A Report
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AN ASSESSMENT OF THE HIV PREVENTION NEEDS OF MEN WHO HAVE SEX WITH MEN
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A Note from the Project Director:

This report is divided into two distinct sections. Section I examines the HIV prevention needs of men who have sex with men (MSM), who for the most part, are “out” to other people about their sexual orientation. Section II of the report examines the HIV prevention needs of MSM who are not out about their sexual orientation (closeted), or who identify as bisexual or heterosexual men who have sex with other men (referred to in this report as Men on the Down Low). Because these two populations have distinct needs, the methods of collecting data and the conclusions drawn from that data are reported separately.

As with all needs assessment projects, it is important that the reader carefully consider the limitations of the information found in this report. Those limitations are discussed on pages 25 and 64.

There are many people without whom this project would not have been possible. At the risk of omitting important contributors, I would like to recognize the following people:

First and foremost I want to thank my project co-directors Kelly Hart and Amee Schwitters. Not only did they commit an enormous amount of time and energy to doing excellent work, but they also were the heart and soul of the project.

In the early stages of the project Nick Heck, Jon Freeland and David Herrera spent many hours assisting in the development of the research methodology and in providing valuable insights into the issues surrounding MSM and HIV infection. They also developed the Gay Men’s Health Survey, implemented the survey and conducted the data analysis.

Steven Barrios, Rick Holman, Greg Smith, DJ Svetich and Kelly Thibault were instrumental, not only in the data collection process, but also in providing moral support and encouragement to the project directors.

And finally, thanks to the staff at DPHHS for their support of this project and their ongoing support of the researchers who worked on it.

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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, 2010e). 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).

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, 2010d). 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, 2010e).

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, 2010). 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 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 is to collect information about the HIV prevention needs of 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.

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?

METHODS

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).

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).
Data Collection

Key Informant Interviews

Instrument Development:
The structured interview questions were developed based on the latter stages of the PRECEDE logic model. 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 1 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 9 individuals was 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.

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. 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.

**MSM Focus Group Interviews**

**Instrument Development:**
These structured focus group interview questions were also developed based on the latter stages of the PRECEDE logic model. There were nine structured questions for the interviews, which can be found in Table 1 at the end of this chapter and in Appendix A. 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. Four focus groups were conducted with 6 to 10 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. 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, 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 themselves including 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. On the back of this form, focus group members were also asked to fill out the Outness Inventory as a way to make comparisons with respondents to the survey. 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. The OI provides a score from one (1) to seven (7), where one represents someone who is not out at all to the particular individual and seven represents someone who is out and discusses their sexual orientation with the other individual openly. No identifying information was included in the transcription. Immediately following the transcription the recordings were erased.

During the focus group, the facilitators 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 one to one and a half hours.
**Men’s Sexual Health Survey**

**Instrument Development**

An online survey developed and administered by FDH Associates in Missoula, Montana 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.

**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.

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. Table 1 below shows each of the research questions and the data collection method used to answer each of the questions. The five methods of data collection were interviews with key informants and focus groups, the Men’s Sexual Health Survey, epidemiological data, and the available literature related to the study topic.
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<td>Interviews with key informants, focus groups, Men’s Sexual Health Survey</td>
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<td>What personal characteristics might influence men to not engage in risky behavior?</td>
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<tr>
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<tr>
<td>What social or cultural changes are needed to meet the HIV prevention needs of MSM?</td>
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DISCUSSION OF RESULTS

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 170 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. 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.

Figure 1 Montana Counties Included in Assessment

The following discussion represents a synthesis of data collected from various 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 identified in the focus groups and interviews 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. Most frequently, men in the assessment reported using drugs and alcohol 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. One concern specific to the reservation included in the assessment was fear of the spread of HIV amongst injection drug users who may share works like needles, spoons, and tourniquets.

Using the Internet to find sexual partners also leads to a higher risk of infection (Benotsch, Kalichman, & Cage, 2001; CDC, 2007; 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.

Hiding one’s sexuality is another factor contributing to the spread of HIV (Mancoske, 1998; Preston, D’Augelli, Kassab, & Starks 2007). 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 outing by seeking an HIV test. Moreover, this reluctance to be out and open creates unique educational needs on the reservation; in particular, both men and women are targeted for HIV education. Finally, it was also observed that in order to participate in MSM specific events, one needs to be out about their sexual identity as they will be outed by association when attending these events.

**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; approximately one-third of survey respondents reported driving over 100 miles 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 make it necessary for 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 was 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. Concurrently, focus group participants and key informants reported that MSM with positive self-esteem, who were involved with their culture and traditions, and those who felt good about themselves 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, 2007; CDC, 2009; 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.

“A lot of our people that 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.”

“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 in any place public.”

***

“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.”
Several factors influence whether or not survey respondents were likely to get tested. One important factor was 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 (i.e. blood draw), 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 someone 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 about 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 was highlighted both in the qualitative and quantitative assessment – though there was a lot of confusion around this. MSM in the focus groups reported not knowing whether or not 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). Furthermore, family and peer support are important for positive self-esteem and mental health (Cody & Welch, 1997; Shernoff, 1997). 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.

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. In addition, younger MSM perceived older MSM as more experienced and therefore younger MSM could be influenced to not use a condom if the older MSM did not want to use one.

Finally, a factor influencing risky behavior identified 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 same sex relationships.

Available Resources in Montana

A number of resources were identified in the assessment by focus group participants and key informants when asked what resources they knew of that targeted MSM in the state. In particular, the following organizations were named:

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 unspecific resources were also identified. These include adult bookstores, bars, City/County health nurses, discussion groups, dorm resident assistants, individual community testers, peers, personal physicians, retreats, support groups, and various websites.

