

HIV Prevention in Rural Alaska for At-Risk Men who Have Sex with Men (MSM)

Project Name: HIV Prevention Consultant
Solicitation Number: 0609-027

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Submitted: November 30, 2009

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Acknowledgements

Our gratitude goes out to those who graciously gave us their time to openly discuss important issues around HIV prevention, at-risk men who have sex with men (MSM), and the challenges that are often faced by individuals and health care, prevention, and support services providers. Many thanks to the organizations, programs, and individuals dedicated to serving those at risk, while providing prevention outreach and education to the general population.

A special note of appreciation goes to Carl Aronson, HIV Program Director, and all of the administrative staff for their support during this endeavor, as well as to Desiré Shepler and Ella Morris, graduate students in the Master of Public Health (MPH) Program at the University of Alaska Anchorage-Department of Health Sciences, for their invaluable assistance with this project.

Glossary

AK DHSS	Alaska Department of Health & Social Services
AI/AN	American Indian/Alaska Native
AIDS	Acquired Immune Deficiency Syndrome
ANTHC	Alaska Native Tribal Health Consortium
EMS	Emergency Medical Services
Four A's	Alaska AIDS Assistance Association
HIV	Human Immunodeficiency Virus
IDU	Injection Drug Users
MSM	Men Who Have Sex with Men
PDQ	Partnership Defined Quality
STI	Sexually Transmitted Infections

I. Introduction

The Alaska Department of Health & Social Services (DHSS), Division of Public Health, HIV Program requested a consultant to provide assessment information and recommendations for a HIV prevention strategic plan. Determining ways to improve and enhance prevention strategies throughout the state of Alaska is the focus, especially for the at-risk population of men who have sex with men (MSM) in the rural areas. The term *men who have sex with men (MSM)* refers to all men who have sex with other men, regardless of how they identify themselves (gay, bisexual, or heterosexual). The Alaska HIV Prevention Plan is designed to provide guidance for HIV prevention activities in Alaska. Significant HIV prevention interventions are employed to target the at-risk population. However the majority of the services and activities are more urban-based. Additional approaches are being sought to address risk behaviors among MSM with a primary focus in rural areas of Alaska.

One goal of this project was to assess the current HIV prevention services available for MSM in rural Alaska. A second purpose was to propose recommendations for a strategic plan to improve HIV prevention strategies to better serve the MSM population in rural areas of Alaska.

This final report provides a synthesis of assessment information from organizations and program representatives and service providers, and proposes recommendations for improving rural MSM prevention strategies applicable to the state of Alaska. In addition, an HIV prevention resource inventory was generated.

II. Background

One important at-risk population in the United States that has been significantly affected by HIV and AIDS is the group of men who have sex with men (MSM). Since the beginning of the epidemic in the US in the early 1980s, an estimated 517,992 MSM (452,111 MSM and 65,881 MSM who are injection drug users – IDUs) received a diagnosis of AIDS. This accounts for 68% of male adults and adolescents who received a diagnosis of AIDS, and 54% of all people who received a diagnosis of AIDS. Also

during this time period, an estimated 300,669 MSM (260,749 MSM and 39,920 MSM IDUs) with AIDS died, accounting for 68% of male adults and adolescents with AIDS who died and 57% of all people with AIDS who died. In 2006, records showed that half (50% or 17,465) of all estimated HIV/AIDS cases in 33 states were attributed to male-to-male sexual contact.¹

The incidence and prevalence of HIV/AIDS is increasing among rural MSM. However, limited data are available. The design and implementation of HIV prevention programs targeted to the MSM population have been especially challenging in rural areas. Little is known regarding the social environment of the US rural frontier (Williams, Bowen & Horvath, 2006). The MSM population may have few identifiable meeting venues, particularly in rural areas (Horvath, Bowen & Williams, 2006). A study conducted in Wyoming identified the need for programs that keep one's sexual preference protected from public knowledge (Williams, Bowen & Horvath, 2006). The authors of this study concluded that the Internet, because it can be privately accessed, might offer a mechanism for the delivery of prevention programs. In addition, a survey of 663 MSM noted that the highest rate of risk behaviors may be associated with dating via the Internet and in places where immediate sexual encounters occur. It was also suggested that prevention in rural areas should be aimed at multiple-risk environments (Horvath, Bowen & Williams, 2006). A 2007 report of a randomized control trial of internet-delivered HIV prevention noted the efficacy and acceptability of the Internet for the delivery of HIV prevention messages to rural MSM (Bowen, Horvath & Williams, 2007).

