tested negative for HIV, feels better/don't like them, and trust in their partner. Reasons for using a condom with someone other than a steady partner were for birth control and protection from STDs and HIV/AIDS. Reasons for not using a condom with someone other than a steady partners were that they were careless, don't like condoms, didn't have a condom to use, and alcohol use.

Native Americans with High-Risk Behavior

Common Behavior Themes

Four of the five assessments assessed behaviors of the Native American population. The most common themes emerging from these assessments were sexual activity practices and drug/alcohol use. Three of the assessments indicated that the majority of the Native Americans surveyed are not always practicing safe sex (with a condom). In the focus group conducted in 1998 on the Flathead Indian Reservation, the researchers found unprotected sex to be a common behavior. In addition, the focus groups indicated a lack of proper and effective condom use.

Two of the assessments asked respondents about the number of partners they have or have had sex with in the past. One of the assessments was a telephone survey and indicated that the age group that frequently has sex with multiple sex partners are the 18-30 year olds. The second of these assessments was the Montana Youth Risk Behavior

Survey and it indicated that twenty-three percent of the 9th-12th grade students reported having sex with four or more people during their life. Another finding in two of the assessments was that very few Native American men and women reported changing their behavior because of what they know about AIDS.

Alcohol and/or drug-use related questions were included in three of the five assessments. According to the focus group results from the Flathead Reservation, intravenous drug use and sharing needles were common among the Native American population. A second focus group, conducted statewide, included members that admitted to substance abuse problems; some were recovering alcoholics and had not drunk for many years. Finally, the Montana Youth Risk Behavior Survey, conducted with American Indian Students in urban schools, concluded that forty-one percent of all surveyed students reported using alcohol or drugs before sex.

Common Knowledge Themes

Two assessments surveyed the population to determine how many respondents were aware of and/or had knowledge about affordable STD clinics, the AIDS hotline, and HIV/AIDS testing locations. These assessments indicated that less than the majority of respondents are aware of these services. While the focus group results from the Flathead Reservation indicated that the Native American participants were unaware of the statistics regarding AIDS in Montana and their own community, the focus group conducted statewide indicated that the majority of participants had heard or knew of HIV/AIDS cases within the population. The focus group from the Flathead also indicated a lack of knowledge regarding proper condom use and factual HIV/AIDS information.

Common Attitude, Perception, and Belief Themes

The telephone survey reported that fifty percent of men and fifty-seven percent of women believed a needle exchange program would be acceptable. The phone survey and the Flathead Reservation focus group results also indicated a strong support for condom distribution.

Of the four assessments that questioned respondents' feelings of personal risk for HIV, the vast majority of respondents reported they are at low-or-no-risk of the disease. When asked why the respondents/participants were not being tested for HIV, the responses varied. One perception was that "nobody gets checked" in the community. Another common theme was the fear of getting tested and finding out the results. The most dominant theme was the fear of confidentiality being lost.

HIV-infected individuals and sex partners of HIV-infected individuals

Common Behavior Themes

Of the four assessments conducted with this high-risk group, numerous themes were identified in regards to behavior. Intravenous drug use was a very common behavior of the respondents. In addition to the intravenous drug use, sharing needles or using unclean needles was reported and interest in a clean needle exchange program was minimal. In the 1997 survey conducted by David Herrera (in conjunction with Yellowstone AIDS Project), 100% of respondents reported they had not participated in intravenous drug use, but 50% reported using marijuana in the past year; 44% reported using alcohol in the past year; and 11% reported using crystal/crank in the past year.

Common sexual behaviors that came forth during the analysis were: unprotected sex, anal sex, oral sex, and sex in public areas. Specific questions regarding sexual

practices were asked by the 1997 survey conducted by David Herrera. Results of this survey indicated that 50% of the nineteen respondents had engaged in anal sex in the last year and 56% of those individuals stated they did not always use a condom. Eighty-percent of respondents who reported not always using a condom stated they had multiple partners. Ninety-four percent reported they did not participate in vaginal sex and seventy-eight percent reported participating in oral sex. Twenty-eight percent of the respondents reported having mouth to rectum contact and all of those respondents reported they did not use a barrier when participating in this activity. Fifty-percent of respondents reported safer sex practices over the past year and the other fifty-percent reported no change in their sex practices.

Common Knowledge Themes

The majority of respondents from all four assessments reported knowing about their HIV-infected status for over five years. A second common theme was the group's high level of knowledge and awareness of HIV-related services and help available in their area, as indicated by the survey conducted by the City-County Health Department of Great Falls. The respondents also indicated knowledge of who to contact for HIV-related services information.

Knowledge regarding the safety of specific behaviors was examined by the 1997 survey conducted by David Herrera. Having unprotected sex, either receptive or insertive, was reported as unsafe by 84% of the respondents (19 total). Seventy-eight percent of respondents reported unprotected oral sex to ejaculation as unsafe behavior.

Common Attitude, Perception, and Belief Themes

One common attitude/perception theme identified by HIV-infected individuals in the Great Falls survey was the feeling of being discriminated against, particularly by medicaid, social security, and private insurance companies. A second theme revealed reasons for not always practicing safe sex. The most common reasons, reported by the majority of respondents in both assessments, were that it interferes with intimacy, it doesn't feel good, they lack access to condoms/lubricant, alcohol or drug use, and they don't care anymore. On the other hand, respondents identified several supportive individuals and reasons for practicing safer sex. Among those were families, partners/lovers, gay/lesbian/bisexual organizations, the health department, and spiritual affiliation.

Incarcerated Populations

One assessment was administered with the incarcerated population in 1996 by Dianne Kimball, from the Butte-Silver Bow Health Department. There were fifty-nine total respondents.

Common Behavior Themes

The majority of the questions regarding behaviors asked participants how many people they think engage in specific behaviors within the prison. The response choices were "some", "about half", "most", or "all." Seventy percent of the respondents stated that "some" people within the prison have sex with no protection and sixty-three percent stated that "none" of the prison population use condoms during sex. Seventy-three percent indicated that "some" of the population share injection needles without cleaning them and seventy-two percent stated that "some" share injection needles after cleaning

them. Finally, seventy-three percent report that “some” of the incarcerated population share other needles (tattoos and piercing) without cleaning them.

Common Knowledge Themes

Over fifty percent of the respondents indicated high level of HIV/AIDS knowledge regarding activities that are safe or unsafe in regards to becoming infected. The following responses were considered “safe” by over fifty-percent of all participants: giving blood, being bitten by mosquitoes or other insects, having a blood test, and touching toilet seats, bathtubs, spoons, cups or other objects. The following responses were considered “unsafe” by over fifty-percent of all participants: sharing needles or syringes with an infected person, having sexual intercourse with an infected person, sharing needles to make tattoos or pierce ears.

Additional questions determined level of knowledge regarding how a person can keep from getting the AIDS virus. The following were viewed, by over fifty-percent of the respondents, as ways to avoid getting the AIDS virus: having fewer sex partners, avoiding sexual activity, using condoms, avoiding the use of needles, and avoiding certain types of sexual partners. Fifty-four percent of respondents did not consider protection like plastic gloves, saran wrap or baggies to be a way of avoiding AIDS. Forty-two percent of respondents felt that cleaning needles before using them was not a way to decrease the risk of HIV/AIDS.

In regards of assessing the respondents’ knowledge of how to find HIV/AIDS information, eighty-one percent stated they knew how to find information. Forty-one percent have talked to someone about HIV/AIDS. Fifty-six percent indicated they know about the AIDS hotline and eighty-percent know where to get tested for the AIDS virus.

A final question assessing knowledge asked respondents if they had seen an AIDS brochure or poster in the past six months, and sixty-one percent said they had.

Common Attitude, Perception, and Belief Themes

Ninety-five percent of the respondents believed you can get AIDS from a person who looks healthy. The percent of respondents reporting how likely they think they are of becoming infected with the AIDS virus while in prison is as follows: 5% very likely; 15% likely; 25% unlikely; 42% very unlikely; 22% not sure.

When respondents were asked why they did not get tested for the HIV virus, twenty-percent reported that they didn't trust the prison health services. Nine percent didn't know where to get tested. Nine percent also reported that they didn't care to know if they were infected; seven percent felt they wouldn't have privacy and two percent felt fear of having the virus. Other reasons for not getting tested included: they have safe sex, tested negative, don't mess around, don't care, not a worry, and not at risk for HIV.

Respondents were also asked about the best way to get information about HIV/AIDS to the incarcerated populations. Forty-seven percent said that printed materials would be the best source of information; twenty-eight percent said video tape or television; and twenty-five percent said through group discussions. Suggestions for other ways the prison health department might help the prison population avoid becoming infected with the AIDS virus were: more education, condom distribution, clean needles, and finding a cure.

People With Hidden Risk Behavior

Common Behavior Themes

Two of three assessments examined common behaviors among “people with hidden risk behavior.” The 1994 survey, conducted at the University of Montana, indicated that males reported more risky sexual behavior and assumed more sexual risk than females. In addition, this survey indicated that low knowledge of HIV/AIDS is associated with the highest levels of risky sexual behavior. The 1996 focus group, conducted at Flathead Community College, indicated that people are having unprotected sex and drinking has increased in young people.

Common Knowledge Themes

The survey conducted at the University of Montana examined levels of HIV/AIDS knowledge and its association with types of information channels. High knowledge for females was most associated with educational and print media channels. High knowledge for males was most associated with medical/professional and educational channels. Broadcast media channels were most associated with low knowledge for both males and females. Females have a higher knowledge of AIDS, regardless of the number of channels they use for AIDS information. For both males and females, the higher one’s knowledge of HIV/AIDS, the more humane their AIDS attitudes.

Common Attitude, Perception, and Belief Themes

In the 1994 survey by the University of Montana, results indicated that females have more humane attitudes towards those with HIV/AIDS, regardless of where they receive their information. Human attitudes peak for females when they are exposed to

three types of information channels. The number of channel categories does not effect AIDS attitudes for males.

The focus group conducted at Salish Kootenai College in 1996 indicated that sixty-seven of the sixty-eight respondents said “yes”, HIV/AIDS-related information should be readily available on campus. Participants felt that the library, school, homes, work, physical fitness areas, workshops, counseling centers, health services, bars, students services area, and job corps were places to have HIV/AIDS information. When asked what the attitude of the general population about the risk of HIV infection was, the respondents stated the following: people fee they can’t get HIV; it’s a serious problem; they’re unconcerned; don’t realize it’s a dangerous disease; most people don’t take time to think about safe sex; people are fearful. In addition, respondents felt that the general attitude on campus was that of “it won’t happen to me.”

The 1996 focus group conducted at Flathead Community College indicated that participants felt that people need to realize that HIV is here and it exists in Montana. Their belief, in regard to the attitudes of the general population regarding risk for HIV, is that Montana people don’t feel it is a concern and that we are sheltered. The attitude of the campus population regarding HIV is identified as lack of concern.

Both focus groups’ participants agreed that HIV/AIDS information should be readily available on campus and it shouldn’t be restricted. The participants also identified permiscuous and sexually active individuals with multiple partners, drug users, women, the uninformed, young teens, women, and gay men as those at most risk for HIV. Both focus groups also asked for input regarding HIV prevention strategies. Participants’

most common responses were increased education and information, condom distribution, mandatory HIV classes, needle distribution, and information regarding safer sex.

CHAPTER V

Discussion and Recommendations

Throughout the course of this study, observations were made by the researcher pertaining to HIV/AIDS in Montana. The following chapter includes discussion and recommendations for HIV/AIDS needs assessment processes and activities in Montana. This chapter is divided into three sections. Section one identifies the HIV/AIDS needs assessment information gaps within Montana's high-risk groups. Section two provides recommendations for future HIV/AIDS needs assessment activities for each high-risk group, based on the identified information gaps in section one. Section three provides recommendations for future HIV/AIDS needs assessment activities for the state of Montana.

Section One: Needs Assessment Information Gaps

The purpose of this study was to synthesize the existing statewide HIV/AIDS prevention needs assessment data into a comprehensive report. The synthesized results provide information that will allow future needs assessment activities to expand and become more comprehensive. Based on the researcher's qualitative research synthesis, information gaps emerged within the collected needs assessments. In order to expand the needs assessment activities within the state of Montana, these information gaps must be fully recognized and addressed. The following population categories provide the information gaps for each high-risk group, identified by the researcher.

Men Having Sex With Men

Six needs assessments were collected for the “men having sex with men” group. The risky health behaviors of this group are what place them at particularly high-risk for HIV/AIDS and a reduction in these behaviors can decrease their risk. However, throughout a needs assessment process, primarily focusing on a group’s high-risk behavior does not provide comprehensive information about that group. Thoroughly examining a high-risk group’s health behaviors, levels of HIV/AIDS knowledge, and attitudes, perceptions, and beliefs about HIV/AIDS allows program planners to develop comprehensive interventions.

The largest information gap in Montana’s MSM population was the lack of assessment regarding the levels of HIV/AIDS knowledge. One out of six collected assessments assessed levels of HIV/AIDS knowledge by using true/false questions and this survey’s sample size was relatively small, with seven men participating. Due to this small sample size, this single survey does not provide an overall assessment of HIV/AIDS knowledge of MSM in Montana.

A second assessment asked participants if they felt they were receiving adequate information about AIDS and how much they felt they knew about the HIV/AIDS epidemic. Both of these questions are vague and fairly subjective. More in-depth, specific questions about the disease would provide the necessary, comprehensive information. Furthermore, because the majority of the six assessments examined high-risk behaviors of MSM, questions pertaining to what MSM know about those high-risk behaviors would be most beneficial.

In general, the assessments did not thoroughly examine HIV/AIDS attitudes, perceptions, and beliefs of MSM, another piece of a comprehensive needs assessment. Assessing the attitudes, perceptions and beliefs of MSM can provide information for HIV/AIDS prevention programs and essentially find the link between those attitudes, perceptions, beliefs and high-risk behaviors of MSM. Within the two assessments that did assess this category, the questions tended to focus on feelings of risk for HIV, reasons for not practicing safe sex, and perceived sources of support. Missing information from this category included attitudes toward HIV/AIDS, beliefs about high-risk behaviors, beliefs about HIV among Montana's MSM, and perceptions of safe sex practices that prevent HIV/AIDS.