In addition,

LIMITATIONS

A number of limitations exist in this research. 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.

HIV PREVENTION NEEDS AND RECOMMENDATIONS

A number of needs and recommendations 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 often are most 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 illuminates the need to educate both men and women on the risks associated with HIV.

Cultural changes were also identified as necessary 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 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.

**CONCLUSIONS**

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. These unique geographic and social factors in Montana allow MSM to be largely invisible or under the radar. This invisibility may 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 that leads to 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 and the
invisibility of LGB individuals allows Montana law and sex education curriculum to ignore homosexuality. 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.


APPENDIX A:

Key Informant Interview and

Focus Group Questions
KEY INFORMANT INTERVIEW AND FOCUS GROUP QUESTIONS

Behavioral and Environmental Diagnosis

• What are some behaviors that you can think of that might help spread HIV?

• What are social or environmental factors that might help spread HIV among MSM?

Educational and Organizational Diagnosis

• What personal characteristics might influence men to engage in risky behavior? What personal characteristics might influence men to not engage in risky behavior?

• 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?

• What about the social relationships of MSM might reinforce risky behavior? What about the social relationships of MSM might deter risky behavior?

Administrative and Policy Diagnosis

• What are some resources that you are aware of that target MSM?

• Can you think of any health-related interventions that are needed for MSM 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:

Requests for Additional Information
Additional documents related to this assessment can be requested. Available documents include:

- A comprehensive review of the literature regarding HIV and MSM;
- An in-depth description of the study methods;
- A copy of the Men’s Sexual Health Survey;
- Comprehensive descriptive results from the Men’s Sexual Health Survey;
- A copy of the Outness Inventory form;
- Participant consent forms for key informant interviews and focus groups;
- An in-depth description of the key informant interviews and focus group results including more quotes from participants;
- Participant recruitment scripts for the key informant interviews and focus groups; and,
- A copy of the demographic form used for the focus groups.

Requests for these documents should be directed to:

**Project Director:** Annie Sondag, Ph.D., CHES  
**Phone:** 406-243-5215  
**Email:** Annie.Sondag@mso.umt.edu

**Project Director:** Kelly Hart, MS, CPH  
**Email:** kellyhart@gmail.com
Appendix C

Resources
## HIV Testing Services in Montana

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<th>Organization</th>
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<td>Yellowstone AIDS Project</td>
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<td>Rocky Boy Tribal Health</td>
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<td>Bridger Clinic</td>
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<td>Valley County AIDS Task Force</td>
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<td>Dawson County Health Department</td>
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<tr>
<td>Roosevelt County Health Department</td>
<td>Wolf Point</td>
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Gay-Friendly Health Care Providers

- Please use the following link: http://www.mtgayhealth.org/medical/
INTRODUCTION

“I sleep with men, but I am not bisexual, and I certainly am not gay. I am not going to read your brochures, I am not going to get tested. I assure you that none of the brothers on the down low like me are paying the least bit of attention to anything you have to say” (J.L. King 2001, New York Times).

Closeted men who have sex with men (MSM) remain a hidden subset of the population, often forced to hide their identity in response to social pressures. The process of identity formation and sexual risk behaviors among rural closeted MSM remain largely unknown among public health officials. Currently, an entire sub-population of Montana men are being underrepresented in HIV prevention efforts. As of 2009, MSM comprised 66% of all persons living with HIV in Montana1. To better target closeted MSM through public health prevention programs, their experiences influencing identity formation must be better understood. Within the anthropological literature, research on homosexuality within a Western context was until recently, almost non-existent. Despite the increase in Western LGBTIQ research, there are still no studies focusing entirely on closeted MSM.

Recently, the Greater than AIDS movement was launched in the United States in response to the HIV/AIDS crisis. The movement calls for knowing, talking, protecting, getting tested, and taking action. This current study provides an opportunity to respond to this call. We still do not know much about closeted MSM’s sexual risk behaviors and influencers shaping the formation of identity – this study, guided by anthropological theory, seeks to answer these questions. By increasing the knowledge base, this study can start the conversation about the HIV prevention needs of rural closeted MSM

1 Excluding the prison population and veterans, who are not included in HIV data in Montana.
leading to an overall potential increase in programs targeting protective behaviors and testing. Through an increase in prevention programs, we are taking action against HIV and the stigma associated with same sex sexual behavior.

Despite stories of gay men fleeing rural, conservative areas for the larger, more accepting cities, not all men have chosen to leave. Some have chosen to quietly hide their identity, to modify their sexual schemata in response to the desire to fit within the rural cultural environment. It is known that homophobia and the stigmatization of same-sex sexual acts regulate a person’s ability to be open about their sexual encounters, but exactly how they influence closeted MSM’s daily lives remains unknown. Heterosexism through homophobia and stigmatization can regulate the behavior of MSM forcing them to fit the construct of the heterosexual community out of fear they will be socially marginalized if their true sexual orientation is revealed. Pervasive homophobia in rural areas makes the gay self-labeling process a personal struggle, not a joyous affirmation (D’Augelli and Hart 1987). Men report that controlling when and how to be visibly gay is a means of survival in rural areas (Boulden 2001; Green 2006; and Williams, et al. 2005).

Sexuality is a part of one’s identity and recognizing sexuality involves responding to and acting on one’s sexual desires. Guided by queer theory and schema theory and influenced by phenomenological-style interviewing, this study attempts to tell a story of the everyday lives of closeted men who have sex with men (MSM), including HIV prevention needs.
METHODS

Research Design
This study utilized qualitative methods to gain a better understanding of the reasons why some men who have sex with men (MSM) choose to remain on the down-low\(^2\) and how, if at all, this decision influences the ability to communicate about sexual risk behaviors. Data were collected through semi-structured in-depth interviews with men identifying as being on the down low. The interviews were conducted between April and October 2010.

