An Assessment of the HIV Prevention Needs of Men who have Sex with Men in Montana

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

By

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Bachelor of Arts, Temple University, Philadelphia, Pennsylvania, 2004

Thesis

Presented in partial fulfillment of the requirements
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ABSTRACT

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An Assessment of the HIV Prevention Needs of Men who have Sex with Men in Montana

Chairperson: Dr. Annie Sondag

The purpose of this study was to collect information about the HIV prevention needs of men who have sex with men (MSM) living in Montana. Prevention needs were explored by identifying the environmental factors and behaviors that put MSM at risk for HIV infection, describing the demographic and contextual factors that influence those behaviors, and comparing current prevention needs to existing resources and services. To evaluate the prevention needs, primary qualitative data was collected in the form of four focus groups and nine key informant interviews. Supporting secondary quantitative and qualitative data in the form of an online survey and interviews with men on the “down low” were also assessed. The results of this assessment identified behaviors that contribute to HIV infection including unprotected anal intercourse, alcohol and drug use, using the Internet to find sexual partners, and hiding one’s sexuality. Aspects of the environment that increase risk of HIV infection were also identified including geographic and social isolation, and communal hostility towards MSM. Factors contributing to HIV risk behaviors include depression and poor mental health, HIV testing issues, misperceptions about HIV and HIV medications, lack of social support, skills, younger age, and lack of comprehensive sex education. Finally, a number of HIV prevention needs were identified including needed resources such as more gay community centers, outreach efforts such as publicizing HIV rates in Montana and its communities, and health-related interventions such as comprehensive sex education, more support groups, and anonymous HIV testing. Other needed resources include cultural changes such as cultural competency training for individuals working with the public and greater acceptance of individuals who are two-spirit; social changes such as more MSM community and socializing events and greater political clout of the MSM community; and policy changes such as equal rights for lesbian, gay, and bisexual individuals, along with greater funding for HIV testing, treatment and education. The findings from this study will be used by the Montana Department of Public Health and Human Services and the Montana HIV Prevention Community Planning Group to further shape the programs and resources offered to MSM.
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CHAPTER ONE

Introduction to the Study

It has been nearly four decades since the first known cases of Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS) appeared on the medical landscape. The Centers for Disease Control and Prevention (CDC) estimate that more than one million people in the United States were living with HIV at the end of 2006, with 21% of those cases undiagnosed (CDC, 2010f). Worldwide, an estimated 33 million people are infected with HIV (Stevens, Lynm, & Glass, 2008). Despite many breakthroughs in the detection and treatment of the virus, this incurable disease continues to infect thousands of individuals in the United States annually. A disproportionate majority of those are men who have sex with men (MSM) (CDC, 2010b).

Transmission of HIV occurs through contact with infected bodily fluids such as breast milk, blood, semen, and vaginal fluids. There are various routes of infection; the primary routes are through unprotected sex and injection drug use. In regards to unprotected sex, the CDC reports that anal sex is riskier than vaginal sex for HIV infection. Furthermore, unprotected receptive anal sex carries more risk of HIV infection than insertive anal sex (CDC, 2010a).

According to the most recent epidemiological data available from the CDC, an estimated 56,300 people were infected with HIV in 2006 in the United States. Over half of those new infections were MSM. Further, CDC estimates that while MSM represent only 4% of the male population in the United States States (CDC, 2010c), they represent nearly
half of those currently living with HIV/AIDS (CDC, 2010e). Clearly, MSM are overrepresented in the HIV/AIDS epidemic. Moreover, MSM represent the only at-risk group with annual increases in new HIV infections (CDC, 2010f).

A March 2010 press release from the CDC states that “the rate of new HIV diagnoses among men who have sex with men (MSM) is more than 44 times that of other men and more than 40 times that of women” (CDC, 2010c). In Montana, MSM continue to overwhelmingly bear the burden of HIV/AIDS infections. According to the Montana Department of Public Health and Human Services (DPHHS), there have been over 950 reported cases of HIV in the state since 1985 and there are currently an estimated 445 people living with HIV/AIDS (DPHHS, 2010). Of all people living with HIV/AIDS in Montana, nearly two-thirds are MSM (DPHHS, 2009a). The percentage of newly diagnosed cases of HIV/AIDS in Montana where MSM is the identified risk factor has been on the rise. According to DPHHS, during the five year period of 2000 through 2004, 49% of newly diagnosed cases of HIV reported MSM as the mode of exposure. During the three years of 2005 through 2007, this percentage rose to 62% and in the year 2008 alone, 50% of newly diagnosed cases were MSM. The rates become higher when factoring in MSM who are also injection drug users (DPHHS, 2009b).

The CDC identifies a range of factors contributing to the high rates of infection among MSM. These include “complacency about HIV risk, difficulty of consistently maintaining safe behaviors with every sexual encounter over the course of a lifetime, and lack of awareness. Additionally, factors such as homophobia and stigma can prevent MSM from
seeking prevention, testing, and treatment services” (CDC, 2010c). Furthermore, men in general are less likely than women to utilize health care services and often do so only when in need of serious care. This can lead to undiagnosed HIV infections in MSM who do not get tested for the virus (National Alliance of State & Territorial AIDS Directors, 2010a). These factors are especially compounded in rural communities like those in Montana. MSM in rural communities have additional challenges such as lack of identifiable settings where MSM gather, limited or no resources for MSM, conservative values regarding sexual behavior, social hostility including homophobia and antigay violence, and isolation and loneliness (Simon Rosser & Horvath, 2007; Williams, Bowen, & Horvath, 2005). In addition to these rural issues, Preston, D’Augelli, Cain, and Schulze (2002) report that the response to HIV/AIDS has largely been urban:

“For instance, the complex system of social and medical services available to gay and bisexual men in urban areas is nonexistent in rural settings. Nor is the social envelope - both protective and risk-inducing - of urban gay communities present in rural settings” (p.200).

Further complicating the issue for rural MSM is the use of the Internet to locate sexual partners as a result of the unseen MSM community. Horvath, Bowen, and Williams (2006) report that use of the Internet to meet sexual partners is linked with both high risk behavior and sexually transmitted infections. The researchers report,

“Although the Internet may reduce isolation, it may also contribute to increasing HIV prevalence in rural MSM. Meeting online sex partners has been associated with high rates of sexually transmitted diseases (STDs). Internet-dating MSM report greater use of methamphetamines, having more sexual partners, and
engaging in higher rates of unprotected anal receptive and insertive intercourse than MSM who had not used the Internet as a venue to seek sex partners. Finally, 43% of HIV-positive men who sought partners on the web admitted to having unprotected anal intercourse with HIV-negative or HIV-status-unknown men” (p.237).

In addition to the risk of men not disclosing their HIV status to a potential sexual partner, another risk involves those who are unaware of their own HIV status. One study tested over 5,600 MSM for HIV. Of those tested, 10% were positive and of those testing positive, 77% were not aware of their infection (MacKellar, Valleroy, Secura, Behel, Bingham, Celentano, et al., 2005, p. 605). Because of these complex issues, it is important that HIV prevention providers examine the multifaceted psychosocial prevention needs of MSM.

There are current prevention efforts taking place in Montana targeting MSM. These include social marketing, retreats, Internet outreach and services, speakers’ bureaus, support groups, and other programs. Some methods are directed at target MSM populations such as youth or American Indian MSM while others are targeted to the general MSM population. A statewide needs assessment will help to improve these HIV prevention efforts.

**Purpose of the Study**

The purpose of this study was to collect information about the HIV prevention needs of men who have sex with men (MSM) living in Montana. Prevention needs were explored
by identifying the environmental factors and behaviors that put MSM at risk for HIV infection, describing the demographic and contextual factors that influence those behaviors, and comparing current prevention needs to existing resources and services.

**Statement of the Problem**

Despite current prevention efforts, MSM continue to be the group most at risk for HIV infection. Nearly two-thirds of people living with HIV/AIDS in Montana are MSM. Effective HIV prevention efforts must recognize the diverse needs of MSM living in rural communities along with the barriers MSM face when seeking resources. Determining the needs of MSM in Montana will ultimately improve the quality and availability of HIV prevention resources, which in turn will improve the quality of life for MSM and decrease the spread of HIV in this population.

**Significance of the Study**

Following completion of the study, a statewide assessment of the prevention needs of MSM will be provided to DPHHS and to the Montana HIV Prevention Community Planning Group (CPG). Information from the assessment will be used to further shape the programs and resources offered to MSM. Highlighting the needs of MSM, and both facilitators and barriers to prevention resources will assist service providers, policy makers, and community members to improve HIV prevention strategies directed at MSM in Montana. Ultimately, this will improve resource access and increase prevention efforts.
Research Questions

Using the PRECEDE/PROCEED model to inform this case study, the research questions will focus on MSM in Montana:

Behavioral and Environmental Diagnosis

- What behaviors contribute to the spread of HIV among MSM in Montana?
- What are social or environmental factors contribute to HIV risk behaviors in Montana?

Educational and Organizational Diagnosis

- What personal characteristics might influence men to engage in risky behavior in Montana?
- What personal characteristics might influence men to not engage in risky behavior in Montana?
- What resources or skills do MSM lack that may contribute to the spread of HIV in Montana?
- What resources or skills do MSM have that may encourage them to not engage in risky behaviors in Montana?
- What social relationships of MSM might reinforce risky behavior in Montana?
- What social relationships of MSM might deter risky behavior in Montana?

Administrative and Policy Diagnosis

- What are some resources that target MSM in Montana?
• What are health-related interventions that are needed for MSM to prevent HIV in Montana?
• What policy changes are needed to meet the HIV prevention needs of MSM in Montana?
• What social or cultural changes are needed to meet the HIV prevention needs of MSM in Montana?

**Delimitations**

The delimitations of the study are:

1. The study is delimitated to men aged 18 or older who have sex with men (MSM) and live in Montana.

2. Data will be collected through focus groups with MSM and interviews with key informants, along with secondary data from an online sexual health survey and interviews with MSM who are on the “down low” or are not “out” as gay or bisexual men.

3. Data collected from participants will be restricted to self reports.

4. Participants in the study will be volunteers who may discontinue involvement at any time, at their own discretion.

**Limitations**

The limitations of the study are:

1. Data collected during interviews and focus groups will be limited to the experiences of the participants.
2. Data collected will be limited to the participants’ honesty, openness, and willingness to share.

3. Data collected will be limited to individuals who are recruited by key informants in addition to the key informants themselves.

4. Data analysis is limited to the researcher’s bias and ability to carry out the study methodologies.

**Definition of Terms**

**Acquired Immune Deficiency Syndrome (AIDS):** The infection caused by the human immunodeficiency virus (HIV). One receives an AIDS diagnosis during the later stages of HIV after the immune system has been severely compromised. At the present time, there are no vaccines or cures for the AIDS virus (CDC, 2010a).

**Human Immunodeficiency Virus (HIV):** The virus which causes the AIDS infection. According to the CDC, “HIV damages a person’s body by destroying specific blood cells, called CD4+ T cells, which are crucial to helping the body fight diseases” (CDC, 2010a). The virus is spread through contact with infected bodily fluids such as blood, semen, breast milk, and vaginal fluid (CDC, 2010g).

**Men who Have Sex with Men (MSM):** All men who have sexual contact with other men regardless of their self-identification as gay, bisexual, or heterosexual men (CDC, 2010d).
**Met Needs:** “A need within a specific target population for HIV prevention services that is currently being addressed through existing HIV prevention resources. These resources are available to, appropriate for, and accessible to that population” (CDC, 2003, p. 42).

**Needs Assessment:** “A process for obtaining and analyzing information to determine the current status and service needs of a defined population or geographic area” (CDC, 2006).

**Rural:** “According to official U.S. Census Bureau definitions, rural areas comprise open country and settlements with fewer than 2,500 residents…Urban areas comprise larger places and densely settled areas around them. Urban areas do not necessarily follow municipal boundaries. They are essentially densely settled territory as it might appear from the air. Most counties, whether metropolitan or nonmetropolitan, contain a combination of urban and rural populations” (United States Department of Agriculture, 2007).

**Unmet Needs:** “A requirement for HIV prevention services within a specific target population that is not currently being addressed through existing HIV prevention services and activities, either because no services are available or because available services are either inappropriate for or inaccessible to the target population” (CDC, 2003, p. 42).
CHAPTER TWO

REVIEW OF LITERATURE

PRECEDE/PROCEED Logic Model

The information collected during the review of literature will be presented in a format which outlines the PRECEDE/PROCEED logic model in order to best synthesize the material. The PRECEDE/PROCEED model is a common logic model used in community health program planning. The PRECEDE/PROCEED acronym stands for “Predisposing, Reinforcing, and Enabling Causes in Educational Diagnosis and Evaluation” (PRECEDE) and “Policy, Regulatory, and Organizational Constructs in Educational and Environmental Development” (PROCEED). This logic model reflects the increasing importance of including both organizational and environmental concerns in evaluating health issues. As Doyle, Ward, and Oomen-Early (2010) note, the model “is designed to help us develop a full picture of our community of interest- its health needs and the factors that influence them” (p.116). Simons-Morton, Greene, and Gottlieb (1995) note that the PRECEDE/PROCEED model occurs in a series of steps “to help the planner move from the recognition of problems or impediments to the overall quality of life through the analysis of these problems, and to the development of a program designed to address them” (p.128). The review of literature will address the PRECEDE portion of the model.

The PRECEDE part of the logic model comprises the first five steps. The first step is the Social Diagnosis or social assessment. The Social Diagnosis assesses the quality of life for the given community. Simons-Morton et al. (1995) describe this process as “a review
of the specific ‘symptoms’ of community health or dysfunction” (p.129). These symptoms, or social indicators, can be both on a community or organizational level (Doyle et al., 2010).

The second step of the process is the Epidemiological Diagnosis where the health issues specific to the community that affect quality of life are identified. These health issues may be genetic, behavioral, or environmental in nature. Identifying these health issues will help the researcher select the most pressing health issue related to the community, unless one has already been identified by stakeholders.

The third step of the process is the Behavioral and Environmental Diagnosis. This step examines behavioral and environmental factors that may contribute to the health issues identified in step two. The result of this phase should be behaviors identified on an individual or organizational level that may require changes to improve health and ultimately, quality of life (Simons-Morton et al., 1995).

The fourth step, Educational and Organizational Diagnosis, analyzes why the behavior identified in step three is occurring. More specifically, this step identifies the predisposing, reinforcing, and enabling factors that influence the health behaviors and environmental factors identified in step three. Predisposing factors “involve those thought processes that motivate the targeted behaviors” such as attitudes, values, beliefs, and knowledge (Doyle et al., 2010, p. 119). Doyle et al. (2010) describe reinforcing factors as “rewards or encouraging feedback (positive or negative) that community members
receive from other people” (p.119). Lastly, enabling factors “include resources and skills needed for behavior change to occur or barriers that may prevent it from happening- or both” (Doyle et al., 2010, p.119).

The fifth and final step of the PRECEDE model is the Administrative and Policy Diagnosis. During this phase, an analysis of the existing health or policy-related services is done. It also assesses the available resources for developing and implementing a program to encourage changes in behaviors or factors contributing to the behavior.

**Social Diagnosis**

While anyone can be at risk for contracting HIV/AIDS in the United States, it is men who have sex with men (MSM) who represent the most at-risk population. MSM are also the only at-risk group continuing to see increases in new infections (CDC, 2010f). The quality of life for MSM at risk for HIV/AIDS can be shaped by many variables including acceptance by one’s community, family, and self; and institutional heterosexism.

Montana is the fourth largest state in the United States, behind Alaska, California, and Texas, yet has a small population; the 2009 estimated population was 974,989 people (United States Census Bureau, 2010). The state has 56 counties. Of those, 45 are classified as frontier (six or less people per square mile) and 10 counties are considered rural (six to 50 people per square mile). There are three communities in the state that are considered “metropolitan statistical areas”: Billings, Great Falls, and Missoula. The
population is evenly split by gender with men accounting for 50% of the population (Montana Department of Public Health and Human Services [DPHHS], 2009b).

While it is not possible to know the number of MSM living in Montana at this time, the Williams Institute\(^1\), using data from the United States Census, suggests that there are lesbian, gay, and bisexual (LGB) couples in at least every Montana county in the state but one. Furthermore, the Williams Institute estimates that there were 18,703 LGB individuals living in Montana in the year 2005 (Williams Institute, 2008). This data shows that LGB individuals are present in all areas of the state, large and small, eastern and western.

The World Health Organization defines quality of life as:

“Individuals’ perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards, and concerns. It is a broad ranging concept affected in a complex way by the person's physical health, psychological state, level of independence, social relationships, personal beliefs and their relationship to salient features of their environment” (World Health Organization, 1997, p.1).

For MSM living in a rural state like Montana, there are many factors which shape quality of life; some factors are unique to the LGB community while others are not. Acceptance and tolerance of MSM or the lack thereof by others can dictate satisfaction with various aspects of life- community (both social and physical), health, income, housing and job

\(^1\) The Williams Institute is a national think tank of the University of California Los Angeles School of Law.
security, self-esteem, and interactions with institutional systems such as legal, political, and religious institutions, to name a few.

Preston, D’Augelli, Kassab, & Starks (2007) describe stigma as the following:

“Stigma results from an attribute of an individual that can be deeply discrediting. It is a complex concept that refers to prejudice, mistreatment, and discrimination that can be real or perceived. The discrimination related to stigma can result in self-hatred developed from internalizing the negative responses of others. Stigma serves to reduce the social status of the stigmatized person because of judgments based on attitudes about the stigma expressed by significant others in a person’s life (family, friends, community)” (p. 219).

Continuing, the researchers discuss stigma as it relates to MSM:

“AIDS in the United States has been most prevalent among MSM, and most of the stigma associated with AIDS has derived from its association with homosexuality. For many MSM, the stigmatization resulting from the negative attitudes of others can result in internalized homophobia, a form of self-denigration that can erode self-esteem and cause depression. As such, the stigma associated with sexual orientation and AIDS is both personal (reflecting a threat to the mental health and well-being of MSM) and social (reflecting a threat to core social values concerning sexual behavior, morality, and religious views). Stigma may be even more influential in rural areas where there is less experience with and tolerance of diverse lifestyles, greater fear of HIV, and less anonymity” (p. 219).
The stigma associated with being an MSM can be far reaching into multiple levels of one’s life such as community, family and self.

Tolerance on a community level, while not absolute to one’s quality of life, can serve as either a positive or negative impact. There are many important community factors contributing to one’s quality of life. LGB services and resources help to address community needs while also offering an identifiable community network and community identity. Oftentimes, these services and resources can offer a safe haven to those who may otherwise feel isolated.

Violence perpetrated towards the LGB community and the resulting community response to such violence is also a factor which affects one’s quality of life. The ability to be safe not only at home but also when out in public is something often taken for granted by heterosexuals who do not think to be on guard with public displays of affection. A community which tolerates anti-gay violence helps to perpetuate the stigma associated with being “non-heterosexual”. Herek and Garnets (2007) report that experiencing anti-gay violence can have profound consequences:

“For example, for gay men and lesbians, being the target of antigay violence can be even more traumatic than ‘routine’ criminal victimization; victims of hate crimes manifest heightened levels of depressive symptoms, anxiety, and symptoms of posttraumatic distress compared with sexual minority victims of violent crimes that were not motivated by antigay animus” (p.360).
Community level acceptance and tolerance can either improve or debase one’s quality of life. Another area with even greater influence can be one’s family.

Family can be one of the first groups of people that an LGB individual informs of his or her sexuality. The initial reaction, whether supportive or not, can have profound effects for mental health and well-being. Cody and Welch (1997) report that a mother’s knowledge of her son being gay is a predictor for high self-esteem among gay men from rural communities. Further, the researchers report that “satisfying relationships with both parents best predicted high self-esteem among gay males from small-town homes” (p. 54). Acceptance by one’s family can be critical for MSM, particularly those who may rely on their families for emotional, financial, or even physical support during times of illness. Shernoff (1997) describes the importance of support from families, particularly for gay men returning to their rural communities after an HIV/AIDS diagnosis. For these men already grappling with their own health issues, their mental health can be compromised by the level of support offered by their families. For families who do not accept homosexuality and have a son returning home for their support, this may turn into an opportunity for more guilt, shame, and other negative emotions to manifest, thereby furthering the stigma and declining quality of life. This stigmatization can manifest itself as minority stress, or internalized homophobia. Minority stress refers to “‘a state intervening between the sequential antecedent stressors of culturally sanctioned, categorically ascribed inferior status, resultant prejudice and discrimination, the impact of these forces on the cognitive structure of the individuals, and consequent readjustment or adaptational failure’” (Matthews & Adams, 2009, p.13). Matthews and Adams (2009) go
on to further clarify that minority stress in relation to sexual minorities can be used “as a framework for describing and exploring the ways in which lesbians and gay men experience stress-related mental health consequences because of their socially prescribed inferior status due to their non-heterosexual orientation” (p.13). Hatzenbuehler, Nolen-Hoeksema, and Erickson (2008) describe impacts of minority stress:

“The minority stress model describes several stress processes leading to adverse behavioral and mental health outcomes among sexual minorities, including objective discrimination events, expectations of rejection, and the internalization of negative societal attitudes. As members of a stigmatized minority group, sexual minorities are the target of objective prejudice events, including antigay violence and discrimination, and research with probability samples has documented that sexual minorities experience discrimination with greater frequency than their heterosexual peers. One consequence of discrimination is that individuals begin to expect rejection based on their stigmatized identify, and such expectations often engender hyper-vigilance to rejection cues in the environment. Finally, in addition to confronting external stigma, sexual minorities may incorporate negative social views of homosexuality into their self-concept, a process known as internalized homophobia” (p. 455).

This leads to another important aspect of quality of life- acceptance of one’s own self.

Most people experience feelings of self-doubt and question their self-worth. For MSM, these feelings can be complicated by community and familial stigma towards their sexuality. Stigma and homophobia are everywhere in US culture; derogatory terms used
to label gay men and lesbians are used without thought, directed as insults to anyone regardless of their sexual orientation (Eldridge, Mack & Swank, 2006). Use of the word “gay” as an insult perpetuates the construct that being gay is not socially acceptable and sends such a message to LGB individuals. The degree of internalized homophobia or minority stress can have bearing on coping mechanisms. Herek and Garnets (2007) report that this “internalized homonegativity” can have a detrimental effect on one’s physical and mental health including “diminished self-esteem, demoralization, depression, increased use of alcohol and drugs, and relationship instability” (p. 361). A final area which influences the quality of life for MSM is one which is beyond the control of any one person; these are the institutions which are a part of a community’s fabric- the legal, political, and religious systems at work.

It is important to discuss the concept of heterosexism when describing quality of life issues for MSM. Heterosexism is the inherent prejudicial assumption that heterosexuality is the norm and anything non-heterosexual is the other; that heterosexuality is superior to homosexuality; and that one is assumed to be heterosexual unless otherwise indicated. Institutional heterosexism then, refers to “societal-level conditions that constrain the opportunities, resources, and well-being of socially disadvantaged groups” (Hatzenbuehler, McLaughlin, Keyes, and Hasin, 2010, p.452), or in this case, the well-being of LGB individuals. The United States supports a heterosexist climate in many spheres. Gay marriage is not federally recognized due to the 1996 Defense of Marriage Act (DOMA). Same sex marriage is legal in only a handful of states: Connecticut, Iowa, Massachusetts, New Hampshire, and Vermont, along with the District of Columbia.
Despite full faith and credit, other states do not have to recognize the validity of these marriages as a result of DOMA. Herek and Garnets (2007) speculate that the inability for same-sex couples to marry causes added stress and challenges to those relationships in comparison to heterosexual couples. Don’t Ask, Don’t Tell is the military policy encouraging lesbian, gay, and bisexual service members to remain closeted regarding their sexuality; those open about their homosexuality are discharged from the military. Furthermore, blood donations by MSM are currently banned in the United States despite consistent blood screening of all donors. Homosexuality was labeled a mental health disorder in the Diagnostic and Statistical Manual of Mental Disorders until 1973 (Eldridge, Mack & Swank, 2006) regardless of the fact that psychoanalysts such as Sigmund Freud asserted that being gay was not an illness: “Even Freud, who believed that homosexuality represented a less-than-optimal outcome for psychosexual development, nevertheless asserted in a now-famous 1935 letter that ‘it is nothing to be ashamed of, no vice, no degradation, it cannot be classified as an illness’” (Herek & Garnets, 2007, p.355). Federal and Montana state anti-discrimination laws do not include LGB individuals as a protected group although one city in Montana recently enacted an ordinance to include them in its anti-discrimination policy. Without inclusion in anti-discrimination policies, housing and employment discrimination towards LGB individuals is legal. Heterosexism has financial repercussions for MSM as well (Herek & Garnets, 2007). The Williams Institute (2008) finds:

“On average, men in same-sex couples in Montana earn $17,141 each year, much less than $35,993 for married men. The median income of men in same-

\footnote{2 During the course of this study, Don’t Ask Don’t Tell was repealed and is in the process of being implemented into military policies.}
sex couples in Montana is $11,750 or 61% less than that of married men ($30,000).”

Further, a hostile political climate adds to the validity of heterosexism. In the Montana Code Annotated (MCA), which is the compilation of all Montana statutes, one statute in particular stands out: §45-5-505, regarding “Deviate sexual conduct”. It states:

“(1) A person who knowingly engages in deviate sexual relations or who causes another to engage in deviate sexual relations commits the offense of deviate sexual conduct.

(2) A person convicted of the offense of deviate sexual conduct shall be imprisoned in the state prison for any term not to exceed 10 years or be fined an amount not to exceed $50,000, or both.

(3) The fact that a person seeks testing or receives treatment for the HIV-related virus or another sexually transmitted disease may not be used as a basis for a prosecution under this section and is not admissible in evidence in a prosecution under this section.”

“Deviate sexual conduct” is defined in § 45-2-101 as “sexual contact or sexual intercourse between two persons of the same sex or any form of sexual intercourse with an animal.” Sodomy laws, as this type of law is referred to, were struck down by the United States Supreme Court in 2003 and the “deviate sexual conduct” law, as applied to consenting adults engaging in sexual contact between two same sex individuals, was struck down by the Montana State Supreme Court in 1997. However, the law remains in the MCA until legislative action is taken to remove the law. At first, this may appear to

be a non-issue for Montanans. However, the platform adopted in 2010 by the Montana Republican Party, under the heading “Homosexual Acts” reads, “We support the clear will of the people of Montana expressed by legislation to keep homosexual acts illegal” (Montana Republicans, 2010; Mayrer, 2010). The last piece of institutionalized heterosexism to address is found in religious institutions.

Religions are free to dictate their core values and beliefs. Some Christian denominations accept and welcome LGB individuals while others do not. Many individuals rely on religious or spiritual guidance in addressing areas of stress in their lives. Unfortunately, this means that for some LGB individuals who are believers of one faith or another, these two aspects of their lives may be discordant. As a result, a potentially healing resource is discounted (Herek & Garnets, 2007). Considering all of these aspects, minority stress can be difficult to avoid. Rounds (1988) puts the effects of internalized homophobia eloquently: “One respondent said that the most difficult task in working with gay persons with AIDS was to prevent them from internalizing the homophobia prevalent in rural communities” (p.259).

The quality of life for MSM can be complicated solely by their sexual orientation and the stigma placed upon it. The stigma associated with being a gay man is shaped by one’s community, family, and self-acceptance. Quality of life is a result of one’s environmental factors such as how connected one is to their local LGB community (if one exists) and the significance of institutionalized heterosexism. Each of these quality of life variables
informs the individual’s risk factors for HIV/AIDS. In the next section, health issues specific to MSM are analyzed and addressed.

**Epidemiological Diagnosis**

As explored in the previous section, the quality of life for MSM is complicated by numerous variables. These factors also play roles in the overall health of MSM. MSM have numerous health issues which are related to factors specific to their community. The health issues examined here include HIV/AIDS, HIV and Hepatitis C co-infection, mental health issues, and drug and alcohol use. These few topics are not by any means an exhaustive representation of the health issues facing MSM but rather issues contributing to HIV/AIDS. Further, it should be stated that other sexually transmitted infections are contributing factors to HIV/AIDS but are not explored in this epidemiological diagnosis.

*HIV and AIDS*

Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS) impact the immune system functions. This causes those with the infection to have suppressed immune systems and puts them at risk for developing illnesses that may have otherwise been fought off by their immune system.

There is no vaccine or cure for the disease. During the early years of the disease, a diagnosis of HIV was considered a “death sentence”; however, people today are living longer with what can be described now as a “chronic disease”. In fact, “the projected life expectancy for those infected with HIV, if they remain in optimal HIV care, has
increased from less than seven years in 1993 to more than 20 years today” (DPHHS, 2010b).