Intravenous Drug Users

Because a thorough understanding of the target population is necessary when developing effective HIV/AIDS prevention interventions, recording the age of participants is critical. Of the four assessments conducted with the IDU population, two did not provide specific age breakdown of participants and one did not provide any information regarding the age of participants. By only reporting an age range (for example, 18 and older) it is difficult to determine the average age of participants and/or what age group the majority fall under.

Another missing component of the demographic information was racial/ethnic background. Three of the four IDU assessments did not indicate or report specific race/ethnicity breakdown of the participants. This provides more specific information about the participants and the high-risk group itself.

Another gap within the basic demographic information existed within all four assessments. None of the assessments asked the participants about their sexual orientation. This information is highly relevant, considering the epidemiological information that indicates men who reported injecting drug use and men reporting a combination of male-to-male sexual contact and injecting drug use make up 22% of reported AIDS cases in Montana (Damrow & Murphy, 1998). In addition, none of the assessments asked questions regarding their sexual practices. The majority of assessments asking participants about their high-risk behaviors focused solely on drug use, sharing needles, and cleaning of “works.”

Three of the four assessments did not assess level of HIV/AIDS knowledge of IDU. One assessment did ask participants if they felt they had adequate HIV knowledge. This question will determine a high-risk group’s perception of their level of knowledge, but it does not specifically examine HIV/AIDS knowledge. In order to prevent the spread of HIV/AIDS among IDU, determining if they know what specifically places them at risk will provide more insight on where to direct future prevention interventions.

A final observation made by the researcher was that two of the assessments did not indicate who administered the assessment. By providing the name of the administrator, other prevention programmers across Montana will have a contact person if questions arise while reviewing the assessment.

Youth At Risk

All of the demographic information provided by the Montana Youth Risk Behavior Surveys was comprehensive. They all indicated total number of participants,

age, number of males/females, racial/ethnic background, and who administered the surveys.

All seven of the “youth at risk” assessments were the Montana Youth Risk Behavior Survey, so behavior was the only category examined. Because over 82% of all students reported having been taught about HIV/AIDS infection in school, it would be beneficial to determine their level of HIV/AIDS knowledge. To further determine this group’s risk of HIV/AIDS, a comprehensive needs assessment would include attitudes, perceptions, and beliefs of youth at risk. Questions may be answered as to why youth take part in high-risk behaviors, if HIV/AIDS knowledge, attitudes, perceptions and beliefs about HIV/AIDS are addressed.

Women with High Risk Behavior

One assessment was collected for the “women with high-risk behavior” group. As observed by the researcher, this is an information gap, as one assessment will not provide comprehensive, generalizable results. The collected assessment was given to women in various STD clinics across Montana in 1995. Another gap emerges based on the lapse in time since this assessment. New information regarding health behaviors, HIV/AIDS knowledge, attitudes, perceptions, and beliefs toward HIV/AIDS would be necessary to determine current prevention needs of women with high-risk behavior.

The assessment asked comprehensive questions regarding the behaviors and attitudes, perceptions, and beliefs of women with high-risk behavior. However, no questions on the survey assessed level of HIV/AIDS knowledge. In addition, questions regarding women’s knowledge of how HIV or other sexually transmitted diseases are transmitted from mother to child were not asked.

Native Americans with High-Risk Behavior

Of the five needs assessments, one reported the sexual orientation of participants. Information regarding the sexual orientation of participants or their sexual behaviors with other males and females would provide better understanding of the group's HIV/AIDS prevention needs. In addition, several assessments lacked specific demographic information in the following areas: age breakdown, average age, total number of male and female participants, and year of assessment.

Lack of assessing level of HIV/AIDS knowledge is missing in all five assessments. Questions regarding knowledge of HIV/AIDS services were asked, but specific questions regarding the transmission of HIV, risks of HIV/AIDS and ways to prevent HIV were not asked. Determining a target population's level of HIV/AIDS knowledge is the foundation for the prevention of HIV/AIDS.

Overall, the assessments lack comprehension regarding health behaviors, HIV/AIDS knowledge, and attitudes, perceptions, and beliefs about HIV/AIDS. Questions focused on one or two of these categories. In addition, questions were not included in the assessments that would determine the relationship between the different categories.

HIV-infected individuals and sex partners of HIV-infected individuals

Missing demographic information within the four assessments included: age breakdown, average age, year of assessment, and name of the administrator. This information is useful to determine specific characteristics of participants and who to contact for information regarding the assessment.

None of the assessments gathered information from the sex partners of the HIV-infected individuals. This high-risk group includes those currently infected with HIV and

their sex partners, who may not be HIV⁺. The researcher identifies this as a gap in information that is critical to understanding the potential spread of HIV.

In addition, level of HIV/AIDS knowledge was not thoroughly assessed. One assessment asked about participants' knowledge regarding HIV-related services and another assessment asked knowledge questions regarding specific sexual behaviors. However, an information gap exists due to the lack of specific HIV/AIDS knowledge questions. Overall, the assessments lacked examination of health risk behaviors among HIV-infected individuals and their sex partners. Questions regarding sexual behaviors and use of alcohol and drugs will further the understanding of the potential spread of HIV/AIDS.

Incarcerated Populations

One assessment was collected and was conducted in 1996. This indicates two information gaps. One, there has been a lack of needs assessments conducted with this population. Two, the information from the single assessment is from 1996, indicating a need for current information. The demographics, health behaviors, levels of HIV/AIDS knowledge, and attitudes, perceptions, beliefs about HIV/AIDS of this population could easily change in three years.

In terms of the demographics of the incarcerated population, no information was gathered regarding the sexual orientation of the participants or number of males and females. This information would help guide the development of HIV/AIDS prevention programs for this group. Additionally, the specific age breakdown of participants was not indicated, nor was the average age of participants.

People with Hidden Risk Behavior

Of the three collected assessments, two were focus groups. Both of the focus groups lacked basic demographic information of the participants. Sexual orientation was not reported in either focus group. One focus group did not provide any information about the age of its participants, while the other focus group provided an age range. Age breakdowns and average age of participants would provide more specific information about this target population. One of the focus groups did not indicate total number of participants, number of males/females, or racial/ethnic background. Another gap was the lack of information regarding who the facilitators of the focus groups were.

Both focus group assessments focused primarily on the attitudes, beliefs, perceptions of the participants. A complete understanding of the group's behaviors and level of HIV/AIDS knowledge was not discussed. Examination of these categories would give the facilitators and future program planners adequate direction for planning HIV/AIDS prevention activities and interventions.

Section Two: Recommendations for Future Needs Assessment Activities for Each High-Risk Group

Based on the information gaps identified by the researcher, the following are recommendations for future needs assessment activities. A primary recommendation for needs assessment activities and processes among all high-risk groups is the implementation and utilization of the Social Indicators Model. The Social Indicators model is a needs assessment model that would be applicable and useful for Montana's statewide HIV/AIDS planning groups. This model relies on the use of certain sociodemographic variables and data as indicators or surrogates of need (CDC, 1996).

The use of data on social problems and risk factors or behaviors provides indirect estimates of community need. Social problem and environmental indicators such as teen birth rates, high school drop-out rates, unemployment rates, crime rates, population density, and poverty are used to estimate needs and problems.

Sources of data that would provide these indicators include public records, health departments, police departments, and census data. Specifically for HIV prevention, high-risk behavior indicators such as teen pregnancy, STD, delivery of low birth weight infants, and substance abuse hospital records are important to examine and consider (CDC, 1996). The researcher's recommendation is to determine whether or not the implementation of such a model is feasible, especially in terms of time constraints and budgeting. However, such a model provides a starting point when determining quality of life issues and HIV/AIDS prevention needs that should be targeted through prevention efforts.

The following sections provide recommendations for each high-risk group in Montana.

Men Having Sex With Men

Needs assessments conducted with members of the MSM population lacked comprehensive demographic data and it is recommended that close monitoring and recording of demographic information is performed during needs assessments. Recording and reporting complete demographic information about the needs assessment participants is essential for three reasons: 1) better understanding of the target population; 2) it provides direction for prevention interventions; and 3) other community planning groups will have access to the information. Basic demographic information

about representatives of the target population includes: age breakdown, average age, sexual orientation, total number of participants, race/ethnicity, administrator of assessment, where the assessment was conducted, and the year of the assessment.

A second recommendation for HIV/AIDS needs assessments targeting MSM in Montana is to begin examining levels of HIV/AIDS knowledge. Questions related to what MSM know about HIV/AIDS, how it is transmitted, what risk behaviors place them at individual risk, and knowledge of available HIV/AIDS information and services would provide further, in-depth information about the prevention needs of MSM. Assuming that MSM have accurate HIV/AIDS knowledge is often an oversight of program planners and the result can be ineffective HIV/AIDS prevention programs. The following questions are examples of HIV/AIDS knowledge questions that are recommended for the MSM needs assessments (Torabi & Ahua, 1998):

- 1) Is there a difference between having the AIDS virus and having the disease AIDS (Yes or No)?
- 2) AIDS is especially common in older people. Do you believe it is: definitely true, probably true, probably false, or definitely false?
- 3) AIDS can damage the brain. Do you believe it is: definitely true, probably true, probably false, or definitely false?
- 4) AIDS is an infection caused by a virus. Do you believe it is: definitely true, probably true, probably false, or definitely false?
- 5) A person can be infected with the AIDS virus and not have the disease AIDS. Do you believe it is: definitely true, probably true, probably false, or definitely false?

In addition to identifying levels of HIV/AIDS knowledge, assessing MSM knowledge of high-risk behaviors would also benefit prevention programs. For example, if MSM are reporting frequently engaging in unprotected oral sex, an HIV/AIDS knowledge-related question would be: “Is unprotected oral sex a low or high-risk behavior in regards to the transmission of HIV/AIDS?”

In regards to high-risk behavior, few questions addressed drug and alcohol use. It is therefore the recommendation of the researcher to further assess the drug and alcohol use among MSM in Montana. Because 22% of reported AIDS cases in Montana are men reporting a combination of male-to-male sexual contact and injecting drug use, questions regarding drug and alcohol behavior is essential information. A sample question would be: “Have you ever or do you currently use injection drugs? If yes, how often? Does the drug use influence your sexual risk behavior?”

Attitudes, perceptions, and beliefs toward HIV/AIDS among MSM in Montana should be addressed by using more in-depth questions. Included in this category should be questions regarding the following: perceived risk of HIV, concerns related to HIV testing, attitudes and perceptions of safe sex, reasons for not practicing safe sex, perceptions of support from other gay/bi individuals, family, friends, and partners for practicing safe sex, and perceived HIV/AIDS prevention needs. Examples could include the following questions: 1) “Please circle the response that corresponds to your feelings of your personal risk for the HIV/AIDS virus?” (options would be “no risk”; “low or no risk”; “low risk”; “not sure”; “moderate risk”; “high risk”) 2) “How do you feel about your partner asking you to wear a condom?” (open-ended question) 3) “What are the three main reasons you or your partner/s do not wear condoms?”

The final recommendation for HIV/AIDS needs assessments targeting MSM in Montana is to examine the relationship between risk behaviors, level of HIV/AIDS knowledge, and attitudes, perceptions, and beliefs about HIV/AIDS. Total examination of each separate category is the first step. To determine what types of questions should be asked in each category, it is useful to review past HIV/AIDS needs assessments and the Montana Epidemiological Profile. These resources will provide information regarding what has been reported from Montana's MSM in the past and the incidence of HIV/AIDS among MSM. Examples of questions that will examine the relationship between the different categories include:

- 1) "Please list several reasons why MSM do not always wear condoms?"
- 2) "Do you believe that HIV/AIDS is a concern among MSM in Montana?"
- 3) "What efforts would be most effective to prevent the spread of HIV/AIDS among MSM in Montana that are not currently being utilized?"

Intravenous Drug Users (IDU)

The first recommendation is to closely monitor the demographics of this high-risk group. Because of the lack of specific age breakdowns and average age of participants, HIV/AIDS needs assessments targeting IDU need to record and report the specific age information of participants. In addition to the age information, race/ethnicity of participants is also essential because it provides more specific information about the target population. Those two components of the demographic information are critical to determine a basic profile of the intravenous drug users in Montana. Sexual orientation of participants is also highly relevant among IDU. This might indicate whether prevention

efforts need to focus strictly on drug use behavior or on both drug use behavior and sexual behavior. By consistently including a demographic section on each HIV/AIDS needs assessment, this information is easy to obtain, record, and report.

A second recommendation is to further assess the levels of HIV/AIDS knowledge among IDU. Determining the level of HIV/AIDS knowledge among IDU will assist in determining the relationship of their knowledge and the high-risk behaviors that they practice. In addition, asking questions specifically related to HIV/AIDS and the risk among the IDU population provides an in-depth examination of this specific population. Only asking their perception of their HIV/AIDS knowledge is very limiting and does not provide any information about what they actually know. Examples of HIV/AIDS knowledge-related questions include (Torabi & Ahua, 1998):

- 1) A person will get AIDS infection from sharing needles for drug use with someone who has the AIDS virus. Do you think it is: very likely or somewhat likely?
- 2) Any person with the AIDS virus can pass it on to someone else during sexual intercourse. Do you believe it is: definitely true, probably true, probably false, or definitely false?
- 3) There is a vaccine available to the public that protects a person from getting the AIDS virus. Do you believe it is: definitely true, probably true, probably false, or definitely false?
- 4) The HIV virus cannot be transmitted through needles that have been cleaned with bleach, even if they have previously been used. Do you believe it is: definitely true, probably true, probably false, or definitely false?

Because each high-risk group is unique and categorized based primarily on behaviors, considerations need to be made in terms of collecting HIV/AIDS prevention needs data from members of the high-risk group. One important consideration is that the survey method of data collection might be the most effective with one high-risk group, but not as effective with another. The recommendation for needs assessments conducted with IDUs is to utilize the Ethnographic or Street Studies Model. This model monitors and assesses problems and needs directly in the field or “on the street.” The use of the model would provide more in-depth and specific information from members of the IDU population in Montana. Many individuals at risk, hard-to-reach clients, and those in need of high priority services can be found near drug markets; in jails and juvenile detention centers; among homeless people; commercial sex workers, runaways, and persons otherwise on the street (CDC, 1996).

Sources of data can include field reports that monitor at-risk activity, observational studies of high-risk areas, and studies of high-risk group. CDC (1996) notes that this model has been used extensively in urban, high-density areas, but it is also useful in rural, lower-density areas. For example, studies have been conducted at truck and rural highway rest stops. The major advantage of this model is that it can reach high-risk priority groups that are not reached through more structured and formal needs assessments, such as surveys.