Study Sample
The target population for the current study were MSM between the ages of 18 and 69 who resided in Montana at the time of the interview and who identified as being on the down low about their same-sex sexual activity.

Instrumentation

Demographics
Participants were asked for basic demographic data such as age, sex, race, sexual orientation, sexual attraction, county of residence, and sex of primary sexual partners.

Outness Inventory
The Outness Inventory (OI) is an 11-item scale designed to assess the degree to which lesbian, gay, and bisexual 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. Analysis of the OI data can be used to gain a better understanding of the respondent’s level of outness among family, world, religion, and an overall level of outness.

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\(^2\) Down low is described as perceived straight men who are closeted and having sex with other men.
**Semi-Structured Interviews**

Questions for the interviews were developed by the researcher to gain a better understanding of the overall experience of remaining down low/closeted and how the decision to remain down low influences men’s understanding of HIV and their ability to communicate about risky sexual behaviors.

**Data Collection**

Participants were recruited through various websites (20) and through members of the Montana HIV Community Planning Group (CPG) (8). In total, 28 men participated in the first round of interviews. Men responding to the Internet advertisements contacted the researcher and an interview time was set up. During the scheduled interview time, an information and consent form was read and oral consent to continue the interview and audio record the interview was given. A brief (11-item) demographic questionnaire was administered followed by the Outness Inventory and the interview itself.

Participants were offered $25.00 for their participation in the interviews, although several men declined the money\(^3\). Men were reminded their participation was voluntary and they were free to leave at any time. At the end of the interview, time was allocated for additional questions the men might have and an informational handout containing various testing facilities and MSM resources was given to the participant.

**Data Analysis**

**Demographics**

Demographic information for all 28 men was compiled to ensure representation from each of the five planning regions in Montana.

\(^3\) The declined money was used to conduct further interviews.
Outness Inventory
Each participant’s Outness Inventory scores were looked at individually by overall score and were further divided by family, world, and religion scores. In addition, the mean score was calculated for each of the above categories utilizing scores from all 28 participants.

Interviews
Analysis of the interview data was based on qualitative research techniques (Bernard 2006; Charmaz 2000; Creswell 1998). The interviews were audio recorded and notes were taken. The audio recordings were transcribed by the researcher and were reviewed to look for emergent themes. Codes were created from the emergent themes and used to further analyze the transcripts.

RESULTS

Demographics
Twenty-eight men were included in the first round of the current study. The average reported age of men was 39 (19-63). Men reported their race as Caucasian (22), Hispanic (3), Native American (2), and Black/African American (1). Fourteen men reported their relationship as single, 5 were in married but open relationships, 6 were in married monogamous relationships, and 3 were in dating relationships. Eight men reported their sexual orientation as gay, 1 as straight, 1 as other, and 18 as bisexual. Three men lived in towns between 0 and 500 individuals, 2 from towns between 1,000 and 10,000 individuals, 11 from towns between 10,000 and 50,000 individuals, and 12 resided in towns of 50,000 or more individuals.
**Outness Inventory**

The average overall Outness Inventory score was a 1.80 (1-4.7) with average sub-scores of religion 1.14; family 1.94; and world 1.74. All average scores support men’s self-reported closeted or down-low status.

**Interviews**

Several themes emerged from the interviews. The themes are described below and are divided into five larger categories: (1) Reasons for remaining closeted; (2) Environmental factors contributing to HIV; (3) Behaviors contributing to HIV; (4) Factors influencing HIV risk factors; and (5) Protective factors.

**Reasons for Remaining Closeted**

**Masculinity**

Men reported feelings of association between being gay and being less of a man. Men were afraid they would lose power within various aspects of their lives or that they would be viewed as being effeminate and therefore weaker than their more masculine male counterparts. Some men reported over-exaggerating their masculinity in attempting to remain closeted.

“I grew up in a pretty strict household and uh, my father and my brothers openly joked about gays and just talked about them in really negative terms and how they weren’t really men and how they were just basically women.”

“I just think that there is a double standard for men and women, and for men I think it’s very, the term gay is very de-masculating. You lose your power as a male in society when you are relabeled gay.”
Personal Relationships

“Uh yeah, I know it (coming out) definitely would. They (friends) would be very disgusted over my choices and want absolutely nothing to do with me. Possibly one or two would be very spiteful and do everything they can to try and trash my name.”

In an attempt to hide a stigmatized identity in a response to social oppression, some men who have sex with men (MSM) choose to remain closeted about their sexuality. This determination to remain closeted is often accompanied by a large magnitude of energy and focus to ensure the avoidance of exposure or suspicion (Seidman 2002). The decision to remain closeted is influenced on several levels. The closet can be viewed as a form of social oppression enforced by heteronormativity. The closet enforces concealment, social isolation, and fear. To understand the closet, it is necessary to understand the overall cultural influences that reinforce heterosexual domination (Seidman 2002). Men reported a fear of changing relationships, either with family, friends, or acquaintances in the community as the most influential reason for remaining closeted. Married men reported a fear of losing access to their children. Several men stated their family would disown them, if they were to find out about their sexual orientation. Men were afraid they would lose friendships or their status in the community. This fear of changing personal relationships was strongly linked to a decrease in overall emotional health through feelings of depression and isolation.

“Fear of being rejected in the community and family. I want to fit in with the norm of society. Open gay guys around here are sort of shunned from society.”

“A fifteen year old secret, it’s getting to the point where I need to say something because um, but then at the same time, I don’t want to lose my friends and I know I got a lot of homophobic friends. If I tell my mom she’d want me to go to see not a clinical doctor, but a psychiatric doctor, like what’s wrong with him.”