As detailed in Chapter One, an estimated 56,300 people were infected with HIV in 2006 in the United States (CDC, 2010e). This averages out to one person becoming infected every nine and a half minutes in the United States (DPHHS 2010b). The HIV/AIDS epidemic has affected southern states the most. However, every corner of the country has been impacted by the disease. According to 2007 CDC data, 17% of new AIDS diagnoses were in the western portion of the United States, the only geographic area where whites were the most impacted racial group. The west was also home to 20% of the people living with AIDS and 16% of those who died with AIDS in the United States (CDC, 2009a). The estimated population of people living with HIV or AIDS (PLWHA) in Montana, as of February 2010, is 445, including both adults and children (DPHHS, 2010a). DPHHS has estimated that nearly two-thirds of PLWHA in the state are MSM (DPHHS, 2009a), representing a disproportionate majority.

Some facts about HIV/AIDS in Montana:

- “Nearly 9 out of every 10 reported cases of HIV/AIDS have been men.
- Men who have sex with men (MSM) account for four times as many reported cases of HIV/AIDS as do persons of other known risk factors.
- Nearly 90% of HIV/AIDS cases occur in persons reporting race as White, a percentage consistent with the general Montana population. The same proportionate representation is seen with the largest minority group, American Indians, who represent about 6.3% of the general population and about 7% of the reported HIV/AIDS cases.
- The average age at HIV diagnosis has remained in the upper 30s since 2000.
- 67% of known persons living with HIV/AIDS sought care in 2008.”

Source: DPHHS, 2009b, p.4

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5 The CDC defines the west as: Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, and Wyoming.
Prevention efforts are estimated to have prevented more than 350,000 HIV infections in the U.S. (DPHHS 2010b). However, prevention efforts could be improved. For example, the most recent data available from the Montana Behavioral Risk Factor Surveillance System shows that as of 2007, an estimated 31.9% of men in the state have ever had an HIV test (DPHHS, 2007). Only 7% of adults in Montana reported that they had had an HIV test within the past year. Because knowing one’s HIV status is vital in preventing HIV infections, regular testing is an important prevention effort (DPHHS, 2010b). The CDC recommends yearly testing for sexually active MSM at a minimum (CDC, 2008c).

According to the CDC (2010a), within two to eight weeks after initial contraction of HIV, most people have detectable antibodies present that can be detected by commonly used tests in the United States. Within the first three months of infection, 97% of people will develop detectable antibodies in their system. After becoming infected, some people may develop symptoms that may last for one or two weeks while others may have no symptoms. The longer the virus is untreated in the body, the greater the potential symptoms. These symptoms may include swollen lymph nodes; fever, chills, and night sweats; diarrhea; weight loss; coughing and shortness of breath; fatigue; skin sores; blurred vision and headaches; and development of other infections (Stevens, Lynm, & Glass, 2008). Early HIV infection that has not been treated has also been associated with cardiovascular, kidney, and liver disease along with some types of cancer (CDC, 2010a).
A diagnosis of AIDS occurs during the later stages of HIV infection. HIV has more recently been defined in four stages, with use of the term “AIDS” being discontinued. The CDC reports (2008a),

“[World Health Organization(WHO)] recommends reporting cases of HIV infection as HIV infection or advanced HIV disease (AHD), including AIDS. All cases of HIV infection, AHD, and AIDS require a confirmed diagnosis of HIV infection based on laboratory testing, using the appropriate national testing algorithm. The revised WHO surveillance case definitions include the following: HIV infection (stages 1 and 2), AHD (stage 3), and AIDS (stage 4).”

Each stage is based on the CD4 blood cell count where normal CD4 blood cell counts in adolescents and adults ranges from 500 to 1500 cells per mm$^3$ of blood (WHO, 2007). The World Health Organization outlines these stages in the following table:

<table>
<thead>
<tr>
<th>HIV-associated immunodeficiency</th>
<th>WHO Clinical Stage</th>
<th>Age-related CD4 Values</th>
</tr>
</thead>
<tbody>
<tr>
<td>None or not significant</td>
<td>1</td>
<td>&gt;35</td>
</tr>
<tr>
<td></td>
<td></td>
<td>&gt;30</td>
</tr>
<tr>
<td></td>
<td></td>
<td>&gt;25</td>
</tr>
<tr>
<td></td>
<td></td>
<td>&gt;500</td>
</tr>
<tr>
<td>Mild</td>
<td>2</td>
<td>30 - 35</td>
</tr>
<tr>
<td></td>
<td></td>
<td>25-30</td>
</tr>
<tr>
<td></td>
<td></td>
<td>20-25</td>
</tr>
<tr>
<td></td>
<td></td>
<td>350-499</td>
</tr>
<tr>
<td>Advanced</td>
<td>3</td>
<td>15-29</td>
</tr>
<tr>
<td></td>
<td></td>
<td>20-24</td>
</tr>
<tr>
<td></td>
<td></td>
<td>15-19</td>
</tr>
<tr>
<td></td>
<td></td>
<td>200-349</td>
</tr>
<tr>
<td>Severe</td>
<td>4</td>
<td>&lt;25</td>
</tr>
<tr>
<td></td>
<td></td>
<td>&lt;20</td>
</tr>
<tr>
<td></td>
<td></td>
<td>&lt;15</td>
</tr>
<tr>
<td></td>
<td></td>
<td>&lt;200 or &lt;15%</td>
</tr>
</tbody>
</table>

Note: This table is a compilation of tables found in the 2007 WHO Case Definitions of HIV for Surveillance and Revised Clinical Staging and Immunological Classification of HIV-Related Disease in Adults and Children found on pages 12 and 15.

Over half of new HIV infections in 2006 were in MSM and it is estimated that MSM represent nearly half of those currently living with HIV/AIDS (CDC, 2010e). MSM

6 To learn more, see http://www.who.int/hiv/pub/guidelines/HIVstaging150307.pdf
represent the only at-risk group with annual increases in new HIV infections (CDC, 2010f). In fact, the rates of HIV infection among MSM are projected to be more than 44 times higher than rates among heterosexual men and more than 40 times higher than rates among women (National Alliance of State & Territorial AIDS Directors [NASTAD], 2010a). It is estimated that nearly 560,000 adult and adolescent men have been infected with HIV through MSM sexual contact or MSM sexual contact and injection drug use through the year 2007 (CDC 2010b).

Current HIV medications offer HIV-positive individuals improved health, decreased viral loads, and can limit or slow damage to the immune system. It is recommended that PLWHA receive regular care from an experienced health care provider (CDC, 2010a). Because the medications can be costly, the federal government enacted the Ryan White CARE Act in August 1990, which provides funding to states for drug assistance and public health clinics, among other supports (DPHHS, 2009b). While there are many benefits from the medications which treat HIV, there are drawbacks: “existing treatments need to be taken daily for the rest of a person’s life, need to be carefully monitored, and come with costs and potential side effects” (CDC, 2010a). In addition, Heckman, Catz, Heckman, Miller, and Kalichman (2004) report, “To achieve the highest likelihood of maximal viral suppression, adherence must be 95% or better over time. This 95% goal for consistent adherence translates into missing less than one dose in seven days for twice daily regimens” (p. 221).
HIV and Hepatitis C Co-Infection

Hepatitis C is a virus which affects the liver; there is currently no vaccine for the disease. Some individuals are able to clear the infection without treatment (J. Scott, personal communication, July 30, 2010) and more than half of those treated result in a cleared infection (NASTAD, 2008). Hepatitis C is transmitted through contact with infected blood. The most common routes of transmission are sharing needles, exposure to needle sticks, from mother to child during pregnancy or birth, sex with an infected partner, and sex with multiple partners (NASTAD, 2008; Alter, 2006). Other risk factors such as blood transfusion and organ transplants have diminished with the advent of widespread infectious disease screening in the United States. Franciscus and Highleyman (2010) from the Hepatitis C Support Project report that an estimated 4 million people are infected with Hepatitis C in the United States. Hepatitis C is the most common co-infection for PLWHA; an estimated 30 to 40% of PLWHA may be co-infected with Hepatitis C.

Hepatitis C is far more infectious than HIV (Alter, 2005) and is more prevalent in HIV-positive MSM than HIV-negative MSM. Urbanus et al. (2009) speculate that “HIV-infection might facilitate [Hepatitis C] transmission by increasing both viral infectiousness due to higher [Hepatitis C] viral loads in blood and semen and viral susceptibility through HIV-impaired immunological control” (p.F6). Co-infection of Hepatitis C and HIV has been associated with accelerated hepatic fibrosis; end-stage liver disease is a leading cause of death for PLWHA (Danta et al., 2007). Co-infection has increased in recent years due in part to newer treatments for HIV/AIDS. Researchers van
de Laar, Matthews, Prins and Danta (2010) found “that after the introduction of combination antiretroviral therapy (cART) in 1996, the [Hepatitis C] incidence in HIV-positive MSM increased from about 1 – 3 per 1000 person years to over 10 per 1000 person years” (p.1800).

MSM who are also injection drug users (IDU) are at further increased risk for Hepatitis C infection (Bollepalli et al., 2006; Buffington et al., 2007; Urbanus et al., 2009; van de Laar et al., 2010). In fact, one study suggests that MSM who are also IDU were five times more likely to be co-infected with Hepatitis C (Bollepalli et al., 2006). While much research has pinpointed IDU as a predominant factor for co-infection of HIV and Hepatitis C, emerging research has begun to identify Hepatitis C as a potential sexually transmitted infection (STI) among HIV-positive MSM (Danta et al., 2007; Hart & Elford, 2010; Urbanus et al., 2009; van de Laar et al., 2010). Various researchers have identified high-risk sexual behavior to be a culprit in the emergence of Hepatitis C as a STI for MSM (Hart & Elford, 2010; Urbanus et al., 2009; van de Laar et al., 2010). van de Laar et al. (2010) note,

“This sudden emergence in [Hepatitis C] coincides with a rise in sexual risk behaviour [sic] and increased STI rates among MSM due to a decrease in the perceived threat of HIV/AIDS in the cART era. The fact that multiple strains of different [Hepatitis C] genotypes circulate among HIV-positive MSM also suggests behavioural [sic] factors in the MSM population rather than evolution of the virus into a specific more virulent variant are responsible for the recent transmission of HCV in this population” (p.1802).
Researchers Hart and Elford (2010) identify multiple potential factors for the rise in Hepatitis C incidence, namely biological, social, and behavioral factors such as serosorting\(^7\), use of the Internet to find sexual partners, and sexual networks of HIV-positive MSM. They conclude,

“serosorting among HIV-positive MSM permits unprotected sex without the risk of HIV transmission to an uninfected person. However, if a new infection emerges in a particular sexual network of HIV-positive MSM, its spread can be rapid.” (Hart & Elford, 2010, p. 42).

In Montana, the most recent DPHHS data available shows that in 2008, there were 943 cases of Hepatitis C reported. The majority of these cases were in individuals within the age range of 45 – 54. Between 1985 and 2008, there have been 49 cases of HIV and Hepatitis C co-infection amongst MSM, with 24 reporting their risk category as MSM alone and 25 reporting their risk category as both MSM and IDU (DPHHS, 2009b).

**Mental Health**

In addition to the health risks of HIV/AIDS and Hepatitis C, MSM have the added risk of poor mental health such as depression and low self-esteem to contribute to their overall health and wellbeing. As outlined above, stigma can have a profound effect on MSM. In a meta-analysis by Newcomb and Mustanski (2009), results were mixed regarding the association between internalized homophobia and risky sexual behavior. However, they cite an article from their review which suggests there may be a relationship:

\(^7\) Serosorting is the term used to describe the act of engaging in unprotected sex with a partner of the same serostatus (e.g., HIV negative or HIV positive).
“According to Williamson’s (2000) review of the literature, a positive relationship between these two variables is logical for three reasons: (1) gay and bisexual men with high levels of [internalized homophobia] are likely to be more isolated from the gay community and have less access to safer sex information and resources; (2) higher levels of [internalized homophobia] have consistently been shown to be associated with lower levels of self-esteem, which may, in turn, lead to less self-protection; and (3) higher levels of [internalized homophobia] may be associated with more substance use and alcohol consumption, which could impair decision making processes and lower inhibitions” (“IH and Risky Sexual Behavior”, para. 2).

A study by Safren et al. (2010) found that HIV-positive MSM with depression had lower self-efficacy and higher risk behaviors. Further, the researchers note that “clinical depression is one of the most common comorbid diagnoses in HIV, with prevalence rates up to 37%” (p. 216).

*Drug and Alcohol Use*

As stated, the use of drugs and alcohol is another health risk for MSM. Use of drugs and alcohol may be a coping mechanism or simply enjoyed by those engaging in sensation seeking activities. Koblin et al. (2006) found an increased risk of HIV infection through the use of drugs, both injection and non-injection, heavy use of alcohol, and use of alcohol or drugs prior to sex:

“The relationships between substance use, high-risk sexual behaviors and HIV infection are complex. Both amphetamine use and heavy alcohol use have been
shown to be associated with high-risk sexual behaviours. . .Several studies have demonstrated an independent association of amphetamine use and heavy alcohol use and risk of HIV infection” (p.736).

The correlation between HIV infection and drug and alcohol use is problematic, particularly for those who use substances as a coping mechanism to manage their mental health.

Because one of the most pressing health issues facing MSM in the United States is HIV/AIDS, and because each these other health concerns relate to HIV/AIDS, it is vitally important for health care practitioners to utilize effective HIV prevention methods. In order to promote health, wellbeing, and quality of life for MSM, a needs assessment of the MSM community in Montana as it relates to HIV/AIDS will be important to improve resources, eliminate barriers, and establish effective resources. However, it is important to also identify the contributing behavioral and environmental factors and a number of these are outlines in the following section.

**Behavioral and Environmental Diagnosis**

Because the focus of this study is HIV prevention needs, the remainder of this analysis will focus on HIV as the predominant health issue for MSM. This section will explore the behavioral and environmental factors of MSM which may contribute to HIV/AIDS. By identifying these factors, the goal is not to project blame but instead to identify areas which may need change or improvement in order to promote increased quality of life and health.
In order for HIV infection to occur, an act must take place where a person who is HIV-negative comes into contact with the bodily fluid of someone who is HIV-positive. The most common routes of infection involve behavior which has risk associated with it. This may be sharing needles for injection drugs or engaging in unprotected anal intercourse. Other risk factors for HIV/AIDS include multiple sexual partners and previous STI diagnoses (Koblin, et al., 2006).

Research suggests that MSM are engaging in increasingly higher rates of high risk sexual behavior than in previous years. Newcomb and Mustanski (2009) highlight the increase in rates of syphilis infection, which increased in men by 81% between 2000 and 2004; MSM represented 64% of those infections. It may be stating the obvious, but it is important to reiterate a statement from the CDC (2008c): “Increasing HIV prevalence means increased opportunities for transmission to HIV-negative persons who engage in risky behaviors.” Because of the increase in the number of PLWHA, the potential increase in high risk behavior, and because there is no cure for HIV/AIDS, prevention methods must combat the risk associated with engaging in high risk behaviors. There are a number of behavioral factors that contribute to the prevalence of HIV/AIDS in MSM. Most HIV infections in MSM are due to sexual risks (CDC, 2007a).

One contributing behavior is engaging in sexual contact with another person without knowing their HIV status. Jaffe, Valdiserri, and De Cock (2007) note a National HIV Behavioral Surveillance System survey which included approximately 10,000 MSM and
excluded men who knew they were HIV positive. More than 4,000 men reported not knowing the HIV status of their male sex partner and 21% of those reported having unprotected anal intercourse with that partner. In another study of young MSM, of those who tested HIV positive during the study, 77% incorrectly believed that they were not infected. One way to protect oneself from infection would be to discuss HIV status with potential sex partners.

Drug use is another risk factor contributing to HIV incidence. The use of drugs in MSM has been associated with mental health issues such as low self-esteem, depression, and internalized homophobia (Herek & Garnets 2007). The use of crystal methamphetamines has been identified as an HIV risk factor for MSM in the United States along with the use of erectile dysfunction medication (Hart & Elford, 2010). Other studies have found an independent association with other substances including heavy alcohol use, amphetamine, nitrite inhalants, and cocaine use (Koblin et al., 2006). Further, MSM who also use injection drugs are at increased risk for HIV if they share or use unsterilized needles.

Yet another behavior which has been associated with sexual risks is the use of the Internet to find sexual partners (Benotsch, Kalichman, & Cage, 2001; CDC, 2007a; Danta et al., 2007; Jenness et al., 2010; Salyers Bull, McFarlane, & Rietmeijer, 2001). The Internet is an accessible, affordable, and anonymous tool for MSM to use to meet sexual partners. Further, there is increased acceptability in using the Internet to meet other people (Bowen, 2005). One study found that individuals using the Internet to meet sexual partners were significantly more likely to report using Viagra compared to those who did
not report meeting a sexual partner through the Internet. Further, researchers found that MSM who used the Internet to meet a sexual partner were more likely to engage in unprotected anal and oral intercourse, and did so at higher frequencies, with more partners than those who did not use the Internet to meet partners (Benotsch et al., 2001; Jenness et al., 2010). Other factors related to high-risk sexual behavior include engaging in unprotected anal intercourse, multiple and unknown sexual partners, age, education, and mental health issues such as low self-esteem and depression (Koblin, et al., 2006; Preston, et al., 2007).

In addition to behavioral factors, the environment within which one lives is another health determinant. “Physical, social, cultural, organizational, community, economic, legal, and policy dimensions of the environment can facilitate or impede individual efforts to avoid HIV infection” (Simon Rosser & Horvath, 2008, p. 159). Communities with larger populations tend to be more anonymous yet diverse and offer more ease for those seeking sub-communities which have been marginalized. However, as previously mentioned, the state of Montana is a largely rural state with communities of a smaller scale. Mancoske (1998) estimates that nearly 25% of all Americans live in rural communities which also host “the greatest concentrations of the poor and of elderly on fixed incomes” (p. 42). Rural communities have unique strengths and challenges that are not present in urban or suburban settings. They also seek tradition and conformity. Oswald and Culton (2003) have found that rural communities rely on uniformity to uphold culture and social order which perceives being different (e.g., LGB) as a threat. The researchers have found this “traditional rural culture” has experienced other threats
such as development, corporate agribusiness, and the urban migration of youth. Furthermore, challenges presented by rural life affect MSM in ways not experienced by their urban counterparts: lack of anonymity and confidentiality concerns, access to health care and other social services, stigma, isolation, transportation issues (e.g., lack of public transportation), barriers to medical services including a shortage of experienced health professionals, and rural traditions and culture itself (Heckman & Carlson, 2007; Mancoske, 1998; Preston et al., 2007; Shernoff, 1997; Ullrich, Lutgendorf, & Stapleton, 2002; Uphold, Rane, Reid, & Tomar, 2005). Moreover, rural areas often lack the visible, viable LGB communities that thrive in urban settings. There are communities in Montana that are better than others at supporting and sustaining their LGB community, though even in those locales acceptance and tolerance are not assured. The ability to be immersed in the LGB culture and community is another environmental factor for MSM; physical and/or emotional isolation from this scene can have a deleterious effect. The combination of these rural characteristics can promote fear and intolerance, resulting in depression, stress, lack of social supports, and poor coping mechanisms among HIV-positive MSM (Uphold et al., 2005).

The ability to identify with others improves one’s social life and sense of connectedness to the community. Since the HIV/AIDS epidemic began decades ago, older MSM have experienced the profound loss of many friends and loved ones, contributing to a sense of isolation and loneliness (Cody & Welch, 1997; Herek & Garnets, 2007). The ability to relate to others in a given community offers a safeguard against stigma and hostility directed towards sexual minorities. The community can also offer support, networking
opportunities to meet others, and the skills to safely navigate the community at large. In fact, Herek and Garnets (2007) write, “Nonheterosexuals who actively participate in a sexual minority community report less psychological distress than those who do not” (p. 361). Thus, environmental factors in a rural community can be affected by the visibility of and acceptance by other MSM. The next section outlines the factors which motivate or influence the health behaviors identified in this section.

**Educational and Organizational Diagnosis**

In addition to identifying the behavioral and environmental factors which contribute to HIV/AIDS, it is also important to understand the predisposing, enabling, and reinforcing factors which contribute to the risky behavior and environment in the first place. The predisposing factors comprise the knowledge, attitudes, beliefs, values, and perceptions which encourage or deter a given behavior. These are what influence a person to engage in high risk sexual behavior.

The first of these predisposing factors is stigma, which was described in detail earlier in this chapter. Many MSM experience stigma on an individual and community level, which may cause minority stress. The predisposing factor here is heterosexism or others’ beliefs that homosexuality is wrong or abnormal. Preston et al. (2007) found in their research that high risk behavior in rural MSM may be a coping mechanism to manage stress related to intolerance. They note:

“In addition, although a direct relationship between stigma and rural MSM’s risky sexual behaviors could not be determined, stigma from families, health
care providers, and their rural communities was related to low self-esteem among the men. This was in turn related to high levels of risky sexual behavior. These results suggest an indirect relationship between stigma and sexual risk behavior of MSM that is mediated by feelings of self-worth” (p. 227).

Furthermore, they note that other studies have shown a relationship between sexual risk taking and the use of sex as a way to manage stress. The attitudes that create the stigmas associated with being gay and being HIV positive are internalized by MSM. Ullrich, Lutgendorf, and Stapleton (2002) report that HIV infection “is often associated with markedly increased levels of anxiety, traumatic stress, and depression” (p.46). They also found that gay men, regardless of HIV status, have higher rates of depression than the general heterosexual population. HIV infection may lead to the assumption that the individual is a member of a stigmatized group, namely a gay man or injection drug user. Because of this, there is additional pressure for MSM to remain closeted about their sexuality and/or HIV status. In a joint statement released in 2010, NASTAD along with the National Coalition of STD Directors (2010b) speak to this attitude which silences MSM:

“The silence that ushered in the beginning of the domestic HIV/AIDS epidemic in the early 1980s has again taken hold of our nation and most Americans offer little more than sympathy for a crisis that continues to claim thousands of gay men’s lives each year. Gay and bisexual men, particularly those of color, feel the acute and sustained effects of oppression, despite any progress that is being made toward equality, and experience rejection and discrimination at personal and institutional levels.”
This stigma creates an invisible, often voiceless community for fear of the repercussions of being outed as an MSM, being HIV positive, or both.

Another predisposing factor contributing to behavior is this perceived fear related to discovery. The first of these fears is the fear of getting tested for HIV in the first place. A 2005 article in the Journal of the American Medicine Association by the CDC reports that compared to HIV negative MSM, proportionally more MSM with unrecognized infections had not been tested because they were afraid to learn they were HIV positive and concerned that others would find out. Further, Foster and Frazier (2008) identify other areas of fear: fear of discrimination based on HIV status; fear of ostracism from family and friends; fear of violence; and fear of rejection by potential sexual partners. The researchers continue:

“‘In contrast to individuals with chronic diseases such as diabetes mellitus, hypertension, cardiovascular disease, and rheumatoid arthritis, HIV positive individuals are faced with not only the chronic illness but also chronic fear- fear of what the most recent laboratory studies will show, fear of being told that their current antiretroviral regimen is failing due to viral resistance, fear of accessing resources because the individual has to disclose their HIV positive status. In addition, patients fear loss of health, abandonment by friends and family, loneliness and isolation, and death’” (p.13).

Perceived fear can prevent individuals from seeking needed health care and social support, and it can also put others at risk by inhibiting HIV positive individuals from disclosing their status to potential sex partners.
Another predisposing factor is the belief that HIV/AIDS is less of a concern than in years past. Many older gay men watched a number of their friends die from AIDS and continue to carry memories associated with the loss of their community. However, for younger MSM, the threat of HIV/AIDS may be perceived to be diminished with the advent of more recent medications. Danta et al. (2007) suggest that there is an association between high-risk sexual behavior and the belief that highly active antiretroviral therapy (HAART) reduces HIV transmission or that there should be less concern with HIV/AIDS because of the availability of HAART. Jaffe et al. (2007) bluntly states: “In 2007, AIDS is simply not as frightening as it was before highly active antiretroviral therapy (HAART) became available” (p. 2412). In addition, because people are able to stay healthy while adhering to HAART, it is not possible to assume what an HIV infected individual might look like. However, this may be something that some individuals incorrectly rely on when seeking a sexual partner. One study by Stratford, Ellerbrock, and Chamblee (2007) found that individuals look for particular characteristics in deciding upon potential sexual partners and the use of protection.

“One decision pattern appeared consistently: judgments about sex partners, which ultimately determine whether or not one used a condom with that partner, were based primarily upon appearance, behaviour [sic], and, in some instances, familiarity with the person’s sexual history. . . Clean clothing and general attention to personal hygiene, and demonstrating some consistency in these matters, as well as indicators such as weight loss and skin or hair condition, were typically reported as decision-making criteria with regard to choosing sex partners and use of condoms” (p. 125).
This practice is risky and dangerous. Without outright asking a potential sex partner his HIV status, one should never assume another person’s HIV status.

The last predisposing factor identified in this review of literature is the assumption that one harm reduction method, HIV seroconcordant sexual partnering, is in fact reducing harm. HIV seroconcordant sexual partnering takes place when “MSM of concordant HIV status have negotiated unprotected sex” (van de Laar et al., 2010, p.1806). It is a result of the belief that two individuals who are HIV positive are not putting the other at risk because they are both infected. In the United States, there are two strains of HIV and infection from both is possible and can lead to super-infection in addition to the transmittal of other sexually transmitted infections (Danta et al., 2007; Morin et al., 2008). In addition, van de Laar et al. (2010) have found that serosorting contributes to higher risk behavior.

Reinforcing factors are those that offer feedback to community members regarding their particular behaviors or rewards for engaging in or not engaging in risky behavior. These can be either positive or negative. There are a number of reinforcing factors which contribute to the predisposing factors and to the health behaviors. Staying closeted about one’s sexuality is reinforced by the fact that other LGB individuals are closeted, which may offer the assumption that either there are no other LGB individuals or that it is best to remain closeted. Further, the reward may also simply be not being “outed”. Boulden (2001) notes that “it is very evident that part of the way to survive in a rural setting is to control ‘how and when’ you are willing to be ‘visibly gay’” (p.67). This invisibility
perpetuates “a public and personal denial of the very existence of gay behavior, gay identity, gay relationships, or a gay community” (Boulden, 2001, p.71).

The invisibility of a LGB community may also lead individuals to use the Internet as a way to find sexual partners. While this has been identified as a high risk behavior, it may simply be the case in rural communities that the Internet is a convenient way to meet other MSM. For instance, Bowen (2005) has found that in Wyoming, MSM have indicated that the Internet is a primary resource to connect with other MSM. Since Wyoming is a neighboring state of Montana and one with similar qualities, one might assume this also holds true for MSM in Montana, particularly those in frontier or rural counties with smaller populations.

Further, for MSM who are closeted, it may not be feasible to purchase condoms if they are believed to be heterosexual or single. While urban counterparts benefit from anonymity, rural MSM may know or be related to someone working at the drug store in their community. Additionally, testing for HIV may not be feasible if it requires going to a place that is known to be the HIV testing site in the community. Community stigma and violence perpetrated against MSM is another reinforcing factor which may prevent someone from being open about his or her sexuality or engaging in activities such as HIV testing if it is believed that this will alert another about his or her sexual orientation. Mancoske (1998) sums up the overall health impact of stigma:

“Homophobia kills- whether it is socially enforced by the growing stigmatization of AIDS as the epidemic advances or is internalized. Persons who are forced to conceal their sexual orientation, via both social oppression and
internalized psychological dimensions, have an accelerated course of HIV diseases” (p. 47).

Enabling factors include resources and skills that are needed for behavior changes to occur and also barriers that may prevent the behavior changes or enable the behavior to continue. There is one element which has been shown to reduce high risk behavior. Often, MSM change their risky behavior after they test positive for HIV infection (CDC, 2007a; CDC, 2009b; Jaffe et al., 2007). In fact, Jaffe et al. (2007) found that following HIV diagnosis, high risk behavior reduced by approximately 66%. There are other areas which have been identified as resources needed for behavior changes to occur. The first of these is the rural medical community and medical services available to rural MSM.

Researchers have identified discrepancies in the level of medical services provided in rural communities in addition to the previously identified environmental factors of rural communities. These include shortages of medical and social services, fewer health care providers, limited technological resources, higher proportions of uninsured individuals, problems with laboratory follow-ups and diagnostic testing, small numbers of health care providers experienced in HIV/AIDS care, lack of outpatient and inpatient services, lack of availability of consultation services, poor coordination of services, and limited funding for AIDS services, in addition to the fear of loss of privacy (Cohn et al., 2001; Mancoske, 1998; McKinney, 2002; Preston et al., 2002). Further, because of these factors, many rural residents with HIV choose to receive their care from urban settings, presenting a catch 22- rural care providers are not seeing as many HIV patients as they could be to gain the valuable experience needed to encourage other patients to come to them for care.
(Cohn et al., 2001). In fact, McKinney (2002) has identified the following reasons for seeking care in an urban setting: “(a) concerns about confidentiality, (b) belief that their primary care physician lacked sufficient knowledge about HIV to provide adequate care, and (c) referral by their primary care physician” (p.460).