Youth At Risk

While the Montana YRBS takes a comprehensive approach to the risk behaviors of youth, it does not provide any other information. This limits the potential of

HIV/AIDS prevention interventions that target youth at risk. Because over 82% of all students reported having been taught about HIV/AIDS infection in school, it would be beneficial to determine their actual level of HIV/AIDS knowledge. This information would provide direction for HIV/AIDS curriculum or prevention programs within and outside of the school systems.

A comprehensive needs assessment would also assess attitudes, perceptions, and beliefs about HIV/AIDS and could provide information about why youth are participating in high-risk behaviors. An ideal approach to comprehensive needs assessment data would be to supplement the Montana YRBS with questions regarding level of HIV/AIDS knowledge and HIV/AIDS attitudes, perceptions, and beliefs of youth. Members of this target population could provide great insight about their personal attitudes, perceptions, and beliefs about HIV/AIDS and ways to improve prevention efforts.

Two other data collection methods, other than the survey method, are focus groups and community forums/public hearings. Focus groups would be an ideal option for supplementing the YRBS. As stated by CDC (1994), planning groups can use focus groups to have community members generate or screen new ideas, provide preliminary guidance, identify key issues, or provide insights into the needs and opinions of the target population. Because of the possible sensitivity that exists with HIV/AIDS, focus groups with only females and only males would be optimal and possibly provide more information.

Yarber and Sanders (1998) conducted focus groups with thirty-eight adolescents that were recruited from two 4-H clubs located in two rural (less than 50,000 population), southern ~~Indiana~~ Indiana counties. All adolescents volunteered to be included in the study and

were 11-17 years old. Based on this study's data collection methods and development of the focus group questions, several recommendations can be made for conducting a similar study with Montana's youth. First, subjects can be recruited in a similar fashion, such as asking adolescents involved in 4-H clubs or other extracurricular organizations to volunteers in the focus groups. Additionally, utilizing the information from the Indiana study would provide guidance for the structure and organization of the focus group.

The recommendation for utilizing the focus group method among 4-H clubs and other extracurricular organizations may not include high-risk youth. To insure a comprehensive needs assessment, focus groups should also be conducted with youth in alternative schools, juvenile detention centers, and youth homes. The focus group procedures would remain the same, but recruitment of individuals may differ. Steps to take in order to gain a sample of high-risk youth include: offering incentives and rewards for participation, creating an open and non-threatening atmosphere, and providing the focus group as a social situation.

It is recommended that standard focus group procedures be examined by following various focus group guidelines and recommendations. The focus group conducted in Indiana used the theory of planned behavior (Ajzen, 1988) to structure the discussion questions with the questions reflecting the theory's major components: attitude toward the behavior, subject norm, and perceived behavioral control. Examples of questions for the focus groups regarding these components include the following (Yarber & Sanders, 1998):

- 1) Do teens in your community believe that AIDS can be a serious problem in a small town?

- 2) Are teens in your community afraid of getting HIV?
- 3) Would teens in your community not have sex if there were a chance of getting HIV?
- 4) Why do some teens in your community not practice abstinence or safe sex to avoid HIV?
- 5) Do teens in your community support their friends who practice abstinence to avoid HIV?
- 6) Do teens in your community who become sexually active want to use condoms?
- 7) Are teens in your community strong enough to insist that condoms be used during sex to avoid HIV?..strong enough to avoid injecting drugs to avoid HIV?
- 8) Would teens in your community feel comfortable getting condoms?...using condoms?

Another option, other than the focus group, is a community forum with youth participants. A community forum would allow a community planning group to observe and gather great amounts of qualitative information from the participants. Such a forum could take place during school hours or be an option for students to attend after school. A community forum differs slightly from a focus group in that it involves more individuals and is open to any interested individuals. Optimally, it would attract youth of all ages, genders, sexual orientations, and racial/ethnic backgrounds. The forum should ideally include between fifteen and thirty individuals and should be taped and recorded in

writing (AED, 1999). One or two facilitators would be needed to conduct the forum and allow students to express their feelings, attitudes, beliefs, perceptions, and knowledge about HIV/AIDS.

Women with High Risk Behavior

The first recommendation is to conduct more assessments with women. One assessment that surveyed seventy-five women does not provide comprehensive, generalizable results. The information from the 1995 survey, conducted in STD clinics across Montana, could easily differ from information obtained today. In addition, utilization of the information in the state epidemiological profile is important to determine where HIV infection among women is greatest and what major factors are placing women at risk for HIV. This information would then assist in determining who to include in a needs assessment and what types of questions to ask within the assessment.

A final recommendation is to gain a complete understanding of women's behaviors, HIV/AIDS knowledge levels, and attitudes, perceptions, beliefs about HIV/AIDS. By focusing on only one or two of these categories, pertinent information may be left out. A few examples of HIV/AIDS knowledge-related questions for women include the following (Torabi & Ahua, 1998):

- 1) A woman uses a diaphragm to prevent getting the AIDS virus through sexual activity. Do you think it is: very effective, somewhat effective, or not at all effective?

- 2) A pregnant women with the AIDS virus can give the AIDS virus to her baby.
Do you believe it is: definitely true, probably true, probably false, or definitely false?
- 3) Any person with the AIDS virus can pass it on to someone else during sexual intercourse. Do you believe it is: definitely true, probably true, probably false, or definitely false?
- 4) Is there a difference between having the AIDS virus and having the disease AIDS (YES or NO)?

Native Americans with High-Risk Behavior

The first recommendation is to systematically record and report demographic information. This includes the need for the following: specific age breakdown, average age, sexual orientation of participants, number of males and females, where the assessment was conducted, and the year of the assessment. Because several of the collected needs assessments lacked this information, there is an obvious need for this information about members of the target population and it is the first step in conducting needs assessments.

The telephone survey conducted by the Montana Department of Public Health and Human Services was successful in interviewing Native Americans from each reservation in Montana. This survey could be expanded by asking more questions and conducting the survey annually or biannually. The results of the telephone survey would be valuable information for those program planners creating and implementing HIV/AIDS prevention programs that target Native Americans. Results could also be used to determine

differences in behaviors, HIV/AIDS knowledge, and attitudes, perceptions, and beliefs about HIV/AIDS between the seven reservations in Montana.

In addition to the statewide survey, needs assessments within each individual Native American reservation or tribe would assess attitudes, perceptions and beliefs regarding personal risk for HIV, risk of the reservation populations, reasons for participating in risk behaviors, and overall attitudes toward HIV/AIDS. Because of the diverse beliefs and values associated with each tribe, attitudes, perceptions and beliefs about HIV/AIDS may differ greatly between Montana's Native American tribes. The following questions are examples regarding attitudes, perceptions, and beliefs about HIV/AIDS:

- 1) Do you feel that HIV is a concern among members of your tribe? Why or why not?
- 2) Do you believe that members of your tribe or individuals living on your reservation consider themselves at risk for HIV infection? Why or why not?
- 3) What do you believe are the best ways to provide information about HIV/AIDS to your tribal members and other Native American individuals?
- 4) What are your thoughts and/or beliefs about HIV prevention activities on the reservation, such as condom distribution and needle exchange programs?

Several assessments did not examine HIV/AIDS knowledge among Native Americans. The examination of HIV/AIDS knowledge can determine what relationship exists, if any, between attitudes, perceptions, and beliefs about HIV/AIDS and HIV/AIDS knowledge. Examples of questions regarding HIV/AIDS knowledge are:

- 1) Is there a difference between having the AIDS virus and having the disease AIDS (Yes or No)?
- 2) AIDS is an infection caused by a virus. Do you believe it is: definitely true, probably true, probably false, or definitely false?
- 3) HIV is only transmitted through sexual contact and blood transfusions. Do you believe it is: definitely true, probably true, probably false, or definitely false?

The Montana Youth Risk Behavior Survey (MTYRBS) was first conducted with Native American students in urban schools in 1997. The continuation of this survey, conducted every two years, is a final recommendation. The 1997 survey included 151 Native American students in grades nine through twelve. Recruiting a larger sample size of Native American youth would provide a wealth of information about their health risk behaviors. Conducting the survey with youth in seventh and eighth grade is also recommended. Specific questions regarding what sources Native American youth are utilizing to receive HIV/AIDS information is also recommended. An additional recommendation is to determine who or what are the main sources of support in terms of practicing healthy behaviors that would prevent HIV infection. For example: 1) Where or from who do you receive information about HIV/AIDS?; and 2) Who do you believe has the most influence on you in terms of practicing safe sex and preventing HIV infection?

In addition to the MTYRBS, focus groups should be conducted to assess attitudes, perceptions, and beliefs about HIV/AIDS among Native American youth. Gathering as much information from youth provides great insight in regards to the potential threat that

HIV/AIDS may have among Native Americans. If possible, focus groups with Native American youth attending school and those not attending school would further the understanding of attitudes, perceptions, and beliefs about HIV/AIDS. Another comparison could be made with youth living on and off the reservations.

It is also essential to recognize the need for culturally sensitive needs assessments among Native Americans. For example, a focus group conducted and facilitated by three non-Native facilitators could create an uncomfortable atmosphere for participants and valuable information would not likely be obtained. In addition, questions asked within surveys and focus groups should initially be examined by members of the tribes and reservations. Identifying “key informants” or “gatekeepers” is recommended by the researcher. These individuals have likely interacted and/or worked with members of the tribes and can provide assistance to facilitators of focus groups and surveys. “Key informants” and “gatekeepers” have developed close relationships with members of the community and are highly trusted.

HIV-infected individuals and their sex partners

None of the current HIV/AIDS needs assessment data regarding HIV-infected individuals includes prevention needs of their sex partners. When available, it is recommended that surveys, interviews, and/or focus groups are conducted with the sex partners of HIV-infected individuals. Because sex partners may not be HIV-infected, information from partners regarding their risk behavior is valuable information and provides greater insight. For example, an assessment of sexual risk behaviors among sex partners of HIV-infected individuals would include questions regarding safe sex practices

and number of current sex partners. Questions regarding their levels of HIV/AIDS knowledge should focus on modes of transmission, physical and psychological aspects of HIV/AIDS, and awareness of HIV-related services. Finally, questions regarding attitudes, perceptions and beliefs would address their personal perception of risk for HIV, attitudes about the spread of HIV, and perception of support from family and friends regarding their relationship status.

A second recommendation to specifically gain more information from HIV-infected individuals and their sex partners is to thoroughly assess drug and alcohol use and specific sexual behaviors. Unfortunately, HIV-infected individuals develop attitudes of apathy toward risk behaviors, drug and alcohol use, and life in general. This attitude can lead to drug and alcohol use and abuse, unsafe sex, and other risky behaviors.

A third recommendation is to continue the assessment of the needs and services that are perceived as most important to HIV-infected individuals and their sex partners. One of the most important components of a needs assessment is the identification of needs and service gaps (Academy for Educational Development, 1994). Determining how effective or adequate the existing HIV-related services are for HIV-infected individuals will lead to further development and improvement of those services. The implementation and use of the Performance Model is a final recommendation made by the researcher. This model assumes that if needs are to be met adequately, services must have a minimum level of effectiveness in terms of client satisfaction and services. Because HIV-infected individuals require a variety of HIV-related services, this model is quite applicable and would determine gaps in needs and services, because it examines services to identify their appropriateness, adequacy, and effectiveness. In addition, it

would identify individuals who are currently receiving services and their needs are only met partially (CDC, 1996).

Sources of data collection include client utilization/satisfaction surveys, quality assurance methods, and focus groups. These sources can indicate direct estimates of problems, needs, and demands of services (CDC, 1996). The coordination and collaboration of several agencies and organizations within each health planning region in Montana would be beneficial to the determination of the problems, needs, and demands of HIV-related services. For example, if the Missoula AIDS Council is providing educational information to HIV or AIDS-infected individuals and then refers the clients to the local health department or hospital, coordination and collaboration between these agencies should include the examination of needs. Surveys and/or focus groups are recommended to gain a comprehensive needs assessment and could be conducted by the collaborating agencies to save time and money.

Incarcerated Populations

One assessment has been conducted with the incarcerated population in the past five years; thus indicating a need for current and more extensive information. It is the researcher's recommendation that the assessment conducted with the incarcerated population in 1995 be conducted again. In addition, to supplement the survey data, focus groups and personal interviews would provide qualitative data.

In addition to repeating the 1995 survey, a needs assessment should be conducted within the women's prison population statewide. The HIV/AIDS prevention needs of

incarcerated men and women would differ greatly, specifically in terms of risk behaviors and attitudes, perceptions, and beliefs about HIV/AIDS.

A recommendation for improving the existing survey is to add questions asking the incarcerated populations to self-report their risk behaviors. The 1995 survey only asked questions regarding the perceptions of other people's risk behaviors within the prison. Because those questions are asking participants to report their perception of others' behaviors, the data may not be as valid and reliable as self-reported behavior.

Another recommendation is to ask specific questions about why the incarcerated populations do not trust prison health services. Such questions should be included in the survey format or in focus groups or interviews. The 1995 survey indicated that the incarcerated population does not trust prison health services and this lack of trust prevents them from utilizing HIV testing and counseling services. Knowing why the lack of trust exists is critical to the future development of prison health services and HIV prevention programs within the prisons.

Assessing beliefs regarding personal risk for HIV in and out of prison is the final recommendation. If a difference existed between beliefs in personal risk, HIV prevention programs within the prison need to directly target the attitudes, perceptions, and beliefs about risk of being infected with HIV in prison. Examples of questions that would address this issue include:

- 1) Do you feel at greater risk for HIV infection within or outside of the prison?
Why?
- 2) Do you believe that transmission of HIV is likely within the prison?

People with Hidden Risk Behavior

Gaining insight and information from the general public regarding their health risk behaviors, HIV/AIDS knowledge, and attitudes, perceptions, and beliefs about HIV/AIDS identifies a community's possible hidden risks for HIV/AIDS. Needs assessments conducted with college campus populations, community members, and rural populations would include numerous individuals who do not consider themselves at risk for HIV infection.