Men reported a fear of changing relationships, either with family, friends, or acquaintances in the community as the most influential reason for remaining closeted. Married men reported a fear of losing access to their children. Several men stated their family would disown them, if they were to find out about their sexual orientation. Men were afraid they would lose friendships or their status in the community. This fear of changing personal relationships was strongly linked to a decrease in overall emotional health through feelings of depression and isolation.
Employment

Men reported a fear of coming out in their largely male-dominated work fields. This was often connected with a sense of masculinity and losing power or prestige within their chosen occupational field.

“My line of work. It’s more of a manly type of work in theory or the perception of it anyway.”

Military

Men with military experience reported that this was a large influence in their decision to remain closeted. Many men harbored a fear of being dishonorably discharged from the military had their sexual orientation been revealed, despite successful military careers.

“I have the U.S. government above my head, that if they found out about me at the time and place I was in the army, you were gone, you were out of the military, you know, disgracefully at that, no matter how honorably you served.”

Religion

A lack of acceptance of same-sex sexual orientation within religious communities was noted. Several men stated because of these views they were no longer actively involved with the church or religion in general.

“Catholic, Catholic schools, so I repressed it.”

Tribe

Men reported tribal influences and fear of no longer being accepted by their tribe if they came out about their same-sex sexual orientation.

“Well since I’m Native American I can’t be out there yet, but hopefully one of these days I will be.”
Physical Safety

In William’s (2005) study, men reported that the ability to control when and how to be visibly gay was a means of survival in rural areas. Men reported believing that “acting gay” within their community would bring about physical violence directed at homosexual men by heterosexual men. The fear and victimization of “hate crime” related violence has been shown to inflict greater psychological trauma on victims than other forms of violent crime (Herek 2009). To avoid being labeled as gay in small communities, many MSM have adopted heterosexual behaviors and appearances often taking these to extremes.

“With someone my size and my age it’s one of those things that yeah, I could get killed very very easily.”

Many men describe being constantly aware of their surroundings, being “hypersensitive” or hyper-vigilant to who is around them and what type of environment they are in – using their “gaydar.”

Men reported a sense of fear for their personal physical safety if their sexual activities were made publicly known. Fears arose from personal experiences or friend’s experiences of harassment. Sometimes threats came from members of the community or in some cases friends of the men.

Social Labels/ Social Identities

In general, the term identity depicts how we imagine ourselves and how we publicly project that image. While some identities are more superficial there are identities that create our core-sense of self-definition (Seidman 2002). It is partially through our projected identity that we are able to portray our gender, sexuality, social class, and ethnic identity among countless other traits. Our identities are

“You know, yeah, it’s crossed my mind whether I would get beat up, whether someone would try to, say, like the Boogie Nights thing where Mark Walhberg gets beat up. Yeah I think about it.”

“Um, I just don’t want to be perceived as a gay male. It’s like if you do something then all of a sudden it becomes you.”
influenced in part, by the culture in which we live. Foucault viewed identity as a product or effect of the overall larger networks of power and discourse to which we are subjected (1979, 1980). What we typically view as traditional ideas of gender, gender roles, and sexuality are products of the larger social and cultural influences in which we live (Mead 1935; Ortner and Whitehead 1981). Identities are multifaceted and throughout our lives we move in and out of them, adding new ones and removing or modifying obsolete ones.

While limited, a growing field of research has highlighted the complexity of sexual identity. In several studies a distinct difference has been found between how respondents identified sexual orientation in relation to sexual experiences and sexual attraction (Diamond 2000; Lippa 2008; Rust 1992; Smith et al. 2003; Thompson and Morgan 2008). In a recently released study conducted by the United States Department of Health and Human Services from 2006-2008, approximately 58,000 men living in the United States, ages 18-44 responded to questions about sexual identity, attraction, and activity (2011). While 1.2% of male respondents reported same-sex sexual attraction and 1.7% reported their sexual identity as homosexual or gay, 5.2% reported same-sex oral or anal sexual activity. These results are representative of the discrepancy between sexual attraction, orientation, and activity and demonstrate the need to better understand the relationship between each. Closeted men who have sex with men do not always identify as gay or bisexual indicating differences between sexual orientation, sexual attraction, and sexual experiences.

“I have pride in who I am…I can see how difficult being gay. I wouldn’t wish being gay on anyone, I think it’s uh, a very hard thing because you have to evaluate yourself compared to the community norms, churches, everyone else.”

“I remain closeted because people in general are misled so easily and jump to conclusions.”

Negative societal perceptions of gay men were the second most commonly cited reason for remaining closeted. Men reported fear of being identified
solely by their sexual activities and the social difficulties they associated with being publicly gay as reasons for remaining closeted.

Figure 1: Reasons Commonly Cited for Remaining Down-Low about Sexual Activity

Environmental Factors Contributing to HIV

Stigma / Homophobia

Over the last several decades, sexual orientation research has increasingly focused on the manifestations of antigay stigma in the lives of lesbian and gay individuals (Mohr and Fassinger 2000). Stigmatization occurs when a person possesses or is believed to possess “some attribute or characteristic that conveys a social identity that is devalued in a particular social context” (Crocker et al. 1998). In William’s (2005) study, homosexuality was often clouded in silence, while heterosexual behaviors

“Totally, especially in Republican central, as in central Montana. I have friends who talk about fucking gays and so on, and that, it’s just not right. There are a lot of people who are not in favor of gay guys and you have to watch what you say.”
dominated social standards. Participants believed that if they talked positively about anything relating to homosexuality they would be perceived as being gay. Most participants were able to recall hearing anti-gay comments leading to an acute awareness of the hostility towards homosexuality. This marginalization of gay men often leads to a loss of true identity where one becomes a stranger not only in society, but also a stranger to themselves.