One skill which has been identified as needing improvement is communication. The ability to communicate HIV status and navigate safe sexual practices is important to maintain health. Koblin et al. (2006) found that poor communication skills regarding safer sex were significantly associated with high-risk sexual behaviors. Jaffe et al. (2007) report that person-to-person communication about HIV is an important factor in reducing risk. Sex can be a taboo topic for some populations. Discomfort with discussing safe sex, sexual practices, and sexual health can inadvertently put one’s health at risk. In addition, fear of rejection can also prevent someone from disclosing his or her HIV status.

Lastly, eliminating the stigma associated with both MSM and HIV are vital to health and well-being. Various researchers have identified the importance of rural community leaders discussing HIV as a community issue and calling for the end of stigma towards MSM (Foster & Frazier, 2008; Jaffe et al., 2007). Stigma has been a prominent theme throughout this analysis and it plays just as prominent a role in the lives of marginalized people. Combating stigma may be just as important as other prevention methods in the fight against HIV. St. Lawrence (1999) addresses the fact that many community leaders are anxious about encouraging programs or education that pertain to sexuality for fear of
crossing community boundaries about taboo topics or that they may be perceived as promoting sex outside of marriage. She states:

“These concerns persisted despite the reality that one out of every four new infections in the United States is in youth younger than age 21; the television programming watched by most American teenagers contains 2,000 allusions to sexual intercourse during the course of a year; and three-quarters of all high school seniors have engaged in sexual intercourse” (p.342).

Considering the saturation of sex on television and advertising, along with the fact that the youth is engaging in sexual activity, sex should be discussed with far more openness than it currently is. The next section identifies available HIV prevention resources for MSM. To be effective, they should take predisposing, reinforcing, and enabling factors into account.

**Administrative and Policy Diagnosis**

The final phase in the PRECEDE logic model involves identifying available resources and existing health or policy services related to HIV. Prevention and/or reduction programs, activities, and services comprise HIV prevention activities. These are targeted to individuals, families, and communities. Some examples of prevention activities for MSM include behavioral risk assessment; condom promotion and distribution; public information programs and media campaigns; partner elicitation, notification and counseling for those newly diagnosed with HIV; and mental health services (NASTAD & Kaiser Family Foundation, 2009).
There are a number of prevention resources available around the country and the state. St. Lawrence (1999) notes that a mix of effective approaches is needed to stop the spread of HIV, instead of one single intervention method. Some communities offer HIV testing at gay pride events, which provides an opportunity to connect with MSM who are not already connected to the medical community (CDC, 2007b). Previously mentioned was the act of sexual partner serosorting, which can be an effective method to reduce HIV transmission risk, if other precautionary measures are taken. Promoting the use of and providing free condoms can be another effective intervention effort.

There are current prevention efforts taking place in Montana targeting MSM. These include retreats, Internet outreach and services, speakers’ bureaus, support groups, and other various programs. Some methods are directed at target MSM populations such as youth or American Indian MSM while others are targeted to the general MSM population. A statewide needs assessment will help to improve these HIV prevention efforts.

**Conclusion**

HIV/AIDS is a complex issue for MSM involving many health, behavioral, and environmental factors. Stigma and heterosexism, with the resulting minority stress can have profound effects on lives, contributing to depression, low self-esteem, and poor coping mechanisms. High risk behaviors such as injection drug use and unprotected anal intercourse increase the risk for HIV/AIDS along with Hepatitis C. Predisposing, reinforcing, and enabling factors motivate this behavior and at times discourage change.
To be successful, prevention efforts need to take all of these varying factors into account. In order to improve the resources offered in Montana, a needs assessment of HIV prevention for MSM will be conducted. The Methodology for this study is outlined in Chapter Three.
CHAPTER THREE

Methodology

Introduction

The purpose of this study was to collect information about the HIV prevention needs of men who have sex with men (MSM) living in Montana. An exploration of the demographic and contextual factors that contribute to HIV infection is included in this project’s focus. Information gathered from this study will be used to further develop and potentially improve the effectiveness of HIV prevention interventions offered in Montana and will ultimately reduce the prevalence of HIV among MSM.

Description of Target Population

The target population in this study was men over the age of 18 who have sex with men in Montana. For the purpose of this study, MSM are defined as all men who have sexual contact with other men regardless of their self-identification as gay, bisexual, or heterosexual men (CDC, 2010d).

Protection of Human Subjects

The human subject application material and consent forms were completed in accordance with the University of Montana Institutional Review Board.

Research Design

This research was conducted using the case study method with a combination of both qualitative and quantitative data. The case study is an ideal research design for research
which looks at present-day issues where the behavior being studied cannot be manipulated or examined in a controlled setting. Yin (2003) defines case study as “an empirical inquiry that investigates a contemporary phenomenon within its real-life context, especially when the boundaries between phenomenon and context are not clearly evident” (p.13). Because of the complexity of studying present-day, real life situations, the case study relies on multiple sources of data. One of the benefits of using a case study research method is that case studies allow the researcher to explain causal links that are too involved to be easily identified through other means (Yin, 2003). As such, Yin (2003) describes one of the major strengths of case study to be “the opportunity to use many different sources of evidence” (p.97). The figure below outlines the various sources of data used in this research:

**Figure 1 Sources of Data**

![Source of Data Diagram](image)

**Procedures**

Both primary and secondary data was utilized in this study. The methods of primary data collection were key informant interviews and focus group interviews. The secondary data
stems from an online Men’s Sexual Health survey administered by FDH Associates and in-depth interviews with men who are on the “down low” conducted by a research assistant at the University of Montana. Each method is described in detail below.

**Primary Data Collection**

**Key Informant Interviews**

**Instrument Development:**

The first source of primary data was the key informant interviews. The structured interview questions were developed based on the latter stages of the PRECEDE logic model, described in detail at the beginning of Chapter Two. The stages addressed in this study were: Behavioral and Environmental Diagnosis, Educational and Organizational Diagnosis and Administrative and Policy Diagnosis. There were nine structured questions for the interviews, which can be found in Table 2 at the end of this chapter and in Appendix A. Depending on the depth of the responses, these questions were followed by more specific probes to elicit further information.

**Sample Selection:**

A convenience sample of 8 to 12 individuals were recruited to participate in a face-to-face or telephone interview regarding HIV prevention needs. The snowball sampling technique was used whereby leaders in the gay in the community (referred to as key informants) who are known to the researcher were asked to take part in an interview and also to contact or provide contact information for other key informants to the research assistant (see Appendix B).
Data Collection:

A convenient meeting time and/or place (depending on interview method) was arranged with key informants who were interested in volunteering for the study. Prior to the interview, key informants were given a verbal description of the study and were asked to read and provide informed consent (see Appendix C). The interviews were audio recorded and lasted between fifteen minutes to approximately one hour. Immediately upon transcription of the recordings, the recordings were destroyed. Names of interviewees were not connected to the data. Following the interview, key informants were asked to recommend other gay leaders or professionals who work primarily with MSM who might be interested in volunteering for an interview. Potential interviewees were contacted by the research assistant who explained the study and asked if they were interested in participating in an interview.

During the interview, the research assistant solicited information regarding the interviewees’ perceptions of the HIV prevention needs of MSM with whom they have come in contact. Specifically, information regarding factors that influence HIV risk behaviors such as unsafe sex and drug use was gathered from key informants. Following the interview, contact summary sheets were completed to notate general information about the interview such as themes and issues, impressions, questions, speculations, and any information to be included in future interviews (See Appendix D).
MSM Focus Group Interviews

Instrument Development:

The second source of primary data was the MSM focus group interviews. These structured focus group interview questions were also developed based on the latter stages of the PRECEDE logic model, described in detail at the beginning of Chapter Two. There were nine structured questions for the interviews, which can be found in Table 2 at the end of this chapter and in Appendix E. Depending on the depth of response, the questions were followed by more specific probes to elicit further information.

Sample Selection:

A convenience sample of MSM was recruited to participate in focus group interviews. Three to five focus groups were to be conducted with 6 to 12 volunteers taking part in each focus group. Montana MSM support group facilitators whose groups are funded by the Montana Department of Public Health and Human Services and other key informants were asked to recruit MSM with whom they were acquainted (see Appendix F). The majority of focus groups were also conducted by these facilitators, who were provided a $100 incentive for organizing and facilitating. Focus group composition was in part determined based on input from the Montana HIV Prevention Community Planning Group in relation to the various demographics of HIV positive MSM in the state.

Data Collection:

Men who were over 18 years of age and expressed an interest in participating were given a copy of the focus group questions and provided with information about the time and
location of the group. Upon arriving for the focus group, the men were given a copy of the informed consent (see Appendix G), and provided with the opportunity to ask questions. Participants were asked to read the informed consent and provide verbal consent rather than written consent. In this way, group participants’ names could not be connected to the study. Participants were reminded that the names of individuals and information shared within the group were confidential and should not be shared outside the group meeting. The focus groups were audio recorded. Participants received a $25 incentive at the beginning of the focus group and offered snacks and non-alcoholic beverages during the group. Immediately following the focus groups, the recordings were transcribed. Focus group participants were asked to fill out a demographic form to notate general information about the participants including location and date of interview, age, self-identified sexual orientation, HIV status, and demographic data such as education level, income level, county of residence, and residence in a rural or urban setting (see Appendix H). On the back of this form, focus group members were also asked to fill out the Outness Inventory (see Appendix I) as a way to make comparisons with participants in the secondary data. The Outness Inventory (OI) is an 11-item scale designed to assess the degree to which lesbian, gay, and bisexual (LGB) individuals are open about their sexual orientation. It asks about openness with various individuals including mother, father, siblings, work colleagues, and new and old heterosexual friends, among others. No identifying information was included in the transcription. Immediately following the transcription the recordings were erased.
During the focus group, the facilitator solicited information regarding participants’ perceptions of their HIV prevention needs and of the needs of other MSM with whom they have come in contact. Specifically, information regarding factors that influence HIV risk behaviors such as unsafe sex and drug use was gathered from focus group participants. Focus groups lasted from 1 to 2 hours.

**Secondary Data**

**Men’s Sexual Health Survey**

**Instrument Development**

An online survey developed and administered by FDH Associates in Missoula, Montana serves as secondary data for this study. The survey was uploaded to the Survey Monkey online program and asked a total of 135 questions, divided into seven sections. Section one asked the survey respondent about his basic demographic information including age, ethnicity, relationship status, and about the location and size of his county and city, respectively. Section two of the survey covered questions regarding his sexual orientation such as his definition of his sexual orientation, sexual attraction to men and women, how “out” he is and how accepting others are of his sexual orientation. The third section of the Men’s Sexual Health Survey asked about the survey taker’s sexual history, in particular, the number of sexual partners overall and within the last year, sexual activities, use of protection, awareness of HIV status in partners, and risky sexual behavior. Section four consisted of questions regarding testing and barriers to testing; these questions related to HIV testing, frequency of and comfort level with testing, and HIV status. Survey respondents who were HIV negative were able to jump forward in the survey to a section
of questions specific to them regarding engaging in unprotected sex. The section for the HIV positive men provided questions regarding their HIV treatment, disclosure activity, and sexual activity. The next section for all survey-takers, section five, asked about history of sexually transmitted infections, followed by questions about cigarette, alcohol, and recreational drug use. Section six asked questions regarding use of the Internet to meet sexual partners, disclosure of HIV status and sexual activities with those met online, and other locations for meeting sexual partners. The final section of the survey asked questions regarding emotions, behavior, and depression (see Appendix J).

**Sample Selection:**

The online survey participants were recruited by two methods. First, members of Montana’s Gay Men’s Task Force set up an informational sexual health booth at organized events specific to the MSM population (e.g., Gay men’s retreats, Pride Celebration, American Indian Two Spirit retreats). The booths contained information about the study and one or two lap top computers. MSM attending these events and who stopped by the sexual health booth were verbally invited to participate in the study. MSM from Montana over the age of 18 who agreed to participate were given an informed consent form to read prior to beginning the online survey in the privacy of the booth.

The second method of data collection involved posting the link to the on-line survey on a variety of social network web sites that are frequently visited by MSM. For example, web sites such as Craigslist, Facebook, Manhunt, etc. provided a link to the survey. MSM who clicked on the link were given information about the study. If they were from
Montana, over the age of 18 and wished to participate in the study they indicated their wish to continue by clicking “I Agree” on the informed consent and continuing on to the actual survey.

Data Collection:

Monkey Survey uses SSL technology and does not collect any information other than what the data participants enter (i.e., no IP addresses are collected). Upon completion of the survey participants were given the option to enter into a drawing for one of ten iPod Shuffles. A link was provided at the end of the survey which took them to a second and separate webpage where they could enter their contact information (name, and e-mail address) so they could be notified should they win. By entering their information into a second webpage survey, their information was automatically stored in a separate database. These measures ensured that their personal information could not be traced back to their data. The survey took 20 to 25 minutes to complete.

“Down Low” Interviews

Instrument Development:

This phenomenological study asked a minimal number of questions which allowed participants the freedom to discuss their perceptions of being a closeted MSM in the rural state of Montana. Participants were asked the following structured questions with leading questions utilized as needed: “Can you tell me about your experience being a closeted man who is sexually attracted to other men?” followed by “Is the threat of HIV/AIDS a concern for you as a man living in a rural area? Do you think the threat is different for
men living in a rural area? Does being a closeted MSM influence your perception of risk?” This data collection method focused on “closeted” MSM was conducted by a University of Montana research assistant and was approved by the University of Montana Institutional Review Board.

**Sample Selection:**

Interview participants were recruited through purposive sampling as it was necessary to locate individuals within a specific segment of the population. Interview participants were recruited through members of the Montana HIV Prevention Community Planning Group (CPG). These members were asked to offer an interview opportunity to men who are known to be out about their sexuality to only select persons (closeted). The members gave the potential interviewee a business card with the research assistant’s phone number on it and asked to call to set up an interview. This phone number was a cell phone number, and only the research assistant had access to the phone. Members of the CPG informed the potential interviewee they would remain anonymous and it would be not necessary to provide their name when they call the phone number. Participants in the study were provided a $25 incentive for participating.

Subjects were also recruited through the Craigslist.com and gay.com websites. The postings on the website provided an email address and phone number to contact for individuals interested in the study. Additionally, the postings outlined the opportunity to do the interview either in person or over the phone. Readers were also informed that the study was completely anonymous and that while the interview would be audio recorded,
the recording would be destroyed following transcription of the interview. Lastly, readers were informed of the financial incentive and that the study had been approved by the University of Montana IRB.

Interviewees were asked to provide only a first name or a pseudo name that could be used during the interview and to identify the participant during transcription and write-up. No identifying information was collected. Due to the rural nature of Montana, the men’s hometowns were not disclosed. Instead, data was classified by population size. The interviews were audio recorded.

**Data Collection:**
During the interviews, participants were asked about perceived barriers influencing their ability to be open about their sexuality and how these barriers collectively influence their ability to practice safer sex behaviors and access HIV prevention information, programs, and services. In addition, participants were asked to fill out the “Outness Inventory” (see Appendix I) along with providing basic demographic information.

**Data Analysis – Primary Data**
Primary data was analyzed qualitatively and took place in a five step process as outlined by Ulin, Robinson, and Tolley (2005). Immediately after each interview and focus group took place, the research assistant reviewed all notes and tape recordings. Each interview and focus group was transcribed in its entirety. After transcription, all tapes were destroyed.
The first step of the qualitative data analysis process was reading, which is described as “developing an intimate relationship with data” (Ulin, Robinson, & Tolley, 2005, p.145). During this process, the research assistant was immersed in the data to become well-versed and familiar with its content. This was a gradual process as each interview and focus group was conducted. By becoming familiar with the data as it was collected, the research assistant was able to identify gaps in questions or other areas that may need improvement. During this time, the research assistant also began to identify tentative themes in the data.

The second step in the process described by Ulin, et al. (2005) is coding, described as “identifying the emerging themes” (p. 146). After the transcriptions were completed, they were read through to identify the emerging themes. The potential themes were compiled in a list, then collapsed to reduce the number of themes and to develop themes that were not detail-specific. Using Microsoft Word and printed transcriptions, the research assistant was able to identify multiple segments of data that relate to specific themes and to identify multiple themes in individual segments.

Ulin, et al. (2005) define the third step in the data analysis process “displaying data” as “distinguishing nuances of a topic” (p.157). This is elucidated as “laying out or taking an inventory of what you know related to a theme; capturing the variation or richness, of each theme; separating qualitative and quantitative aspects; and noting differences between individuals or among subgroups” (p.157). At this step, the research assistant
further explored the themes and data in depth for subthemes that were present and overlooked.

The fourth step, data reduction, is described as “getting the big picture” (Ulin, et al., 2005, p. 160). The authors characterize this as “the process of distilling the information to make visible the most essential concepts and relationships” (p.160). This step took place after all of the data was collected and the research assistant had become intimately familiar with the data. The researcher also reviewed themes for internal validity and further condensed the themes.

The fifth and final step in the qualitative data analysis process was interpretation. This is explained by the authors to be “the act of identifying and explaining the data’s core meaning. . . it is to identify ways that the many different pieces of the research puzzle (emerging themes and subthemes, connections and contradictions) fit and what it all means” (Ulin, et al., 2005, p. 162). In this step, the qualitative, primary data from the key informant interviews and focus groups were analyzed while the secondary data was used to support, fill in gaps, and further explain the results.

**Data Synthesis**

The data compiled for this case study was reviewed and organized using the PRECEDE/PROCEED Model. This is a common logic model used in program planning and was described in detail in Chapter 2 (see page 10). Table 2 below shows each of the research questions and the data collection method used to answer each of the questions.
The six methods of data collection were interviews with key informants and focus groups (primary data) and interviews with MSM on the “down low”, the Men’s Sexual Health Survey, epidemiological data, and the available literature related to the study topic (secondary data). Only the primary data was analyzed by the research assistant.
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<thead>
<tr>
<th>RESEARCH QUESTIONS</th>
<th>DATA COLLECTION METHOD</th>
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<tr>
<td><strong>Stage 3: Behavioral and Environmental Diagnosis</strong>&lt;br&gt;What behaviors contribute to the spread of HIV among MSM?&lt;br&gt;What are social or environmental factors that might help spread HIV among MSM?&lt;br&gt;<strong>Stage 4: Educational and Organizational Diagnosis</strong>&lt;br&gt;What personal characteristics might influence men to engage in risky behavior? What personal characteristics might influence men to not engage in risky behavior?&lt;br&gt;What resources or skills do MSM lack that may contribute to the spread of HIV? What resources or skills do MSM have that may encourage them to not engage in risky behaviors?&lt;br&gt;What about the social relationships of MSM might reinforce risky behavior? What about the social relationships of MSM might deter risky behavior?&lt;br&gt;<strong>Stage 5: Administrative and Policy Diagnosis</strong>&lt;br&gt;What are some resources that you are aware of that target MSM?&lt;br&gt;Can you think of any health-related interventions that are needed for MSM to prevent HIV?&lt;br&gt;What policy changes are needed to meet the HIV prevention needs of MSM?&lt;br&gt;What social or cultural changes are needed to meet the HIV prevention needs of MSM?&lt;br&gt;Primary Data: Interviews with key informants, focus groups&lt;br&gt;Secondary Data: Interviews with MSM on the “down low”, Men’s Sexual Health Survey, review of literature&lt;br&gt;Primary Data: Interviews with key informants, focus groups&lt;br&gt;Secondary Data: Interviews with MSM on the “down low”, Men’s Sexual Health Survey&lt;br&gt;Primary Data: Interviews with key informants, focus groups&lt;br&gt;Secondary Data: Interviews with MSM on the “down low,” available literature (i.e., state HIV resource directory)</td>
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CHAPTER FOUR

Results

The purpose of this study was to collect information about the HIV prevention needs of men who have sex with men (MSM) living in Montana. The needs assessment included primary and secondary data sources. The results of this assessment will be discussed below, beginning with the primary data, the Key Informant Interviews and the Focus Group Interviews, followed by a discussion of the secondary data, the Men’s Sexual Health Survey and the Down Low Interviews.

The individuals included in the assessment come from a range of counties and various size towns in Montana. In total, demographic data exists for 191 individuals who participated in the focus groups, responded to the Men’s Sexual Health Survey, and were interviewed as a part of the down low (DL) assessment. There may be some overlap in the individuals who responded to the survey and were participants of the focus groups. The known counties of focus group participants and survey respondents are highlighted in grey in the map below, and illustrate the inclusion of all Montana regions.
Primary Data

Key Informant Interviews

From January 2011 to March 2011, nine interviews with key informants helped to inform the needs assessment. Individuals involved in the interviews included HIV educators, members of the Montana HIV Prevention Community Planning Group (CPG), and other leaders in the MSM community. These individuals were from the following counties: Yellowstone (2 interviews), Glacier (1 interview), Lewis and Clark (1 interview), Flathead (2 interviews), Custer (1 interview), and Missoula (2 interviews), representing a wide range of communities in the state.

The key informant interviews ranged in duration from fifteen minutes to nearly one hour. Interviewees ranged in age from young professionals to retired individuals. Four of the interviews were conducted face-to-face while the remaining five were completed over the phone. All of the interviews were conducted by the research assistant. Because themes
from the key informant interviews were analyzed in conjunction with the focus group interview themes, they will be discussed following the description of focus group interviews.

Focus Group Interviews

Four focus groups were conducted in Gallatin County, Missoula, Glacier County, and Yellowstone County, Montana.

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<tr>
<th>Gallatin County Focus Group:</th>
<th>Glacier County Focus Group:</th>
</tr>
</thead>
<tbody>
<tr>
<td>6 participants</td>
<td>6 participants</td>
</tr>
<tr>
<td>Missoula County Focus Group:</td>
<td>Yellowstone County Focus Group:</td>
</tr>
<tr>
<td>10 participants</td>
<td>8 participants</td>
</tr>
</tbody>
</table>

The researcher and research assistant conducted the Missoula County focus group while the focus groups in the remaining counties were conducted by gatekeepers of the MSM community. Gatekeepers that agreed to conduct focus groups were provided with a digital recorder (unless they had access to their own), informed consent forms for participants, focus group questions, demographic forms to be completed by the attendees, a small stipend for organizing and facilitating the group, and incentives for participants. Upon completing the focus group, the gatekeepers mailed the digital recorder and the demographic forms to the researchers. A total of 30 MSM were involved in the focus groups. Two self-identified as bisexual and the rest self-identified as gay. The ages of the participants ranged from 20 to 55, with one individual preferring not to disclose his age; the mean age was 34. One participant was HIV positive, one participant preferred not to disclose his status, and the rest were HIV negative. The participants were residents of the counties in which the focus group took place- Gallatin, Missoula, Glacier, and
Yellowstone Counties. Four participants misread the demographic form question as “Country of Residence” and so did not include their county of residence. The majority (80%) lived in an urban town, defined as having a population of 2,501 or more residents. The majority of the participants also had some college level education or higher. The table below identifies the various levels of education.

Table 3 Focus Group Participant Levels of Education

<table>
<thead>
<tr>
<th>Highest Level of Education</th>
<th>Percent</th>
<th>(n=)</th>
</tr>
</thead>
<tbody>
<tr>
<td>High School Diploma or GED</td>
<td>6.7%</td>
<td>2</td>
</tr>
<tr>
<td>Some college</td>
<td>40%</td>
<td>12</td>
</tr>
<tr>
<td>2-Year College Degree (Associate’s)</td>
<td>3.3%</td>
<td>1</td>
</tr>
<tr>
<td>4-Year College Degree (Bachelor’s)</td>
<td>33.3%</td>
<td>10</td>
</tr>
<tr>
<td>Master’s Degree</td>
<td>13.3%</td>
<td>4</td>
</tr>
<tr>
<td>Professional Degree (JD, MD)</td>
<td>3.3%</td>
<td>1</td>
</tr>
</tbody>
</table>

Most of the participants had an annual income of $45,000 or less, as seen in the table below.

Table 4 Annual Income of Focus Group Participants

<table>
<thead>
<tr>
<th>Annual Income of Focus Group Participants</th>
<th>Percent</th>
<th>(n=)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than $15,000</td>
<td>33%</td>
<td>10</td>
</tr>
<tr>
<td>Between $15,000 and $45,000</td>
<td>53%</td>
<td>16</td>
</tr>
<tr>
<td>Greater than $45,000</td>
<td>10%</td>
<td>3</td>
</tr>
<tr>
<td>Prefer not to answer</td>
<td>3.3%</td>
<td>1</td>
</tr>
</tbody>
</table>
Focus group participants were also asked to complete an Outness Inventory, a tool used to assess how out someone is regarding their sexual orientation to a number of different people in one’s life. The scale values are as follows:

1 = person definitely does NOT know about your sexual orientation status
2 = person might know about your sexual orientation status, but it is NEVER talked about
3 = person probably knows about your sexual orientation status, but it is NEVER talked about
4 = person probably knows about your sexual orientation status, but it is RARELY talked about
5 = person definitely knows about your sexual orientation status, but it is RARELY talked about
6 = person definitely knows about your sexual orientation status, and it is SOMETIMES talked about
7 = person definitely knows about your sexual orientation status, and it is OPENLY talked about
0 = not applicable to your situation; there is no such person or group of people in your life

The overall scores are averaged based on the item response and number of defined items to be included in each category. The men involved in the focus groups were fairly out, as displayed below:

<table>
<thead>
<tr>
<th>Out to…</th>
<th>Mean Score</th>
<th>Out to…</th>
<th>Mean Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother</td>
<td>Mean: 5.97</td>
<td>Work Supervisors</td>
<td>Mean: 5.65</td>
</tr>
<tr>
<td></td>
<td>n=29</td>
<td></td>
<td>n=26</td>
</tr>
<tr>
<td>Father</td>
<td>Mean: 5.54</td>
<td>Religious Members</td>
<td>Mean: 4.23</td>
</tr>
<tr>
<td></td>
<td>n=26</td>
<td></td>
<td>n=13</td>
</tr>
<tr>
<td>Siblings</td>
<td>Mean: 6.21</td>
<td>Religious Leaders</td>
<td>Mean: 4.69</td>
</tr>
<tr>
<td></td>
<td>n=29</td>
<td></td>
<td>n=13</td>
</tr>
<tr>
<td>Extended Family</td>
<td>Mean: 5.0</td>
<td>Strangers/new acquaintances</td>
<td>Mean: 4.52</td>
</tr>
<tr>
<td></td>
<td>n=29</td>
<td></td>
<td>n=29</td>
</tr>
<tr>
<td>New Straight Friends</td>
<td>Mean: 5.4</td>
<td>Old Straight Friends</td>
<td>Mean: 6.0</td>
</tr>
<tr>
<td></td>
<td>n=30</td>
<td></td>
<td>n=30</td>
</tr>
<tr>
<td>Work Peers</td>
<td>Mean: 5.65</td>
<td></td>
<td>n=26</td>
</tr>
</tbody>
</table>

The instrument can also be utilized to provide four scores based on the responses: Out to Family (defined as mother, father, siblings, and extended family), Out to World (defined
as new straight friends, work peers, work supervisors, and strangers and new acquaintances), Out to Religion (defined as members and leaders of one’s religious community), and Out to World (all of the previous factors plus old heterosexual friends). Each category score equals the average of the various items within the category. The table below shows the mean score for each category, along with the range of scores, and the number of people in each category for whom it applies.

<table>
<thead>
<tr>
<th>Category Score</th>
<th>Mean, Range, and Number of Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Out to Family</td>
<td>Mean= 5.72 Range: 1.74 to 7.00</td>
</tr>
<tr>
<td></td>
<td>n= 30</td>
</tr>
<tr>
<td>Out to World</td>
<td>Mean= 5.35 Range: 2.25 to 7.00</td>
</tr>
<tr>
<td></td>
<td>n= 30</td>
</tr>
<tr>
<td>Out to Religious Community</td>
<td>Mean= 4.46 Range: 1.00 to 7.00</td>
</tr>
<tr>
<td></td>
<td>n=13</td>
</tr>
<tr>
<td>Overall Outness Score</td>
<td>Mean= 5.49 Range: 3.27 to 7.00</td>
</tr>
<tr>
<td></td>
<td>n= 30</td>
</tr>
</tbody>
</table>

The focus groups ranged in duration from one hour to one and a half hours. The recording for the Billings focus group was distorted; as such, there is an incomplete picture of that discussion, though the major themes were still apparent.