To design an effective HIV/AIDS education and prevention campaign, it is essential to understand the public's risk behaviors, level of HIV/AIDS knowledge, and attitudes, perceptions, and beliefs about HIV/AIDS (Torabi & Ahua, 1999). As noted by Torabi, McAllister & Kotecki (1994), public opinion is an important component in creating public policies and legislative decisions regarding public health issues. Torabi and Ahua (1999) conducted a study that was designed to investigate the knowledge, attitude, and behaviors among Indiana adults regarding HIV/AIDS. A random sample was used to gain representatives of the general public, age 18 years and older.

A similar investigation is recommended for the state of Montana. The 1999 study, conducted in Indiana, utilized the National Health Interviewer Survey to conduct the telephone interviews and surveys (U.S. Centers for Disease Control and Prevention: National Center for Health Statistics, 1994). This survey consists of 106 questions and six demographic items regarding age, gender, marital status, education, income, and community setting were added. The 106 closed ended questions were developed to provide information based on adults' knowledge, attitudes, and action about HIV/AIDS, transmission of HIV, and their experience with HIV testing. Utilization of this survey

would allow a statewide investigation to occur in Montana without the concern of developing an entire survey and testing it for validity and reliability. Additionally, the data obtained from Montana could be compared to the National data collected for the United States. Torabi and Ahua (1999) suggest that effectively monitoring the progress and establishing any trends in public awareness regarding HIV/AIDS prevention in the state would require the completion of this survey every two years.

In addition to a statewide telephone survey, conducting HIV/AIDS needs assessments on each college campus in Montana is recommended. Surveys could be distributed in several academic classes to obtain representation from all classes of students. The survey should be voluntary and permission from the Office of Student Affairs must be granted. This type of survey would provide insight into the general college-aged population's behaviors, HIV/AIDS knowledge, and attitudes, perceptions, and beliefs about HIV/AIDS. The obtained information would be an essential component of HIV/AIDS prevention campaigns on campuses across Montana.

Section Three: Recommendations for future HIV/AIDS Needs Assessment Activities in Montana

An HIV/AIDS needs assessment is a planned process that identifies the reported HIV/AIDS prevention needs of a target population. The process involves obtaining and analyzing findings through multiple methods of information and data collection. Using primary and secondary data to determine HIV/AIDS prevention needs of specific target populations provides comprehensive information about each population. Primary data are newly collected data from members of the target population and include methods such as focus groups, surveys, community forums, and interviews. Secondary data is

HIV/AIDS prevention needs information that already exists, such as an epidemiological profile, health department data, behavioral risk factor surveys, information from previously conducted needs assessments, and information about human services in the area.

The basic steps involved in a needs assessment process are: 1) define focus and scope of the needs assessment; 2) select appropriate mix of needs assessment methods; 3) collect needs data and information; 4) collect services data and information; 5) analyze needs and services data and information; 6) identify gaps in programs and services; and 7) establish priorities among the gaps and unmet needs (Centers for Disease Control (CDC), 1994).

According to the Centers for Disease Control (1996), a needs assessment should be the initial step in the planning of any new program or in the redirection of any existing HIV prevention program or activity. CDC (1996) also states that a needs assessment should be done annually or biannually as part of the program planning and should not be viewed as a one-time activity but rather as an important aspect of an ongoing cycle of program planning, development, implementation, monitoring, and evaluation. Consistent needs assessment activities contribute to the refinement and redirection of HIV prevention program goals, objectives, and activities in response to the changes in HIV/AIDS needs of Montana's high-risk groups, communities, services, and providers as well as to population and epidemic movements.

An initial recommendation is to examine several needs assessment models that provide guidance and structure that is applicable to Montana's HIV prevention programming. The Comprehensive Planning Gap Model (CDC, 1996) is one option the

researcher recommends for Montana's statewide HIV needs assessment process. This model assesses need using comprehensive, sequential, formal approaches including services and capacity inventory, gaps analysis, and priority setting. The advantages of this model include its straightforward approach, reliance on a variety of data, and indications of service gaps. This model relies on consistent use of a variety of data sources and collection methods, including epidemiologic data, community surveys, social indicators, and key informant surveys (CDC, 1996).

Based on the identified information gaps within the collected HIV/AIDS needs assessments in Montana, several steps can be taken to improve the overall process. Recommendations are made to: 1) increase the consistency of needs assessment activities in Montana; 2) develop and implement a statewide needs assessment process; and 3) develop, implement, and evaluate HIV prevention interventions in Montana.

The first recommendation is to implement a statewide needs assessment process that includes the following: creating a specific timeline and work plan, using valid and reliable instruments to gather HIV/AIDS prevention needs data, utilizing a variety of methods to gather HIV/AIDS prevention needs data, and thoroughly examining the risk behaviors, levels of HIV/AIDS knowledge, and attitudes, perceptions, and beliefs about HIV/AIDS.

The development of a work plan and time line that includes specific starting and ending points and indicates when each year's needs assessment data collection is recommended. A realistic time line and work plan are critical for organizing activities efficiently (Academy for Educational Development's Center for Community-Based Health Strategies (AED), 1999). The work plan identifies specific tasks and activities,

while the time line summarizes those tasks and activities with specific beginning and ending dates.

To begin the timeline, a decision must be made on the duration of the needs assessment process from start to completion. The timeline's main purpose is to outline the starting and ending dates for group activities and projects by month or week. The work plan's purpose is to detail each activity and/or project, such as what types of activities and tasks will be conducted and who will perform them. As noted by the Academy for Educational Development (1999), the five main steps to developing the work plan and time line include the following: 1) list major tasks, such as "conduct focus groups"; 2) decide on the duration of effort from start to completion; 3) add specific activities and processes for each task; 4) decide on the deadlines for each task; and 5) prepare a detailed time line with the start and end date by day, week, or month.

Decisions regarding what type of instrument and/or method should be used to collect HIV/AIDS prevention needs data is the next step in developing and creating a consistent needs assessment process. Secondary data sources, such as the Montana Epidemiological Profile, provide information that was previously collected and can help determine what remaining and current information is needed regarding Montana's identified high-risk groups. Primary data is the data collected and analyzed for a specific purpose, such as creating current HIV prevention interventions. Current information regarding the HIV prevention needs of Montana's high-risk groups is critical in the development of future prevention activities and the primary data will guide those activities.

Primary source data collection methods include focus groups, in-depth interviews, community forums, and surveys. Existing surveys that are valid, reliable, and applicable to the high-risk groups are useful and conserve time. Focus groups provide valuable insights into the prevention needs of high-risk groups and typically elicit participants' responses regarding attitudes, perceptions, and beliefs about HIV/AIDS.

A comprehensive needs assessment includes the thorough examination of risk behaviors, levels of HIV/AIDS knowledge, and attitudes, perceptions, and beliefs about HIV/AIDS. The assessment of prevention needs should provide information about the extent to which Montana's high-risk groups are aware of modes of HIV transmission, aware of high-risk behaviors, engaging in high-risk behaviors, reached by HIV prevention activities, and likely to take part in HIV prevention activities. Because Montana's current needs assessment data lacks the comprehensive examination of all categories, the researcher recommends the implementation and utilization of several methods for data collection.

When possible and available, using previously conducted needs assessments is recommended. However, development of needs assessment instruments, such as survey and focus group questions, is very valuable. Current information must be obtained through the needs assessment process and older versions of needs assessment instruments may not be capable of identifying the current HIV/AIDS prevention needs of high-risk groups. When designing the needs assessment instrument, the goal should be a design through which the most information can be collected in the most efficient manner with the least burden on respondents (Academy for Educational Development, 1999). The needs assessment questions are based on the desired outcomes of the needs assessment.

For example, if a needs assessment is being created that will survey the HIV-related service needs of HIV-infected individuals, the questions would specifically pertain to the participants' beliefs and perceptions of those services. Because the needs assessment process is continuous, the individuals conducting the needs assessments should expand and/or refine the research questions over a period of time based on earlier findings.

To determine the scope and focus of the research questions, the Academy for Education Development (1999) recommends that the following basic questions be asked for each high-risk group: 1) what are the HIV-related risk behaviors of the target population?; 2) to what extent is the target population receiving prevention services?; 3) what barriers to accessing or using prevention services do members of the target populations experience or perceive?; 4) what strategies or interventions work best with the target population?; 5) what HIV prevention or related services are available, accessible, and appropriate for this population? 6) what are the differences among specific subpopulations regarding prevention needs and access issues?

While the implementation of a comprehensive needs assessment process is time consuming and sometimes overwhelming, the researcher's recommendation is to begin the initial process by focusing on the top three high-risk populations (men having sex with men, intravenous drug users, and youth at risk). For example, coordination and collaboration among regional planning groups will allow the time line and work plan to be created. Decisions must be made regarding which methods and/or instruments will be used to collect the HIV prevention needs data. Based on those decisions, the researcher's recommendation is to utilize two or three different methods of data collection. The data should be collected within each health planning region of Montana, using the same

instrument and/or method. The result would be HIV prevention needs data within each health planning region and combined data indicating statewide needs assessment data for each high-risk group.

Limitations of the Study

Within any research study, it is fair to acknowledge limitations that existed during the process. Several limitations existed within this study that could have impacted the data. This section outlines those limitations.

An initial limitation existed when data collection began. The researcher utilized the reputational approach to obtain HIV/AIDS needs assessments from Montana. Throughout the course of data collection, several agencies, organizations, and individuals were contacted to obtain data and several individuals referred the researcher to other organizations and individuals. While the process assisted the researcher in obtaining names and phone numbers of individuals or organizations, the desired data was not always available. Several times, the researcher was not able to obtain a needs assessment that was essentially "lost in the shuffle." The result was not being able to obtain every HIV/AIDS needs assessment that had been conducted within the last five years in Montana.

In addition to the above limitation, several individuals who had previously conducted the desired HIV/AIDS needs assessments had relocated. This limited the number of needs assessments that were collected. Re-organization of staff at various locations across Montana also had impact on the number of needs assessments that were attainable.

During the process of data analysis, it is reasonable to identify limitations that occurred. Conducting qualitative research has the potential of researcher bias. While analyzing and interpreting the collected needs assessment data, the researcher's personal perceptions, beliefs, attitudes, and biases may have interfered. Because the method of analysis was a qualitative research synthesis, it is also important to note the possibility that not all information and data was specifically reported for each needs assessment. Thus, by synthesizing the results of several studies, there is the possibility of overlooking findings from each needs assessment.

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Appendix A

Data Analysis Chart

HIGH RISK GROUP: _____ **Assessment #:** _____
Method: _____ **HPR:** _____ **#TOT:** _____ **Age:** _____
SO: _____ **#Males:** _____ **#Females:** _____
Race/Ethnicity: _____
Administrator: _____ **Year:** _____

OUTCOMES/RESULTS

<p><u>BEHAVIORS</u></p>
<p><u>KNOWLEDGE</u></p>
<p><u>ATTITUDES/BELIEFS/PERCEPTIONS</u></p>

Additional Comments:

Appendix B

**Completed Data Analysis Charts for Each
High-Risk Group**

Men Having Sex With Men (MSM)

HIGH RISK GROUP: MSM **Assessment #:** 1
Method: survey **HPR:** 3 **#TOT:** 140 **Age:** 18 and up
SO: gay and bisexual men **#Males:** 140 **#Females:** _____
Race/Ethnicity: white = 93%; African American = 1%; Hispanic = 2%; American Indian = 2%; Other = 2%
Administrator: task force members **Year:** 1997

OUTCOMES/RESULTS

BEHAVIORS

Anal Sex: 71% of respondents said they engaged in anal sex in the last year
Unprotected anal sex: 43% reported they did not always use a condom.
Of the 60 men who indicated they engaged in anal sex and didn't always use a condom in the last year: 32 reported they were not in a long-term relationship.
Alcohol and drug use of those reporting unprotected anal intercourse and not being in a long-term relationship: 21 had used alcohol, 18 had used marijuana, 8 had used some other recreational drug
Oral Sex: 129 respondents reported engaging in oral sex over the last year.
Unprotected oral sex: 60 men stated such behavior.
Vaginal sex: 67% (of the 12 men reporting) did not always use a condom.
Mouth to rectum contact: 43% of men report this behavior in the past year. Only 4 of these men reported that they always used a barrier, such as a dental dam.
Mutual masturbation: 116 (83%) reported engaging in mutual masturbation in the past year.
Alcohol/Drug Use: includes alcohol (65%), marijuana (47%), poppers, crystal, cocaine, ecstasy, heroine.
Number of sexual partners: 79 (56%) report having more than one partner in the past year. The average number of partners was five for those reporting more than one partner.
Forty-six percent of respondents were in a relationship
Twenty-six percent report talking about safer sex "OFTEN" before having sex with a new partner.
How long ago they were last tested for HIV: 12% tested within past 3 months; 24% had tested w/in 6 months. 19% tested w/in past year; 19% tested w/in past two years; 9% tested over two years ago; 13% never been tested.

KNOWLEDGE 17% reported they were HIV-infected. Six reported being infected in MT; 12 outside MT; and 6 did not know.

ATTITUDES/BELIEFS/PERCEPTIONS

Many gay men perceive unprotected oral sex as low risk behavior.
Forty-nine percent report oral sex to ejaculation w/o a condom is unsafe.
Seventy-four percent report anal sex, as active partner, without a condom as unsafe.
Seventy-six percent report anal sex, as receptive partner, without a condom as unsafe.
Nineteen percent of respondents report their sex practices, over the last year as "more safe."
Forty-one percent of respondents report their sex practices, over the last year, as "less safe."
Fifty-eight percent report feeling "comfortable" talking with partner(s) about safer sex.
Fifty-six percent report feeling "comfortable" talking with partner(s) about HIV status.
Concerns related to HIV testing: confidentiality, waiting time for results, feared the results of the test, satisfied with testing, concerned about the cost of the test, lack of cultural sensitivity regarding testing, testing done at inconvenient locations/times, mistrust of Health Dept.,
Anonymous and name reporting testing: 62% reported that if anonymous testing were not available, they would still test. 45% stated that if name reporting were required, this would prevent them from being tested.
Feelings of risk for HIV: 35% felt at risk; 60% don't feel at risk.
Ways to help stop HIV/AIDS: continued communication and education!!!!

Additional comments: Survey was administered by Task Force Members at Annual Gay and Lesbian Pride Weekend Celebration held in Bozeman, MT. Additional surveys were mailed out to gay and bisexual men using mailing lists from the Focus newsletter. Task Force members also distributed surveys to gay and bisexual men living in their respective communities.