A. Alaska-Specific Data

According to a recent State of Alaska Epidemiology Bulletin, 56% of the cumulative cases of HIV between 1982 and 2008 were in the MSM population. In 2008, 53% of the 57 reported HIV cases in Alaska were MSM.² HIV prevention interventions targeting MSM have traditionally been difficult to implement in regional hubs and rural areas of Alaska outside of Anchorage.

¹ State of Alaska Department of Health and Social Services. *Alaska HIV Prevention Plan 2007-2009*.

² State of Alaska Epidemiology Bulletin. Bulletin Number 10, February 20, 2009.

III. Plan and Methods for Community Needs Assessment

The initial assessment strategy plan was to use a 3-tiered participatory approach, gathering information on the current status of HIV prevention services and activities (specifically those interventions directed towards the MSM population) and identifying any existing gaps in services. The primary target audiences were: 1) regional representatives from state health agencies; 2) HIV prevention and service providers from health-related non-profit and/or community based organizations working with local groups, including MSM; and 3) at-risk MSM individuals. For this assessment process, various locations were identified by the partnering representatives as geographical areas for focused efforts—urban centers such as Fairbanks, Juneau, and the regional rural hubs of Barrow, Bethel, Cordova, Dillingham, Ketchikan, Kodiak, Kotzebue, Nome, Petersburg, Sitka, Unalaska, Valdez, and Wrangell. An important consideration during this process was the status of the workforce capacity, so as to not place an undue burden on any individuals and/or communities.

Two primary methodologies were anticipated to be used as the overall approach during this project: a modified version of Partnership Defined Quality (PDQ) and Barrier Analysis. Though these approaches were not fully used during the assessment process due to limited community member participation, they were considered to be valuable tools when both target populations, providers, and the at-risk group(s) were available and willing to participate. Both methods are briefly described, with the anticipation that they may be utilized in future assessments and studies.

Partnership Defined Quality (PDQ), developed by Save the Children, is a tool that has been used globally to promote collaboration between communities/specific populations and health service providers for quality improvement, and has been used in multi-cultural settings.³ This tool is most often used to better identify existing service delivery gaps and barriers. During the PDQ process, the separate groups identify problems and gaps (including service delivery, attitudes, social, and/or cultural considerations) from

³ Save the Children. *Partnership Defined Quality Manual*.
<http://www.savethechildren.org/publications/programs/health/PDQ-Manual-Updated-Nigeria.pdf>

the perspective of service consumers and health care and service providers. The information gathered and synthesized from this setting provides awareness on current issues, which are then prioritized and recommendations for action plans are developed. In this particular case, the overall goal is to improve the quality and utilization of care and support services around HIV prevention activities in the communities and throughout the state.

Barrier Analysis is a rapid assessment tool used to identify behavioral determinants for specific behaviors within a given population.⁴ Participants are asked to respond to questions about the eight potential determinants, many of which are considered barriers that can keep people from taking action to improve their own health or lives. This evidence-based approach was developed using behavior change theories, such as the health belief model. It was once thought that having knowledge on an issue would change behavior, but health practitioners, program managers, and scientists realized that most people know what they should and should not do, but do not practice the behaviors. The information generated was to be used to improve support services and develop more effective behavior change communication messages.

The initial step of the assessment process was to communicate with the first tier of contacts: state and regional health offices and HIV/AIDS and health program representatives. These contacts were identified in collaboration with the Alaska Department of Health and Human Services. From these first contacts, additional potential participants were acquired using a snowball sampling method. Snowball sampling is an approach designed to identify key informants who have knowledge on a specific subject matter or have characteristics that are needed for a particular process, project, or study. When using this approach, a few initial contacts are made for discussing key subject areas. During the discussion or interviews, these respondents are asked to identify other possible contacts that may have particular knowledge of the specific subject matter. This tool allows one to identify resources within a community and to select contacts who can best identify the needs for a community or population

⁴ Food for the Hungry. *Barrier Analysis*. <http://barrieranalysis.fhi.net/>

involved in a project or study. Once these contacts are identified, other tools are used, such as surveys and interviews.