**Themes**

A number of themes related to the HIV prevention needs of MSM in Montana were identified in the focus groups and interviews. Themes were organized into five sections: 1) factors that influence risky behaviors; 2) protective factors; 3) prevention needs; 4)
needs specific to American Indians; and 5) available resources in Montana. Included with each theme are quotes from either the focus group or key informant interviews that best represent the theme. Quotes from Key Informants are notated with “KI” and quotes from Focus Group participants are notated with “FG” to differentiate between the two. The quotes have also been edited for reading ease; that is to say extraneous words such as “like”, “you know”, “yeah” and other words which affected the flow of the quote were removed.

**Section 1: Factors that Influence Risky Behaviors**

**Theme 1: Drug and Alcohol Use and Abuse**

The use of drugs and alcohol in Montana was a theme that was mentioned in every single focus group and interview. It was understood that drug and alcohol use affected decision making while under the influence. The reasons expressed for drug and alcohol use were varied; drugs and alcohol serve as a coping mechanism, a form of recreation, a way to enhance sex, and they are an expected part of the nightlife.

“And, which, a lot of people self-medicate with alcohol or drugs for the depression and that can lead to risky behaviors.” – KI

“Well alcohol because your inhibitions are lower. You don’t care when you get drunk. It’s sex. Yeah, drugs are the same way.” – FG

“A lot of times when alcohol is used in the MSM community, sometimes it leads to unprotected sex because of lapse of judgment. And general substance abuse like prescription drugs or recreational drugs also play a role in how sex is experienced. In some cases, drug abuse is used as a coercion factor into unprotected sex.”- KI
Normalized drug and alcohol use was also noted. In particular, the “culture of drinking” in Montana as a whole was mentioned, in addition to having MSM events and gathering places in a bar.

“I haven’t always lived in the north, but the thing I noticed when I moved north is that everybody’s drinking and drinking and drinking. Some people say, ‘well, that’s what we do to keep warm’.” – KI

“If we get kids off of drugs and alcohol, they’re more likely to be making healthier choices. But that’s a hard thing to do because the only place in eastern Montana for people to gather is the Loft in Billings, which is a bar. So any time you normalize that as your only meeting place, you’re always going to have to contend with alcohol and drugs.” – KI

Theme 2: Geographic Isolation

Geographic isolation in Montana communities leads to a number of risky behaviors. Smaller communities lack recreational opportunities, along with educational resources and opportunities. Moreover, the geographic isolation of smaller communities contributes to the social isolation experienced by MSM in Montana.

“And [one] of the other things [about] being in a rural area is that there’s so much alcohol [and] there’s nothing for the young people to do. We don’t have a movie house in our town. The only place to go for any recreation is to the bar or the casino.” - KI

“The people that are willing to acknowledge that they are MSM, they might need to seek out educational opportunities or skills opportunities. Those opportunities might not necessarily be available to them because of their geographical location.” – KI

“In terms of the longest distance that you’re willing to drive or travel for a one-time encounter is much higher here in Montana. I’ve had plenty of friends that are on their way from one town to another town to another town and they’ll just sleep with people in each town.” - KI
Theme 3: Social Isolation

Social isolation, whether as a result of geographic isolation in Montana or the small MSM community in a given area, also has an impact on risky behavior of MSM. This can lead to desperation for sexual activity when the opportunity presents itself, regardless of attraction or risk.

“I was going to say just the rural aspect of Montana. Especially when you’re younger, you think, ‘Oh my God. [This is] the only time I’m ever going to have sex, so I might as well grab onto it even if it’s a toad or whatever’. Jump on it while you got it. Can’t get picky.” – FG

“And when you have that isolation, you’ll take that physical contact where you can get it because it is so limited. And so, some people don’t think about the risky behaviors because they’re craving the intimacy so much.” – KI

Theme 4: Conservative/Anti-Gay Community Attitudes

Conservative and anti-gay community attitudes in Montana were another theme that emerged from the focus groups and key informants. While Missoula was identified as a community that was more progressive and accepting, many of the communities in the state hold conservative values which do not align with the acceptance of the lesbian, gay, bisexual (LGB) community. This impacts outreach services, HIV education and knowledge, the ability for MSM to identify one another, and feel comfortable and safe. It also contributes to a focus on sexual activity instead of appreciating the intimacy that can be had between two same sex individuals.

“The whole closeted environment just plays havoc with HIV rates and I think that if people were available to be free like they are in Missoula, then the different kinds of outreach [would be] more effective whereas here, the only outreach we have for HIV testing is the county health nurse. It’s not like we can go set up a table and distribute literature because somebody over here doing that would probably get the shit beat out of them.” – KI
“I bowl a lot and when I’m down at the bowling alley, I hear people talking about gays. You can tell from the tenor of the conversation that it’s not a welcoming place and you still have to be very, very careful with whom you trust to hear that information.” – KI

“An environment that strongly disapproves of homosexuality can lead to more anonymous sex, which tends to be less safe.” – FG

“I just do not feel safe. We had a rally a few years ago and the whole time I just was expecting at any minute to be shot or run over or punched in the back of the head...A lot of times I’ll go into rooms and I always know where the exit is, I always know who my friends are and who I can count on and who I can’t.” – FG

“We kind of have an uphill battle because there’s more resistance to us being able to be intimate with each other. There’s more resistance in our culture for men to have that kind of intimacy or even touching or being close. There’s a pretty heavy prejudice against that.” – FG

One gatekeeper did note the importance of expressing that acceptance in a community which is often not done.

“I think that the acceptance is there a lot more than many MSM realize but it’s not communicated. We hear all of the negative, the people who are against MSM, but the vast majority of people who are not angry or upset are pretty quiet. So really making [it] known that that acceptance is there and helping people feel that acceptance.” – KI

**Theme 5: Hiding One’s Sexual Identity**

A person’s comfort with his identity also contributes to risky behavior. Particularly, it can lead to unprotected sex and discourage HIV testing. Some MSM in Montana reported feeling the need to hide their sexuality for a number of reasons including discrimination and job security. Further, in order to engage in the MSM community, one must be willing to be publicly out regarding his sexuality, as he will be outed by association.
“Somebody who’s on the down low won’t use a condom because they’re just so glad to have sex with another man. And then, they think that the only people who get HIV are gay people so they don’t even want to get caught getting tested for HIV.” - FG

“One of my personal concerns [is], that people whose kids I teach find out and they become narrow minded. If I were in a state where I knew I could not lose my job for anything to do with my sexuality, I probably wouldn’t be as afraid when I’m shopping with [my partner] to actually say, ‘This is my partner’ instead of ‘This is my roommate’ when people ask.” - KI

“People [have to be] willing to be publicly out in social situations where it’s obvious that you must have some kind of connection to being MSM, like being in any of these gay bars and stuff like that.” - KI

“The thing about the [gay bar] is that there are people from the community who go there specifically to see if somebody they suspect or know is there. And that’s happened to me personally. I’ve had people [say], ‘We knew it’. It’s like you’re down here dancing and that’s the only reason you came here?” – FG

**Theme 6: Seeking Sexual Partners on the Internet**

In part because of the social isolation that exists in Montana, many MSM turn to the Internet as a way to connect with other MSM. Some MSM use the Internet to seek sexual partners, who tend to be anonymous, as a way to combat their desperation for physical contact with other MSM. As such, men must trust their anonymous sex partners in terms of HIV status and safety.

“But they’re [MSM are] not going to go online to research HIV or HIV prevention. They’re going online for a hook-up.” – KI

“When people are afraid to come out in their own cities, then they rely on the Internet to get that physical contact. When you mix in the Internet, then you have the problem that somebody in their profile may say they’re HIV negative whether they are or not. So even if the person says they are negative, they could be positive and people just take that at face value a lot of times.” – KI
“I was going to say ease of it. You’ve got Manhunt, Craigslist, Facebook, whatever, you know?” – FG

Theme 7: Lack of Communication and Negotiation Skills

The need for communication and negotiation skills was identified as factors contributing to risky behavior. In addition to basic communication and negotiation skills, the need for these skills in relation to two male sexual partners was especially important.

“I think that the biggest [resource or skill that is lacking] is communication and negotiation skills.” – KI

“The same [negotiation] skills loosely apply to heterosexual partners [and] MSM. So there’s a lot of heteronormativity in our sexual education programs, even the ones that are provided by community organizations. It’s assumed that it’s a male and a female that are negotiating condom use in the bedroom.” – KI

Theme 8: Low Perception of Risk for HIV in Montana

Another factor contributing to risky behavior was the low perception of risk for HIV in Montana. Specifically, there were attitudes that HIV is no longer a concern and HIV is not present in Montana; there was also denial about one’s susceptibility to the disease.

“Both a lack of awareness of HIV being in the area but also a lack of awareness of it being a big deal now. We hear people almost to the attitude of, ‘Well, if I get HIV, it’s not a big deal, I’ll just take a pill. Why bother worrying about it?’” – KI

“The feeling is that it’s no longer a death sentence. That was the message of the 80s and 90s, that the disease was a death sentence. You get it, you’re done. It’s guaranteed. It’s guaranteed you’re dying. I don’t think that message has come across anymore. It has become complacent.” – FG

“You can’t get HIV in Montana. Honestly, that’s what people think. They think you get it in the big city or California or some high populated area where there’s a lot of people having anonymous, unprotected sex but really there’s a lot of that going on here in Montana.” – FG
“Any human being has the ability to justify any action. Like, ‘oh I’ll do this, it’s okay ‘cause of this or that. I’ll get away with it’, you know? And people always think with bad things, ‘It will never happen to me. No matter the situation, it will never happen to me. It happens to other people.’” – FG

Theme 9: Younger MSM are at Greater Risk for HIV

There was much discussion around which age groups were at most risk for HIV. Young MSM were perceived to be at the greatest risk for HIV due to a complacency about HIV, their lack of experience with the HIV/AIDS crisis of the 80s and 90s, lack of comprehensive sex education including education about HIV, influences from older MSM, and lack of a visible MSM community in Montana.

“Younger people, especially those that were born after the AIDS crisis started, they’ve lived their entire lives during the AIDS crisis, they’ve just become weary of it.” – KI

“40, 50 year olds live in a different community really than 20 year olds do and they have experiences and have seen it and young people haven’t. They don’t know what the risk is really.” – FG

“I don’t think we do well with anyone under 18. The hardest part is really getting into those schools. The sex ed curriculum at an earlier age would be very beneficial. They should at least let people know about homosexuality, acknowledge that it exists, whether you believe that it’s a choice or not. That would help de-stigmatize that identity and that behavior.” – KI

“[My] partner came from a very heavily religious background and sex education wasn’t good. He was taught abstinence only until marriage and all that stuff. Once he realized he was gay, he thought, ‘Well none of this applies to me’ and he kind of ended up going hog wild.” – FG

“My concerns are with the older men in our community putting unwanted moves onto the younger men of our community. Primarily I am speaking of men over forty hitting on men in their teens to early twenties. There seems to be a lack of respect from the older men towards the wishes of the younger men.” – KI

“You get the young kids growing up and [they] don’t know anybody who’s gay, so it’s all about anonymous sex.” – KI
Theme 10: Unrealistic Beliefs about HIV Medications

There were a number of beliefs about HIV medications that also contributed to risky behavior. Particularly, the availability of HIV medications has led some MSM to believe that HIV is no longer a concern. Other unrealistic beliefs about HIV medications included the financial and physical cost of HIV medications, and the risk of infecting others while on HIV medications.

“Once something becomes a chronic condition, then people don’t care because they’re not seeing the deaths and they figure the medications can handle it. So I don’t really need to be [safe] ‘cause if I do happen to catch HIV, look at all of these wonderful drugs.” - KI

“Now you see the ads asking for donations like, ‘HIV medications, 50 cents a day’, or donate to this or that, it’s a ‘Treat HIV in Africa’ kind of thing. But it creates a reaction here for us and our community. It’s like, ‘Oh if I get HIV, it’s 50 cents a day. I pay five times that for coffee.’” – FG

“We as Americans are taught to pop pills, pop pills, pop pills, til popping pills for HIV is no big deal. And then they don’t realize that people with HIV age faster, get osteoporosis sooner and get dementia earlier. So those kinds of educational things may need to get out there. HIV is a manageable disease but look, this is what it’s going to do to your body in 20 years.” – KI

“What we were talking about earlier, what do they call it? Undetectable or something? They’re like, ‘So, it doesn’t even matter. You can’t even get it.’ And it’s like, ‘Woah, I don’t believe that.' But I’ve heard people say it before. It can’t be spread, and I don’t even know if that’s true or not but I don’t believe it.” – FG

Theme 11: Negative Attitudes Towards Condom Use

A number of beliefs and negative attitudes regarding the use of condoms were identified in the focus groups and interviews. MSM were embarrassed to purchase condoms, they do not want to wear condoms, they are not going to reproduce so there is no need for condoms, condoms are not sexy and it is unrealistic to make condoms a “part of the
moment”. Furthermore, there is subtle pressure to not use condoms if one’s partner does not want to use them and pressure to not use them if one is in a committed relationship.

“I bury my condoms when I go to Walmart. It still embarrasses me. I literally cover it with the deodorant and the toothpaste. It’s like, ‘oh God, I’m so embarrassed’.” – FG

“How about that nobody ever wants to wear a condom?” – FG

“Well look, a big thing with gay men, it’s like, we’re not going to reproduce, let’s not use a condom.” – FG

“It’s not a sexy thing to think about.” – FG

“And you hear people say, ‘well make it part of the moment.’ That’s just not the way it works. And it’s just unrealistic.” – FG

“It’s not like someone’s forcing you to have unprotected sex but if they don’t think that the condom is a big deal and it’s just this snowball effect. And it’s very, very subtle a lot of times, it’s not forced on you.” – FG

“There’s [sexual] get-togethers and you’ll notice that none of them will ever use condoms and you don’t know any of those people. That happens all the time, and to me, that’s more peer pressure than anything because condoms will be laying there on the table and nobody will use them. Nobody will even touch them.” – FG

“One of my early relationships when I was younger, it was maybe a month or two [when we stopped using condoms] ‘cause I didn’t know anything about that, I was just coming out and I didn’t have a very big knowledge base. Now, I’ve been in a relationship for two years, we waited a year. Now we don’t [use condoms] because we’ve built that trust level.” – FG

Section 2: Protective Factors

Theme 1: Positive Self-Esteem and Mental Health

Having positive self-esteem and mental health were identified as protective factors which deter MSM from engaging in risky behavior. This was mentioned in every interview and half of the focus groups. It was recognized that individuals with positive self-image and who felt good about themselves were less likely to put themselves at risk.
“People who feel good about themselves don’t generally do things to hurt themselves.” – KI

“I’ve noticed people with a lower self-worth don’t stand up for themselves as much. Even if they don’t have an ability to communicate well or they don’t know how to communicate, if they have higher self-worth they get it done regardless of how effortless it is or how much work it takes. So that self-esteem factor is huge.” - KI

“If you don’t have self-worth, then you’re more likely to put yourself at risk and get yourself into situations where, and be okay with the situations, where it’s not the best.” – FG

Theme 2: Abstinence from Sexual Activity

Some MSM identified that they had chosen to abstain from sexual activity in part as a protective mechanism. The reasons for abstinence included a recent break-up, having a scare and a desire to cleanse.

“I took a break by choice.” – FG

“I went a whole year of abstinence one time.” – FG

“Yeah usually you get screwed over and you’ve sworn off men forever.”- FG

“Having something scary that happens to you.” – FG

“Cleansing. A desire to cleanse.” – FG

Theme 3: Strong Family and Peer Support

Having strong family and social supports were also identified as protective factors for MSM. Friends who hold one another accountable and responsible have positive influence, discouraging risky behavior. Families who provide an accepting and open support system both set a tone for future relationships and also play a role in risky
behavior. The presence of other MSM also acts as a positive social support as they decrease social isolation and provide opportunities for interaction without any risk.

“There’s a level of accountability held amongst your friends. There’s a certain group that I hang out with, whenever sex is mentioned, they always ask, ‘Did you have safer sex? Did you use barriers? Did you use protection? What did you use?’ That’s part of the conversation as opposed to, ‘Well, were they good?’ or those general questions that people tend to ask.” – KI

“People who have strained family situations have a much higher risk factor in their social relationships. I’ve noticed people who have a more settled, comfortable family dynamic don’t tolerate higher risk social situations like friends and stuff. And a lot of gay men have really strained relationships with their families. That family support system is really important.” – KI

“There’s a total difference between game night at a friend’s house with a bunch of other people in the community and going to the truck stop uptown at the end of whatever highway.” – FG

“Gaining a sense of community is probably one of the greatest deterrents to risky behavior that we have because you’re able to [be] around other people who probably aren’t involved in that risky behavior.” – FG

Section 3: Prevention Needs

Theme 1: Places for MSM to Meet and Socialize

As was just mentioned, having opportunities to socialize with and meet other MSM is important in preventing risky behavior. Montana currently has only one gay bar in the state, the Loft, which is in Billings. Some MSM have found this to be both a positive and a negative influence. However, as was also mentioned, it is important to have gathering places that do not revolve around the use of drugs and alcohol. As such, there is a need for more LGB community centers around the state and more support and discussion groups. In fact, after the focus groups were over, it was often mentioned that the
participants enjoyed the opportunity to talk with one another and that it also increased their awareness level of HIV.

“People have told me, ‘Yeah, when I was young and I came out I went to the Loft and it was really helpful for me because I could meet other gay people’. But they’ll tell me that they did their time in terms of the rotating door in the bedroom.” – KI

“[I’m] not saying that we need [a LGB center] in Libby, and every little town in the state, because I don’t believe we have that much of a population, but it is a resource that is necessary in terms of preventing HIV. I’m sure there are men who have sex with men in Libby, I would have no doubt.” – KI

“I think where towns lack a support group, larger towns especially; I think they’re key to helping build a better community.” – KI

“We need to go out from something like this, and say, ‘you know what we did yesterday?’ We talked about HIV/AIDS, it’s impact on us, but also what we can do about it. I didn’t come in here tonight thinking about anything about HIV or AIDS. You can darn well bet when I leave here, I’m going to think about it. I’m serious, when was the last time we sat around a table and talked about it?” – FG

Theme 2: Greater Awareness of HIV through Social Media/Marketing

The need for greater awareness of HIV through social marketing was also identified as a prevention need. One outreach effort identified in multiple focus groups was letting people know the risk of HIV in their community while also not stigmatizing those with HIV. Outreach on available resources was also important as some MSM stated that there is a lack of awareness of what is available. The messaging was also important for outreach as MSM felt the advertisement should acknowledge their attitudes, for example negative attitudes about condom use, and provide something to counteract that. It was also acknowledged that oftentimes, men see messages directed to them but shrug them
off or do not pay attention to them. Finally, outreach to men on the down low was also important because they are a self-isolated group that is difficult to reach.

“The numbers need to be out there more like, ‘x number of people in [name of town], Montana right now are HIV positive.’ And that’s just in your face but you don’t ever see that here.” – FG

“Well it’s kind of an interesting thing because you want to prevent the spread without stigmatizing people that have it. So you don’t want them to feel like, ‘Oh my God, I’m one of 300 people in Western Montana that have HIV’. ” – FG

“One, I didn’t know where the gay community was, two, I couldn’t tell you, unless I was going to a regular hospital, [where] to get an HIV test.” – FG

“I also know there’s the [community organization] so I think that if they did more outreach to [the eastern] part of Montana, it would be wonderful because I’m willing to drive to [name of town] all the time for my doctor’s appointments and I think a lot of other people would go there for testing and stuff if they knew it were available.” – KI

“Just be honest. Yeah, condoms suck but it’s worth it and this is why.” – FG

“I don’t pay attention to billboards unless it’s witty.” – FG

“I feel like you don’t see them though. You just kind of shrug it off cause you know that you should [get tested] obviously but that’s not going to [get me to].” – FG

“You know, I think that’s more effective than advertising because people just get dead to all of it. They’re just like, ‘Oh yeah, another condom flyer, another condom ad, whatever’. And they get numb to it and they don’t think about it. And so I think you get more people involved in it, you network and you peer [educate].” – FG

“Or else just a broad campaign cause if they are on the down low, just planting some seeds that there are these resources for them and places for them to go.” – FG

Theme 3: HIV Testing Designed Specifically for the MSM Population

HIV testing was identified as an important component of HIV prevention. There were a number of concerns regarding confidentiality and anonymity that discouraged MSM from
getting tested in Montana. There was a lack of trust in HIV testers and medical providers who gossiped and shared information, because they felt a sense of responsibility to warn others in the community about a person’s HIV status. There were also attitudes about the low perception of risk in older MSM, who felt that they did not need to be tested. Other reasons for not getting tested included denial and fear of finding out one has been infected and misunderstanding what is involved in an HIV test.

“I don’t do my doctoring in [name of town] cause even with the HIPA laws, I don’t trust the people who work there to keep their mouths shut. I’ve actually had information about myself released before. This wasn’t about HIV, but it was still personal information.” – KI

“I’ve even heard of the gossip that comes from the testing community. There are individuals who do the testing [that] feel that it’s their responsibility to then actually notify everyone, even though they’re sworn to secrecy, which is a huge turn-off to getting tested any place public.” – FG

“I really feel like it’s actually having to go and subject yourself to the environment and the stigma that’s involved or possibly being identified as gay. If you could anonymously do that at home, I think that would be huge. Huge.” – FG

“I think that the whole issue of HIV testing is important. If there’s a thought among older folks it’s that, ‘I don’t have to be tested’.” – KI

“The fear and the stigma and people won’t get tested because they don’t want to find out bad news.” – FG

“At the same time, even if [testing] was that easy, it was cheap and accessible, ignorance is bliss. People, if they have unprotected sex, they’re like, ‘I might have this, I don’t want to know about it. I just want to live in my own little world.’” – FG

“There’s misinformation about what a test involves. People still think that it’s a urethra swab and that’s intimidating. Or a needle, it’s less oral swab.” – FG

“They just don’t know what it means, and I think that unknown creates fear.” – FG
Theme 4: Greater Focus on Social and Cultural Changes

A number of needed social and cultural changes were also identified. Culturally sensitive training for individuals working with the public and in the medical field is important. An end to discrimination within the MSM community was another identified need as it often discourages men from engaging in social opportunities with other MSM. On a more general level, there was a need to put a human face to MSM, to “re-humanize” them instead of speaking of them in derogatory terms.

“Any type of diversity training is good whether it be in schools with teachers [during] an in-service day when they can do some diversity training or with law enforcement or any group of people that are working with the public. I know mailmen that have thrown people’s mail away or written things on people’s mail.” – KI

“Health care providers [need to] get HIV training, like MSM competency training.” – FG

“There is a certain amount of drama amongst gay men that is tolerated and accepted and almost condoned. And the drama is something that forces relationships apart, really breaks apart the community. I do some social organizing and I will plan an event, just something fun that a lot of people are interested in. And then I’ll start getting text messages, ‘Is so and so going to be there? If they are, I’m not going to show up’. It just ruins so much stuff, so much positive stuff.” – KI

“I’m a big advocate of re-humanizing the gays. Make us human again. I see the Fred Phelps people and they’re not talking about human beings, they’re talking about fags and queers and it’s not even human. I just think we need to re-humanize ourselves in the face of everybody else.” – FG

In addition to the needed cultural changes, a number of social changes were also identified. Greater community involvement and a need for the MSM community to have greater political influence, a strategic plan for political change, and programs funded by the MSM community in order to be sustainable were all important changes and improvements needed. Finally, there was also a need for businesses involved in some of
the factors contributing to risky behavior, such as bars and adult bookstores, to play a role in becoming part of the solution.

“I would have people be more involved in our community. Just being more involved with friends, with family, with just community at large because a lot of people don’t feel involved with their community. And make it a social thing, make it fun. Things to end that isolation and that desperation.” – KI

“Money needs to [be used for] lobbying for stronger comprehensive sex education. Even what’s happening now, Planned Parenthood might not be in the schools at all in Montana coming up and what’s going to happen when we have a Republican governor?” – FG

“Somehow we have to get strategic and we have to go, as the gay community, to the list of legislators and literally choose who we want to defeat and then go out to defeat them.” – KI

“I would like to see [MSM] actively contribute to developing funds for some of these programs. That way at least funding can be secured without necessarily the approval of the state. Just some kind of movement that encourages developing funds to help ourselves.” – KI

“I’d like to see establishments that are kind of implicated in some of the factors that influence MSM to engage in risky behaviors, like bars. I’d like to see them step up and take ownership of the issue.” – KI

Theme 5: Greater Focus on Policy Changes

A number of needed policy changes were identified; these changes were on an organizational, local, and statewide level. One programmatic policy change needed was related to drug and alcohol use. While many stated that it was important to not encourage drug and alcohol use, there was also the recognition that there are individuals who use drugs and alcohol and they needed to be a part of prevention efforts.

“[Resources are] still limiting in ways. The retreats are drug and alcohol free. Expecting people to give up things that are a part of their life like they smoke weed all day or they drink all day or they take pills all day. Asking people to
step out of that and then access these resources is really ridiculous especially because we have muscle memory, right? Well, we also have memory when we are using substances so, if I know what it feels like to put a condom on when I’m wasted, I’m probably going to have an easier time putting it on correctly when that moment happens.” – KI

On a more statewide level, the most often mentioned policy change was the need for comprehensive sex education. Other statewide policy changes include equal rights for LGB individuals such as recognition of civil unions, legalizing gay marriage, partner benefits, and anti-discrimination ordinances were also needs discussed. Anti-bullying policies were also important policy needs.

“If it were mandatory to have sex ed be an option in high school rather than mandatory that sex ed is not available, I just think they are the most vulnerable sexually active group now and they’re the ones not getting the information.” – KI

“Without that comprehensive sex ed, I think we’re doing a real disservice to the next generation.” – KI

“And also...equal rights for gays and lesbians in our society, I think that that helps de-stigmatize HIV. There’s some things that would benefit us as MSM in Montana [like] if we had a civil unions bill.” – KI

“If gay marriage was legalized, like full gay marriage, I would perceive gay relationships differently. There [is] this concept that it could be taken seriously, like a legitimacy to the relationship.” – KI

“And along the same topic, employee benefits, like partner benefits through work and stuff, those kinds of policies could lead somewhere.” – KI

“Getting an anti-sexual orientation and anti-gender identity discrimination policy. Cause once you have that, instead of it just being in Bozeman and Missoula, have it statewide, well, then you’re a little bit less afraid to ask the questions or to be tested or to get the information or to go and pick up what you need.” – KI

“I’d like to see stronger anti-bullying. I know everyone’s jumping onto that bandwagon right now but that would be a good foot in the door a, to get a dialogue started and especially start it at the base level of children.” – FG
A number of health-related policies were also identified. Particularly, the need for needle exchange programs, including a question regarding sexual orientation on the Behavioral Risk Factor Surveillance System (BRFSS), mandatory STI testing for individuals getting married, more openness to sex education, and a policy against locking up condoms in stores were health-related policies described in the discussions.

“A lot of the needle exchange programs, the policies around that make it difficult for those programs to exist.” – KI

“So I know some policy that’s been looked at is expanding the BRFSS that’s conducted in Montana in terms of actually including [a] sexual orientation related question.” – KI

“Now I have been married. I have been heterosexually married and I was in a state where we had to have STD tests before, so I would imagine having [that would help].” – KI

“One thing is a less embarrassed approach towards sex education in public policy and actually saying the words “gay”, “lesbian”, “bisexual”, “transgender” in our words, in our policies as the state health department.” – FG

“You shouldn’t be able to lock up condoms. I think there needs to be a law that you cannot lock up condoms. I don’t care if they’re being stolen or not. Write it off on taxes, make a tax break or whatever they have to have in policies.” – FG

Section 4: Needs Specific to American Indians

One key informant interview and one focus group were conducted with American Indians who live on one of Montana’s seven reservations. Many of the themes that arose in the discussions on the reservations were similar to those that emerged in the off reservation focus groups and interviews. There were, however, some unique aspects regarding the HIV prevention needs of American Indians and those aspects are discussed below. Because there was a small American Indian sample, the quotes will not be distinguished by Key Informant or Focus Group as done previously.
Sub-Section 1: Factors that Influence Risky Behaviors

Theme 1: Drug and Alcohol Use and Abuse

While alcohol and drug use was a concern for American Indian MSM, there was a great concern for the spread of HIV through injection drug use.

“One of the main things that I know of that really, really scares me on our reservation is we’re having a lot of intravenous drug users now. A lot of them are MSM, young MSM... If we get one person in there that has HIV and does not know it and then [they start to] share [needles, tourniquets, etc.], it could start an epidemic there.”