HIGH RISK GROUP: MSM **Assessment #:** 2
Method: survey **HPR:** 3 **#TOT:** 161 **Age:** 18+ (see below)
SO: gay men **#Males:** 161 **#Females:** n/a
Race/Ethnicity: 89% caucasian; 9% N.American
Administrator: FDH **Year:** 1996

OUTCOMES/RESULTS

BEHAVIORS

Anal Sex: 72% engage in anal sex.
Unprotected anal sex: 41%
Oral sex: 92%
Unprotected oral sex: 33%
In a relationship: 42%

KNOWLEDGE

ATTITUDES/BELIEFS/PERCEPTIONS

Places men meet other men: Friends (72%); Bars (60%); and social/cultural gatherings (52%)
Places Men have sex: Home (91%); Motels (28%); Parks/Outdoors (15%)
Why men don't always practice safer sex: Feel safe in a relationship; interferes with intimacy, alcohol and/or drug use
What supports men in practicing safer sex: Circle of Friends; partner/lover; literature on safer sex
Concerns about HIV Testing: Confidentiality; fear of results; waiting time for results

Additional comments: 75% reported HIV-; 9% reported being HIV+; 71% currently living in MT. Age breakdown: (18-24) = 21%; (25-34) = 40%; (35-44) = 25%; (45-65) = 13%; (over 65) = 1%

HIGH RISK GROUP: MSM **Assessment #:** 3
Method: FDH Survey **HPR:** 3 **#TOT:** 133 **Age:** 18+ (see below)
SO: gay men **#Males:** 133 **#Females:** n/a
Race/Ethnicity: white = 88%; NA = 4%; H = 3%; other = 2%
Administrator: FDH **Year:** 1995

OUTCOMES/RESULTS

BEHAVIORS

Anal sex: 89% of all respondents

Vaginal sex: 12% of all respondents

More than one male sexual partner: 60% of respondents

Unprotected anal intercourse: 41%

89% reported having been tested for HIV

37% report being in a relationship

89% reported having had a friend tell them they'd had unsafe sex

14% reported having had a condom break in the last year

KNOWLEDGE

ATTITUDES/BELIEFS/PERCEPTIONS

*Additional comments: 83% reported having friends that are HIV+; 72% reported knowing a friend that died from AIDS. Age breakdown: (under 18) = 1%; (18-24) = 30%; (25-34) = 38%; *35-44) = 20%; (45-65) = 11%*

HIGH RISK GROUP: MSM **Assessment #:** 4
Method: criticare survey **HPR:** 3 **#TOT:** 100 **Age:** 32.2 yrs (mean)
SO: gay men **#Males:** 100 **#Females:** n/a
Race/Ethnicity: white = 81%; NA = 4%; H = 3%; other = 8%
Administrator: Criticare Health Education Services **Year:** 1993

OUTCOMES/RESULTS

BEHAVIORS

86% report anal sex

40% report more than 1 male sexual partner

34% report engaging in unprotected anal intercourse

81% report having been tested for HIV

30% report being in a relationship

KNOWLEDGE

ATTITUDES/BELIEFS/PERCEPTIONS

Additional comments: 77% report having friends that are HIV+; 79% report knowing a friend that died from AIDS.

HIGH RISK GROUP: MSM **Assessment #:** 5
Method: survey **HPR:** 5S **#TOT:** 62 **Age:** 18+
SO: gay men **#Males:** 64 **#Females:** n/a
Race/Ethnicity: _____
Administrator: Robin Mochi, U of MT **Year:** 1996

OUTCOMES/RESULTS

BEHAVIORS

Tested for HIV: 61% report being tested; 11% not sure; 28% untested.

KNOWLEDGE

ATTITUDES/BELIEFS/PERCEPTIONS

Barriers to HIV testing (n = 16) from top reasons to lowest reasons: perceive themselves at no or low risk; too scared; always practiced safe sex; feared people finding out; usually practiced safe sex; results took too long; didn't trust health department; in a monogamous relationship.

Sources of HIV/AIDS information: Gay Men's Task Force; the gay community, literature.

Social stigma and fear

Suggestions for HIV testing improvements: reduce time frame for HIV results; lack of services during the long waiting period; lack of testing sites on the Flathead Indian Reservations; and lack of information in the high schools; satellite testing sites; concerned with lack of men, gay or heterosexual, working at testing sites.

HIGH RISK GROUP: MSM **Assessment #:** 6
Method: survey **HPR:** 4 **#TOT:** 7 **Age:** 25-53
SO: gay men **#Males:** 7 **#Females:** n/a
Race/Ethnicity: n/a
Administrator: Jeff Feathergill (at Gay/Bi Men's Group) **Year:** 1997

OUTCOMES/RESULTS

BEHAVIORS

Oral sex (majority reported this)

Unprotected oral sex (majority reported this)

Anal sex (majority)

Unprotected anal sex (majority)

Sex with 1 to 5 partners (majority)

KNOWLEDGE

High knowledge of unprotected anal sex being the main sexual route of transmission for HIV

High knowledge regarding unprotected oral intercourse as a route of transmission for HIV

High knowledge that an HIV negative test result doesn't mean that unprotected anal or oral sex is okay

High knowledge regarding use of oil based lubricants NOT being good to use with condoms

High knowledge of unsafe sexual behavior occurring while under the influence of alcohol/drugs

ATTITUDES/BELIEFS/PERCEPTIONS

On a scale of 1 to 5, from "no support" to "all the support I need", the group average was 2.7

Most popular forms of support: friends, family, partners, other gay/bi men, counselor, gay/bi groups, work colleagues

Meeting others: Scale of 1 (very difficult) to 5 (very easy), rated how difficult it has been to meet other gay/bi people or groups. Average = 2.4

Life Satisfaction: Scale of 1 to 5 how satisfied men reported they were. Average = 3.0

Greatest needs as gay men: support groups, social groups, friendship, casual sex, dating skills and opportunities, becoming involved in a primary relationship, ability to negotiate for safer sex, information/resources on HIV/AIDS, counseling/mental health services, improving the quality of primary relationship (top 10 needs reported)

Safety and comfort with the State Health Dept. HIV testing site: Five respondents stated that they didn't feel safe and comfortable

Intravenous Drug Users (IDU)

HIGH RISK GROUP: IDU **Assessment #:** 1
Method: survey **HPR:** state **#TOT:** 117 **Age:** 14-up
SO: n/a **#Males:** 67.5% **#Females:** 32.5%
Race/Ethnicity: white 80.3%; NA 12.8%; Hispanic 4.3%; Black 0.9%; other 1.7%
Administrator: drug treatment centers in MT **Year:** 1995

OUTCOMES/RESULTS

BEHAVIORS

Have injected drugs: 42.6% (N = 115)
Have shared needles: 71.4% (N= 49)
Cleaning works when sharing needles (N = 35)
 Always 71.4%; sometimes 22.9%; rarely 5.7%
Use Bleach when cleaning works by all identified IDUs: (N = 47) 46.8% said YES
Have changed drug/needle use to protect self from HIV infection: 56.3% (N = 96)
Have changed sex life to protect self from HIV infection: 72.6% (N = 117)
Report using injection drugs: 49% of 25-35 year olds; 30.6% of people over 35; 18.4% of 19-24 year olds
Sharing needles: 79.4% of males report; 20.6% of females report

KNOWLEDGE

Recognized as protective action against HIV infection (N = 117): use of a sterile needle and syringe every time injecting drugs 44.4%; Share "works" only after proper cleaning 8.5%; Share needles only with people you know 3.4%; seek treatment for substance abuse 35.9%; stop injecting drug use 68.4%
Knowledge of sexual behaviors that place you at risk for HIV infection (N = 117): having multiple sex partners 94%; having unprotected sex (no condom) with another injecting drug user 91.4%; having unprotected oral, anal or vaginal sex 94%; trading sex for money or drugs 84.5%; having sex with someone who is HIV positive 86.2%; having sex while using a condom 37.9%; having sex while either self or partner was intoxicated 70.7%; having sex while using drugs other than injectable drugs 71.6%
Knowledge of protection against HIV infection (N = 117): using a new condom, correctly, for each time you have sex 85.5%; using spermicide each time you have sex 24.8%; withdrawing prior to "cumming" 12.8%; douching after each act of vaginal intercourse 12%; refraining from anal sex 44.4%
Knowledge of Modes of transmission of HIV infection (N = 117): exchange of HIV infected semen or blood during sex or injecting drug use 92.3%; sharing eating and drinking utensils of a person infected with HIV 2.6%; donating blood 4.3%; sharing the same space with a person who is HIV infected 0.9%; blood transfusion 18%
Knowledge of High-Risk Behavior: Higher proportion of males report a higher level of knowledge

ATTITUDES/BELIEFS/PERCEPTIONS

Risk for exposure to AIDS: 34.5% of 117 respondents said YES they considered themselves at risk

Additional comments: Sources of information: TV and/or radio 66.4%; newspaper 25.9%; magazines 34.5%; health care professionals 40%; support groups 19.1%

HIGH RISK GROUP: IDU **Assessment #:** 2
Method: survey **HPR:** 5S **#TOT:** 39 **Age:** 18 and up
SO: n/a **#Males:** 17 **#Females:** 15
Race/Ethnicity: n/a
Administrator: Robin Mochi/University of MT **Year:** 1996

OUTCOMES/RESULTS

BEHAVIORS

Fifty-three percent (21 individuals) had been tested; 7.7% were not sure; 38.5% were untested
29.9% (of 24 respondents) usually practiced safe sex

KNOWLEDGE

ATTITUDES/BELIEFS/PERCEPTIONS

Reported they had no or low risk of HIV infection: 45.8% (of the 24 who responded); 37.5% were too scared

Believed the HIV test costs too much: 16.7% (of 24 respondents)

Internal barriers to HIV counseling and testing: perceived low or no risk, did not care, feared people finding out, uninformed about AIDS in Montana, lacked trust of health department, uneducated about HIV, too scared

External barriers include: usual practice of safe sex, always practice safe sex, and practice only oral sex

Suggestions for public health department: free testing, guaranteed confidentiality, appointments to suit work schedules (evening and weekend testing), and more advertising, free needle program

HIGH RISK GROUP: IDU **Assessment #:** 3
Method: in-depth interview **HPR:** 5N **#TOT:** 1 **Age:** 36
SO: n/a **#Males:** n/a **#Females:** 1
Race/Ethnicity: n/a
Administrator: n/a **Year:** August 8 & 15, 1997

OUTCOMES/RESULTS

BEHAVIORS

Sharing needles

Use of crank and heroine

Dispose of needles in coffee cans, milk cartons, or whatever is available

Sharing needles when high... "you'll do whatever it takes."

Rinse needles with water

Rinse with bleach if it's available

Only use condoms "sometimes"

KNOWLEDGE

Lack of knowledge regarding Hepatitis C from IDU and sex

ATTITUDES/BELIEFS/PERCEPTIONS

Kalispell has a large IDU population

Kalispell is called the "Spin City", because of it's easy access to drugs

Concern about HIV/AIDS is not as obvious as concern about Hepatitis C

Lack of information

IDUs would participate in a needle exchange program if the police were not monitoring it.

Some users are unemployed and can't afford new needles

Other IDUs are embarrassed to go into the stores and buy needles (lots of paranoia)

Good places for informational poster: Food banks, Salvation Army, Kalispell Bar, Rosebriar Inn, Rainbow Bar, Finish Line, Black Angus, etc.

If informational posters have a picture of a needle or something about Hepatitis C, IDUs would be more likely to read it

Put ads in classifieds; Fliers in bathrooms; Pamphlets in jail to increase awareness of sharps containers, bleach kits, needle exchange, anonymous HIV testing and education.

Additional comments: Suggestions for distribution of bleach kits, needles and sharps containers: convenient locations, needle containers should contain full 10 pack of needles in 12cc or 1cc size. Inside the container, you could include information re: Hepatitis B and C and AIDS, how and where to get tested. This individual was a 36-year-old female IDU that was receiving her second HIV test in the county jail.

HIGH RISK GROUP: IDU **Assessment #:** 4
Method: focus group **HPR:** 4 **#TOT:** 8 **Age:** n/a
SO: n/a **#Males:** n/a **#Females:** n/a
Race/Ethnicity: n/a
Administrator: Dianne Kimball **Year:** n/a

OUTCOMES/RESULTS

BEHAVIORS

Sharing needles/using dirty needles

At-risk sexual behaviors among addicts

Seven of the eight individuals said they would do drugs if the needle wasn't clean

KNOWLEDGE

Majority (6 of the 8) felt IDUs have adequate HIV knowledge

ATTITUDES/BELIEFS/PERCEPTIONS

Majority support a needle exchange program

One respondent noted that if you are well into your addiction/disease, you'll use dirty needles—don't care HIV information, condoms, bleach solution, needles and syringes should be available all together

Need safe places to get needles, such as porno shops, rescue mission, or family services

Need to work in our own communities to approach places

Concern/fear of small community paranoia

Addicts are concerned about HIV testing; few people getting tested identify themselves as IDUs

Anonymous needle exchange and a safe, comfortable place would be optimal

People are not willing to give up their behaviors until they are ready or sent by a judge

Can't influence people with fear of AIDS to give up drugs

Need to increase the level of awareness of people of the number of drugs that are injected

Awareness of the nature of the disease/addiction needs to be raised

Pharmacies should dispense clean needles and syringes

Don't believe needle exchange will increase habit

Don't believe needle exchange would lead to relapse

Would go to family planning for needles

All participants said they would give clean works to a friend and encourage its use

All participants know someone that shares needles

Building a relationship with a person at a needle exchange at a health dept. would increase testing

Youth At Risk

HIGH RISK GROUP: youth at risk **Assessment #:** 1
Method: MT YRBS **HPR:** state **#TOT:** 5,602 **Age:** 7-8 graders
SO: n/a **#Males:** 2848 **#Females:** 2728
Race/Ethnicity: W= 80%; B= 0.6%; H= 1.9%; NA= 10.5%; Asian/Pacific Islander= 0.7%;
Other = 6.5%
Administrator: OPI/teachers **Year:** 1993