Participants in William’s (2005) study in Wyoming reported being very aware of an overtly hostile environment for gay men whose sexual preferences differed from traditional heterosexual lifestyles. Social disapproval of homosexuality is made overtly clear in most cases with the imposition of a rigid standard of social interaction clearly favoring heterosexual persons. Sexual stigma reinforces social roles and expectations for behavior that are understood by all members of society regardless of sexual orientation (Herek 2009).

Stigma was a reason commonly cited for remaining closeted. Many men reported seeing or hearing negative acts or attitudes directed towards lesbian, gay, and bisexual (LGB) individuals. Men associated homophobia with decreased safety for LGB individuals.
Geographic Isolation

Of the literature that addresses “out” gay men living in rural communities, much of it has emphasized their relative invisibility (Green 2006). This is said to stem from the exclusion imposed upon them by the community in which they live (Boulden 1999) and a self-imposed restriction stemming from knowing they do not fit into a heterogeneous world (Green 2006). This can lead to feelings that invisibility by gay men is obligatory in a rural community (Brown 1996; D’Augelli and Hart 1987). Felt stigma encourages men to conceal information relating to their sexuality often leading to feelings of living a double life. These feelings lead to isolation, decreased social support, and decreased well-being (D’Augelli and Hart 1987; Herek 2009). Green (2006) concluded men often wished for a closer connection to their community, to be a part of their hometown, yet many had concluded this was not possible if their gay identities were known.

Geographic isolation was associated with higher rates of stigma, an urgent sense of having to hook up when partners were available, and was seen as a barrier to coming out. Some men associated their lack of access to partners with feelings of having to hook up, being less cautious about asking their partners about HIV status or date of last HIV test, and being less likely to turn down sexual opportunities they felt they would turn down if they had more access to sexual partners on a more regular basis. Men also reported a decreased sense of physical safety associated with coming out in a rural environment.
Behaviors Contributing to HIV Risk

Not out to Doctor

Reasons for not being open with medical care providers included fear of being outed by the providers (doctor, nurse, reception staff), knowing staff in the office, a lack of trust with the provider, or feelings of it being none of the provider’s business.

“I would rather be totally open on stuff like that, but I can’t, and then I was nervous about the nurses. My ex used to work there. I just don’t trust, so yeah, I lie about it.”

Alcohol and/or Drug Abuse

Researchers have hypothesized that increased substance abuse may be linked to coping mechanisms associated with discrimination and sexual stigmatization (Diamond and Wilsnack 1978).

In Cochran and Cauces’ (2006) study, gay men were found to use tobacco at higher rates and abuse methamphetamine at higher rates than heterosexual men.

“I think alcoholism and drug use is prevalent in the gay community because of the pressures society has put on us.”

Alcohol and drug abuse was often linked to attempts to lose inhibitions about meeting anonymous or same-sex partners or as a coping mechanism for having to remain closeted, the stigma associated with same-sex sexual acts, and the constant stress associated with always worrying you may be outed.

“I used some crank and it just drove me out to do it (have sex with a man).”

Seeking Partners on the Internet / Long Distance Travel

“It (alcohol) lowers inhibitions and security... you don’t have as many precautions... you take unreasonable risks at times.”

“I think it (alcohol use) may be a coping thing, it lets you out, it lets you be who you want to be. I just want to be free.”
It can be difficult when MSM attempt to find new sexual partners in rural areas. Thus, men often resorting to driving long distances or looking on the internet to meet new partners. Unlike the majority of heterosexual persons, non-partnered rural gay men often find themselves making trips to nearby urban centers to satisfy sexual urges that are unable to be fulfilled in small towns.

MSM living in rural frontier areas are often left with little other choice than to turn to driving long distances to urban areas, informal friendship networks, and/or internet sites. Driving to urban centers to engage in anal intercourse often involves many hours of travel including the possibility of traveling out of state. This sense of isolation coupled with the amount of effort needed to reach urban centers can lead to a sense of “having to hook up”. Sex is generally identified as something gay men must go looking for when living in rural areas. In internet “hookups”, men often know little to nothing about their partner’s sexual history and are often brief encounters where men may sometimes remain completely anonymous to one another.

Men reported favorable attitudes towards finding sexual partners through the Internet because of the added sense of anonymity. Men reported looking for out of town / out of state partners as an added precaution against protecting their identity. Several men reported relying on their partner’s written HIV status. Men reported driving long distances to hook up with sexual partners and expressed a desire towards hook up sites outside of their hometown if at all possible.

Negative Attitudes about Condom Use
In the United States, MSM account for more than half (53%) of all new HIV infections each year (CDC, 2010). Although many gay and bisexual men appear well informed about HIV transmission and safer sex practices, many do not consistently engage in low-risk behavior (Preston et al. 2004). Despite claiming to understand safe sex practices, many MSM do follow safe sex practices themselves. Unprotected anal intercourse (UAI) with MSM has been correlated to age (Preston et al. 2004), low self-esteem (Stokes & Peterson 1998), depression (Mills et al. 2004), relationship status (Preston et al. 2004), and heavy use of alcohol and/or drugs (Cochran et al. 2004). The decision to be out or closeted within one’s community has potential implications in the decision and/or ability to practice safer sex. Preston et al. identified that perceived community intolerance for homosexuality is directly linked to low self-esteem/self-worth and sensation seeking behaviors in rural MSM and is indirectly linked to sexual risk (2007).