Theme 2: Hiding One’s Sexual Identity

MSM on the down low was another issue which was of concern for American Indian MSM. They perceived there to be more men on the down low, which not only affected other men, but women on the reservation as well. This creates a need to educate both men and women of the risks attributed to unprotected intercourse. There is some awareness of this bisexuality as some MSM are asked by women about the sexuality of other men in the community.

“In Indian country, I think it’s more prevalent here with straight men. You can go into a straight bar here on the reservation at 2:00... ‘let me get rid of my woman and I’m gonna go with you.’ I mean, that’s just normal practice around here.”

“And I try to share that information with the young women to protect themselves also because we do have a lot of men on the down low and you just never know if that person has HIV or an STD and they’re going to share it with another man or another woman, so.”

“Well my co-workers, a lot of them know I’m gay, and have been around, slept with a lot of men in this town. When they’re out dating, or wanting to date somebody, they’ll come and ask me, ‘Okay, has this person that I’m going to date, have they been with other men?’ And so, we’re a source of information for the straight females, giving them all that information.”
Theme 3: Low Perception of Risk for HIV in Montana

There was also the perception that there is low risk of contracting HIV in Montana, especially on the reservation.

“Well culturally some Natives think it’s not a Native disease. That can’t happen to us.”

“It can’t come to the rez.”

Theme 4: Younger MSM are at Greater Risk for HIV

There was a similar perception that younger MSM are at greater risk for HIV, in part because they are apathetic about HIV. The younger MSM also present their sexuality in a way that is different from the older MSM, so that they have a different experience of what it means to be gay.

“And the youth today, they don’t care. They have the education. They don’t care. You know what they say? ‘AIDS? So what. Big deal.’”

“And then youth. Just not knowing, not being educated about it.”

“You see 18 year olds and they’re out. They’re in-your-face out. But what concerns me is what are they facing? And they present their being gay in a different light than we do. I think being gay is just part of me, it’s not all of me, whereas I see [for] a lot of our youth, being gay is a driving force. It’s in your face. And that’s pretty much what’s steering their life right now, being gay but they’re not looking at jobs, education, career, even family ‘cause a lot of them [have] outed themselves, even outing themselves away from their family.”

Sub-Section 2: Protective Factors

Theme 1: American Indian Culture

Having pride and taking part in American Indian culture and traditions is a protective factor identified for American Indian MSM. Having pride in the historical role of two-
spirit individuals is also an important part of American Indian culture. This pride can translate into improved self-esteem and less risky behavior.

“I think culture has a lot to do with it too. A lot of our people that are really practice their native way of believing and ceremonies, that really grounds them, and gives them a different outlook on life, to protect themselves and have more pride in themselves.”

“As a two-spirit person, I try to educate our youth and even our adults on who we were as a people, as a two-spirit society, and sometimes when you let these younger people know that they’re just not a faggot or a queer or a homo, or, you know, what people call gay people, the derogatory terms, a lot of times when they find out who they really are as a Native person and their culture, and that was part of our culture at one time. It really gives them more self-esteem of who they are and a sense of pride. When they realize that, ‘Oh, I’m just not a little queer’, they really start to change and once you let them know that, it changes their whole outlook on their life. Once you have more self-esteem and pride, you’re more likely to take care of your body and who you are as a person.”

Theme 2: Strong Family and Peer Support

Strong family and peer support were also protective factors for American Indian MSM. Some MSM make a point to provide other family members with condoms, which helps to normalize and encourage their use. As mentioned above, it is also important to have recreational events that do not include the use of drugs and alcohol, which helps to deter the spread of HIV.

“I get extra condoms…I give them to my brothers and sisters, and my nieces and nephews. You know, I tell them the same thing I was told growing up, ‘it’s better to have it and not need it than to not have it and need it’.”

“If you’re able to hang out with a group that’s not involved in alcohol or drugs, and get together and talk about the things that are happening in your community, on your reservation, how we can reach these people and stuff, I think a social scene like that is one of the ways [to] deter HIV if you can get that message out.”
Sub-Section 3: Prevention Needs

Theme 1: Places for MSM to Meet and Socialize

There is a great need for resources and recreational opportunities on the reservation. Without knowing or being a part of the MSM community, it is difficult to find resources or others to help navigate life as an MSM. There is also a need for discrete socialization opportunities.

“We know what’s scary is it’s like walking through a mine field, being gay on an Indian reservation, because in terms of if you don’t have friends or the support, it’s a hit and miss how you’re going to pursue that lifestyle cause you don’t have someone to go to, whether it’s a counselor or a resource at the hospital or any type of social services. There’s not one office you can go to and say, ‘I’m gay, what challenges do I have to face?’”

“It would be nice if there was a place that we could go, just for the male community and I’m sure if they had a place like that, you’d have to be very careful on the reservation because people won’t want to be seen going there.”

Theme 2: HIV Testing Designed Specifically for the MSM Population

Confidentiality and anonymity concerns with HIV testing were also present on the reservation. There is also a need on the reservation to encourage and target all people to get tested for HIV, regardless of their sexual orientation. One way to do this is through the use of incentives.

“There’s really nothing where we can really go and talk to somebody one on one about the health things that are going on. We have to go to our IHS and the confidentiality there is so bad.”

“[HIV testing] needs to be encouraged more in our social functions. Because we as a culture and a people, we need to accept the fact that we’re not immune to this disease. We need to put an element in there where we’re not just targeting the gays, we’re targeting everybody.”
“[One way to encourage] people [to] get tested [is] doing a raffle on a beautiful Pendleton blanket. The raffle’s free, all they have to do is get tested first, [then] get a ticket. Then the next day, [they’ll] bring [the] tickets back after everybody’s tested, and then pull one of the tickets out and see who wins. This way you get people [in] that might not ever get tested and they’re saying, ‘Oh, the only reason I did it [is] I’m trying to win that Pendleton’.”

Theme 3: Greater Focus on Social and Cultural Changes

Social and cultural changes were also identified as needed and important in preventing the spread of HIV. Socially, there is a need for greater recreational opportunities on the reservation that do not revolve around the use of drugs or alcohol. A cultural change identified is the increased acceptance of two-spirit individuals in the American Indian community.

“We’ve got to have a lot more recreation for our people where there’s none. Our tribe should be able to bring in something for our youth that would deter them from alcohol and drugs. If they had other choices of things to do, it would take them away from that environment and a lot of times, away from the crowds they hang in.”

“Some of the schools are bringing the children up in the [Tribal] language and the culture. They’re instilling into these younger children, ‘This is your culture. You should be proud of who you are’. The history of our culture, of our people is there but they tend to leave out of the circle the two-spirit people who were once part of that circle. And so that is not being taught to our own people. Other cultures call them gay. At one time, if you had a two-spirit child that was born into your family, you were blessed. And now, it’s the opposite because of the European culture that came in and said it was evil and it was wrong to be that way, and it was from the devil. They took that part of our culture away.”

Theme 4: Greater Focus on Policy Changes

A political or policy change identified at the governmental level was the need for the tribal government to acknowledge and accept that HIV is an issue on Montana’s reservations. This includes the tribal government encouraging more HIV education.
There was also the need for policies including American Indians to be more culturally sensitive and to be more easily understood.

“And not just IHS, the tribe as a sovereign nation needs to accept the fact that this is a problem and it’s not going away and we are not immune to it.”

“And you know, as a tribal sovereign nation, they need to embrace it. They need to encourage more education.”

“Policies are aimed at the people in the MSM community as a whole. I would like to see policies [that are] cultural for Native American communities that would help the communities. A lot of times the way wordings are done in policies, a lot of people don’t understand them and people working on policies for the Native community kind of [need to] make it clearer, more down to earth English, that they would understand. Like, what kind of policy is it going to be? Is it going to be a policy for an intervention or a prevention? What is this policy for?”

Section 5: Available Resources in Montana

A number of available resources around the state were identified in the focus groups and interviews. Because these were often singly listed during discussions, they will be listed out in alphabetical order instead of within quotes.

Organizational resources around the state include: BASS; Birds and Bees; Bozeman AIDS Outreach; Bozeman Gay and Lesbian Resource Center; Curry Health Center of the University of Montana; FDH; Gay Flathead; Gay Men’s Taskforce; LAMBDA; Missoula AIDS Council; Montana Human Rights Network; Montana State University; Montana State University-Billings; Out Words; Partnership Health Center; PFLAG in Billings, Hamilton, and Kalispell; Riverstone Health Clinic; Sexual/reproductive health clinics such as Planned Parenthood/ Montana Men’s Clinic, Bridger Clinic, and Blue Mountain
Clinic; Shout AIDS; Western Montana Community Center, and Yellowstone AIDS Project.

A number of resources not specific to any organization were also identified. These were: adult bookstores, bars, City/County health nurses, discussion groups, dorm resident assistants, individual community testers, peers, personal physicians, retreats, support groups, and various websites.

**Secondary Data**

**Men’s Sexual Health Survey**

A survey developed and administered by the Montana’s Gay Men’s Taskforce was available online for completion from June 8 to September 20, 2010. The purpose of the survey was to gather information about issues related to sexual orientation, sexual history, barriers to HIV testing, history of sexually transmitted infections, substance use, use of the internet to find sexual partners and depression. Survey participants were recruited through LGBT group listservs, events specific to the MSM population (e.g., Gay men’s retreats, Pride Celebration, Native American Two Spirit retreats), and a posting of the survey link on a variety of social network websites that are frequently visited by MSM such as Craigslist, Facebook, Manhunt, etc. (See Appendix I to review the survey; it is also described in further detail in Chapter 3.) Because the survey was advertised in a number of ways which prove difficult to track potential survey respondents, there is no return rate available.
Survey Results

Demographics

One hundred and thirty-four individuals identifying as MSM participated in the survey. However, not all 134 individuals completed 100% of the survey, as a number of people were early quitters. Only surveys where the respondent answered the first twenty questions were entered into the database. The table below shows the age break-down of the respondents; the majority was in the 19 to 29 age range.

Table 7 Age of Survey Respondents

<table>
<thead>
<tr>
<th>Age of Survey Respondents (n=133)</th>
<th>Percent</th>
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<tbody>
<tr>
<td>14 – 18</td>
<td>3.8%</td>
</tr>
<tr>
<td></td>
<td>(n=5)</td>
</tr>
<tr>
<td>19 – 29</td>
<td>45.8%</td>
</tr>
<tr>
<td></td>
<td>(n=61)</td>
</tr>
<tr>
<td>30 – 39</td>
<td>12.0%</td>
</tr>
<tr>
<td></td>
<td>(n=16)</td>
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<tr>
<td>40 – 49</td>
<td>17.3%</td>
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<td></td>
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<td>50 – 59</td>
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<td></td>
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<tr>
<td>60+</td>
<td>5.3%</td>
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<td></td>
<td>(n=7)</td>
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The majority of the survey respondents were also white, as demonstrated in the chart below.
Survey respondents were most likely to be single, followed by those in a committed monogamous relationship with a man. The table below shows the break down for each of the relationship status categories.

### Table 8 Ethnicity of Survey Respondents

<table>
<thead>
<tr>
<th>Ethnicity of Survey Respondents</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caucasian</td>
<td>90.2%</td>
</tr>
<tr>
<td>American Indian/Alaskan Native</td>
<td>5.3%</td>
</tr>
<tr>
<td>Hispanic or Latino</td>
<td>1.5%</td>
</tr>
<tr>
<td>Black or African American</td>
<td>2.3%</td>
</tr>
<tr>
<td>Native Hawaiian or Pacific Islander</td>
<td>0.8%</td>
</tr>
</tbody>
</table>

### Table 9 Relationship Status of Survey Respondents

<table>
<thead>
<tr>
<th>Relationship Status of Survey Respondents</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>65.7%</td>
</tr>
<tr>
<td>Married to a woman, and on the DL</td>
<td>1.5%</td>
</tr>
<tr>
<td>In a committed relationship with a man</td>
<td>25.4%</td>
</tr>
<tr>
<td>In a non-monogamous, open relationship with a man</td>
<td>6.7%</td>
</tr>
<tr>
<td>Married to a woman but in a non-monogamous, open relationship</td>
<td>0.7%</td>
</tr>
</tbody>
</table>

The survey respondents lived primarily in communities that had a population of 10,000 people or more.
Table 10 Population of Survey Respondents’ Town

<table>
<thead>
<tr>
<th>Population of Survey Respondents’ Town n=133</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - 500</td>
<td>3.8% (n=5)</td>
</tr>
<tr>
<td>500 – 1,000</td>
<td>3.8% (n=5)</td>
</tr>
<tr>
<td>1,000 – 10,000</td>
<td>18.0% (n=24)</td>
</tr>
<tr>
<td>10,000 – 50,000</td>
<td>31.6% (n=42)</td>
</tr>
<tr>
<td>50,000+</td>
<td>42.9% (n=57)</td>
</tr>
</tbody>
</table>

Respondents hailed from 21 different counties out of Montana’s 56 counties. The top five counties represented were: Missoula (32%, n=43), Lewis and Clark (16%, n=21), Yellowstone (11%, n=15), Gallatin (9%, n=12), and Cascade (6%, n=8).

Sexual Identity and Outness

When asked about sexual partners over their lifetime, 84% of survey respondents primarily had sex with men only (n=112), just under 10% had sex with both men and women (n=13), 4% had sex with women only (n=5), 1.5% had sex with men, women, and transgender partners (n=2) and 0.8% had sex with men and transgender partners (n=1). The majority of the respondents self-identified primarily as gay or homosexual (92%, n=121); the remaining identified as bisexual (8%, n=10) and straight/heterosexual (0.8%, n=1).
The survey included the Outness Inventory questions. (Note that the Inventory did not include the exact same questions as those used during the Focus groups and DL interviews.) Again, the scale values are as follows:

1 = person definitely does NOT know about your sexual orientation status
2 = person might know about your sexual orientation status, but it is NEVER talked about
3 = person probably knows about your sexual orientation status, but it is NEVER talked about
4 = person probably knows about your sexual orientation status, but it is RARELY talked about
5 = person definitely knows about your sexual orientation status, but it is RARELY talked about
6 = person definitely knows about your sexual orientation status, and it is SOMETIMES talked about
7 = person definitely knows about your sexual orientation status, and it is OPENLY talked about
0 = not applicable to your situation; there is no such person or group of people in your life

<table>
<thead>
<tr>
<th>Out to…</th>
<th>Mean Score</th>
<th>Out to…</th>
<th>Mean Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother</td>
<td>Mean: 5.09</td>
<td>Current Straight</td>
<td>Mean: 6.36</td>
</tr>
<tr>
<td></td>
<td>n=134</td>
<td>Friends</td>
<td>n=133</td>
</tr>
<tr>
<td>Father</td>
<td>Mean: 3.86</td>
<td>Co-workers</td>
<td>Mean: 5.47</td>
</tr>
<tr>
<td></td>
<td>n=128</td>
<td></td>
<td>n=116</td>
</tr>
<tr>
<td>Siblings</td>
<td>Mean: 5.87</td>
<td>Members of religious</td>
<td>Mean: 4.58</td>
</tr>
<tr>
<td></td>
<td>n=127</td>
<td>community</td>
<td>n= 67</td>
</tr>
<tr>
<td>Past Straight</td>
<td>Mean: 5.82</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Friends</td>
<td>n=133</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

On average, survey respondents were 20 years old when they came out to their mother and 21 when they came out to their father. Overall, mothers were more accepting than fathers when the survey participants came out about their sexuality; both mothers and fathers increased their acceptance from the time the respondent came out to the time when the survey was completed.
Sexually Transmitted Infections

Survey respondents were asked if they had ever been diagnosed with a sexually transmitted infection (STI). Of 113 respondents answering the question, 34 reported that they had previously received a diagnosis of an STI. The table below identifies the number previously diagnosed, the STIs and frequency of diagnosis, and how the STI was contracted.

Table 12 STIs Reported by Survey Respondents

<table>
<thead>
<tr>
<th>Which STIs have you had? (n=113)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gonorrhea: 12.4% n=14</td>
</tr>
<tr>
<td>HPV (genital warts): 11.5% n=13</td>
</tr>
<tr>
<td>Chlamydia: 4.4% n=5</td>
</tr>
</tbody>
</table>

The table below identifies the ways that the individuals contracted the STI.

Table 13 How STI Was Contracted

<table>
<thead>
<tr>
<th>How did you contract the STI? (Of those reporting previous diagnosis, n=34)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unprotected anal intercourse: 70.6% n=24</td>
</tr>
<tr>
<td>Unprotected oral intercourse: 26.5% n=9</td>
</tr>
</tbody>
</table>
**HIV Status**

Respondents of the survey were asked about their HIV status (n=116). Just over 12% were HIV positive (n=14), 78% were HIV negative (n=91), and nearly 10% did not know their HIV status (n=11). Of those who were HIV positive, 50% believed that HIV medications help decrease the chance of transmitting the disease (n=7); 43% do not believe this (n= 6; one respondent who was HIV positive did not answer this question). The majority of individuals who stated they are HIV positive report that they always disclose their HIV status (64%; n=9); 29% (n=4) disclose their status most of the time, and 7.1% (n=1) sometimes disclose their status. Since testing positive, 57% (n=8) of the respondents have not engaged in unprotected anal intercourse with a partner whose HIV status is unknown or negative; 43% (n=6) report having engaged in unprotected anal intercourse with a partner whose HIV status is unknown or negative.

When asked about their comfort level being tested for and counseled about HIV by various individuals and organizations, the respondents reported being the most comfortable with other gay men; they were least comfortable being tested in a doctor’s office. The results of this survey question can be seen in the table below.
Table 14 Comfort Levels with HIV Testing

<table>
<thead>
<tr>
<th>Getting tested &amp; counseled for HIV by a gay man? (n=118)</th>
<th>Getting tested &amp; counseled for HIV by a doctor’s office? (n=114)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all comfortable</td>
<td>Not at all comfortable</td>
</tr>
<tr>
<td>.8%</td>
<td>14.0%</td>
</tr>
<tr>
<td>2</td>
<td>4.4%</td>
</tr>
<tr>
<td>3</td>
<td>7.9%</td>
</tr>
<tr>
<td>4</td>
<td>16.7%</td>
</tr>
<tr>
<td>5</td>
<td>8.8%</td>
</tr>
<tr>
<td>6</td>
<td>8.8%</td>
</tr>
<tr>
<td>Very Comfortable</td>
<td>Very Comfortable</td>
</tr>
<tr>
<td>78.8%</td>
<td>39.5%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Getting tested &amp; counseled for HIV by a straight man? (n=117)</th>
<th>Getting tested &amp; counseled for HIV at a public health department? (n=114)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all comfortable</td>
<td>Not at all comfortable</td>
</tr>
<tr>
<td>8.5%</td>
<td>9.6%</td>
</tr>
<tr>
<td>2</td>
<td>9.6%</td>
</tr>
<tr>
<td>3</td>
<td>7.0%</td>
</tr>
<tr>
<td>4</td>
<td>13.2%</td>
</tr>
<tr>
<td>5</td>
<td>13.2%</td>
</tr>
<tr>
<td>6</td>
<td>7.9%</td>
</tr>
<tr>
<td>Very Comfortable</td>
<td>Very Comfortable</td>
</tr>
<tr>
<td>43.6%</td>
<td>39.5%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Getting tested &amp; counseled for HIV by a gay woman? (n=116)</th>
<th>Getting tested &amp; counseling for HIV by a community based organization (YAP, MAC, GMTF, etc.)? (n=117)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all comfortable</td>
<td>Not at all comfortable</td>
</tr>
<tr>
<td>5.2%</td>
<td>3.4%</td>
</tr>
<tr>
<td>2</td>
<td>2.6%</td>
</tr>
<tr>
<td>3</td>
<td>0%</td>
</tr>
<tr>
<td>4</td>
<td>7.7%</td>
</tr>
<tr>
<td>5</td>
<td>6.0%</td>
</tr>
<tr>
<td>6</td>
<td>16.2%</td>
</tr>
<tr>
<td>Very Comfortable</td>
<td>Very Comfortable</td>
</tr>
<tr>
<td>58.6%</td>
<td>64.1%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Getting tested &amp; counseled for HIV by a straight woman? (n=117)</th>
<th>Discussing certain aspects of your sex life with your health care provider? (n=117)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all comfortable</td>
<td>Not at all comfortable</td>
</tr>
<tr>
<td>7.7%</td>
<td>6.8%</td>
</tr>
<tr>
<td>2</td>
<td>4.3%</td>
</tr>
<tr>
<td>3</td>
<td>3.4%</td>
</tr>
<tr>
<td>4</td>
<td>15.4%</td>
</tr>
<tr>
<td>5</td>
<td>14.5%</td>
</tr>
<tr>
<td>6</td>
<td>17.1%</td>
</tr>
<tr>
<td>Very Comfortable</td>
<td>Very Comfortable</td>
</tr>
<tr>
<td>45.3%</td>
<td>38.5%</td>
</tr>
</tbody>
</table>

Alcohol Use

Survey respondents were asked about their alcohol use based on questions from the Alcohol Use Disorders Identification Test (AUDIT), used to indicate unhealthy alcohol use and to determine alcohol dependence (World Health Organization, Babor, Higgins-
Biddle, Saunders, & Monteiro, 2001). This test, developed by the World Health Organization, provides a range of scores from zero to 40. According to the World Health Organization et al. (2001):

“AUDIT scores in the range of 8-15 represented a medium level of alcohol problems whereas scores of 16 and above represented a high level of alcohol problems. On the basis of experience gained from the use of the AUDIT in this and other research, it is suggested that the following interpretation be given to AUDIT scores:

- Scores between 8 and 15 are most appropriate for simple advice focused on the reduction of hazardous drinking.
- Scores between 16 and 19 suggest brief counseling and continued monitoring.
- AUDIT scores of 20 or above clearly warrant further diagnostic evaluation for alcohol dependence” (p. 20).

Survey respondent scores on the AUDIT comprise a range from 0 to 18, with a mean score of 5.2; the standard deviation of the scores is 4.3. A distribution of scores can be seen below; no respondents scored 15 or 16.

<table>
<thead>
<tr>
<th>Score Range</th>
<th>Percentage of Survey Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>n=111</td>
<td></td>
</tr>
<tr>
<td>0 - 7</td>
<td>73.9% n=82</td>
</tr>
<tr>
<td>8 - 14</td>
<td>22.5% n=25</td>
</tr>
<tr>
<td>17 - 18</td>
<td>3.6% n=4</td>
</tr>
</tbody>
</table>

Table 15 AUDIT Scores of Survey Participants
Internet Use

The survey respondents were asked if they had ever used the Internet to meet guys for sex (n=111): 68.5% said they did (n=76), 31.5% said they did not (n=35). Respondents who used the Internet to meet other men were asked to indicate the websites that they used. The top websites used are listed below.

Table 16 Websites Used By Survey Respondents to Meet Sexual Partners

<table>
<thead>
<tr>
<th>Number of Resondents Using Website</th>
</tr>
</thead>
<tbody>
<tr>
<td>manhunt.net</td>
</tr>
<tr>
<td>gay.com</td>
</tr>
<tr>
<td>craigslist.org</td>
</tr>
<tr>
<td>facebook.com</td>
</tr>
<tr>
<td>myspace.com</td>
</tr>
<tr>
<td>adam4adam.com</td>
</tr>
<tr>
<td>silverdaddies.com</td>
</tr>
<tr>
<td>dudesnude.com</td>
</tr>
<tr>
<td>bigmusclebears.com</td>
</tr>
<tr>
<td>bear411.com</td>
</tr>
<tr>
<td>adultfriendfinder.com</td>
</tr>
<tr>
<td>Okcupid.com</td>
</tr>
</tbody>
</table>

Survey respondents reported using the Internet to meet guys for sex in the previous month from zero to over 30 times. These break-downs are shown in the table below.
Survey respondents report a range of 0 to 2,000 miles as the furthest distance they have traveled for a hookup they met online (n= 69): 66.7% reported driving 100 miles or less (n= 46), 27.5% drove between 101 and 500 miles (n= 19), and 5.8% drove 950 to 2000 miles (n= 4). Survey respondents reported that when traveling out of town or state (n= 109), 11.9% were very likely to have sex (n= 13), 28.4% were somewhat likely (n=31), 17.4% were somewhat unlikely (n= 19), and 42.2% were very unlikely (n= 46). Furthermore, when traveling out of town or state (n=104), 71.2% were very likely to use condoms for anal sex (n=74), 14.4% were somewhat likely to use condoms for anal sex (n= 15), 6.7% were somewhat unlikely to use condoms for anal sex (n= 7), and 7.7% were very unlikely to use condoms for anal sex (n= 8). A number of safety precautions were taken by the survey respondents when meeting sexual partners from the Internet. A number of these include bringing and using condoms, meeting in public, telling others about plans, trying to learn some general information about the person ahead of time, keeping phone handy, and trying to get a vibe for the person prior to meeting.

<table>
<thead>
<tr>
<th>Number of Times Internet Used for Sex in Previous Month</th>
<th>n=42</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 time</td>
<td>6 times</td>
</tr>
<tr>
<td>n=23</td>
<td>n=2</td>
</tr>
<tr>
<td>2 times</td>
<td>7 – 10 times</td>
</tr>
<tr>
<td>n=5</td>
<td>n=1</td>
</tr>
<tr>
<td>3 times</td>
<td>11 – 15 times</td>
</tr>
<tr>
<td>n=6</td>
<td>n=2</td>
</tr>
<tr>
<td>5 times</td>
<td>30+ times</td>
</tr>
<tr>
<td>n=1</td>
<td>n=2</td>
</tr>
</tbody>
</table>
Depression

The Center for Epidemiological Studies Depression Scale (CES-D) was “designed to measure current level of depressive symptomatology, with emphasis on the affective component, depressed mood” (Radloff, 1977, p. 385). The 20-item scale has a range of scores from zero to 60, “with the higher scores indicating more symptoms, weighted by frequency of occurrence during the past week” (Radloff, 1977, p. 386). The mean score for the survey respondents was 15.8, with a standard deviation of 11.5. The scores ranged from 0 to 46; a distribution of scores can be seen below.

Table 18 Range of Survey Respondents' CES-D Scores

<table>
<thead>
<tr>
<th>Score Range</th>
<th>Percentage of Survey Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 – 10</td>
<td>40.2% n=39</td>
</tr>
<tr>
<td>11 – 20</td>
<td>29.9% n=29</td>
</tr>
<tr>
<td>21 – 30</td>
<td>17.5% n=17</td>
</tr>
<tr>
<td>31 – 40</td>
<td>7.2% n=7</td>
</tr>
<tr>
<td>41 – 46</td>
<td>5.2% n=5</td>
</tr>
</tbody>
</table>

Unprotected anal intercourse

In a typical month, the respondents engaged in anal intercourse anywhere from zero to 29 times (n=112). When participating in anal intercourse (n=113), more than half of the respondents stated that they always use a condom (n=69); approximately a quarter of the respondents sometimes used condoms (n=27), approximately 10% never used condoms.
(n=11) and 5% rarely used condoms (n=6). The table below shows the number of times survey respondents engaged in unprotected anal intercourse in a variety of ways with partners of different HIV statuses.

Table 19 Types and Frequencies of Survey Respondents’ Unprotected Anal Intercourse

<table>
<thead>
<tr>
<th># of times in past year participants engaged in unprotected anal sex…</th>
<th>…As a bottom with a partner of unknown HIV status (n=113)</th>
<th>…As a top with a partner of unknown HIV status (n=112)</th>
<th>…As a bottom with a partner who is HIV positive (n=113)</th>
<th>…As a top with a partner who is HIV positive (n=113)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>83.2% n=94</td>
<td>76.8% n=86</td>
<td>97.3% n=110</td>
<td>94.7% n=107</td>
</tr>
<tr>
<td>1</td>
<td>5.3% n=6</td>
<td>8% n=9</td>
<td>1.8% n=2</td>
<td>2.7% n=3</td>
</tr>
<tr>
<td>2</td>
<td>8.8% n=10</td>
<td>5.4% n=6</td>
<td>0%</td>
<td>.9% n=1</td>
</tr>
<tr>
<td>3</td>
<td>1.8% n=2</td>
<td>2.7% n=3</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>4</td>
<td>0%</td>
<td>1.8% n=2</td>
<td>.9% n=1</td>
<td>.9% n=1</td>
</tr>
<tr>
<td>5</td>
<td>.9% n=1</td>
<td>.9% n=1</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>6</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>7</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>8</td>
<td>0%</td>
<td>.9% n=1</td>
<td>0%</td>
<td>.9% n=1</td>
</tr>
<tr>
<td>9</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>10</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>11 – 19</td>
<td>0%</td>
<td>1.8% n=2</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>20 – 29</td>
<td>0%</td>
<td>1.8% n=2</td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>

Since 2005, five years prior to taking the survey, 13 respondents had engaged in unprotected anal intercourse with a partner who was HIV positive. Eight of those
respondents had done so in the previous two years (2009 and 2010). The ten most frequently cited reasons for engaging in unprotected anal intercourse reported by survey respondents can be seen in the chart below.