OUTCOMES/RESULTS

<p><u>BEHAVIORS</u> <i>Report they have had sexual intercourse: 24% of 7th and 8th grade students</i> <i>Report having intercourse with four or more people during their life: 17%</i> <i>Report using (or partner using) a condom during last sexual intercourse: 58%</i> <i>Reported having had sexual intercourse with multiple partners: 13%</i> <i>Reported not using a condom the last time they had sexual intercourse: 42%</i> <i>Percent who used alcohol or drugs before sex: 26% of total respondents; 28% of female respondents; 25% of male respondents</i> <i>Males were more likely to report having had sexual intercourse than females</i></p>
<p><u>KNOWLEDGE</u></p>
<p><u>ATTITUDES/BELIEFS/PERCEPTIONS</u></p>

Additional comments: 17% report no AID/HIV Education; 83% reported having been taught about AID/HIV infection in school; 61% report having talked w/parents or other family adults about AIDS/HIV infection. Female participants were more likely to have discussed AIDS/HIV infection w/parents

HIGH RISK GROUP: youth at risk **Assessment #:** 2
Method: YRBS **HPR:** state **#TOT:** 2,518 **Age:** 9-12 graders
SO: n/a **#Males:** 1322 **#Females:** 1193
Race/Ethnicity: W=89.4%; B=0.8%; H=1.7%; As/PacIsl=0.8%; NA=4.8%; other=2.5%
Administrator: OPI/teachers **Year:** 1993

OUTCOMES/RESULTS

BEHAVIORS

Report ever having sexual intercourse: 51%

Report having sexual intercourse with four or more people during their life: 18%

Percent of youth 15 years or younger report having had sexual intercourse: 37%

Percent of sexually active Montana youth who report wearing a condom during their last sexual intercourse: 55%

Respondents who report multiple sex partners: 19% of all; 16% of females report multiple sex partners; 20% of males report multiple sex partners

Respondents who report using alcohol or drugs before sex: 32% of all; 28% of females report using alcohol/drugs before sex; 36% of males report using alcohol or drugs before sex

Respondents who report not using a condom: 45% of all; 54% of females report not using a condom; 37% of males report not using a condom

Percent of students who reported ever having had sexual intercourse, by grade and gender:

- 9th grade—45% of males; 31% of females*
- 10th grade—47% of males; 47% of females*
- 11th grade—56% of males; 56% of females*
- 12th grade—67% of males; 63% of females*

KNOWLEDGE

ATTITUDES/BELIEFS/PERCEPTIONS

Additional comments: 8% report no AIDS/HIV education; 93% of 9th graders report being taught about AIDS/HIV in school and 67% report talking with parents or other family adults; 93% of 10th graders report being taught about AIDS/HIV in school and 65% report talking w/parents or other family adults; 92% of 11th graders report being taught about AIDS/HIV in school and 70% report talking w/parents or other family adults; 88% of 12th graders report being taught about AIDS/HIV in school and 71% report talking w/parents or other family adults.

HIGH RISK GROUP: youth at risk **Assessment #:** 3
Method: YRBS **HPR:** state **#TOT:** 5,549 **Age:** 7th & 8th grade
SO: n/a **#Males:** 2800 **#Females:** 2749
Race/Ethnicity: W=78.3%; B=0.7%; H=1.6%; As/PI=0.7%; NA=11.6%; other=7.1%
Administrator: OPI/teachers **Year:** 1995

OUTCOMES/RESULTS

BEHAVIORS

Report ever having sexual intercourse: 23%

Report having sexual intercourse with four or more people during their life: 6%

Percent students reported wearing a condom during their last sexual intercourse: 58%

Multiple sex partners: 12% of all respondents; 8% of females; 17% of males

Used alcohol or drugs before sex: 31% of all; 35% of females; 29% of males

Did not use a condom the last time they had sexual intercourse: 42% of all; 45% of females; 42% of males

Percent who reported ever having had sexual intercourse: 23% of all; 15% of females; 30% of males

KNOWLEDGE

ATTITUDES/BELIEFS/PERCEPTIONS

Additional comments: 18% report having no AIDS/HIV education; 82% report having been taught about AIDS/HIV infection in school; 56% of respondents reported having talked w/parents or other family adults about AIDS/HIV infection. Females were more likely to have discussed AIDS/HIV infection w/parents than males.

HIGH RISK GROUP: youth **Assessment #:** 4
Method: YRBS **HPR:** state **#TOT:** 2,527 **Age:** 9-12 graders
SO: n/a **#Males:** 1312 **#Females:** 1215
Race/Ethnicity: W=88.3%; B=0.8%; H=1.6%; As/PacIsl=0%; NA=8.9%; other=0.4%
Administrator: teachers in MT **Year:** 1995

OUTCOMES/RESULTS

BEHAVIORS

Percent of respondents report ever having sexual intercourse: 47%

Percent of students report having sexual intercourse with four or more people during their life: 15%

Percent of students 15 years old or younger report having had sexual intercourse: 32%

Percent of sexually active students report using a condom during last sexual intercourse: 54%

Multiple sex partners: 28% of all respondents; 23% of females; 35% of males

Used alcohol or drugs before sex: 32% of all; 28% of females; 36% of males

Did Not use a condom last time they had sexual intercourse: 45% of all; 54% of females; 37% of males

Percent of students who reported ever having had sexual intercourse: 45% of 9th grade males and 31% of 9th grade females; 47% of male and female 10th grade students; 56% of male and female 11th grade students; 67% of male and 63% of female 12th grade students

KNOWLEDGE

ATTITUDES/BELIEFS/PERCEPTIONS

Additional comments: 9% report no AIDS/HIV education; 93% of both 9th and 10th grade students report being taught about AIDS/HIV infection in school; 92% of 11th grade students report being taught about AIDS/HIV in school; 88% of 12th grade students report being taught about AIDS/HIV in school; 67% of 9th grade students report talking w/parents about AIDS/HIV infection; 65% of 10th grade students report talking with parents or other family adults; 70% of 11th grade students report talking w/parents or other family adults; and 71% of 12th grade students report talking w/parents or other family adults

HIGH RISK GROUP: youth **Assessment #:** 5
Method: YRBS **HPR:** state **#TOT:** 2,450 **Age:** 9-12 grade
SO: n/a **#Males:** 1177 **#Females:** 1273
Race/Ethnicity: W=85.6%; B=0.6%; H=2.2%; As/PasIsl=0%; NA=11.2%; other=0.4%
Administrator: OPI/teachers **Year:** 1997

OUTCOMES/RESULTS

BEHAVIORS

Percent who report ever having had sexual intercourse: 46%

Percent who report having sexual intercourse w/four or more people during their life: 16%

Percent of students 15 years or younger report having had sexual intercourse: 28%

Percent who report using a condom during last sexual intercourse: 55%

Percent of students who reported ever having had sexual intercourse: 33% of males and 19% of female 9th grade students; 43% of male and 46% of female 10th grade students; 46% of male and 54% of female 11th grade students; 71% of male and 64% of female 12th grade students

Multiple Sex Partners: 63% of all, females and males

Used alcohol or drugs before sex: 30% of all; 27% of females; 34% of males

Did Not Use Condom during last sexual intercourse: 45% of all; 49% of females; 41% of males

KNOWLEDGE

ATTITUDES/BELIEFS/PERCEPTIONS

Additional comments: 7% report no AIDS/HIV education; 91% of 9th grade students report being taught about AIDS/HIV in school; 94% of 10th grade students report being taught about AIDS/HIV in school; 95% of 11th grade students report being taught about AIDS/HIV in school; 94% of 12th grade students report being taught about AIDS/HIV in school; 59% of 9th grade students report talking w/parents or other family adults about AIDS/HIV; 60% of 10th grade students; 64% of 11th grade students and 66% of 12th grade students.

HIGH RISK GROUP: youth **Assessment #:** 6
Method: YRBS **HPR:** state **#TOT:** 151 **Age:** 9-12 grade
SO: n/a **#Males:** 85 **#Females:** 65
Race/Ethnicity: American Indian Students (in urban schools)
Administrator: OPI/teachers **Year:** 1997

OUTCOMES/RESULTS

<p><u>BEHAVIORS</u></p> <p><i>Report ever having had sexual intercourse: 61% of American Indian students (9-12th grade)</i></p> <p><i>Percent who report having sexual intercourse w/four or more people during their life: 23%</i></p> <p><i>Percent who report using a condom the last time they had sexual intercourse: 49%</i></p> <p><i>Percent of American Indian students in urban schools who report ever having had sexual intercourse: 64% of all respondents; 72% of females and 57% of males</i></p> <p><i>Multiple sex partners: 70% of all; 67% of females; 73% of males</i></p> <p><i>Used alcohol or drugs before sex: 41% of all; 33% of females; 49% of males</i></p> <p><i>Did not use a condom during last sexual intercourse: 59% of all; 53% of females; 65% of males</i></p>
<p><u>KNOWLEDGE</u></p>
<p><u>ATTITUDES/BELIEFS/PERCEPTIONS</u></p>

Additional comments: 12% report no AIDS/HIV education; 88% of all respondents report being taught about AIDS/HIV in school (89% of females and 88% of males). Sixty-one percent of all respondents report talking w/parents or other family adults about AIDS/HIV (61% of females and 61% of males)

HIGH RISK GROUP: youth **Assessment #:** 7
Method: MTYRBS **HPR:** state **#TOT:** 6544 **Age:** 7th & 8th grade
SO: n/a **#Males:** 3400 **#Females:** 3144
Race/Ethnicity: W = 81%; B= 1%; H=1.8%; As/PacIsl=1%; NA=9.4%; other=5.9%
Administrator: OPI **Year:** 1997

OUTCOMES/RESULTS

BEHAVIORS

Percent who reported having had sexual intercourse: 22% of all students; 17% of females; 27% of males

Percent who report having multiple sex partners (two or more): 59% of all; 53% of females; 62% of males

Percent who report using alcohol or drugs the last time they had sex: 34% of all; 40% of females; 31% of males

Percent who did not use a condom the last time they had sex: 42% of all; 46% of females; 40% of males

Percent who report being taught in school and/or having talked w/parents or other family adults about AIDS/HIV infection: 83% of all students report being taught in school; 55% of all students report talking w/parents or other family adult

KNOWLEDGE

ATTITUDES/BELIEFS/PERCEPTIONS

Women with High-Risk Behavior

HIGH RISK GROUP: Women **Assessment #:** 1
Method: survey **HPR:** state **#TOT:** 75 **Age:** 14-47
SO: n/a **#Males:** 0 **#Females:** 75
Race/Ethnicity: white 97.3%; other 2.7%
Administrator: std clinics/Krista M. Brumley **Year:** 1995

OUTCOMES/RESULTS

BEHAVIORS

Ever had a sexually transmitted disease? YES = 36.1%; NO = 61.0%; Maybe = 2.8%
Sexually transmitted disease by marital status: single, never married = 30.7%; married = 23.1%; divorced/legally separated = 38.5%; living w/sexual partner = 7.7% (of 72 total respondents)
Number of partners in last 12 months: None = 1.4%; 1 partner = 59.7%; 2-4 partners = 31.9%; 5-9 partners = 6.9% (of 72 total respondents)
Sexual partners: men only = 93.1%; mostly men, but some women = 1.4%; mostly women, but some men = 0%; women only = 4.2%; never had sex = 1.4%
Traded sex for money, alcohol, drugs, or shelter: Yes = 4.0%; No = 96.0% (75 respondents)
Ever had sex without barrier protection with someone who may have HIV: Yes = 5.3%; No = 93.3%; Don't know = 1.3% (75 respondents)
Sex with individual who has used or uses needles: Yes = 10.7%; No = 78.7%; Don't know = 10.7% (N = 75)
Drink alcohol or use drugs before or during sex: Never = 22.5%; Rarely = 42.5%; sometimes = 35.2% (N = 71)
Ever had sex with a man you knew had sex with another man: Yes = 2.9%; No = 94.2%; don't know = 2.9% (N = 69)
Ever had anal sex: Yes = 39.4%; No = 59.2%; don't know = 1.4% (N = 71)
Majority of respondents said it would be easy to do the following behaviors: say no to unprotected sex if I did not know my partner's sex or drug history; be comfortable buying condoms; have sex with only one partner; ask my partner about his or her sex or drug history; say no to unprotected sex if I felt my partner was at risk for HIV infection; ask my sexual partner to use a condom during sex
Ever had blood tested for HIV infection: Yes = 40.3%; No = 56.9%; Don't Know = 2.8% (N = 72)
Behavior changed because of knowledge of HIV/AIDS: 95.5% did not stop having sex; 82.5% stopped having sex with partners they didn't know well; 86% have fewer sex partners; 62.6% stopped having sex with a particular person; 79.7% have sex with only one person; 59.3% use condoms more often; 62.1% started using condoms; 70.8% changed use of drugs; 70.8% stopped having sex when they use drugs or alcohol; 50% behavior did not change at all;
*****NOTE:** # of respondents differs for each question.
Stopped having sex when using drugs or alcohol: Adolescents = 0%; Young adults = 10%; Adults = 10%; over 35 years = 80% (N = 48). Low education level = 55.6%; middle = 11.1%; High = 33.3%(N=47)
Frequency of individuals with steady partners: 85.5% (of 69 respondents)
Condom use(use condoms with steady partner): Always = 15.5%; sometimes = 22.4%; Never = 62.1% (N = 58 respondents)
Sex with someone other than steady partner (N = 69): Yes = 24.5%; No = 75.4%
Condom use for individuals having sex with someone other than steady partner (N = 69): Always = 18.2%; Sometimes = 59.1%; Never = 22.7%

ATTITUDES/BELIEFS/PERCEPTIONS

Condom and sex attitudes: 56.2% (of 73 total respondents) said they tell partner what you do or do not like to do during sex; 87.3% (of 71 respondents) stated it was "not true" that partner would become angry or upset if asked to use a condom; 82.9% (of 70 respondents) stated it was "not true" that partner would think I was cheating if I asked for a condom to be used during sex; 74.3% (of 70 respondents) stated it was "not true" that I would think my partner was cheating if he/she asked to use a condom during sex
Reasons for using condom(N= 42): Birth control = 74%; protection from STDs = 10%; protection from HIV/AIDS = 12%; other = 4%.
Reasons for not using condoms (N = 49): using oral contraceptives, tested negative, feels better/don't like them, trust partner
Reasons for not using a condom with someone other than steady partner (N= 22): careless/don't like them; monogamous relationship/trust; didn't have condom; alcohol; don't know
Reasons for using condom with someone other than steady partner (N= 46): birth control; protection from STDs and HIV/AIDS