Assessment Methods

E-mails were prepared and sent to all of the individuals on the contact list. They were sent individually to protect confidentiality of potential organizational, program, and provider participants. The message contained information on the overview of the assessment project, the broad questions that were being addressed, as well as contact information to ask any questions and to designate a preferred date and time for further discussions. The e-mails were followed by telephone calls to cover discussion points on HIV prevention activities with a specific focus on what worked (the strengths), what did not work (the challenges), areas for improvement, barriers encountered, and awareness of support in rural areas.

Attempts were made to identify key MSM informants in order to conduct anonymous interviews either by telephone or in-person. However, following discussions with program key informants revealed that an acceptable channel for communicating within the MSM community might be an online survey.

An online survey was developed on Survey Monkey and placed on a designated, non-organizational website. The survey consisted of 16 questions that were a mix of multiple answer (including an "other" option with a line for specifics), yes/no, and open-ended with a text box. Questions addressed where participants went for health information related to sexual health and for condoms; where they went for HIV testing, HIV counseling, and vaccinations against hepatitis A and B; what barriers they encountered; and what recommendations they had for improving related information and services. Additionally, broad demographic information was requested, such as Alaska residency and nearest regional hub or urban center. The website and survey were promoted by information flyers which were distributed to and posted by key contacts.

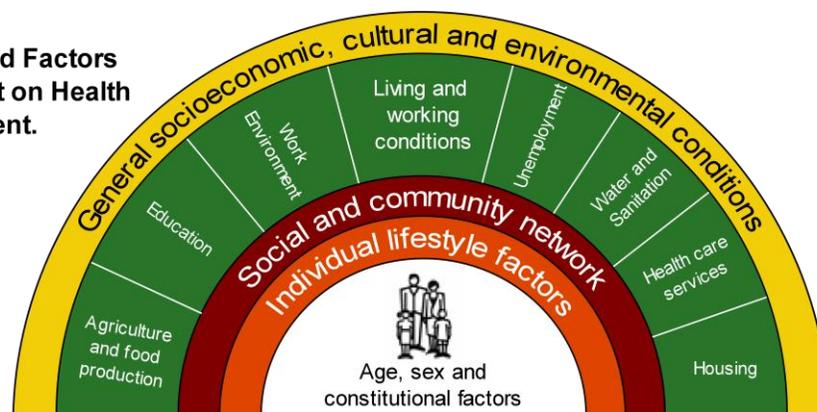
Analysis of Data

Provider data were collected and entered into an Excel database. Themes/domains were identified and responses were compiled accordingly. The project team conducted a contextual analysis of the responses and summarized key content that focused on accessibility to and acceptability of services, service delivery, and communication strategies, along with the social and cultural considerations for these areas.

IV. Assessment Findings

The aggregated data were summarized into major concept areas. Figure 1 illustrates the major influences considered, such as individual lifestyle factors and the social and community networks, which can include the organizations, programs, and service providers. The overarching influences are general socio-economic, cultural, and environmental conditions.

Figure 1:
Inter-related Factors
that Impact on Health
Improvement.



Source: Dahlgren G, Whitehead M. Policies and Strategies to promote social equity in health. Stockholm: Institute of Futures Studies, 1991

Information was collected according to pre-determined discussion points, and informant responses were compiled and aggregated by contextual domains. Key points that were noted by informants are highlighted in this report.

A. Organization and Program-Level Discussion Points and Responses

The leaders of several community organizations were receptive to sharing their perspectives and insights related to prevention activities reaching the MSM population. Insight and concern for the MSM population, grounded in knowledge and field experience, was conveyed by the leaders. The single, overarching theme portrayed from community organizations was that of a complex interplay of social, cultural, and economic factors influencing the health-related behaviors among the MSM population. A major obstacle consistently reported was self-identification. It was relayed that if men choose to reside in the villages, their identity is closely tied to the village. While attitudes vary between villages and between different groups in the community, historically, the Alaska Native culture has been accepting of the role of special individuals, including those with a gay lifestyle, in community life. However, the level of acceptance varies among tribal entities. Generally, in rural villages, acceptance is based on not acknowledging or discussing the MSM lifestyle. Not openly acknowledging the gay lifestyle is a key factor as it relates to the more conservative, church-going village residents. Further, one leader relayed the impression that, among the various tribal organizations, some tended to be conservative and generally were not supportive of prevention efforts. These complicating factors are especially relevant as they relate to reaching the population of MSM who are outwardly straight, but may have occasional sexual encounters with men.