Table 20 Survey Respondents’ Reasons for Engaging in Unprotected Anal Intercourse (n= 19)

<table>
<thead>
<tr>
<th>Reason</th>
<th>Number of Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>I wanted the physical sensation</td>
<td>9</td>
</tr>
<tr>
<td>I was the top during anal sex</td>
<td>8</td>
</tr>
<tr>
<td>I thought the risk of transmitting HIV was low</td>
<td>8</td>
</tr>
<tr>
<td>He did not cum inside of me</td>
<td>7</td>
</tr>
<tr>
<td>I did not even think about the possibility of HIV infection</td>
<td>6</td>
</tr>
<tr>
<td>He knew I was negative and he said it was okay</td>
<td>6</td>
</tr>
<tr>
<td>I was under the influence of alcohol or drugs</td>
<td>5</td>
</tr>
<tr>
<td>I was feeling depressed and did not care what happened to me</td>
<td>4</td>
</tr>
<tr>
<td>He was very hot</td>
<td>4</td>
</tr>
<tr>
<td>I was unaware he was HIV positive</td>
<td>3</td>
</tr>
</tbody>
</table>

There were 27 individuals who reported unprotected anal intercourse with a partner who is HIV positive or whose status is unknown (hereinafter referred to as “risky sexual behavior”. Of those reporting risky sexual behavior, 92.6% identified as gay or homosexual (n=25), while 7.4% identified as bisexual (n=2).
Further, a comparison was made between those reporting risky sexual behavior in the previous year and those using recreational drugs in the previous year. Of those reporting risky sexual behavior in the previous year, 30.8% reported recreational drug use in the previous year and 69.2% reported that they did not use recreational drugs in the previous year.

A number of t-tests were run to explore differences between two groups of respondents. The first group consists of respondents who are HIV negative or do not know their status and who engaged in risky sexual behavior in the previous year. The second group consists of respondents who are HIV negative and do not know their status and did not engage in risky sexual behavior in the previous year. The variables examined include the following:

- Age (n=92);
- Self-identified sexual orientation (n=91);
- Levels of attraction (n=93);
- Scale of sexual orientation (n=93);
- Age when one’s mother learned about his sexual orientation (n=78);
- Age when one’s father learned about his sexual orientation (n=59);
- Mother’s acceptance level when respondent came out (n=75);
- Mother’s current level of acceptance (n=74);
- Father’s acceptance level when respondent came out (n=62);
- Father’s current level of acceptance (n=62);
- Comfort level being tested by various individuals and organizations (n ranges from 90 to 93);
Outness Total Score (n=84);

CES-D Total Score (n=73); and,

AUDIT Total Score (n=89).

Of the t-tests, only risky sexual behavior and the AUDIT total scores were found to have significance. The mean AUDIT scores for participants who engaged in risky sexual behavior was significantly higher \((p<.001; \text{mean}= 8.2)\) than those who did not \((\text{mean}= 4.5)\).

Chi-square tests of independence were also calculated between two groups of respondents. The first group consists of respondents who are HIV negative or do not know their status and who engaged in risky sexual behavior in the previous year. The second group consists of respondents who are HIV negative and do not know their status and did not engage in risky sexual behavior in the previous year. The variables examined include the following:

- Population of the city/town in which the respondent lives \((n=93)\);
- Self-identified sexual orientation \((n=91)\);
- Recreational drug use in the past year \((n=89)\); and,
- Recreational drug use ever in life \((n=89)\).

Risky sexual behavior and recreational drug use ever in life \((n=89)\) were significant \((\chi^2(1) = 4.981, p<.05)\). Risky sexual behavior and population of the city/town in which the respondent lives \((n=93)\) approached significance \((\chi^2(4) = 9.213, p=.056)\). Risky sexual behavior and recreational drug use in the past year \((n=89)\) also approached significance \((\chi^2(1) = 2.982, p =.084)\).
**Relationships among Age at Coming Out, Drug Use, Depression and Outness**

Pearson’s Correlations were also calculated to examine the relationships between the following variables:

- *How old were you when your mother learned about your sexual orientation (n=81);*
- *How old were you when your father learned about your sexual orientation (n=60);*
- *Rate how accepting your father was when you came out (n=63);*
- *Rate how accepting your mother was when you came out (n=81);*
- *CES-D Total Score (n=75);*
- *AUDIT Total Score (n=79); and,*
- *Outness Total Score (n=80).*

The results of these correlations can be found in the table below. In summary, a strong positive correlation was found between the age when one’s mother learned about his sexual orientation and the age when one’s father learned about his sexual orientation ($r=.815$, $p<.001$), indicating a significant linear relationship between the two. This suggests that individuals were older when they came out to their fathers than their mothers. A moderate positive correlation was also found between the age when one’s mother learned about his sexual orientation and how accepting his father was when he came out ($r=.456$, $p<.001$), indicating a significant linear relationship between the two. This suggests the older one was when he came out to his mother, the more accepting his father was. A weak positive correlation was found to be significant between the age when one’s mother learned about his sexual orientation and the AUDIT Total score ($r=.240$, $p<.05$), indicating individuals who were older when they came out to their mothers were more likely to have higher AUDIT scores. A weak negative correlation was found to be significant between the age when one’s father learned about his sexual orientation
and the Outness total score ($r = -0.276, p < 0.05$), indicating that the older one was when he came out to his father, the lower he scored on the Outness Inventory. A weak negative correlation was found to be significant between how accepting his father was when he came out and the total score on the CES-D ($r = -0.246, p = 0.05$), indicating that the more accepting one’s father was when he came out, the lower the score on the CES-D.

**Figure 2 Relationships among Age at Coming Out, Drug Use, Depression and Outness Correlations**

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. How old were you when your mother learned about your sexual orientation</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. How old were you when your father learned about your sexual orientation</td>
<td></td>
<td>$0.815^{**}$</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Rate how accepting your father was when you came out</td>
<td>$-0.197$</td>
<td>$-0.019$</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Rate how accepting your mother was when you came out</td>
<td>$-0.034$</td>
<td>$-0.009$</td>
<td>$0.456^{**}$</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. CES_Dep_Tot</td>
<td>$0.049$</td>
<td>$0.066$</td>
<td>$-0.247^{**}$</td>
<td>$0.148$</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. AUDIT Total Score</td>
<td>$0.240^{*}$</td>
<td>$0.128$</td>
<td>$-0.036$</td>
<td>$-0.002$</td>
<td>$0.106$</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>7. Outness Total</td>
<td>$-0.192$</td>
<td>$-0.276^{*}$</td>
<td>$0.051$</td>
<td>$0.066$</td>
<td>$-0.189$</td>
<td>$-0.019$</td>
<td>1</td>
</tr>
</tbody>
</table>

*Correlation is significant at the .05 level  
**Correlation is significant at the .01 level

**Relationships among Drug Use, Depression, Outness, Risky Sexual Behavior**

Pearson’s Correlations were also calculated to examine the relationships between the following variables:

- *CES-D Total Score (n= 92)*;
- *AUDIT Total Score (n=91)*;
- *Outness Total Score (n=87); and,*
- *Risky Sexual Behavior (n=84)*.

The results of these correlations can be found in the table below. In summary, a weak positive correlation was found to be significant between risky sexual behavior and the CES-D score ($r = 0.232, p < 0.05$). A weak positive correlation was found to be significant between risky sexual behavior and the AUDIT total score ($r = 0.236, p < 0.05$). These results
indicate that individuals engaging in more risky sexual behavior have higher scores on the AUDIT and the CES-D.

**Figure 3 Relationships among Drug Use, Depression, Outness, and Unprotected Anal Intercourse Correlations**

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>CES_DEP_TOT</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AUDIT Total Score</td>
<td>.106</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outness Total</td>
<td>-.189</td>
<td>-.019</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Past year total number of UAI with partner who is HIV positive or status unknown</td>
<td>.232*</td>
<td>.236*</td>
<td>.019</td>
<td>1</td>
</tr>
</tbody>
</table>

*Correlation is significant at the .05 level

**Relationships among Frequency of Risky Sexual Behavior, Age of Coming Out to Mother and Father, and Level of Mother and Father’s Initial Acceptance and Current Acceptance of Sexual Orientation**

Finally, Pearson’s Correlations were also calculated to examine the relationships between the following variables:

- **Risky Sexual Behavior (n=93);**
- **How old were you when your mother learned about your sexual orientation (n=75);**
- **Rate how accepting your mother was when you came out (n=75);**
- **Rate how accepting your mother is currently (or last visit) (n=74);**
- **How old were you when your father learned about your sexual orientation (n=59);**
- **Rate how accepting your father was when you came out (n=62); and,**
- **Rate how accepting your father is currently (or last visit) (n=62).**

The results of these correlations can be found in the table below. A number of associations were found and some of these have already been discussed. A moderate positive association was found to be significant between how accepting one’s mother was when he came out and how accepting she currently is (r=.539, *p*<.01). A moderate positive association was found to be significant between how accepting one’s mother
currently is and how accepting one’s father was when he came out ($r=.396, p<.01$). There was also a number of significant associations between how accepting one’s father currently is and one’s age when his mother learned of his sexual orientation ($r=-.388, p<.01$), how accepting one’s mother was when he came out ($r=.251, p<.05$), how accepting one’s mother currently is ($r=.561, p<.01$), how old one was when his father learned of his sexual orientation ($r=-.277, p<.01$), and how accepting one’s father was when he came out ($r=.751, p<.01$).

**Figure 4 Relationships among Frequency of Unprotected Anal Intercourse, Age of Coming Out to Mother and Father, and Level of Mother and Father’s Initial Acceptance and Current Acceptance of Sexual Orientation Correlations**

| 1. Past year total number of UAI with partner who is HIV positive or status unknown | 1 |
| 2. How old were you when your mother learned about your sexual orientation | -.074 | 1 |
| 3. Rate how accepting your mother was when you came out | .189 | -.034 | 1 |
| 4. Rate how accepting your mother is currently (or last visit) | .123 | -.151 | .549** | 1 |
| 5. How old were you when your father learned about your sexual orientation | .239 | .815** | -.009 | -.209 | 1 |
| 6. Rate how accepting your father was when you came out | -.001 | -.197 | .456** | .386** | -.019 | 1 |
| 7. Rate how accepting your father is currently (or last visit) | .156 | -.388** | .251* | .561** | -.277* | .751** | 1 |

*Correlation is significant at the .05 level
**Correlation is significant at the .01 level

**Predicting Unprotected Anal Intercourse using Depression Scores, Alcohol Abuse Scores, and Use of Recreational Drugs**

Three regression analyses were carried out to predict past-year risky sexual behavior. The first regression examined the following variables:

- **Risky Sexual Behavior ($n=83$);**
- **CES- D Total Score ($n=83$);**
- **Use of recreational drugs in the past year ($n=83$); and,**
- **AUDIT Total Score ($n=83$).**
Specifically, the regression was calculated predicting risky sexual behavior based on the CES-D total score, use of recreational drugs in the past year, and AUDIT total score. While the overall model is significant ($p = .03$) with an adjusted $R^2$ of .072, none of the individual predictors were statistically significant within the model (although CES-D approaches statistical significance, $p=.065$).

The second regression analysis was conducted looking at the following variables:

- **Risky sexual behavior** ($n=50$);
- **CES-D Total score** ($n=50$);
- **Recreational drug use in the previous year** ($n=50$);
- **AUDIT Total score** ($n=50$); and,
- **Outness Inventory** ($n=50$).

CES-D total scores, past-year recreational drug use, AUDIT Total scores, and Outness Inventory total scores were entered into the first block of the regression, while the ages at which participants came out to their mothers and fathers were entered into the second block. The overall model, which included predictors from the first and second blocks, was statistically significant, ($p <.001$) and had an adjusted $R^2$ of .406. This regression was looking to predict risky sexual behavior and the ages of the respondents when they came out to their mother and father. These two predictors were significant in predicting risky sexual behavior ($p<.001$). The model shows that risky sexual behavior decreased by the Beta weight of .847 for every one year older the respondent was when he came out to his mother. In addition, the model shows that risky sexual behavior increased by the Beta
weight of .855 for every one year older the respondent was when he came out to his father.

The following variables were entered into the first block of the regression analysis:

- **Risky Sexual Behavior (n=53);**
- **CES-D total score (n=53);**
- **Use of recreational drugs in the past year (n=53); and,**
- **AUDIT total score (n=53).**

The following variables were entered into the second block of the regression analysis:

- **How old were you when your mother learned about your sexual orientation (n=53); and,**
- **How old were you when your father learned about your sexual orientation (n=53).**

The adjusted $R^2$ in the first block is .065 and is not statistically significant ($p = .149$). The adjusted $R^2$ in the second block is .068 and the model approaches statistical significance ($p=.092$). While nothing was gained in the second block, the addition of the age variables highlights the importance of considering outness within the context of the ages of coming out.

**Men on the Down Low Interviews**

A total of 27 interviews with men on the down low were conducted from April 2010 through October 2010 by a PhD candidate working with the researcher. The men in these interviews ranged in age from 19 to 63, with a mean age of 39. The majority identified as bisexual (67%), followed by gay (26%), straight (4%) and other (4%). The majority also
came from communities with a population of 10,000 individuals or more, as displayed in the chart below.

Table 21 Population of DL's Town

<table>
<thead>
<tr>
<th>Population of DL Interviews Town</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - 500</td>
<td>11.1%</td>
</tr>
<tr>
<td></td>
<td>(n=3)</td>
</tr>
<tr>
<td>500 – 1,000</td>
<td>0%</td>
</tr>
<tr>
<td></td>
<td>(n=0)</td>
</tr>
<tr>
<td>1,000 – 10,000</td>
<td>7.4%</td>
</tr>
<tr>
<td></td>
<td>(n=2)</td>
</tr>
<tr>
<td>10,000 – 50,000</td>
<td>37.0%</td>
</tr>
<tr>
<td></td>
<td>(n=10)</td>
</tr>
<tr>
<td>50,000+</td>
<td>44.4%</td>
</tr>
<tr>
<td></td>
<td>(n=12)</td>
</tr>
</tbody>
</table>

As can be expected with men on the down low, their scores on the Outness Inventory show them to be less out regarding their sexuality. Again, the scale values are as follows:

1 = person definitely does NOT know about your sexual orientation status
2 = person might know about your sexual orientation status, but it is NEVER talked about
3 = person probably knows about your sexual orientation status, but it is NEVER talked about
4 = person probably knows about your sexual orientation status, but it is RARELY talked about
5 = person definitely knows about your sexual orientation status, but it is RARELY talked about
6 = person definitely knows about your sexual orientation status, and it is SOMETIMES talked about
7 = person definitely knows about your sexual orientation status, and it is OPENLY talked about
0 = not applicable to your situation; there is no such person or group of people in your life

These scores can be seen in the tables below.
Table 22 Overall Down Low Interview Outness Inventory Scores

<table>
<thead>
<tr>
<th>Category Score</th>
<th>Mean, Range, and Number of Cases</th>
</tr>
</thead>
</table>
| Out to Family                   | Mean= 1.95  
Range: 1.00 to 5.75  
n= 27                     |
| Out to World                    | Mean= 1.69  
Range: 1.00 to 4.00  
n= 27                     |
| Out to Religious Community     | Mean= 1.34  
Range: 1.00 to 2.50  
n= 16                     |
| Overall Outness Score           | Mean= 1.79  
Range: 1.00 to 4.11  
n= 27                     |

Table 23 Outness Inventory Mean Scores of Survey Respondents

<table>
<thead>
<tr>
<th>Out to...</th>
<th>Mean Score</th>
<th>Out to...</th>
<th>Mean Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother</td>
<td>Mean: 2.89</td>
<td>Work Supervisors</td>
<td>Mean: 1.42</td>
</tr>
<tr>
<td></td>
<td>n=27</td>
<td></td>
<td>n=24</td>
</tr>
<tr>
<td>Father</td>
<td>Mean: 1.55</td>
<td>Religious Members</td>
<td>Mean: 1.38</td>
</tr>
<tr>
<td></td>
<td>n=22</td>
<td></td>
<td>n= 16</td>
</tr>
<tr>
<td>Siblings</td>
<td>Mean: 1.84</td>
<td>Religious Leaders</td>
<td>Mean: 1.31</td>
</tr>
<tr>
<td></td>
<td>n=25</td>
<td></td>
<td>n= 16</td>
</tr>
<tr>
<td>Extended Family</td>
<td>Mean: 1.41</td>
<td>Strangers/new acquaintances</td>
<td>Mean: 1.89</td>
</tr>
<tr>
<td></td>
<td>n=27</td>
<td></td>
<td>n=27</td>
</tr>
<tr>
<td>New Straight Friends</td>
<td>Mean: 1.63</td>
<td>Old Straight Friends</td>
<td>Mean: 2.59</td>
</tr>
<tr>
<td></td>
<td>n=27</td>
<td></td>
<td>n=27</td>
</tr>
<tr>
<td>Work Peers</td>
<td>Mean: 1.54</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>n=24</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Themes

A number of themes were identified in these interviews. The outline below addresses the various themes identified by the interviewer. The quotes represent a portion of those provided to the research assistant but include those that address each of the themes.
DL Theme 1: Effects of Remaining Closeted

An effect related to being closeted that was identified was a feeling of disconnect in one’s life.

“I would love that (being able to live as an openly gay man), but I don’t really see it working the best way. Like if I came out, I think some doors would shut, some friends…I wish I could just tell everybody, ‘Hey, this is my life, this is what I do’, but the repercussions from coming like that is what I fear.”

“It makes you a liar. It make you have to lie all the time to people that are otherwise important to you and so you live this...lie your entire life, and be that good or bad, that is the position you end up living in.”

There were also individuals who felt no disconnect or effect.

“In modern society, this is just standard operating procedure, you can’t just go out and tell everybody everything about yourself or wear a sign that says these are the tags that apply to me. It’s just common sense, you know?”

“I’m a man and I just happen to love men, but there’s no feminine bone in me.”

DL Theme 2: Social Interaction

Social interactions related to family and friends were also themes that emerged in the interviews.

“Yeah, it [remaining closeted with dad and brothers] has created more than just tension. It’s created serious walls between us, at least in my point of view, and we don’t have much of a relationship.”

“I don’t have many close friends, I don’t have many friends at all. I put up a lot of walls, a lot of defensive walls to protect myself and to prevent anyone from getting too close so they would find out...It definitely affects my daily life. It makes it stressful and it makes it exhausting a lot of times...It makes it very difficult to go into social situations without being fearful.”
DL Theme 3: Stigma and Negative Attitudes

The presence of stigma and negative attitudes impact the life experiences of the men.

“Yes, I definitely see it [negative attitudes] a lot and it has absolutely affected me. It’s so ingrained and so institutionalized... just sitting at a poker game and somebody will say something like, ‘You’re such a fag’ or you know, things like that. It’s so taken for granted and just so common that the prejudice, it’s at such a common level right now that it makes it very difficult to imagine being able to come out and be accepted by people that have those types of views.”

“Yes, being an athlete all my life, it’s, the gay and lesbian community is looked upon in a negative fashion. It doesn’t seem like it is a manly thing to do to be interested in same sex relationships and I’ve had some friends who were openly gay and they were severely harassed both physically and verbally.”

DL Theme 4: Safety

Safety issues were also expressed by men in the interviews. Some men felt safe while others did not.

“Oh absolutely not. I’ve always been a man to defend my own, I’ve never had a problem with that. I like to frequent gay clubs in the city of course, obviously we don’t have any here, but in the city, that’s my niche, that’s where I feel at home. But I’m one of those guys that like to wait for one person to just snap off and say ‘faggot’ one time, and then I just feel really good when I just beat the shit out of him. I feel really good about myself, not myself, but I feel relieved. There’s one more guy who just ate his words, you know, ‘cause we’re minding our own business, we just had a good time, you know, you’re out here harassing us because you’re mad about something for some reason, but yeah, I’m that type of guy.”

“I don’t know, I’ve thought about that many times, like could I meet somebody one time and then go to meet them and they’re like the KKK of gays, yeah, of course.”

“I meet people in a public place first.”
DL Theme 5: Rural Influence

There were also concerns regarding living in rural areas of the state.

“You can get hurt these days being a homosexual, I mean being anything really, you know, discrimination, whatever. Being gay more so, and I found it in rural places like this, like Montana, more difficult. People are way more closed-minded...way closed-minded...That’s why it’s hard living in a small town.”

“Being in a rural area, that’s the hardest thing. I don’t know how any man being gay survives in a place like this unless you’re really comfortable and your family is very supportive. That would be the only possible way I could imagine, cause I couldn’t live without my family, I would be real lonely…I lived in the city for five years and had no problems.”

DL Theme 6: Why Men Choose to Remain Closeted

A number of reasons why men choose to remain closeted were discussed in the interviews.

“I think it could be the small town, the beliefs that were [instilled] in me, maybe it was the religion...”

“Fear of being rejected in the community and family. My family is probably the biggest factor by far. Basically, I want to fit in with the norm of society.”

“I am married.”

“Of course my tribe and my religion and my parents...”

DL Theme 7: Anonymity

Men in the DL interviews discussed their need to be anonymous.

“Sometimes, like I have two separate email accounts that I use for hooking up with people that I think are okay to know who I really am and there’s a different email account that I use for people who I don’t really know or don’t really trust...”
“I like to answer the personal ads from younger guys who are traveling for work, so I can meet them at a hotel and I know they won’t be somebody in town.”

**DL Theme 8: Coping Mechanisms**

A number of coping mechanisms utilized by men on the DL were discussed including drug and alcohol use and suicide attempts.

“I seem to smoke weed to just relax.”

“I would do it [meth], it would definitely enable me.”

“I think alcoholism and drug use is prevalent in the gay community because of the pressures that society has put on us when trying to deal with society.”

“I’ve used alcohol as a coping mechanism in the past.”

“I’ve had a lot of issues with trying to come out, thinking I will be rejected by family and disowned and it will just be horrible. I keep it to myself, I lie about it, and actually, I’ve always had depression issues, but this kind of makes it worse. I ended up attempting suicide my freshman year of high school.”

“About three years ago, [I] was becoming suicidal and was thinking of suicide and going to get guns. I was thinking about getting in a car and just speeding up and tried pushing my wife away. I tried pushing my kids away so that if I died, they would be better off without me and I would be dead.”

**DL Theme 9: Emotional**

Emotional issues related to being on the DL were recognized by the men in their interviews.

“Yeah, yeah I get the anxiety cause I really kind of pushing it out there to where I’m going to get caught, but maybe self-consciously, it would be a relief.”
“Yeah, it contributes to mental health issues. Your fear of discovery is offset by your desire to establish a level of pleasure. You know, we want to justify the position ourselves and we can, well it’s just sex and in our society it is considered a big deal. I don’t know, I don’t like the idea that I have to stay hidden and it’s weird.”

DL Theme 10: Physical

Physical symptoms as a result of the emotional issues were also an issue for the men as were concerns for physical safety.

“I have had physical symptoms, you know, I have had nausea and a lot of panic attacks.”

“Oh yeah, I’ve had some fears, where I’ve vomited, yeah, like when I was in the Army, it would be really stressful because I was just really paranoid.”

“When I was in the Navy, yeah, definitely was a bit on the nervous side on the fact that you know we have had a couple of reports of gays or people that have come out in the military you know being thrown overboard. I think the Marines you know worked on over a little too hard and ended up with a fatality.”

DL Theme 11: Masculinity

The need to be masculine also emerged in the interviews.

“I do feel the need, but I don’t think I do it very well.”

“I’ve never really felt the need to play up the bravado...”

“Yeah, when I was growing up, my parents always wanted me to be like the perfect guy with the perfect girl...”

DL Theme 12: HIV Risk Perception

Men on the DL in Montana had varied perceptions regarding their risk for HIV.

“It is a slight concern, but because I am in Montana rather than Los Angeles or New York, I probably am complacent about it. I am safe most of the time, but
when I’m not, I’m like, ‘Whatever, it’s Montana.’ It’s more of a big city problem.”

“If you’re married you pretty much make sure you don’t bring anything home and you’re pretty careful about what you’re doing cause you don’t want your wife to find out what’s going on.”
“IT should be but I guess it isn’t really much for me personally. I know it’s out there.”

**DL Theme 13: Condom Use**

Use of condoms was also varied for men on the DL.

“I take precautions, I wear condoms, things like that.”

“Have I had unprotected sex? Yes.”

“I should wear them more often.”

“I just, no.”

**DL Theme 14: Testing Locations and Frequency**

The men in the interviews were aware of a number of testing locations. These include free clinics, doctors’ offices, anonymous testing facilities, friends, jail, and the health departments. The frequency of testing was varied.

“Every six months.”

“Once a year.”

“Infrequently.”

“Never.”
“When the opportunity presents itself.”

“Every three months.”

DL Theme 15: HIV/STI/Sexual Health Questions

The men were able to identify a number of resources for information regarding HIV, sexually transmitted infections, and sexual health. These include Internet resources (e.g., Google, WebMD, Wikipedia, Yahoo, other search engines, and hospital websites), doctors’ offices, friends, HIV testing facilities, AIDS organizations, adult bookstores, and the health department.

DL Theme 16: Risk Communication

When asked about their risk communication with partners, the men in the interviews had varied responses and abilities.

“It’s always been more like... ‘What are you doing? How are you?’... We don’t get too much into the personal.”

“Honestly, I don’t [ask my partners about their sexual history, last testing date, and HIV status].”

“Yeah, yeah I’ve had those conversations.”

“Yeah, we usually talk it over before we decide whether or not to use condoms.”

“Yes and this eliminates about 90% of potential partners. Have to be picky.”

“It’s a good thing to do, but I don’t always do it.”
CHAPTER FIVE

Discussion

The purpose of this research study was to assess the HIV prevention needs of men who have sex with men (MSM) in Montana. Included in this analysis were the responses of over 190 men who participated in one of the following data gathering techniques: an online survey, focus group interviews, and key informant interviews. The majority of participants were between the ages of 19 and 29, and were representative of all of Montana’s five health planning regions. Most men reported that they were out to family and friends about their sexual orientation, but rarely talked about it. However, 27 men who participated in the interviews were closeted about their sexuality and identified as men on the down low.

The following discussion represents a synthesis of data collected from primary and secondary sources. The PRECEDE Model was used to organize the discussion. This model leads researchers to ask “why” HIV is a problem among MSM in Montana before it asks “how” to fix it. Thus, the model provides a logical framework for identifying behaviors and environmental factors that contribute to HIV infection among MSM. Once behaviors are identified, factors that influence the behaviors are delineated and examined in relationship to resources and services. Ultimately, the model leads the researcher to identify unmet prevention needs.
Behaviors that Contribute to HIV Infection

The HIV prevention literature has long identified unprotected anal intercourse (UAI) as a major behavioral risk factor for HIV infection (Koblin, et al., 2006; Preston, D’Augelli, Kassab, & Starks 2007). Particularly of concern are men who engage in UAI as the bottom, as this has been shown to increase the risk of HIV infection (CDC, 2010a). While condoms offer protection against infection, findings from this study support the presumption that many MSM engage in anal sex without using a condom. Of the 134 MSM who responded to the online survey, 39% said that they never, rarely, or sometimes used a condom when they engaged in anal intercourse. Furthermore, since testing positive, 43% of respondents who are HIV positive have engaged in UAI with a partner who is HIV negative or whose status is unknown. Focus group and survey respondents cited a number of reasons for not using condoms. One of the most frequently cited reasons for rejecting condom use was the desire to have the physical sensation of not using a condom. Other common reasons for not using condoms were being in a relationship, thinking the risk of transmitting HIV is low, embarrassment, being the top, and peer pressure to not use condoms.

Alcohol and drug use also contribute to risky sexual behavior, which increase the likelihood of HIV infection (Hart & Elford, 2010, Koblin et al., 2006). The link between drug use and risky sexual behavior was confirmed in this study as researchers found a statistically significant relationship between higher scores on the Alcohol Use Disorders Identification Test and the frequency of engaging in risky sexual behaviors. The recreational use of drugs also was related to the frequency of engaging in risky behaviors.
In this study men reported using drugs for a wide variety of reasons. Most frequently men reported using drugs as a coping mechanism for depression, as a form of recreating, an expected part of nightlife and socialization, a way to enhance the sexual experience, a way to relax, and an enabling factor which allows MSM to feel free to be themselves. Furthermore, the use of alcohol in particular was identified as a normal part of Montana culture and the MSM events that take place in bars; alcohol use is also a normal part of socialization on the reservation.