Additional comments: Education level—Low = 43.1%; middle = 47.2%; and high = 9.7% (of 72 total respondents). Marital status—Single, never married = 49.3%; married = 22.7%; divorced/legally separated = 18.7%; living w/sexual partner = 4.0%; widowed = 2.7%; don't know = 2.7%

Native Americans with High-Risk Behavior

HIGH RISK GROUP: Native Americans **Assessment #:** 1
Method: telephone survey **HPR:** state **#Tot:** 57 respondents **Age Range:** M (45 avg.) F (41 avg)
SO: n/a **#Males:** 41% **#Females:** 59%
Race/Ethnicity: Native Americans
Administrator: trained telephone interviewers
Year of assessment: 1997

OUTCOMES/RESULTS

BEHAVIORS

2 or more partners in past year (23% of 18-30 yrs; 9% of 31-40 yrs; 5% of 41-51 yrs)
1 partner (65%; 85%; 75%, respectively)
Condom used last time (for people w/2 or more partners) (54%; 65%; 49%)
Condom used last time (for people w/1 partner) (8%; 8%; 8%)
20% of men and 17% of women changed behavior because of what they knew about AIDS

KNOWLEDGE

Awareness of affordable STD clinics? 50% men; 62% women
Awareness of AIDS hotline? 41% men; 49% of women
What is the effectiveness of properly used condoms? 55% of men and 52% of women answered
SOMEWHAT
Topics of discussion with family in last month (% of all respondents):
33% HIV/AIDS prevention; 44% sexual behavior; 51% drug use; 53% alcohol use

ATTITUDES/BELIEFS/PERCEPTIONS

Have the right to refuse to work with HIV-infected people? 55% of men; 41% of women
Would needle exchange programs be acceptable? 50% of men; 57% of women answered YES
Your chance of being infected? NONE—69% of all respondents w/1 sex partner in past year
NONE—19% of all respondents w/more than 1 partner in past year
LOW—28% of respondents w/1 partner
LOW—58% of respondents w/more than 1 partner
Would you encourage condom use to sexually active teenagers? 92% of all respondents said YES

Additional comments: statewide survey in 1997; 399 completed surveys (57 persons were surveyed).
BRFSS questions were used.

HIGH RISK GROUP: Native Americans **Assessment #:** 2
Method: focus groups **HPR:** 5N **#Tot:** 46 **Age:** 18 and up
SO: n/a **#Males:** 22 **#Females:** 24
Race/Ethnicity: Native Americans
Administrator of assessment: S. Landry, L. Dybdal, and S. Sorrell
Year of assessment: 1998

OUTCOMES/RESULTS

BEHAVIORS

Unprotected sex
 Intravenous drug use
 Needle sharing
 Lack of proper and effective condom use

KNOWLEDGE

Need more factual, accurate HIV/AIDS information
 Lots of HIV/AIDS misinformation
 Trouble deciphering factual and fictitious HIV/AIDS information
 Native youth want "straight facts."
 Participants are unaware of the statistics regarding AIDS in Montana and their own community
 Lack of knowledge or proper condom use

ATTITUDES/PERCEPTIONS/BELIEFS

HIV/AIDS is nonexistent in Montana
 Not susceptible to HIV/AIDS (low or no risk of infection)
 HIV/AIDS is only in larger cities
 HIV/AIDS is downplayed
 Perceived "nobody gets checked" in the community
 Scared to get tested
 HIV/AIDS education for parents would be beneficial
 HIV speakers would be effective
 Condoms should be distributed
 Youth should be targeted and given accurate information

Additional comments: Four focus groups were conducted on the Flathead Reservation with students (18 years and up), Indian Parent/Teacher Council, Tribal educators, and the tribal jail. Results are the common themes across all four focus group sessions. (**Note: This project was a joint effort between Flathead Indian Reservation Health Services and University of Montana—Health and Human Performance Department).

HIGH RISK GROUP: Native Americans **Assessment #:** 3
Method: Survey **HPR:** 5S **#Total:** 82 **Age:** _____
SO: n/a **#Males:** 30 **#Females:** 48
Race/Ethnicity: Native Americans
Administrator: Robin Mochi
Year of assessment: 1997

OUTCOMES/RESULTS

BEHAVIORS

Fifty percent of the respondents were untested

KNOWLEDGE

lack of trust in health department
unsure of HIV testing locations

ATTITUDES/BELIEFS/PERCEPTIONS

Majority feel at no or low risk of HIV infection
Fearful of HIV testing
Confidentiality was the dominant issue for not being tested for HIV

Additional comments: This study focused on barriers to HIV counseling and testing among NA, MSM, and IVDU

HIGH RISK GROUP: Native Americans **Assessment #:** 4
Method: YRBS **HPR:** state **#TOT:** 151 **Age:** 9-12 grade
SO: n/a **#Males:** 85 **#Females:** 65
Race/Ethnicity: American Indian Students (in urban schools)
Administrator: teachers/OPI **Year:** 1997

OUTCOMES/RESULTS

<p><u>BEHAVIORS</u> Sixty-one percent of American Indian students (9-12th grade) report ever having had sexual intercourse Twenty-three percent report having sexual intercourse w/four or more people during their life Forty-nine percent report using a condom the last time they had sexual intercourse <i>Percent of American Indian students in urban schools who report ever having had sexual intercourse:</i> 64% of all respondents; 72% of females and 57% of males <i>Multiple sex partners:</i> 70% of all; 67% of females; 73% of males <i>Used alcohol or drugs before sex:</i> 41% of all; 33% of females; 49% of males <i>Did not use a condom during last sexual intercourse:</i> 59% of all; 53% of females; 65% of males</p>
<p><u>KNOWLEDGE</u></p>
<p><u>ATTITUDES/BELIEFS/PERCEPTIONS</u></p>

Additional comments: 12% report no AIDS/HIV education; 88% of all respondents report being taught about AIDS/HIV in school (89% of females and 88% of males). Sixty-one percent of all respondents report talking w/parents or other family adults about AIDS/HIV (61% of females and 61% of males)

HIGH RISK GROUP: Native Americans **Assessment #:** 5
Method: focus groups **HPR:** state **#TOT:** ~24 **Age:** 21-mid-50s
SO: HM:BI **#Males:** n/a **#Females:** n/a
Race/Ethnicity: all Native Americans
Administrator: Jay LaPlante **Year:** n/a

OUTCOMES/RESULTS

BEHAVIORS

Substance abuse: many of the focus group members admitted to substance abuse problems; some were recovering alcoholics and had not drunk for many years;

Changes in sexual behavior: one group was asked if they changed their sexual practices, not a single person responded.

KNOWLEDGE

Knowledge of HIV/AIDS within Native American population: all participants had heard or knew of HIV/AIDS cases w/in the population

ATTITUDES/BELIEFS/PERCEPTIONS

On Being Invited: most felt "honored", "happy", or "validated"; many felt it was a "good thing"

Family acceptance and support: most found acceptance within the family;

HIV testing: felt community members were afraid to go to local hospitals or clinics because their confidentiality would be broken

Additional Comments: Three focus groups were conducted on Native American reservations and one was conducted in an urban setting. The sites were Blackfeet Reservation, Flathead Reservation, Ft. Peck Reservation, and Missoula. The average number of participants was seven with the exception of one group with only three participants. The ages of participants ranged from 21 to mid-50's.

HIV-infected Individuals and Sex Partners of HIV-infected individuals

HIGH RISK GROUP: HIV+ **Assessment #:** 1
Method: survey **HPR:** 2 **#TOT:** 8 **Age:** _____
SO: HT = 3; gay sex = 3; bisexual = 1 **#Males:** 7 **#Females:** 1
Race/Ethnicity: white = 6; no response = 2
Administrator: City-County Health Dept. of Great Falls **Year:** _____

OUTCOMES/RESULTS

<p><u>BEHAVIORS</u> <i>Use of clean needles?</i> Yes = 1. (also noted as route of HIV exposure by this individual) <i>Would you use a clean needle exchange if one was available in Great Falls?</i> Yes = 1. <i>Unprotected Sex?</i> Yes = 6 report unprotected sex as route of HIV exposure <i>Transfusion:</i> Yes = 1. (noted as route of HIV exposure) <i>Do you practice safer sex?</i> Yes = 5; No = 2. <i>Number of partners since diagnosis:</i> 3 answered 1 partner, 1 answered 3 partners; 1 answered 35-40</p>
<p><u>KNOWLEDGE</u> <i>How long have you known that you have HIV?</i> Less than a year = 2; 1-3 years = 1; 3-5 years = 1; 5 or more years = 3; no response = 1. <i>Number of individuals who have received information from someone and/or applied for service needs:</i> Yes = 5; No = 2. <i>Who has helped?</i> Cascade County Health Department <i>Aware of HIV-related services and help available in your area?</i> Yes = 6; No = 2. <i>Do you know who to contact for HIV-related services information?</i> Yes = 4; No = 2; No response = 2.</p>
<p><u>ATTITUDES/BELIEFS/PERCEPTIONS</u> <i>Top needs identified by HIV-infected individuals:</i> help in getting prescription drugs; money to pay for medical care/hospitalization; help in applying for medicaid or social security; help from emotional support group; help with obtaining food <i>Best/most effective ways to make people with HIV in your community aware of help available to them?</i> Public health nurse; your physician; friends; brochures; radio/TV/newspaper <i>Have you encountered situations in which you felt discriminated?</i> Benefits, such as medicaid or social security (yes = 4); Private insurance (yes = 1). <i>Needs that have been met in the past 6 months (and was it adequate):</i> help in applying for medicaid or social security; help with obtaining food; help in finding dental care; help in getting prescription drugs; help in finding education materials on HIV/AIDS; availability to an exercise/stress relief/fitness class <i>Reasons for not practicing safe sex?</i> Interferes with intimacy; lack of access to condoms/lubricant; not convenient; don't care anymore; don't know;</p>

Additional comments: Household income—less than \$10,000 = 6; \$10-15,000 = 1; \$25-30,000 = 1. One person was diagnosed in another state.

HIGH RISK GROUP: HIV+ **Assessment #:** 2
Method: survey **HPR:** 2 **#TOT:** 26 **Age:** 15 and up
SO: (see below) **#Males:** 26 **#Females:** n/a
Race/Ethnicity: white = 21; Black = 1; other = 4
Administrator: Ron Seibel (at HIV+ Men's Retreat) **Year:** 1997

OUTCOMES/RESULTS

BEHAVIORS
Risk Factors: Bi-sexual males = 4 respondents. Homosexual males = 18. IV Drug Users = 3. Heather care worker exposed to HIV = 1; Sex partner is IV drug user = 1; sex partner is bi-sexual male = 1.

Anal Sex: 65% of all respondents report this behavior

Oral sex: 88% of all respondents

Mouth to rectum contact: 46% reported

Mutual masturbation: 85%

Body Rubbing: 92%

Don't always use condoms: 41!

Getting cum in your mouth through oral sex: 30%

Sex in adult bookstores, public restrooms, parks/outdoors, motels, home, truck stops, work, cars

KNOWLEDGE
 Majority of respondents have known about their HIV infection for 9-12 years.

ATTITUDES/BELIEFS/PERCEPTIONS
Reasons for not always practicing safe sex: partner is HIV+; interferes with intimacy; doesn't feel good; don't know; lack of access to condoms/lubricant; alcohol or drug use; don't care anymore

Who or reasons of support for practicing safer sex: circle of friends; family; partner/lover; gay/les/bi organization; health department; literature on safer sex; spiritual affiliation

Majority Identified as important needs: emotional support for self; education/information on preventing HIV, referrals to other services/people, financial help with medications and medical care, information on treatment/medications, stress management information, information about exercise, nutritional assistance, spiritual health, emotional help,

Additional comments: HIV+ = 11; AIDS = 9; No response = 6. Places they have met their sexual partners: bars, friends, social/cultural, public places, adult book store, home parties, out of town travel. Age Breakdown: (15-19) = 4%; (20-29) = 4%; (30-39) = 54%; (40-49) = 15%; No response = 23%

HIGH RISK GROUP: HIV+ **Assessment #:** 3
Method: survey **HPR:** **#TOT:** 19 **Age:** n/a
SO: n/a **#Males:** n/a **#Females:** n/a
Race/Ethnicity: n/a
Administrator: David Herrera **Year:** 1997

OUTCOMES/RESULTS

BEHAVIORS

Anal Sex: 50% indicated they had engaged in anal sex in the last year (56% of those individuals stated they did not always use a condom) (80% of respondents not always using a condom stated they had multiple partners)
Vaginal Sex: 94% reported they did NOT participate in vaginal sex
Oral Sex: 78% of respondents reported participating in oral sex. (71% stated they did NOT get fluid in their mouths)
Mouth to rectum contact: 28% of respondents reported having mouth to rectum contact and all of those respondents reported they did not use a barrier when participating in this activity.
Mutual masturbation: 83% report this behavior
Injection Drug Use: 100% reported they HAD NOT participated in this behavior.
Long-term relationship: 33% stated they were in a long-term relationship
Recreational drug use: 50% reported using marijuana in past year, 44% reported using alcohol in past year, 11% reported using crystal/crank and 5% reported using cocaine/crack

KNOWLEDGE (asked to "rate" the safety of specific behaviors as "very safe", "somewhat safe", or "unsafe")

Sucking without a condom: 56% reported this is somewhat safe; 22% reported very safe and unsafe
Sucking to ejaculation w/o condom: 78% reported unsafe; 17% reported somewhat safe; 5% report very safe
Fucking partner w/o condom: 84% reported unsafe; 11% report very safe; 5% report somewhat safe
Getting fucked w/o condom: 84% reported unsafe; 11% report very safe; 5% report somewhat safe
Over past year, safer sex practices are: 50% reported more safe and 50% reported no change
Before sex, how often do you talk about safer sex: 56% reported often; 22% report rarely; 5% reported never
How comfortable do you feel talking about safer sex: 78% reported comfortable; 17% reported somewhat; 5% uncomf
How comfortable do you feel talking about HIV: 67% reported comfortable; 22% reported somewhat; 11% uncomf

ATTITUDES/BELIEFS/PERCEPTIONS

Top Five Most Important Services/Needs: help with medication/medical care expenses (63%); appropriate and thorough medical care (53%); therapy/counseling/support groups (53%); better social services systems/help with those systems (32%); housing issues (26%); better insurance programs (16%); help applying for benefits (16%)
Respondents reported they needed help with the following: Applying for benefits
Need Information on: alternative therapies, medical/treatment updates, nutrition and HIV, getting back to work
Counseling services needed: support group for self and one-on-one counseling
Housing Issues (most important): affordable housing, help finding housing
Problems that arise in accessing services: 58% indicated they couldn't afford cost of services; 26% stated that services were not available locally; 25% stated they didn't qualify for services; 21% stated they didn't know who to call; 21% stated they didn't want to go alone to obtain services; 16% reported they didn't know where to look for services.
Reasons for not always practicing safe sex: partner was HIV+, felt safe w/in relationship, lack of feeling
Areas of support that encourage safe sex: partner/lover, circle of friends, AIDS organizations, literature on safer sex, counselors, spiritual/religious support, Gay/Les/Bi organizations, support groups
Suggestions made by respondents to help people stop the spread of HIV/AIDS: find a cure, prevention education, promote scientific research, communication, outreach to all people, better support for people living with AIDS, be visible, provide services HIV+ people can trust and be comfortable with
What might have helped to protect themselves before becoming HIV+: knowing more about safer sex, self esteem, condom information, trust and more info about transmission, communication/negotiation skills, education
If anonymous testing were NOT available, would you still get tested: 56% said yes
Would name reporting requirements prevent testing: 56% said YES
"Re-Infected": 67% reported they did NOT feel at risk for re-infection, and 33% said they did.