Figure 2: Maslow's Hierarchy of Needs, 1943, describes five steps of individual needs: from the basic physiological needs (e.g. food, water, etc.), to safety and security (e.g. housing), to social needs, followed by self-esteem and finally reaching self-actualization (e.g. creativity and problem-solving). (*Psychological Review*, 50, 370-396).



In describing factors associated with the MSM population being hard-to-reach with prevention messages, more than one community leader described a complicated interweaving of low self-esteem, poverty, fear of stigmatization from the community and

judgment from church, and isolation and mental health issues leading to alcohol use and possible abuse. This myriad of influences may be characterized in the framework of Maslow's Hierarchy of Needs as depicted in Figure 2. Participants reported that economics play an important role in motivating individuals to leave the rural areas in search of jobs. The mobility of the population from the rural areas to the regional hubs or larger urban areas in search of employment may also be influenced by their gay lifestyle and the availability of alcohol. A local organization reported that a shift has occurred regarding where men who have sex with men (MSM) seek sexual encounters—fewer individuals are going to gay bars and more are using internet chat rooms.⁵ Employment in an urban area, even short-term, offers access to alcohol and unsafe sexual encounters. Organization leaders unanimously reported that alcohol plays a strong role at multiple levels in the lives of the population of MSM. Experiences with risky sexual behavior in urban areas, and the push- pull of employment to and from urban areas, offer one explanation of the spread of HIV among the population of MSM in rural areas.

Related to the spread of HIV in the rural areas, leaders from community organizations shared their experiences on existing prevention activities. Training on HIV testing had been conducted within the infrastructure of the community health aid program. However, little to no testing was being performed in the community clinics. Leaders explained that, given the influences in the villages described earlier, the community health aides were generally very reluctant to test. For example, a community health aide might be a relative or a neighbor of an individual who required follow-up counseling and referral based on test results. The influence of the church, along with close ties to the community, could impede appropriate HIV testing, education, and follow up activities.

B. Provider-Level Discussion Points and Responses

Telephone calls were conducted to actively seek provider participation for more in-depth discussions. Participants discussed key points on HIV prevention activities in their

⁵ Data from a PowerPoint presentation on *PowerOn Alaska* by the Alaska AIDS Assistance Association (Four A's) Program (n.d.)

areas, with a specific focus on what worked (the strengths), what did not work (the challenges), what areas needed improvement, what barriers were encountered, and what were the levels of awareness of support in rural areas.

1. Current HIV Prevention Activities in Regional Hubs and Rural Areas

Respondents commonly noted that HIV prevention activities and support for individuals in regional/rural areas included free screenings for HIV and sexually transmitted infections (STIs), distribution of condoms, and public health nurse prevention presentations. Distribution of condoms was the most frequent activity reported, and this happened in many ways. The most commonly reported method for individuals to receive condoms was from public health nurses and from behavioral health aides. Other venues for condom distribution included clinic lobbies and bathrooms, vending machines located in convenience stores, entryways to hospitals, public bathrooms, bars, coffee shops, and hotels.

Screenings were most commonly conducted by public health nurses or at the clinic by appointment or a walk-in visit. Pre-test counseling also occurred at this time. Public health nurses presented health sessions to students and clients, as well as routine health messages to the community. Educational services related to HIV prevention available in communities included one-on-one education by a public health nurse or a Four A's representative, community counseling, client outreach, posters, pamphlets, brochures, and health fair information that included the common message of "know your status" and general HIV information. These educational activities also took place at jails, prisons, halfway houses, and rehabilitation facilities.

Youth activities were also an important part of prevention efforts. Participants felt it was important for schools to create a curriculum around HIV and STI prevention, provide youth-related activities, and educate school staff on blood-borne pathogens.

Providers frequently reported a lack of funding for prevention activities and testing services. One provider said there was funding for cardiac and cancer programs, but none for HIV and STIs. Providers also expressed major concern over the day-to-day

workload of clinic and hospital workers, which often made HIV and MSM populations a lower priority because the staff was limited and worked hard.

2. Strengths - HIV Prevention Activities and Programs That Have Worked

A collective strength reported by respondents was the availability of HIV testing at local health fairs, during medical screenings, on a “testing day,” during AIDS day events, in bars, and even at local soup kitchens that serve clients from outlying rural areas. One provider said, “The state does free tests and [we] hope that never ends.” The most common response from participants regarding what programs or activities were working was passing out information, including brochures on STIs and safer sex messages, and using DVDs or videos for training.