Using the Internet to find sexual partners also leads to a higher risk of infection (Benotsch, Kalichman, & Cage, 2001; CDC, 2007a; Danta et al., 2007; Horvath, Bowen, & Williams 2006; Jenness et al., 2010; Salyers Bull, McFarlane, & Rietmeijer, 2001). This higher risk occurs because online sexual partners are often anonymous. Well over half of the participants in the online survey reported using the Internet for this purpose. Finding sexual partners over the internet requires a level of trust regarding openness about one’s HIV status, presence of other sexually transmitted infections (STI), and overall personal safety. When men were asked why they chose to find sexual partners in this way many referred to the social isolation that is prevalent among MSM in Montana, the desperate need for physical contact and the ease of finding a partner via the internet. Men on the down low confirmed in their interviews a preference for anonymous sexual partners in order to keep their sexuality hidden.

Hiding one’s sexuality is another factor contributing to the spread of HIV (Mancoske, 1998; Preston, D’Augelli, Kassab, & Starks 2007). In this study, individuals who came
out to their parents at later ages were identified as having more problems related to alcohol and drug use. These same individuals reported riskier sexual behaviors – particularly if they came out to their fathers at a later age. Foster and Frazier (2008) found that fear of rejection, discrimination, violence and ostracism were reasons that men remain closeted. The present study found similar reasons for keeping one sexual orientation hidden. Men reported hiding their sexuality for fear of job loss, and fear of rejection from family and friends, in addition to being married and feeling like their sexuality is wrong. This fear contributes to the spread of HIV because it can inhibit men from getting tested for HIV (CDC, 2005). The reluctance to be tested was also confirmed through this assessment as some men reported the fear they will be outed by seeking an HIV test.

Aspects of the Environment that Increase Risk of HIV Infection

There are many aspects of living in a geographically, sparsely populated state like Montana that appear to contribute to the likelihood of HIV infection among MSM. MSM living in rural communities face challenges such as conservative values regarding sexual behavior, social hostility including homophobia and antigay violence, and isolation and loneliness (Simon Rosser & Horvath, 2007; Williams, Bowen, & Horvath, 2005). Furthermore, rural communities also have increased concerns regarding anonymity and confidentiality, stigma, and the traditions and cultures within the community (Heckman & Carlson, 2007; Mancoske, 1998; Preston et al., 2007; Shernoff, 1997; Ullrich, Lutgendorf, & Stapleton, 2002; Uphold, Rane, Reid, & Tomar, 2005). Rural areas often lack the visible, viable LGB communities that thrive in urban settings. The combination
of these rural characteristics can promote fear and intolerance, resulting in depression, stress, lack of social supports, and poor coping mechanisms (Uphold et al., 2005). Geographic and social isolation were mentioned by many participants in this study. Geographic isolation appears to increase risk for HIV as rural communities lack educational resources and opportunities; this is compounded by the conservative values in those communities which prevent outreach opportunities as MSM are not willing to provide outreach or education because of the fear of anti-gay violence and risk to their personal safety.

It was also reported in the needs assessment that hostility towards MSM encourages increased anonymous sex as it prevents men from being open about their sexuality. Social opportunities in rural communities often revolve around the use of alcohol in bars, contributing back to risky sexual behavior. Limited or no LGB communities lead to social isolation, contributing to the use of the Internet to seek sexual partners. Moreover, both geographic and social isolation lead to MSM to travel further distances to meet with other MSM; the majority (94.2%) of survey respondents reported driving miles or less to meet someone. This isolation also encourages men to engage in sexual activity when and where the opportunity presents itself, regardless of attraction or risk. Rural communities also have issues with HIV medical services such as confidentiality concerns, and experience with HIV treatment. Inadequate medical services in rural areas cause individuals seeking care to travel to other communities (Cohn et al., 2001; Mancoske, 1998; McKinney, 2002; Preston et al., 2002). Individuals in this assessment reported
issues related to confidentiality with their local health department and also reported it was necessary to travel to larger communities for HIV treatment.

Factors Influencing HIV Risk Behaviors

Review of the available literature has identified a number of factors that contribute to unsafe sexual practices among MSM. These include depression and mental health issues, HIV testing issues, beliefs and attitudes about HIV and HIV medications, availability of social support, communication and negotiation skills, and age. In this assessment, lack of comprehensive sex education also emerged as an important factor influencing risky sexual behavior.

Depression, poor mental health, and low self-esteem all contribute to overall health and wellbeing and influence risky behaviors in MSM. (Newcomb & Mustanski, 2009; Safren et al., 2010.) Ullrich, Lutgendorf, and Stapleton (2002) found higher rates of depression in MSM than in the heterosexual population. The concept that MSM suffer from depression were confirmed in this assessment as almost 30% of survey respondents had scores on the Center for Epidemiological Studies Depression Scale (CES-D) of 21 or higher, suggesting some depression and mental health issues existed in this population. A significant association between risky sexual behavior and the CES-D score was also found; specifically, the higher the CES-D score, the greater the frequency of risky sexual behavior. Moreover, there was also an association between how accepting one’s father was when he came out and the total score on the CES-D. This indicated that the more accepting one’s father was when he came out, the lower the score on the CES-D.
Depression and mental health were discussed by men on the down low, who reported suicidal ideation, attempts at suicide, anxiety, nausea, panic attacks, paranoia, stress, and nervousness. Concurrently, focus group participants and key informants reported that MSM with positive self-esteem were more likely to protect and take care of themselves, and take fewer risks.

One way that men can take care of themselves is to get tested for HIV. The importance of being tested for HIV is twofold. Knowing whether or not one is infected can reduce risky sexual behavior (CDC, 2007a; CDC, 2009b; Jaffe, Valdiserri, & De Cock, 2007). In addition, knowing the HIV status of one’s sexual partner is also important to reduce the spread of HIV (Jaffe et al., 2007). Of the 134 individuals included in the survey, the majority were HIV negative, while 12% were HIV positive and 10% did not know their HIV status. Additionally, only 64% of survey respondents who are HIV positive reported always disclosing their HIV status while the remaining 36% disclosed most of the time or sometimes.

Several factors influence whether or not survey respondents were likely to get tested. One important factor related to the how comfortable men felt getting an HIV test. The majority of MSM reported feeling most comfortable being tested for HIV and counseled by other gay men and were least comfortable being tested in a doctor’s office. There were a number of issues related to HIV testing that were discussed in the qualitative analysis. There was a perception that HIV testing involves invasive techniques, with long wait time for results. Confidentiality and anonymity were major concerns related to getting
tested. Some individuals noted the gossip that comes from testers who were perceived to feel a responsibility to tell others when one has tested positive for HIV. Moreover, it was expressed that going to a testing site that might out or stigmatize someone discourages men from getting an HIV test. Other reasons MSM did not want to be tested included the fear of finding out the results and denial that one has been infected. Some MSM also had an attitude of “ignorance is bliss”; older MSM also had an attitude that there is no need for them to be tested which could be related to a number of attitudes about HIV in general.

Danta et al. (2007) found an association between those who engage in high-risk sexual behavior and their belief that HIV medications reduce concern and susceptibility to HIV. Jaffe et al. (2007) also found the existence of an attitude that HIV medications have reduced the severity of HIV. A number of beliefs and attitudes about HIV and HIV medications were also identified in the assessment. One belief was that HIV is not present in Montana communities or reservations but only in big cities or more populated states. Another attitude was that HIV is no longer a death sentence and therefore is inconsequential because of the effectiveness of HIV medications. An additional attitude was that particular MSM are not at risk for HIV such as Native MSM or MSM in rural communities of Montana. One final attitude regarding susceptibility to HIV was simply one of denial; that bad things happen to other people. The belief that HIV medications may also decrease the risk of transmission to others, though there was a lot of confusion around this, was highlighted both in the qualitative and quantitative assessment. MSM in the focus groups reported not knowing whether or not to believe HIV medications can
decrease the risk of infection. This is also true for survey respondents; of those who were HIV positive, 54% believed that HIV medications help decrease the chance of transmitting the disease while 46% did not. Additionally, the cost of HIV medications both financially and physically were things often not considered or were misconstrued based on humanitarian programs advertising a minimal cost to provide HIV medications to developing countries.

The availability of social support, both from family and friends in the LGB community, is important in decreasing risky sexual behavior. Social support within the LGB community has been found to decrease psychological distress and the sense of loneliness and isolation (Cody & Welch, 1997; Herek & Garnets, 2007). Individuals in the assessment identified positive family relationships and influential friends who hold each other accountable as necessary in the reduction and absence of risky sexual behaviors. The presence of other MSM also encouraged men to develop friendships and seek recreational opportunities that did not involve risky behavior. However, contrary to this, it was also reported that individuals susceptible to peer pressure, whose social supports included individuals engaging in risky behaviors, were more likely to engage in the same or similar behaviors.

Koblin et al. (2006) found that reduced communication skills regarding safer sex were significantly associated with high-risk sexual behaviors. Jaffe et al. (2007) also found communication skills to be important in their role to reduce risk. In the qualitative assessment, it was noted that communication and negotiation skills often are taught with
the end users in mind being a man and a woman, which can make it difficult for two MSM to feel comfortable and confident in their ability to use these skills. Most men on the down low reported that they do address condom use with their partners, though some do more often than others and some not at all.

Recent epidemiological data from the Montana Department of Public Health and Human Services (DPHHS, personal communication, November 2010) showed that the majority of MSM were between the ages of 20 and 39 at their time of HIV diagnosis. The risk for younger MSM was supported by the qualitative assessment. It was observed that younger MSM did not have the experience, education or concern about HIV infections that older MSM had. They also were not involved or aware of an MSM identified community and could be socially isolated from others. There also was a perceived effect on younger MSM by older MSM as those who are more experienced and may not want to use a condom influenced some younger MSM.

Finally, not identified in the review of literature but in the assessment is the lack of inclusive and comprehensive sex education. Because abstinence only sex education is based on abstaining from sexual behavior until marriage, it is heterosexist at its core due to the fact that same sex marriage is neither legal nor recognized in the state of Montana. As such, some MSM disregard abstinence only sex education because marriage is not an option for them. In addition, sex education is heterosexist in that it does not provide information for same sex sexual partnering or even acknowledge the existence of homosexual relationships.
Protective Factors

Family and peer support are important for positive self-esteem and mental health (Cody & Welch, 1997; Shernoff, 1997). This support was also found to be important for MSM in Montana as key informants and focus group participants noted their influence on MSM in terms of relationships, protecting oneself, and decreasing risks. Moreover, Herek and Garnets (2007) identify internalized homophobia as a factor that also impacts self-esteem and mental health of MSM. The current assessment also identified positive self-image and mental health as protective factors for the risk of HIV. Related to this positive self-esteem is pride in one’s culture and traditions as an American Indian, particularly as a two-spirit person. The current study identified this pride as a protective factor which discourages risky behavior.

HIV Prevention Needs

A number of needs were identified by MSM and key informants in the qualitative assessment. These needs are discussed below and include resources, outreach efforts, health-related interventions, social changes, cultural changes and policy changes. Incorporating these factors will help to address the HIV prevention needs of MSM in Montana.

A number of resources targeting MSM were identified as needed in the state. More LGB community centers could provide more education and outreach, and also serve to put a face on the LGB community. The importance of a visible MSM community was already discussed; by having more community centers around the state, they could support the
community, normalize MSM, and serve as a positive social support for younger MSM and others just coming out. There is also a need for community centers on reservations around the state that can support Native MSM.

It was also important that existing resources serving MSM be inclusive to men who are drug and alcohol users, who are also in need of support services. As discussed above, individuals who use and abuse alcohol and drugs are more likely to engage in risky sexual behavior. Therefore, resources targeting those most at risk need to incorporate outreach and support services to drug and alcohol users.

A number of outreach efforts were also identified as needs. The need to publicize the risk of HIV and HIV statistics statewide and on a community level were important in encouraging people to practice safe sex and to counter the belief that HIV is not present in Montana. This outreach effort also needs to be balanced in a way that it does not stigmatize those who are HIV positive. Outreach efforts need to catch the attention of MSM who often disregard the generalized messaging of HIV prevention and should address the various misperceptions and attitudes that are specific to Montana.

Focus group participants and key informants identified a number of health interventions that are needed. Anonymous HIV testing, comprehensive and inclusive sex education, increased numbers of support groups, discussion groups, and awareness events, and providing general health outreach and services to MSM instead of solely HIV-specific resources and information were identified as important health-related interventions
needed. The prevalence of men on the down low on the reservation also requires an added need to educate both men and women on the risks associated with HIV.

Cultural changes were also identified as needed to improve HIV prevention among MSM. Cultural competency for individuals working with the public and the need for more heterosexual individuals to speak out in support of the LGB community were important for the broader culture in Montana. Specific to the MSM community, a needed cultural change includes putting an end to the drama and hate that discourages individuals from socializing with one another. Finally, a cultural change specific to the American Indian community is greater acceptance of two-spirit people.

There were a number of social changes that were identified by focus group participants and key informants. Greater involvement in the broader community and MSM community and more opportunities for social gatherings are needed. Social gatherings and recreational opportunities which do not involve alcohol were needs, both on and off reservations. Greater political influence of MSM such as lobbying efforts on behalf of MSM and strategic political campaigns to elect MSM-friendly legislators were identified as needs. A final social change needed is for businesses that have a role in facilitating risky behavior to become a part of the solution of decreasing HIV infection rates; bars and adult bookstores were both identified as such businesses.

Numerous policy changes were identified. On the reservation, there is also a need for tribal leaders to acknowledge and accept the presence of HIV. In addition, there is a need
for HIV education from the tribe. Policies which affect and include American Indians need to be culturally sensitive and more easily understood in their intentions. Comprehensive sex education was identified often as a need. Equal rights for LGB individuals in the form of civil unions, gay marriage, partner benefits, and anti-discrimination ordinances are all policy changes needed in Montana, as was the need for anti-bullying policies in schools. Health-related policies are also needed such as needle exchange programs, a question about sexual orientation on the Behavioral Risk Factor Surveillance System (BRFSS), mandatory STI testing for individuals getting married, and a policy against stores locking up condoms. Increased funding for HIV education, testing, and treatment are also needed.

**Limitations**

A number of limitations exist in this research as were highlighted in Chapter One. Specifically, the information collected in the assessment was limited and specific to the experiences of the individuals who participated in the focus groups, interviews, and survey. It is also limited to their truthfulness and willingness to share. Many of the participants in the assessment did not come from less populated areas of the state and were recruited through organizations and key informants. As such, many of the views do not represent those MSM who are truly isolated. While attempts were made to include more individuals from reservations around the state, the one reservation that was included can only represent the experiences of that reservation. The data was also limited by the various interviewers’ abilities and biases; additionally, key informants who conducted the focus groups did not receive training prior to conducting the focus group and may have
been limited in their understanding of the research questions. Finally, because the recording from one of the focus groups was distorted, a complete and accurate understanding of that focus group was not available.

Conclusion

Many of the behaviors that put MSM at risk for HIV infection appear to be influenced, to a great extent, by the conservative, anti-gay attitudes of many communities in Montana. Anti-gay attitudes and the resulting stigma related to being a sexual minority is ever present among MSM in Montana as they go to some lengths to avoid being outed, including anonymous sexual partners and avoidance of HIV testing. Stigma also creates fear of rejection, job loss, and physical violence. Moreover, the health of MSM suffers from stigma through the development of depression and decreased self-esteem. The use of drugs and alcohol to cope with poor mental health can also play a role in risky behaviors. Heteronormativity, present in Montana law and sex education curriculum, does a disservice to MSM in Montana. The current sex education available in the state does not address the needs of gay, bisexual, transgender, or questioning youth. As such, the underlying stigma, discrimination, and heteronormativity present in Montana are contributors to the spread of HIV among MSM. In addition to the conservative climate in Montana, attitudes regarding condom use and HIV testing and beliefs about HIV and HIV medications also contribute to the spread of HIV.

In order to reduce the risk of HIV infection among MSM in Montana prevention efforts need to occur on multiple levels. Individual level interventions must be targeted toward
educating young MSM regarding communication and negotiation of condom use and HIV status, and the risk of HIV in Montana. More challenging, however, are interventions that target HIV prevention on a community level. Community level interventions that came to light in this study include strategies focused on cultural competency, increased opportunities for socialization and recreation that do not encourage alcohol or drug use, social marketing addressing attitudes and beliefs, and health-related services that are broad in scope or not otherwise MSM-identifiers. And finally, HIV prevention must include interventions that affect policy and legislation. Without social and policy changes such as greater political influence from the LGB community, equal rights for LGB individuals, increased funding for HIV prevention, education, and treatment, and comprehensive sex education, it will be difficult to have a great impact on the spread of HIV in Montana.

In this study, MSM have characterized Montana as a rural, sparsely populated and socially conservative state. HIV prevention specialists must take into consideration the unique social and geographic nature of Montana when developing a comprehensive plan to reduce the number of MSM who become infected with HIV.


APPENDIX A:

Key Informant Interview Questions
Key Informant Interview Questions

The key informant interview questions ask about the HIV prevention needs of men who have sex with men. They are meant to collect information about behavioral and environmental factors that contribute to the spread of HIV/AIDS. They also seek information about what influences someone to engage in or not engage in risky behavior. Finally, the questions will gather information about available resources and things that prevent someone from accessing those resources.

Behavioral and Environmental Diagnosis

- What are some behaviors you can think of that contribute to the spread of HIV among MSM?

- What social and/or environmental factors do you think play a role in the spread of HIV among MSM? Social factors are things like the community culture, religion, and economic status. Environmental factors are things like isolation and population size.

Educational and Organizational Diagnosis

- What are factors that enable or influence MSM to engage in risky behaviors?
  - What personal characteristics might influence men to engage in risky behavior (age, personal values, etc.)?
  - What resources or skills do they lack?
  - What about their social relationships – family, friends, co-workers – might reinforce risky behavior?

- What are factors that enable or influence MSM not to engage in risky behaviors?
  - What personal characteristics might influence men not to engage in risky behavior (age, personal values, etc.)?
  - What resources or skills do they have?
  - What about their social relationships – family, friends, co-workers – might deter risky behavior?

Administrative and Policy Diagnosis

- What resources exist that are targeted to MSM?

- What health-related interventions are needed for MSM to be able to prevent HIV?

- What policy changes are needed to meet the HIV prevention needs of MSM?

- What social or cultural changes are needed to meet the HIV prevention needs of MSM?
APPENDIX B:

Key Informant Interview Recruitment Script
Verbal Instructions for Recruiting Volunteers for the Interview

Provide each potential volunteer with an explanation of the interview; and a brief explanation of the procedures for the interview.

Purpose: The purpose of this study is to collect information about the HIV prevention needs of Men Who have Sex with Men (MSM) living in Montana. The interview is designed to help gather information for this study to further develop and potentially improve the effectiveness of HIV prevention interventions offered in Montana.

Please remind them:

- The study is completely voluntary and confidential and they may choose not to answer any of the questions posed at the interview.

- If they volunteer they will be asked to meet with the researcher who will ask them questions about HIV prevention needs.

- The interview will be audio recorded, but no identifying information will be transcribed from the interview and the tapes will be erased at a later date.

- By participating they are helping fight the spread of HIV in Montana. The information gathered by the interview will be used to improve HIV prevention programs for men who have sex with men in Montana.

If individuals are willing to participate, give them a copy of the interview questions, the researchers’ contact information, and ask them if it is okay for the researcher to contact them to set up a time and place for the interview.

Allow a few minutes for potential participants to ask any question or talk it over.

- Ask them to fill out a card with contact information if they think they are interested and turn them back in to you.
APPENDIX C:

Key Informant Interview Consent Form
KEY INFORMANT INTERVIEW PARTICIPANT CONSENT FORM

TITLE
An Assessment of the HIV Prevention Needs of Men who have Sex with Men

SPONSOR
The Montana Department of Public Health and Human Services – HIV/STD Section

PROJECT DIRECTOR:
Dr. Annie Sondag
The University of Montana
Department of Health & Human Performance
Missoula, MT 59812
(406) 243-5215
annie.sondag@mso.umt.edu

SPECIAL INSTRUCTIONS
The language in this consent form may be new to you. If you read any words that are not clear to you, please ask the person who gave you this form to explain them to you.

PURPOSE
The purpose of this research study is to find out the HIV prevention needs of men who have sex with men. By participating in this interview you will help provide valuable information that will be used to develop better HIV prevention services for men in Montana who have sex with men.

PROCEDURES
Interview participation for this study is voluntary. You are asked to read this consent form. If you agree to participate you will be asked to answer a number of questions covering various topics concerning men in Montana who have sex with men. The interview will take approximately one hour. The session will be audio recorded and transcribed for accuracy of responses.

RISKS/DISCOMFORTS
You may find some of the questions personal, you may feel you do not know the answer, or some of the questions may make you feel uncomfortable. You are welcome to refrain from answering any question for any reason or to discontinue your participation at any time.

BENEFITS
Your help with this study will provide valuable information to the Montana Department of Public Health and Human Services. By participating in this study, your answers will help staff offer services and develop programs to meet the HIV prevention needs of men in Montana who have sex with men.
CONFIDENTIALLY
All information collected during your interview will be confidential. Interviewers will avoid identifying any of the participants. Interviewers will not use your name or any other identifying information in reports or any other materials related to this study. Specifically:
- The identities of all interview participants will remain confidential and will not be associated with research findings in any way.
- At the conclusion of the study, any and all data containing information about participants will be destroyed.
- All the data collected during this study will be reported and examined as group data.

COMPENSATION FOR INJURY
The project team believes the risk of taking part in this study is minimal. However, the following liability statement is required in all University of Montana consent forms:

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

VOLUNTEER PARTICPATION/WITHDRAWAL
Your decision to take part in this research study is entirely voluntary. You are free NOT to answer any question and to discontinue participation at any time. You also may withdraw from this study for any reason.

QUESTIONS
If you have any questions about the research now or later, you may contact Dr. Annie Sondag at (406) 243-5215 or Kelly Hart at (406) 243-4211.

If you have any questions about your rights as a research subject you may contact the Chair of the Institutional Review Board in the Research Office at The University of Montana – Phone (406) 243-6670.

CONSENT
I have read the above description of this project. I have been informed of the risks and benefits involved, and all of my questions have been answered to my satisfaction. Furthermore, I have been assured that any future questions I may have will be answered by a member of the project team. I voluntarily agree to take part in this study. I am at least 18 years old. I understand this is my copy of this consent to keep.
APPENDIX D:

Interview Contact Summary Sheet
# Interview Contact Summary Sheet

<table>
<thead>
<tr>
<th>Interview Date:________________</th>
<th>Interview Length: ________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interview No.: ________________</td>
<td>Interview Location: _______________</td>
</tr>
</tbody>
</table>

1. Physical description/impressions:

2. Main themes and issues:

3. Research question most directly addressed:

4. New working hypothesis or speculations:

5. Problems or questions:

6. Direction of information needed for next interview:
APPENDIX E:

Focus Group Interview Questions
Focus Group Questions

The focus group questions ask about the HIV prevention needs of men who have sex with men. They are meant to collect information about behavioral and environmental factors that contribute to the spread of HIV/AIDS. They also seek information about what influences someone to engage in or not engage in risky behavior. Finally, the questions will gather information about available resources and things that prevent someone from accessing those resources.

Behavioral and Environmental Diagnosis

- What are some behaviors you can think of that contribute to the spread of HIV among MSM?

- What social and/or environmental factors do you think play a role in the spread of HIV among MSM? Social factors are things like the community culture, religion, and economic status. Environmental factors are things like isolation and population size.

Educational and Organizational Diagnosis

- What are factors that enable or influence MSM to engage in risky behaviors?
  - What personal characteristics might influence men to engage in risky behavior (age, personal values, etc.)?
  - What resources or skills do they lack?
  - What about their social relationships – family, friends, co-workers – might reinforce risky behavior?

- What are factors that enable or influence MSM not to engage in risky behaviors?
  - What personal characteristics might influence men not to engage in risky behavior (age, personal values, etc.)?
  - What resources or skills do they have?
  - What about their social relationships – family, friends, co-workers – might deter risky behavior?

Administrative and Policy Diagnosis

- What resources exist that are targeted to MSM?

- What health-related interventions are needed for MSM to be able to prevent HIV?

- What policy changes are needed to meet the HIV prevention needs of MSM?

- What social or cultural changes are needed to meet the HIV prevention needs of MSM?
APPENDIX F:

Focus Group Recruitment Script
Verbal Instructions for Recruiting Volunteers for the Focus Group

Provide each potential volunteer with an explanation of the focus group; and a brief explanation of the procedures for the focus group.

Purpose: The purpose of this study is to collect information about the HIV prevention needs of Men Who have Sex with Men (MSM) living in Montana. The focus group is designed to help gather information for this study to further develop and potentially improve the effectiveness of HIV prevention interventions offered in Montana.

Please remind them:

- The study is completely voluntary and confidential and they may choose not to answer any of the questions posed at the focus group.

- If they volunteer, they will be asked to attend a focus group. They will receive $25 for participation that they are free to keep should they decide to leave the focus group early.

- The focus group will be audio recorded, but no identifying information will be transcribed from the focus group and the tapes will be erased at a later date.

- By participating they are helping fight the spread of HIV/STDs in Montana. The information gathered by the focus group will be used to improve HIV prevention programs for men who have sex with men in Montana.

If individuals are willing to participate, give them a copy of the focus group questions, the researchers’ contact information, and information about the time and place the focus group will occur.

- Allow a few minutes for potential participants to ask any question or talk it over.

- Remind the potential participants that if they have any questions they can contact the researchers.
APPENDIX G:

Focus Group Consent Form
FOCUS GROUP PARTICIPANT INFORMED CONSENT

TITLE
An Assessment of the HIV Prevention Needs of Men who have Sex with Men

SPONSOR
The Montana Department of Public Health and Human Services – HIV/STD Section

PROJECT DIRECTOR:
Dr. Annie Sondag
The University of Montana
Department of Health & Human Performance
Missoula, MT 59812
(406) 243-5215
annie.sondag@mso.umt.edu

SPECIAL INSTRUCTIONS
The language in this consent form may be new to you. If you read any words that are not clear to you, please ask the person who gave you this form to explain them to you.

PURPOSE
The purpose of this research study is to find out the HIV prevention needs of men who have sex with men. Ultimately, this information will be used to develop programs to prevent the spread of HIV.

PROCEDURES
Participation in this focus group is voluntary. You are asked to read this consent form. If you agree to participate you will be asked a number of questions regarding your perceptions of the needs of men living in Montana who have sex with other men. The focus group interview may take approximately one hour. The session will be audio recorded and transcribed for accuracy of responses.

PAYMENT FOR PARTICIPATION
You will receive $25.00 cash for participating in this focus group.

RISKS/DISCOMFORTS
You may find some of the questions personal, you may feel you do not know the answer, or some of the questions may make you feel uncomfortable. You are welcome to refrain from answering any question for any reason or to discontinue your participation at any time. Contact information for organizations where you can receive confidential answers to your questions or receive more information and/or support are listed at the end of this consent form.
BENEFITS
Your help with this study will provide valuable information to the Montana Department of Public Health and Human Services. By participating in this study, your answers will help staff offer services and develop programs to meet the HIV prevention needs of men in Montana who have sex with men.

CONFIDENTIALITY
All information collected during this focus group interview will be confidential. Researchers and interviewers will avoid recording any identifying information. They will not use your name or any other identifying information in reports or any other materials related to this study. Specifically:
  o The identities of all interview participants will remain confidential and will not be associated with research findings in any way.
  o Audio tapes will be destroyed as soon as they are transcribed.
  o No information related to participants’ identities will appear in the transcription of the audiotapes.
  o All the data collected during this study will be reported and examined as group data.

COMPENSATION FOR INJURY
The project team believes the risk of taking part in this study is minimal. However, the following liability statement is required in all University of Montana consent forms:
  In the event that you are injured as a result of this research you should individually seek appropriate medical treatment. If the injury is caused by the negligence of the University or any of its employees, you may be entitled to reimbursement by the department of Administration under the authority of MCA, Title 2, Chapter 9. In the event of a claim of such injury, further information may be obtained from the University’s claims Representative or University Legal Counsel.

VOLUNTEER PARTICIPATION/WITHDRAWAL
Your decision to take part in this research study is entirely voluntary. You are free NOT to answer any question and to discontinue participation at any time. You also may withdraw from this study for any reason without loss of the incentive money or any other benefits to which you are normally entitled.

QUESTIONS
If you have any questions about the research now or later, you may contact Dr. Annie Sondag at (406) 243-5215 or Annie’s Research Assistant, Kelly Hart at (406) 243-4211.

If you have any questions about your rights as a research subject you may contact the Chair of the Institutional Review Board in the Research Office at The University of Montana – Phone (406) 243-6670.