Inconsistent or no to low condom use was often attributed to being in the heat of the moment, feelings of lost sensation, low perceived risk of HIV in Montana, and partners looking physically healthy.
Factors Influencing HIV Risk Behaviors

Social Isolation / Decreased Emotional Health

While rural American life presents a slower-paced lifestyle with a supportive community for some, for others rural life presents limited access to health care and social services and isolation due to social stigma (D’Augelli et al. 2002; Dreisbach 2010). Almost every society has struggled with the connection between sexuality and society, culture, and power (Sacca 2010). Stigmatization occurs when a person possesses or is believed to possess “some attribute or characteristic that conveys a social identity that is devalued in a particular social context” (Crocker et al. 1998).

Closeted MSM are significantly more susceptible to infectious disease and impaired immunological functioning than those who do not conceal their identity (Pachankis 2007).

Men often reported feelings of having to live a double life, an identity they publically projected and a hidden identity that most wanted the opportunity to express openly. These feelings were often described as walking around with a constant weight on your shoulders. Feelings of depression were often identified and associated with ideations of suicide and suicide attempts, sometimes on more than one occasion. Men reported feeling isolated from friends and family and unable to reach out to support services such
as counselors or support groups. Alcohol use and drug use were cited as methods of coping with depressive feelings. Several men reported the inability to relax around friends and family members for fear of saying something that may reveal their sexual identity. Many men talked about realizing that at some point in their lives they will have to come out if these feelings are ever to disappear.

Physical Health

Attempting to hide one’s sexual identity can lead to an overwhelming preoccupation with behaviors, which can lead to a potential decrease in the individual’s overall well-being and social functioning.

Men reported symptoms ranging from anxiety to physically throwing up to panic attacks that they associated with having to remain closeted and the constant worry of being outed.

Infrequent or No HIV Testing

In addition to day-to-day life, hostility, violence, lack of assimilation, and isolation influence MSM’ decisions to get tested for HIV. While MSM, on average are typically aware of the risk factors for HIV transmission and the importance of testing,
there was some hesitancy among William’s (2005) participants to get tested because of the association between HIV and gay men in many people’s minds.

The fear still exists in many men’s minds that the terms homosexual, gay, or MSM and AIDS are still intertwined and inclusive in the minds of many heterosexuals. This fear acts to reinforce the need to remain closeted while decreasing the desire to be tested and increasing negative coping mechanisms such as alcohol and illicit drug abuse (Herdt 2002).

The desire to be tested, even anonymously, can be outweighed by the fear of beingouted by members of both the heterosexual and homosexual communities. In addition to the fear of being outed, there can be negative repercussions directed towards closeted MSM from openly gay men.

“I mean I went to the health department in (name removed) awhile back and I thought it was really odd. There were just weird hoops that you had to jump through, like guys, this is supposed to be anonymous, don’t get, I’m an adult you don’t have to give me a lecture on you know behavior or be safe, trust me, I know this stuff. I rather resented it.”

“While its in theory anonymous , its just odd they want to do a sexual history. Why do you want to know, well none of your damn business, so that has a tendency to want to make people, to make you less willing to get tested.”

A sense of hostility towards the HIV testing and counseling process was communicated. Men reported feelings of animosity towards being counseled about their sexual habits and “being preached to” by counselors that “had nothing in common with them.” The desire for a testing process that involved the ability to go in and get tested without the accompanying counseling was expressed. Testing frequency ranged from never to once every three months.
Lack of Communication Skills

Some men reported being uncomfortable asking about their partner’s HIV status or date of last HIV test. Alternatives to directly asking sexual partners involved relying on their online profile, their physical appearance, whether they looked like a good person, or waiting for their partner to bring it up first. In addition to feeling uncomfortable, men reported their partner’s status was none of their business or that because they were looking for discreet hookups, they did not want to pry into their partner’s lives. Men that did not feel comfortable talking to their partners about their HIV status or last testing date often acknowledged that they should be doing so.

Anonymity

Reasons for wanting to ensure anonymity during sexual encounters ranged from being married to negative societal and tribal perceptions of same sex sexual activity. Men often went to great lengths to maintain their anonymous status including the use of pseudo names, multiple email addresses, meeting with out of town or out of state sexual partners or traveling to different cities. The use of the Internet was cited often as a means of ensuring
anonymity. Men reported frequently asking for pictures of their potential sexual partners before meeting them as a means to ensure they did not know them in other areas of their lives.

Low Perceived HIV Risk in Montana

Men in Wililams’ 2005 study reported concern about confidentiality and the implications of requesting an HIV test and its effects on controlling their sexual identity in the minds of others. Others in Wyoming relied on the false sense of security that HIV was not of concern, “I don’t feel there is a great deal of risk here. If I was in New York or Seattle or L.A…” (752).

Despite actively looking for partners outside of their hometown or outside of Montana, many men stated they felt that the risk of contracting HIV in Montana was quite low, in part because Montana is a rather rural state. However, married men often reported being paranoid about contracting HIV, because they feared passing HIV onto their wives and because they feared being outed about their same-sex sexual activity.
Protective Factors

Condom Use

Not all men reported hesitations with condom use. Those that did report condom use could generally be divided into one of two categories; those reluctant to use condoms, yet had chosen to wear condoms out of fear of bringing an STD home to their female partner or wife, and those who chose to wear a condom for their own personal safety. Among men that had been married for several years, there were some reports of having to re-learn how to use condoms, which was usually done through the Internet or with male partners.

HIV Testing

HIV testing ranged from never being tested to being tested once every two to three months. Reasons cited for being tested included, but are not limited to not wanting to infect girlfriends/wives, children’s safety, the anxiety of not knowing your status, needing to know your status to hook up with other men, and personal safety.

Risk Communication

Men reported varying levels of comfort when discussing their partner’s HIV status or date of last

“I wear condoms, things like that, but nothing is 100% safe and um, the biggest thing you worry about is catching something and then, this is going to sound terrible, and passing it on to a female partner and her being able to figure out where it came from.”