The second most common HIV prevention strength was providing information on HIV and hepatitis A and B while reviewing patients’ records during clinic visits so as not to miss opportunities for HIV-related care. Additional responses included: working with other professionals, such as the mayor, fire department, and emergency medical services (EMS) personnel; disseminating HIV prevention messages using radio station and online announcements; producing and airing public service announcements; referring patients for condoms and proper medical attention or services; providing patients with ongoing care and support services; and supplying condoms in vending machines in public areas for regular accessibility. It was once stated that “health information needs to be truly accessible and not only handed down from doctors.”

Respondents reported that providing information to adults and those within the MSM populations was working well for many communities. Some communities have had success with early education and peer educators. These avenues of prevention and education have worked in reducing the stigma around testing and mainstreaming the message. There needs to be a consistent presence among health care workers around the availability of services, including HIV testing and counseling. One suggestion was to train all clinic staff to perform HIV tests and to help patients talk through their diagnosis (basic counseling).

3. Challenges - HIV Prevention Activities and Programs That Have Not Worked

Participants frequently identified lack of funding as a major challenge in prevention. One respondent reported that there is a “vicious cycle between funding and staff.”

Two reasons given for activities and programs not working were: information and materials were too focused on a specific population and people in the communities often did not show up to organized activities. Participants said the focus needed to be “less charged” and broader in context, and program coordinators and health care professionals needed to do more new and different activities. Also, trainings should include and target substance abuse and treatment.

One provider’s experience when visiting rural communities was that people may not be ready to change and not ready for a rush of information. A lesson learned was not to have too much on the agenda when visiting. She realized she needed to slow some of it down and “plant those little seeds.” It was important to have respect and listen to village members and make connections with people.

4. Areas for Improvement - Suggested Ways to Improve Services and Activities

The most common response among providers was to bring health education to schools in a curriculum or presentation, such as HIV and STI education and safety classes. Working with young people can create a window of opportunity for learning. Messages can also be sent to youth across the Internet and by cell phone text messages.

Respondents were also concerned about the availability and accessibility to testing. Several emphasized that access to testing and results needed to be easier. The availability of take-home HIV test kits could improve the accessibility of testing for the individual. Health care workers needed to be trained in confidentiality issues and inform their patients about these policies, since this was one barrier that individuals often had around being tested.

Another participant suggested the following: starting an advocacy group to target those who are at risk and to educate others; having community workshops; providing health safety and protection classes; and making information more accessible to “dilute risk factors,” emphasizing “know your status” and knowing what follow-up is needed.

Participants mentioned that seasonal workers, such as fisherman, work crews, forest workers, etc. should be educated about HIV prevention and other blood-borne pathogens. A respondent suggested working with the harbor masters on this issue.

Participants suggested having a full-time staff member dedicated to traveling to villages to provide education and testing for the population. This person needed to be trained and would be an outsider to the communities, which in this case was seen as a positive, so it might help with confidentiality concerns. “Get tested, get into care, and keep in care” was one theme a provider stated. Baseline HIV testing could be used as a vehicle for education.

5. Barriers Encountered for HIV Prevention Activities and Services

Participants reported that a major barrier in small communities was familiarity, since everyone had relatives and friends both in town and, most importantly, in the clinics. Having relatives who worked in the clinic setting could make at-risk residents afraid to access services, because other people in town might find out. In small towns trust was an issue, especially among the youth. Youth were likely to be embarrassed and worried that the village, especially relatives, might find out they visit the clinic. Also, as a provider, being an outsider to the community could be seen as a barrier, though it was also identified earlier as a positive characteristic.

An influx of non-residents, including seasonal workers, to some communities make tracking disease harder for health professionals. It is not uncommon for travelers or visitors to come to town, “hook-up,” and leave. In addition to trust and non-resident influx, the large distance between communities and a central urban location (Anchorage, Juneau, and Fairbanks) may pose barriers for community members. Adverse weather conditions and often high cost of travel to urban areas for testing or

medical care can also create barriers. HIV and STI tests are sent to labs in these urban sites for analysis and the turnaround time for results can sometimes take two to six weeks.

Participants identified the following other barriers to HIV prevention programs and activities: providers may be unaware of MSM in their communities, since this group is often “underground”; there may be a limited number of clinic staff or trained personnel; and there may be language barriers between clinicians and patients, such as with seasonal workers, who do not speak English.

Staff in rural areas often have highly demanding daily schedules and may be occupied with urgent health issues. This gives them little time for less urgent cases like HIV testing and counseling. The cost and accessibility of testing are barriers for those who do not qualify for free services.