Additional comments: Places respondents met their sex partners were social/cultural gatherings (33%), through friends (22%), in bars (17%), during out-of-town travel (17%), through personal ads (11%), adult bookstores (5%)

HIGH RISK GROUP: HIV+ **Assessment #:** 4
Method: telephone survey/interview **HPR:** state **#TOT:** 10 **Age:(see below)**
SO: (see below) **#Males:** 5 **#Females:** 5
Race/Ethnicity: all were Caucasian, except for one male
Administrator: Claudia Montagne **Year:** 1998

OUTCOMES/RESULTS

BEHAVIORS

Relationship status: One female reported being single; three females reported being partnered and one was dating. Two males reported being single; two reported being partnered and one was dating.

KNOWLEDGE

ATTITUDES/BELIEFS/PERCEPTIONS

Meaning of Prevention: prevention education, including safer sex, condom use, celibacy, and hygiene.
Prevention Resources Used: Most often selected resources were retreats and workshops, counseling and testing, Ryan White outpatient services and safer sex education
Barriers to using prevention resources: Three homosexual men reported that sexual orientation was a barrier (due to stigma and homophobia in society). Eight respondents reported being able to relate to the prevention services received in MT. Access to or existence of the services appeared to be the barrier.
What Prevention Strategy would have helped them: The following strategies would have helped them: information on how one get infected, the impact of alcohol on sexual behavior, safer sex information, knowing the warning signs of HIV infection, knowledge of HIV status, knowing other HIV+ persons, being out, and more of an awareness that HIV is in Montana
What prevention strategy is most needed for HIV+ in MT: support groups, acceptance of persons with HIV, retreats, and more HIV+ women out.
Top prevention services (as rated by respondents): 1) retreated for HIV+ men or women; 2) counseling/testing/early intervention services; 3) subscribing to a publication or using Internet resources; 4) access to free condoms; and 5) National AIDS Hotline, support groups, counseling, information, receiving services of an ASO, speakers' bureau.

Additional Comments: The women were exclusively heterosexual; the men all homosexual except one who listed his sexual orientation as other.

The age break down is as follows:

Females: (18-24) = 1; (25-44) = 3; (45-65) = 1

Males: (18-24) = 0; (25-44) = 5; (45-65) = 0

Years since diagnosis:

Females: 2 years = 1; 4 years = 3; 6 years = 1

Males: 4 years = 1; 8 years = 1; 10 years = 1; 12 years = 2

Incarcerated Populations

HIGH RISK GROUP: Incarcerated Populations **Assessment #: 1**
Method: Public Health Survey **HPR: 4** **#Tot: 59** **Age: 18 and up**
SO: n/a **#Males: n/a** **#Females: n/a**
Race/Ethnicity: 63% White; 25% Native American; 2% Black; 10% Hispanic
Administrator: Dianne Kimball (Butte-Silver Bow Health Department) **Year: 1996**
OUTCOMES/RESULTS

BEHAVIORS

Within the prison, how many people do you think are doing the following:
 Have sex with no protection? Some 70%; about half 5%; most 14%; all 5%
 Having sex using a condom? None 63%; some 36%; about half 2%; most 0%; all 0%
 Having sex using a plastic glove, saran wrap or baggie? None 53%; some 41%; about half 0%; most 5%
 Sharing injection needles without cleaning them? None 5%; some 73%; about half 10%; most 10%; all 2%
 Sharing injection needles after cleaning them? None 5%; some 72%; about half 8%; most 10%; all 5%
 Sharing other needles (tatoos and piercing) w/o cleaning them? None 5%; some 73%; about half 10%; most 10%; all 2%
In the past six months: 3% had been treated for a sexually transmitted disease; 86% had not
 46% of respondents had been tested for the AIDS virus while in prison

KNOWLEDGE

Level of knowledge regarding activities that are safe or unsafe in regards to becoming infected::
 Giving Blood (63% safe; 24% unsafe; 14% not sure)
 Being bitten by mosquitoes or other insects (49%; 31% 20%)
 Sharing needles or syringes with an infected person (0%; 100%; 0%)
 Having sexual intercourse with an infected person (98%; 2%; 0%)
 Having a blood test (86%; 5%; 9%)
 Sharing needles to make tatoos or pierce ears (0%; 98%; 2%)
 Touching toilet seats, bathtubs, spoons, cups or other objects (63%; 17%; 20%)
Knowledge regarding how a person can keep from getting the AIDS virus:
 Having fewer sex partners (88% say yes; 12% say no; 0% don't know)
 Avoiding sexual activity (75% say yes; 24% say no; 2% say don't know)
 Using condoms (88%; 10%; 2%)
 Using protection like plastic gloves, saran wrap, or baggies (29%; 54%; 17%)
 Avoiding the use of needles (95%; 5%; 0%)
 Cleaning needles before using them (49%; 42%; 8%)
 Avoiding certain types of sexual partners (85%; 12%; 3%)
In the past six months: 61% had seen an AIDS brochure or poster; 41% talked w/someone about AIDS
Do you know: 81% know how to find information about AIDS; 56% know about the AIDS hotline; 80% know where to get tested for the AIDS virus

ATTITUDES/PERCEPTIONS/BELIEFS

95% of the respondents stated that YES, you can get AIDS from a person who looks healthy
Percent of respondents reporting how likely they think they are of becoming infected with the AIDS virus while in prison: 5% very likely; 15% likely; 25% unlikely; 42% very unlikely; 22% not sure
Reasons for not getting tested: don't trust the prison health services (20%); don't know where or how to get tested (9%); don't care to know if I'm infected (9%); no privacy (7%); fear of having the virus (2%)
Best way to get information about HIV/AIDS to you? Printed materials (47%); Video tape or TV (28%); group discussions (25%)
other reasons for not getting tested: have safe sex; tested negative; don't mess around; don't care; not a worry; not at risk
Suggestions for other ways the PHD might help you avoid becoming infected with the AIDS virus: more education, condoms, clean needles, find a cure,

Additional comments: Length of time in prison is noted in the results: 32% less than one year; 32% 1-2 years; 17% 3-5 years; 19% more than 5 years;

HIGH RISK GROUP: Incarcerated Populations **Assessment #: 1**
Method: Public Health Survey **HPR: 4** **#Tot: 59** **Age: 18 and up**
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OUTCOMES/RESULTS

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Suggestions for other ways the PHD might help you avoid becoming infected with the AIDS virus: more education, condoms, clean needles, find a cure,

Additional comments: Length of time in prison is noted in the results: 32% less than one year; 32% 1-2 years; 17% 3-5 years; 19% more than 5 years;

People with Hidden Risk Behavior

HIGH RISK GROUP: people w/hidden risks **Assessment #:** 1
Method: survey **HPR:** 5S **#TOT:** 590 **Age:** college-aged
SO: **#Males:** 270 **#Females:** 320
Race/Ethnicity: white = 97%; Asians = 11 individuals; African Americans = 4; Hispanics = 10; Native Americans = 17.
Administrator: Ctr. For Population Research/U of MT **Year:** 1994

OUTCOMES/RESULTS

BEHAVIORS

Males indicate more risky sexual behavior in each channel category.

Males assume more sexual risk than females. This trend shows that for males, the higher one's knowledge of HIV/AIDS, the lower their level of risky sexual behavior. Trend is similar for females, but when females reach a certain level of knowledge, further information doesn't effect their sexual behavior. In each age group, low knowledge of HIV/AIDS is associated with the highest levels of risky sexual behavior. The youngest age group (17-19), it can be seen that the higher one's knowledge of HIV/AIDS, the lower one's level of risky sexual behavior. For males in the youngest age group, the higher the knowledge of HIV/AIDS, the lower the level of risky sexual behavior. It is apparent that once females have a base knowledge of AIDS, further information does not effect their level of risky sexual behavior.

KNOWLEDGE

High knowledge for females is most associated with educational and print media channels.

High knowledge for males is most associated with medical/professional and educational channels.

Broadcast media channels are most associated with low knowledge for both males and females.

Females have a high knowledge of AIDS regardless of the number of channels they use for AIDS info.

Using less than three categories seems sufficient for females. Males seem to need a diversity of at least four channel categories to achieve a high knowledge level.

For both males and females, the higher one's knowledge of HIV/AIDS, the more humane their AIDS attitudes.

In each age group, there is a trend such that the higher knowledge of HIV/AIDS, the more humane one's attitudes towards those with AIDS.

ATTITUDES/BELIEFS/PERCEPTIONS

Most Important source for HIV/AIDS information: broadcast media and educational channels (both males and females); Females rely more on print media, medical/professional and interpersonal channels. Males rely more heavily on broadcast media. Non-traditional students (25 and older) are more likely to rely on print media and less on educational channels. Younger age groups rely most heavily on educational and broadcast media channels.

Females rely more heavily on friends for AIDS information than do males.

Females choose relatives as a source more often than males for AIDS information.

Females get AIDS information from more channel categories than do males. Younger students use more channel categories than do older students.

Females have more humane attitudes towards those with HIV/AIDS in each channel category. Females have humane attitudes despite their most important source.

The number of channel categories does not effect AIDS attitude for males. Males overall have less humane attitudes towards those with HIV/AIDS than do females. Females attitudes are comparable to those of males when two or less channel categories were used. Humane attitudes peak for females when they are exposed to three channel categories.

Additional comments: Types of information channels to chose from were broadcast media, print media, educational, medical/professional, and interpersonal. Age groups were 17-19; 20-24; and 25 & older.

HIGH RISK GROUP: hidden risk **Assessment #:** 2
Method: focus group **HPR:** 5N **#TOT:** 68 **Age:** 16 -60
SO: n/a **#Males:** 15 **#Females:** 43
Race/Ethnicity: NA=33; W=15; other=3; none given=17
Administrator: Lake County Health Dept. (at Salish Kootenai College) **Year:** 1996

OUTCOMES/RESULTS

BEHAVIORS

KNOWLEDGE

Fifty-four (majority) of respondents said YES, the information they receive about HIV/AIDS is accurate

ATTITUDES/BELIEFS/PERCEPTIONS

Sixty-seven respondents said YES, HIV/AIDS related information should be readily available on campus

Places to have HIV/AIDS information: Library, school, homes, work, physical fitness areas, classes, workshops, clinics, counseling centers, health service, bars, student services area, job corps, orientation

Attitude of general population about the risk of HIV infection: can't get it; it's a serious problem; they're unconcerned; don't realize it's a dangerous disease and most people don't take time to think about safe sex; fearful; negative—only "those" folks can get AIDS

Attitude of campus population: don't know; not sure; it won't happen to me; apathetic;

Who is at highest risk: people who don't know all the facts; young teens; people who screw around; drug users; health professionals; everyone; multiple sex partners; women; gay men, IV drug users; the uninformed

Ways to prevent HIV on campus: condoms; education; speakers who have HIV; pamphlets; classes;

Ways to prevent HIV with the highest risk groups: educate people more about the virus; teach students the difference between safe sex and just sex; distribute needles; incorporate education into all HPE classes

Does the college need a place to get testing or condoms: Testing (44 said YES); Condoms (60 said YES)

Are condoms easy for you to get: 48 said YES; 2 said NO;

Can you afford to buy condoms: 23 said YES; 6 said NO

Receive information from: TV, School, clinics & educ. Programs, local sources, journals, newspaper (top 6 responses)

HIGH RISK GROUP: hidden risk **Assessment #:** 3
Method: focus group **HPR:** 5N **#TOT:** **Age:** college-aged
SO: n/a **#Males:** n/a **#Females:** n/a
Race/Ethnicity: n/a
Administrator: Flathead Community College (Timothy Fanwand & Sharon Randolph)
Year: 1996

OUTCOMES/RESULTS

<p><u>BEHAVIORS</u> <i>People are having unprotected sex</i></p> <p><i>Drinking has increased in young people</i></p>
<p><u>KNOWLEDGE</u></p>
<p><u>ATTITUDES/BELIEFS/PERCEPTIONS</u> <i>All agree that information should be accessible everywhere on campus; information should not be restricted.</i></p> <p><i>Good resources for obtaining HIV related information: health department, Family planning, doctor's office, media, pamphlets, flyers, college, bulletin boards</i></p> <p><i>Information should be more open and made public</i></p> <p><i>People need to realize that HIV is here and it exists in MT</i></p> <p><i>Attitude of general population regarding risk for HIV: Montana people don't feel it is a concern; we are sheltered;</i></p> <p><i>Attitude of your campus population re: HIV: people aren't concerned; it's important that the total campus have a prevention attitude; no efforts this year to mention HIV</i></p> <p><i>Who is at most risk for HIV: permiscuous and sexually active individuals with multiple partners; drug users and anyone who has unprotected sex; everyone is at risk</i></p> <p><i>What prevention strategies are most effect with campus populations: information and education; condoms on campus; mandatory HIV classes; supportive environment</i></p> <p><i>Where do you get your HIV related information: health dept., media, pamphlets, papers, limited amounts at school</i></p>