“I would like to get tested about every six months. However, have not been tested in a year.”

“I’ve just had too many close calls, when I’m like oh my gosh, like wow, I didn’t use protection last night and I heard that dude had something. Wow, how lucky am I and I still frequently get tested because like people have said, you can have HIV for ten years and not even test positive, but the army maintains every ninety days for blood test for HIV and all that I have come out clean every time to this day I have.”

“Um I will ask them about their status and that’s about it.”
HIV test. These varying levels of comfort resulted in differences in the frequency in which these discussions occurred. Among men that did discuss their partner’s status or testing frequency, this conversation ranged from brief to in depth. Several men reported not wanting to interfere too much with their partner’s private life or counting on the Internet - either relying on posted status or email discussions. The decision to ask partners about their status was sometimes influenced by the physical appearance, whether they looked healthy. Finally, several men reported being comfortable discussing status and testing frequency, but only if their partner brought up the topic first.

**HIV PREVENTION NEEDS FOR CLOSETED MEN**

**Internet-based Prevention**

With over 99% of the men interviewed stating their primary resource for meeting partners was the Internet and with a large majority of men reporting utilizing the Internet to find answers to sex-related questions, the Internet provides a promising possibility for delivery HIV prevention education in an anonymous environment. Researchers in Wyoming (Bowen et al.2007) have shown promising results with trial internet-based prevention programs.
HIV Testing Locations

In general, the difficulties of getting tested were often brought up during interviews. These difficulties ranged from cost, to privacy, to distrust, to resentment of having to be counseled when getting tested. Men from reservations and smaller towns discussed the difficulties in getting tested without being seen by someone you know when walking into the testing location. The association between HIV and gay men was often brought up and men did not want to be perceived as having HIV or being outed by getting tested. The desire to have testing locations in discrete locations was often brought up. Several men mentioned feelings of animosity with having to be counseled or “lectured” while they were waiting for their test results. Men often cited this as a reason for not going to get tested. Men reported a desire for testing locations that were targeted at a general audience, rather than at gay men specifically. Anonymous testing clinics were favored over doctor’s offices and the county health clinic.

RECOMMENDATIONS

The recommendations listed here have been developed from interviews conducted with closeted/down low men. Men overwhelmingly stated that stigmas and negative attitudes directed at the gay and lesbian community, whether from family, friends, acquaintances, or strangers have influenced their decision to remain closeted. At the environmental level, campaigns, including social media, need to continue to be developed to challenge the larger sense of heteronormativity in Montana. HIV testing locations need to continue, not only to provide anonymous testing, but to do so in discrete locations. Internet-based educational and support programs have the potential to be extremely successful with this population that values their anonymity.
There is a high degree of social isolation occurring with closeted men and men on the down low. This social isolation often impacts emotional health, which in turn can lead to riskier sexual behaviors. A support system that guarantees anonymity needs to be created that reaches out to closeted/down low men. Because several men within the study expressed a desire to be tested by and counseled by females, HIV testing locations need to strive to offer a variety of testers.

**LIMITATIONS**

This study shares the same limitations with qualitative research in general. While the current study produced detailed information regarding individuals, the results cannot necessarily be generalized to include larger populations (Creswell 1998; Marshall and Rossman 1999). Because the research focused on a relatively small segment of the larger population, this current study may have limited external validity (Kirk and Miller 1986), instead it provides the opportunity to detail lived experiences and provides rich descriptions of what life is like as a rural closeted/down low MSM.

**CONCLUSIONS/FUTURE WORK**

Overall, the interviews with closeted/down low MSM revealed a sense of isolation stemming from having to remain secretive about their sexuality indicating a need for improved social programs targeting this population. HIV prevention campaigns need to continue to target various groups within this population as some individuals do not necessarily identify with a traditionally recognized sexual identity.

Men reported varying levels of condom use, ability to negotiate safer sex with their partners, and HIV testing frequency. The State of Montana provides a variety of HIV testing locations that could be used to expand the targeted testing audience. Within the HIV testing process
trained counselors need to employ counseling techniques that decrease their client’s sense of being “lectured” about risky behaviors, and instead increases their client’s confidence in the ability to discuss safer sex methods and risk reduction strategies with partners.

There is a need to continue educating men about the potential risks associated with participating in anonymous sex. The internet has been shown to be an effective tool in HIV prevention, several men reported use of the internet when seeking answers to sex-related questions. As there are threatened funding cuts, this may prove to be a cost-effective tool in reaching closeted/down low men.

This report is inclusive of opinions and information gathered during round one of interviewing which took place in 2010. A final report inclusive of round one and round two interviews conducted in 2010 and 2011 will be available in 2012 and can be requested by contacting the researcher, Ame Schwitters, at ameeschwitters@gmail.com or (406) 552-2115.

Thank you to all of the men who participated in the interviews. Without whom, this research would not have been possible. Questions regarding the closeted/down low MSM section of the final report may be directed to the researcher, Ame Schwitters at ameeschwitters@gmail.com or (406) 552-2115.
WORKS CITED

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Centers for Disease Control and Prevention (CDC)

Charmaz, K.

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Creswell, J.W.
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D’Augelli, A.R. and M.M. Hart

Diamond, L.M.

Diamond, D. and S. Wilsnack

Dreisbach, S.

Foucault, M.

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Green, E.J.

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Herek, G.M.
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Stokes, J.P. and Peterson, J.L.

Thompson, E.M. and E.M. Morgan.