CONSENT
I have read the above description of this project. I have been informed of the risks and benefits involved, and all of my questions have been answered to my satisfaction. Furthermore, I have been assured that any future questions I may have will be answered by a member of the project team. I voluntarily agree to take part in this study. I am at least 18 years old. I understand this is my copy to keep of this consent form.
APPENDIX H:

Participant Demographic Info
Participant Demographic Info

Interview Date/Time: ________________________________

Interview Location: ________________________________

Participant ID: ________________________________

For use by researchers

Age: ______

Self-identified sexual orientation: ________________________________

HIV Status:
☐ Negative ☐ Unknown
☐ Positive ☐ Prefer not to answer

Geographical Location

County of Residence: ________________________________

Where do you currently live:

☐ Urban town

☐ Rural town (Population of less than 2,500 people)

Employment/Education

What is your highest level of education:

☐ Less than high school ☐ High school or GED

☐ Some college ☐ 2-Year College Degree (Associate’s)

☐ 4-Year College Degree (Bachelor’s) ☐ Master’s Degree

☐ Doctoral Degree ☐ Professional Degree (JD, MD)

How much do you earn a year:

☐ Less than $15,000

☐ Between $15,000 and $45,000

☐ Greater than $45,000
Appendix I

Outness Inventory
What is the Outness Inventory?
The Outness Inventory (OI) is an 11-item scale designed to assess the degree to which lesbian, gay, and bisexual (LGB) individuals are open about their sexual orientation. Responses on OI items indicate the degree to which the respondent’s sexual orientation is known by and openly discussed with various types of individuals (e.g., mother, work peers).

How can OI data be used?
Our analyses suggested that individuals can use the OI in three different ways. First, data from individual items can be used if the researcher is interested in outness to specific figures or types of figures (e.g., mother, work peers). Second, factor analyses indicated that the OI can be used to provide information about levels of outness in three different life domains: family, everyday life, and religion. Finally, analyses suggested that the OI can also be used to provide an index of overall outness.

How is the OI scored?

Out to Family = average of items 1, 2, 3, and 4
Out to World = average of items 5, 6, 7, and 10
Out to Religion = average of items 8 and 9
Overall Outness = average of the above three subscales

What should be done if participants do not respond to all items?
It is not unusual for participants to leave an item blank because the item is not applicable. For example, some individuals will not be able to provide a rating for “father” because their father died by the time they were aware of their sexual orientation. Similarly, nonreligious individuals will not be able to provide meaningful responses for the religion items. Such situations can be dealt with by simply taking the average of all available information. For example, if a respondent has no response for “father” but has responses for all other Out to Family items, then you can calculate an Out to Family score for this person by averaging the three other relevant items. To calculate person’s score for Overall Outness, you can simply calculate the average of all items for which ratings are available. Finally, it is worth noting that unanswered OI items could be handled with advanced methods developed for dealing with missing data, such as multiple imputation and full information maximum likelihood approaches (see Schafer & Graham, 2002 in Psychological Methods).

Can I add items?
Adding items (or even removing items) may be advisable depending on the population you are surveying. For example, if you know that your population includes many individuals from blended families, then you may want to include stepparent items. Decisions about which subscale such items should go into can be made using common sense (e.g., “stepmother” should probably go into Out to Family) or statistical analyses (e.g., factor analyses, examination of item-total correlations).

Can I change the rating scale?
The rating scale is, in part, what makes the OI a unique and sensitive measure of outness. We discourage users from making any substantive changes to the rating scale. With that said, we have received feedback suggesting that it might be worth changing the “RARELY” on rating point 5 to “NEVER or RARELY.”

**What are the psychometric properties of the OI?**

Data from a large sample of partnered LGB adults provided good initial support for the reliability and validity of the OI. Exploratory and confirmatory factor analyses (conducted separately for women and men) were used to derive the subscales. Before using the OI, we suggest that you read about the instrument development process in the following article:

**OUTNESS INVENTORY**

Use the following rating scale to indicate how open you are about your sexual orientation to the people listed below. Try to respond to all of the items, but leave items blank if they do not apply to you.

1 = person *definitely* does NOT know about your sexual orientation status  
2 = person *might* know about your sexual orientation status, but it is NEVER talked about  
3 = person *probably* knows about your sexual orientation status, but it is NEVER talked about  
4 = person *probably* knows about your sexual orientation status, but it is RARELY talked about  
5 = person *definitely* knows about your sexual orientation status, but it is RARELY talked about  
6 = person *definitely* knows about your sexual orientation status, and it is SOMETIMES talked about  
7 = person *definitely* knows about your sexual orientation status, and it is OPENLY talked about  

0 = not applicable to your situation; there is no such person or group of people in your life

| 1. mother       | 1 2 3 4 5 6 7 0 |
| 2. father       | 1 2 3 4 5 6 7 0 |
| 3. siblings     | 1 2 3 4 5 6 7 0 |
| 4. extended     | 1 2 3 4 5 6 7 0 |
| 5. new straight | 1 2 3 4 5 6 7 0 |
| 6. work peers   | 1 2 3 4 5 6 7 0 |
| 7. work supervisor | 1 2 3 4 5 6 7 0 |
| 8. members      | 1 2 3 4 5 6 7 0 |
| 9. leaders      | 1 2 3 4 5 6 7 0 |
| 10. strangers   | 1 2 3 4 5 6 7 0 |
| 11. old friends | 1 2 3 4 5 6 7 0 |
APPENDIX J:

Men’s Sexual Health Survey
MEN’S SEXUAL HEALTH SURVEY

1. How young are you? _______

2. What is your ethnicity?
☐ American Indian /Alaskan Native    ☐ Asian
☐ Black or African American        ☐ Hispanic or Latino
☐ Native Hawaiian or Pacific Islander ☐ Caucasian / Northern European
☐ Other ______________________

3. Gender:
☐ Male ☐ Female ☐ Transgender (M to F) ☐ Transgender (F to M)

4. What is your relationship status?
☐ Single
☐ In a committed monogamous relationship with a man
☐ In a non-monogamous, open relationship with a man
☐ Married to a woman and on the down low
☐ Married to a woman, but in non-monogamous, open relationship

5. What is the population of the city/town in which you live?
☐ 0 - 500    ☐ 500 - 1000    ☐ 1000 – 10,000    ☐ 10,000 – 50,000    ☐ 50,000+

6. What Montana county do you live in? ____(all counties listed)_______

7. How do YOU identify your sexual orientation?
☐ Gay/Homosexual    ☐ Bisexual    ☐ Straight/Heterosexual    ☐ Other _________

8. Use the scale below and please rate your level of attraction _________

1--------------2-------------3--------------4--------------5--------------6--------------7
Men Only    Both Men and Women Equally (4)    Women
Only

9. Using the scale below, in terms of my sexual orientation towards other adults, I identify myself as _________

1--------------2--------------3--------------4--------------5--------------6--------------7
Exclusively Homosexual    Bisexual (4)    Exclusively
Heterosexual

10. In your lifetime, your sexual partners have been primarily (mark all that apply):
☐ Male ☐ Female ☐ Trans (M to F) ☐ Trans (F to M)
11. In the past year, your sexual partners have been primarily (mark all that apply):

☐ Male    ☐ Female    ☐ Trans (M to F)    ☐ Trans (F to M)

For questions 12 – 18, use the following scale to indicate how open you are currently about your sexual orientation:

1 = Person(s) definitely does not know about your sexual orientation
2 = Person(s) might know about your sexual orientation, but it is never talked about
3 = Person(s) probably knows about your sexual orientation, but it is never talked about
4 = Person(s) probably knows about your sexual orientation, but is it rarely talked about
5 = Person(s) definitely knows about your sexual orientation, but it is rarely talked about
6 = Person(s) definitely knows about your sexual orientation, and it is sometimes talked about
7 = Person(s) definitely knows about your sexual orientation, and it is openly talked about
0 = Does Not Apply

12. Mother __________

13. Father __________

14. Siblings (brothers, sisters) __________

15. Past heterosexual friends __________

16. Current heterosexual friends __________

17. Co-workers __________

18. Members of your religious community __________

19. If out to your mother, how old were you when your mother learned about your sexual orientation? __________

20. If out to your father, how old were you when your father learned about your sexual orientation? __________

Using the scale below, please answer questions 21 - 36:

1-------------------2-------------------3-------------------4-------------------5-------------------6-------------------7

Not Accepting at all                             Very Accepting

0 = Does Not Apply

21. Rate how accepting your mother was when you came out __________

22. Rate how accepting your mother is currently (or last visit) __________
23. Rate how accepting your father was when you came out __________
24. Rate how accepting your father is currently (or last visit) __________

SEXUAL HISTORY

In the past year, have you had one or more sexual partner?  (YES or NO)

37. Approximately (best guess) how many sexual partners have you had in the past year?  (0,1,2,3,4,5,6,7,8,9,10,11-19,20-29,30-39,40-49, 50+)

38. Approximately (best guess) how many times do you have anal sex in a typical month? (0,1,2,3,4,5,6,7,8,9,10,11-19,20-29,30-39,40-49, 50+)

39. Approximately (best guess) how many times do you have unprotected anal sex in a typical month? (0,1,2,3,4,5,6,7,8,9,10,11-19,20-29,30-39,40-49, 50+)

40. When you do have anal sex, how often do you use condoms?
   - Always
   - Sometimes
   - Rarely
   - Never

41. How many times, in the past year, would you say that…
   - You have had unprotected anal sex as a bottom with a partner of unknown HIV status? (If you are having trouble, give us your best guess) ____(0,1,2,3,4,5,6,7,8,9,10,11-19,20-29,30-39,40-49, 50+)
   - You have had unprotected anal sex as a top with a partner of unknown HIV status? (If you are having trouble, give us your best guess) ____(0,1,2,3,4,5,6,7,8,9,10,11-19,20-29,30-39,40-49, 50+)
   - You have had unprotected anal sex as a bottom with an HIV positive partner? (If you are having trouble, give us your best guess) ____(0,1,2,3,4,5,6,7,8,9,10,11-19,20-29,30-39,40-49, 50+)
   - You have had unprotected anal sex as a top with an HIV positive partner? (If you are having trouble, give us your best guess) ____(0,1,2,3,4,5,6,7,8,9,10,11-19,20-29,30-39,40-49, 50+)
Have you ever had a period of time in your life where you engaged in unprotected anal sex (outside of a monogamous relationship)? YES or NO

42. Please think about the period of time in your life (e.g. coming out, stressful breakup, death of a loved one) where you engaged in the RISKIEST sexual activity.

When was the period of time (Month/Year)? __________

43. What was going on in your life at that time? ____________________________

44. During the period of time in your life where you engaged in the riskiest sexual activity, did you have unprotected anal sex where you were the top?
   □ Yes  □ No  □ N/A

45. If yes, did you have unprotected anal sex where you were the top with a partner whose HIV status you did not know?
   □ Yes  □ No  □ N/A

46. During that riskiest period of time, did you have unprotected anal sex where you were the top with anonymous/random/one-time sexual partners?
   □ Yes  □ No  □ N/A

47. During the period of time in your life where you engaged in the riskiest sexual activity, did you have unprotected anal sex where you were the bottom?
   □ Yes  □ No  □ N/A

48. If yes, did you have unprotected anal sex where you were the bottom with a partner whose HIV status you did not know?
   □ Yes  □ No  □ N/A

49. During that riskiest period of time, did you have unprotected anal sex where you were the bottom with anonymous/random/one-time sexual partners?
   □ Yes  □ No  □ N/A

*Testing and Barriers to Testing

50. How often do you typically get tested? (every three months, every six months, yearly, etc.)
   □ At least once every 3 - 6 months  □ At least once every year
   □ Every other year  □ Every few years
   □ Never been tested  □ N/A, I have tested positive
   □ Never been tested  □ Other __________________________
51. Approximately when was your last HIV test? (Month / Year) __________

Using the scale below, please rate how comfortable you would be getting tested for HIV…

1-----------------2-----------------3-----------------4-----------------5-----------------6-----------------7
Not comfortable at all  Very comfortable

52. By a gay man __________
53. By a straight man __________
54. By a gay woman __________
55. By a straight woman __________
56. At a Doctor’s office __________
57. At a Public Health Dept. __________
58. By a community based organization *(Yellowstone AIDS Project, Gay Men’s Task Force, Missoula AIDS Council, etc.)* __________

59. Using the scale below, rate how comfortable you are discussing certain aspects of your sex life with your health care provider __________

1-----------------2-----------------3-----------------4-----------------5-----------------6-----------------7
Very comfortable  Not comfortable at all

60. What is your HIV status?
☐ Positive  ☐ Negative  ☐ Don’t know

***If you are HIV-negative please skip to question 75***

61. When were you diagnosed (tested positive)? __( Month / Year )

62. Are you on an HIV regimen (medication)?  ☐ YES  ☐ NO

63. If you are on an HIV regimen (medication), do you believe they help decrease the chance of transmitting the virus?
☐ Yes  ☐ No  ☐ N/A

64. Have you had more or less sex since your diagnosis?
☐ More  ☐ Less  ☐ About the same
65. Do you disclose your HIV status before engaging in sexual activity with a new partner?
- Always
- Most of the time
- Sometimes
- Never

66. If you disclose your status, when do you do it?
- The first time I meet someone
- When I feel the person wants to be more than friends
- Before kissing
- Before oral sex
- Before anal sex (top, bottom or both – circle one)
- After anal sex (top, bottom or both – circle one)
- N/A

67. Would you rather have sex with someone who is:
- HIV positive
- HIV negative
- Either is fine
- I prefer not to know my partner’s status

68. How often have you been rejected by potential sexual partners because of your status?
- Often
- Sometimes
- Rarely
- Never

69. Since testing positive, have you ever had unprotected anal sex with an HIV-negative (or unknown status) person?
- Yes
- No

70. When you have had unprotected anal sex with a partner of negative or unknown HIV status, were you primarily the top, bottom, or both during sex?
- Top
- Bottom
- Both top and bottom

71. When was the last time you have had unprotected anal sex with a partner of negative or unknown HIV status,? ___( Month / Year ) Approximately

72. How many times have you have had unprotected anal sex with a partner of negative or unknown HIV status in the last year?
- 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12
- 10-19
- 20-29
- 30-39
- 40-49
- 50+

73. Did you disclose your status?
- Yes
- Yes – But I think they already knew my status
- No – They already knew
- No – They don’t know

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74. What are some of the reasons you had unprotected anal sex with a partner of negative or unknown HIV status, since your diagnosis? (Check all that apply)

☐ I wanted the physical sensation  
☐ I was under the influence of drugs or alcohol  
☐ He knew I was positive and he said it was okay  
☐ I thought the risk of transmitting HIV was low  
☐ We only had oral sex or mutual JO  
☐ He said he was HIV positive  
☐ He was very hot  
☐ Other _________________________________

***If you are HIV-positive please skip to question 80***

75. If HIV negative, have you ever had unprotected anal sex with an HIV-positive person?

☐ Yes  
☐ No

76. When was the last time you had unprotected sex with an HIV-positive person? (Month/Year)

77. When this occurred, what role did you play?

☐ Top  ☐ Bottom  ☐ Both top and bottom

78. Did you disclose your status?

☐ Yes  
☐ No

79. When you had unprotected anal sex with an HIV-positive person, what were some of the reasons? (Check all that apply)

☐ I wanted the physical sensation  
☐ I did not even think about the possibility of HIV infection at the time  
☐ I was under the influence of drugs or alcohol  
☐ He knew I was negative and he said it was okay  
☐ I didn’t care about possible infection because HIV is treatable  
☐ I was feeling depressed and didn’t care what happened to me  
☐ I wanted to get infected so that I wouldn’t have to worry about it anymore  
☐ He didn’t cum inside of me  
☐ I was the top during anal sex  
☐ I thought the risk of transmitting HIV was low  
☐ We only had oral sex or mutual JO  
☐ He was very hot  
☐ Other _________________________________
80. Have you ever been diagnosed with a sexually transmitted disease (STD)?
☐ Yes  ☐ No

81. If yes, which one? (Check all that apply)
☐ Gonorrhea  ☐ Chlamydia  ☐ Syphilis  ☐ Herpes
☐ HPV (genital warts)  ☐ Hepatitis  ☐ Other _______________

How did you contract the STD(s)? (Check all that apply)
☐ Unprotected anal sex  ☐ Unprotected oral sex
☐ Mutual masturbation  ☐ Other (please specify) ___________

82. Have you contracted a STD from a:
☐ Man  ☐ Woman  ☐ Transgender person  ☐ I don’t know

83. Have you talked about your sexual behaviors that led to your STD infection(s) with your healthcare provider?
☐ Yes  ☐ No

84. Have you ever had a cigarette in your lifetime?
☐ Yes  ☐ No
***If you never smoked a cigarette please skip to question 91***

85. Do you smoke cigarettes currently?
☐ Never
☐ Sometimes (a few times a month)
☐ Often (a few times a week)
☐ Daily

***If you don’t currently smoke, please skip to question 91***

86. Do you consider yourself a social smoker (with friends, in a bar, when drinking, etc.)?
☐ Yes  ☐ No

87. How many cigarettes do you smoke on an average week?
☐ 1 - 3  ☐ 1 – 2 packs  ☐ 15+ packs
☐ 4 - 6  ☐ 2 – 5 packs  ☐ Other __________
☐ 7 - 10  ☐ 5 – 10 packs
☐ 11 - 20  ☐ 10 – 15 packs
88. If yes, why do you smoke? (Check all that apply)
☐ Nicotine addiction
☐ To unwind
☐ To be social
☐ To reward myself
☐ To overcome feelings of depression
☐ Other ______________________

89. Have you ever tried to quit?
☐ Yes ☐ No

If Yes, how many times have you tried to quit smoking cigarettes?
(1, 2 – 3, 3 – 5, 5 – 7, 7 – 10, 10+, Other _________ )

90. What methods have you used to try to quit?
______________________________________________________________________________
______________________________________________________________________________

91. How often do you have a drink containing alcohol?
☐ Never
☐ Monthly or less
☐ 2 to 4 times a month
☐ 2 to 3 times a week
☐ 4 or more times a week

***If you never drink, please skip to question 100***

92. How many drinks containing alcohol do you have on a typical day when you are drinking?
☐ 1 or 2
☐ 3 or 4
☐ 5 or 6
☐ 7 to 9
☐ 10 or more

93. How often do you have five or more drinks on one occasion?
☐ Never
☐ Less than monthly
☐ Monthly
☐ Weekly
☐ Daily or almost daily
94. How often during the last year have you found that you were not able to stop drinking once you had started?
☐ Never
☐ Less than monthly
☐ Monthly
☐ Weekly
☐ Daily or almost daily

95. How often during the last year have you failed to do what was normally expected from you because of drinking?
☐ Never
☐ Less than monthly
☐ Monthly
☐ Weekly
☐ Daily or almost daily

96. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?
☐ Never
☐ Less than monthly
☐ Monthly
☐ Weekly
☐ Daily or almost daily

97. How often during the last year have you had a feeling of guilt or remorse after drinking?
☐ Never
☐ Less than monthly
☐ Monthly
☐ Weekly
☐ Daily or almost daily

98. How often during the last year have you been unable to remember what happened the night before because of your drinking?
☐ Never
☐ Less than monthly
☐ Monthly
☐ Weekly
☐ Daily or almost daily

99. Have you or someone else been injured because of your drinking?
☐ Never
☐ Less than monthly
☐ Monthly
☐ Weekly
☐ Daily or almost daily
100. Has a relative, friend, doctor, or other healthcare worker been concerned about your drinking or suggested you cut down?

☐ Never
☐ Less than monthly
☐ Monthly
☐ Weekly
☐ Daily or almost daily

Have you ever used recreational drugs (for example: marijuana, cocaine, crystal meth, poppers, ecstasy, etc.)?   YES or NO

In the past year, have you ever used recreational drugs (for example: marijuana, cocaine, crystal meth, poppers, ecstasy, etc.)?   YES or NO

100. Tell us which recreational drugs you have used in the past year (Check all that apply)

☐ Cocaine?  How many times in the past year? __________  How did you take it?

☐ Marijuana?  How many times in the past year? __________  How did you take it?

☐ Crystal Meth?  How many times in the past year? __________  How did you take it?

☐ Ecstasy?  How many times in the past year? __________  How did you take it?

☐ Poppers?  How many times in the past year? __________  How did you take it?

☐ Mushrooms?  How many times in the past year? __________  How did you take it?

☐ Acid?  How many times in the past year? __________  How did you take it?

☐ Prescription pain medication (not prescribed to you)?  How many times in the past year? __________  How did you take it?

☐ Prescription stimulants (not prescribed to you)?  How many times in the past year? __________  How did you take it?

☐ Other __________  How did you take it? __________

* Choices for how many times are:
1
2 – 3
4 – 6
7 – 10
11 – 20
21 – 40
41 – 80
81 – 100
100+

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What other recreational drugs have you used and how did you take them?

______________________________________________________________________________
______________________________________________________________________________

101. Have you ever used the Internet to meet guys for sex?

☐ Yes
☐ No

***If you answered No to meeting guys for sex online, skip to question 112***

102. If yes, what websites did you use to meet men? (Check all that apply)

☐ Gay.com
☐ Craigslist.org
☐ Manhunt.net
☐ Adam4adam.com
☐ Dudesnude.com
☐ Myspace.com
☐ Facebook.com
☐ Silverdaddies.com
☐ Okcupid.com
☐ Other __________________

103. If yes, how many times in the last month have you used the Internet to meet guys for sex? __(1,2,3,4,5,6,7,8,9,10,11-15,16-20,21-30,30+, Other _________)

104. When meeting guys online for sex, how likely are you to disclose your HIV status?

☐ Very likely
☐ Somewhat likely
☐ Somewhat unlikely
☐ Very unlikely

105. When meeting guys online for sex, how often do potential sexual partners disclose their HIV status to you?

☐ Never    ☐ Rarely    ☐ Sometimes    ☐ Often    ☐ Always

106. When meeting guys online for sex, how likely are you to use condoms for anal sex?

☐ Very likely
☐ Somewhat likely
☐ Somewhat unlikely
☐ Very unlikely
107. When meeting guys online for sex, which behaviors are you likely to engage in? (Check all that apply)

☐ Jack off  ☐ Hand job  ☐ Oral sex  ☐ Anal sex (Top)  ☐ Anal sex (Bottom)

108. What information do you gather about a person you have met online before hooking up with them? (Check all that apply)

☐ Name or contact information such as address or phone number
☐ Physical characteristics (including penis size)
☐ Sexual role (top or bottom)
☐ Age
☐ HIV status
☐ STD status
☐ Other ____________________

109. When meeting guys online for sex, do you find it easier than meeting men through other venues (bar, bookstore, house party, etc.)

☐ Always  ☐ Most of the time  ☐ Sometimes  ☐ Rarely  ☐ Never

110. When meeting guys online for sex, what is the furthest distance (miles) you have traveled to hookup? (Approximate guess)

In miles: ____________________

When meeting guys online for sex, what is the average distance you will travel for a hookup? (Approximate guess)

In miles: ____________________

111. When meeting guys online for sex, what safety precautions do you take?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

112. In Montana, have you ever met guys for sex in any of the following locations (select all that apply)?

☐ Local bar (non-gay identified)? If yes, how many times in the past month? ________
☐ Gay bar? If yes, how many times in the past month? ________
☐ Adult bookstore? If yes, how many times in the past month? ________
☐ Public sex environment (i.e. truck stop, park, etc.)? If yes, how many times in the past month? ________
☐ I don’t meet men for sex in any locations
☐ Other ____________________
* Choices for how many times are: (1, 2 – 3, 4 – 6, 7 – 10, 11 – 15, 16 – 20, 21 – 25, 26 – 30, 30+)

113. When traveling out of town or out of state for either work or vacation, how likely are you to have sex?
○ Very likely
○ Somewhat likely
○ Somewhat unlikely
☐ Very unlikely

114. When traveling out of town or state, how likely are you to use condoms for anal sex?
○ Very likely
○ Somewhat likely
○ Somewhat unlikely
☐ Very unlikely

The items below refer to how you have felt and behaved during the last week.

115. I was bothered by things that don’t usually bother me.
○ Rarely or none of the time (< 1 day)
○ Some or a little of the time (1 – 2 days)
○ Occasionally or a moderate amount of the time (3 – 4 days)
○ Most or all of the time (5 – 7 days)

116. I did not feel like eating; my appetite was poor.
○ Rarely or none of the time (< 1 day)
○ Some or a little of the time (1 – 2 days)
○ Occasionally or a moderate amount of the time (3 – 4 days)
○ Most or all of the time (5 – 7 days)

117. I felt that I could not shake off the blues even with the help of my family or friends.
○ Rarely or none of the time (< 1 day)
○ Some or a little of the time (1 – 2 days)
○ Occasionally or a moderate amount of the time (3 – 4 days)
○ Most or all of the time (5 – 7 days)

118. I felt that I was just as good as other people.
○ Rarely or none of the time (< 1 day)
○ Some or a little of the time (1 – 2 days)
○ Occasionally or a moderate amount of the time (3 – 4 days)
○ Most or all of the time (5 – 7 days)
119. I had trouble keeping my mind on what I was doing.
- Rarely or none of the time (< 1 day)
- Some or a little of the time (1 – 2 days)
- Occasionally or a moderate amount of the time (3 – 4 days)
- Most or all of the time (5 – 7 days)

120. I felt depressed.
- Rarely or none of the time (< 1 day)
- Some or a little of the time (1 – 2 days)
- Occasionally or a moderate amount of the time (3 – 4 days)
- Most or all of the time (5 – 7 days)

121. I felt everything I did was an effort.
- Rarely or none of the time (< 1 day)
- Some or a little of the time (1 – 2 days)
- Occasionally or a moderate amount of the time (3 – 4 days)
- Most or all of the time (5 – 7 days)

122. I felt hopeful about the future.
- Rarely or none of the time (< 1 day)
- Some or a little of the time (1 – 2 days)
- Occasionally or a moderate amount of the time (3 – 4 days)
- Most or all of the time (5 – 7 days)

123. I thought my life had been a failure.
- Rarely or none of the time (< 1 day)
- Some or a little of the time (1 – 2 days)
- Occasionally or a moderate amount of the time (3 – 4 days)
- Most or all of the time (5 – 7 days)

124. I felt fearful.
- Rarely or none of the time (< 1 day)
- Some or a little of the time (1 – 2 days)
- Occasionally or a moderate amount of the time (3 – 4 days)
- Most or all of the time (5 – 7 days)

125. My sleep was restless.
- Rarely or none of the time (< 1 day)
- Some or a little of the time (1 – 2 days)
- Occasionally or a moderate amount of the time (3 – 4 days)
- Most or all of the time (5 – 7 days)

126. I was happy.
- Rarely or none of the time (< 1 day)
- Some or a little of the time (1 – 2 days)
- Occasionally or a moderate amount of the time (3 – 4 days)
- Most or all of the time (5 – 7 days)
127. I talked less than usual.
- Rarely or none of the time (< 1 day)
- Some or a little of the time (1 – 2 days)
- Occasionally or a moderate amount of the time (3 – 4 days)
- Most or all of the time (5 – 7 days)

128. I felt lonely.
- Rarely or none of the time (< 1 day)
- Some or a little of the time (1 – 2 days)
- Occasionally or a moderate amount of the time (3 – 4 days)
- Most or all of the time (5 – 7 days)

129. People were unfriendly.
- Rarely or none of the time (< 1 day)
- Some or a little of the time (1 – 2 days)
- Occasionally or a moderate amount of the time (3 – 4 days)
- Most or all of the time (5 – 7 days)

130. I enjoyed life.
- Rarely or none of the time (< 1 day)
- Some or a little of the time (1 – 2 days)
- Occasionally or a moderate amount of the time (3 – 4 days)
- Most or all of the time (5 – 7 days)

131. I had crying spells.
- Rarely or none of the time (< 1 day)
- Some or a little of the time (1 – 2 days)
- Occasionally or a moderate amount of the time (3 – 4 days)
- Most or all of the time (5 – 7 days)

132. I felt sad.
- Rarely or none of the time (< 1 day)
- Some or a little of the time (1 – 2 days)
- Occasionally or a moderate amount of the time (3 – 4 days)
- Most or all of the time (5 – 7 days)

133. I felt that people disliked me.
- Rarely or none of the time (< 1 day)
- Some or a little of the time (1 – 2 days)
- Occasionally or a moderate amount of the time (3 – 4 days)
- Most or all of the time (5 – 7 days)
134. I could not get “going”.
- Rarely or none of the time (< 1 day)
- Some or a little of the time (1 – 2 days)
- Occasionally or a moderate amount of the time (3 – 4 days)
- Most or all of the time (5 – 7 days)

135. How did you learn about this survey?
- Received email/message about it.
- Found out about it at an event such as a retreat, men’s group, Pride, or other community event.
- Found it on mtgayhealth.org or other men’s health website.
- Was told by a GMTF member, outreach worker, or MpowerMT member.
- Other _______________________________ (fill in the blank)