Williams, M. L., A.M. Bowen, and K.J. Horvath
Appendix A

Institutional Review Board
**THE UNIVERSITY OF MONTANA-MISSOULA**
Institutional Review Board (IRB) for the Use of Human Subjects in Research
CONTINUATION REPORT

This report must be completed if data collection or analysis is still in progress at least 6 months after IRB approval. The Institutional Review Board (IRB) is required by Title 42, Code of Federal Regulations (Part 56, 46) and Title 45, Code of Federal Regulations (Part 46, 104) to conduct continuing review of ongoing projects that have been approved.

Submit the completed form to the Office of the Vice President for Research & Development, University Hall 116. NOTE: Submission of this form from a University email account constitutes an individual's signature. Students submitting electronically must copy their faculty supervisors.

<table>
<thead>
<tr>
<th>Project Title: The effects of discrimination on same sex sexual orientation on college men who have sex with men (MSM) sexual risk behaviors and HIV prevention needs.</th>
<th>Principal Investigator: Anne Schwitzroth</th>
</tr>
</thead>
<tbody>
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<td>Email: <a href="mailto:anschwitzroth@umontana.edu">anschwitzroth@umontana.edu</a></td>
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</tbody>
</table>

1. Approximately how many subjects have you tested? 28

2. Is data collection complete (analysis only)? Yes [ ] No [x]

3. Have any subjects complained about the research? Yes [ ] No [x]
   If yes, describe any complaints:

   4. Have any subjects withdrawn from this research? Yes [ ] No [x]
   If yes, describe the circumstances:

   5. Have any adverse effects or unanticipated problems involving risks to subjects been reported? Yes [ ] No [x]
   If yes, describe any adverse effects:

   6. Are there any recent findings or publications regarding risk adverse effects associated with similar research? Yes [ ] No [x]
   If yes, please summarize:

7. Are you making any changes to the originally approved protocol? Yes [ ] No [x]
   If yes, describe:

   8. Principal investigator, I understand that my signature below certifies that all researchers involved in this project have met all the criteria for protection of human research subjects (http://www.irb.montana.edu/protecthumanresearchers.html) within the last three years and that I have signed "Certification of Compliance" each year. Yes [x] No [ ]

IRB Determination:

Approved by Expedited/Administrative Review (see *Note to PI)
Full IRB Determination
Approved (see *Note to PI)
Conditional Approval (see attached memo) - IRB Chair Signature & Date
Resubmission Proposal (see attached memo)
Disapproved (see attached memo)

Final Approval by IRB Chair: [Signature]
Date: [Date]
Expires: [Date]

*Note to PI: This form represents the current status of the proposed research project and is subject to periodic review. Changes in proposed research or in any condition affecting research certification must be submitted to the IRB for approval before implementation. Non-compliance with the IRB protocol or changes in research protocol may result in disapproval of the research project.

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APPENDIX B

Demographic Information
Demographic Information. Please fill out to the best of your ability.

1. How young are you? _____

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

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, in a monogamous relationship
   - 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+


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

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

   Both Men and Women Equally (4)

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

   Women Only

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

   Exclusively Homosexual

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

   Bisexual (4)

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

   Exclusively Heterosexual

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

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 (M to F)
Confidentiality: Your records will be kept private and will not be released to anyone outside of the research team. Only the researchers will have access to the files. Your identity will be kept anonymous. If the results of this study are written in a scientific journal or presented at a scientific meeting, your name and exact location will not be used. The data will be stored in a secure office. Consent forms will be stored in a cabinet separate from the data. The audio recording will be transcribed by a member of the research team without any information that could identify you. The recording will then be erased after one year.

We are conducting this interview in a private setting so that any information you share, can be shared confidentially.

Compensation for Injury: Although there are minimal risks in taking part in this study, the following liability statement is required in all University of Montana consent forms:

"In the event that you are injured as a result of this research you should individually seek appropriate medical treatment. If the injury is caused by the negligence of the University or any of its employees, you may be entitled to reimbursement or compensation pursuant to the Comprehensive State Insurance Plan established by the Department of Administration under the authority of M.C.A., Title 2, Chapter 9. In the event of a claim for such injury, further information may be obtained from the University's Claims Representative of University Legal Counsel. (Reviewed by University Legal Counsel, July 6, 1993)"

Voluntary participation/withdrawal: Your decision to take part in this research is entirely voluntary. You may refuse to take part in or you may withdraw from the study at any time without penalty or loss of benefits to which you are normally entitled. Your participation may be ended by the interviewer if continuing is not in your best interest.

Questions: If you have any questions about the research now or during the study contact: Amee Schwitters, MPH (406) 552-2115. If you have any questions regarding your rights as a research subject, you may contact the Chair of the IRB through the University of Montana Research Office at (406) 243-6670.

Statement of Consent
I have read the above description of this research study. I have been informed of the risks and benefits involved, and all my questions have been answered to my satisfaction. Furthermore, I have been assured that any future questions I may have will also be answered by a member of the research team. I voluntarily agree to take part in this study. I understand I will receive a copy of this consent form.
APPENDIX C

Outness Inventory
OUTINESS 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 RARELY talked about
4 = person probably knows about your sexual orientation status, but it is SOMETIMES 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

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<th>Item</th>
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<th>5</th>
<th>6</th>
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<tbody>
<tr>
<td>1. mother</td>
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<td>2. father</td>
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<td>3. siblings (sisters, brothers)</td>
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<td>4. extended family/relatives</td>
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<td>5. my new straight friends</td>
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<td>6. my work peers</td>
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<td>7. my work supervisor(s)</td>
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<td>8. members of my religious community (e.g., church, temple)</td>
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<td>9. leaders of my religious community (e.g., church, temple)</td>
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<td>10. strangers, new acquaintances</td>
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<td>11. my old heterosexual friends</td>
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