6. Support Services for MSM individuals and HIV Prevention (Community Groups)

The few responses on support services indicated that they were not aware of social or support groups for MSM. Social networks are often through home computers (i.e., internet), at bars, at church, and occasionally support from the entire community. One community also had an STI coalition group that helped provide support for the disparate population, though the group was not currently active.

Providers commented on HIV-related services available to the MSM population. Local clinics were available for testing and counseling in some areas so they did not have to go to the larger, urban centers such as Anchorage, Fairbanks, or Juneau. These centers may be hundreds of miles away where adverse weather and transportation issues are sometimes encountered.

Providers suggested general support services for HIV prevention, beginning with HIV education at a young age (though providers were not sure of sexual education being taught in the schools). Providers stated that clients were welcome from different areas, such as from outlying service areas.

C. Individual-Level (MSM) Responses and Survey Points

Challenges were encountered when seeking informant interviews and soliciting responses to the online survey. Key informants, along with the existing literature, indicated that it would be difficult to identify and recruit people (MSM) for interviews or focus group discussions. With the goal of a larger response rate, the direction of the project changed to an online, anonymous survey format (www.healthalaska.org). This component of the project will be ongoing as a means to maximize data.

V. Lessons Learned

During this assessment process, multiple constraints were encountered in reaching the MSM population. Issues revolved around the delivery system for health services and prevention activities, community and cultural issues, and the use or abuse of alcohol. In examining these more closely, key lessons emerged.

A. Health Care and Support Services in Community and Cultural Context

Health care providers throughout the state reported being aware and respectful of the potential for stigmatization of the MSM population in the rural communities.

Confidentiality of patient identification and testing results was universally the principal concern. This message was consistently offered when exploring barriers to reaching the MSM population with HIV prevention related activities. The clarity and strength of the concerns expressed emphasized the health care providers' understanding and respect for the socio-cultural mores. Further, health care providers indicated that the socio-cultural norms may strongly limit the delivery of health services and prevention activities within the existing health care delivery structure.

The influence of the community and cultural milieu related to self identification was consistently reported as a major obstacle for prevention and educational efforts. Health care providers, along with community organizations, struggled to reach the MSM population based on community and cultural influences. In fact, several health care providers predicted, very matter-of-factly, that the issues surrounding the acceptability

of self-identification were not likely to change. In this context, several providers targeted their prevention and education efforts when a new HIV diagnosis was confirmed, seizing any possible opportunity to promote educational messages. For example, talking about the spread of disease when discussing the patient's sexual contacts (and their potential contacts) uses a disease management task to educate the patient, and in so doing also educates additional MSM individuals.

In addition to concerns related to confidentiality and stigmatization, health care providers in rural communities unfailingly reported that responding to the heavy demands of the immediate medical needs in the community overshadowed their time, interest, and commitment to prevention efforts. Day-to-day patient care was a universal top priority and a limiting factor for prevention activities. Further, given the constraints of resources in the form of time and money, health care providers reported that existing prevention/education efforts occurred on an almost volunteer basis. Providers openly invited the project team to visit their sites and learn first-hand about their prevention efforts. While illustrating impressive energy and commitment to professional and community concerns, this further underscored the fragility of current prevention efforts. Even more evident were the limited prevention efforts that focused specifically on the MSM population.

Given the reports from health care providers throughout the state, adequate funding was a missing essential component of prevention activities focusing on the MSM population. Discussions on current and past prevention efforts revealed that these efforts depended on available funding. After one successful effort to reach the at-risk MSM population, one provider indicated that having a consistent presence in the community was fundamental to efforts to promote prevention activities. This need for health care professionals to have a presence in the community, yet not be a member of the community, underscored the complex intricacy of the influence of community values on prevention efforts.

B. Substance Use in Rural Areas

Representatives of community organizations and health care providers collectively reported alcohol consumption as an overarching and consistent factor associated with risky sexual behavior. Provider and community informants described circumstances for sexual opportunities surrounded by the availability of and access to alcohol. While understood as a significant factor in a host of socio-economic and health concerns, the role of alcohol in risky behavior in the MSM population cannot be ignored in prevention and educational activities.

C. Employment

Given the employment opportunities in Alaska (e.g., mining, fishing, and the oil industry), people are often drawn to the state in search of short-term jobs. Remote locations, severe weather, and lack of transportation contribute toward social isolation and create small communities populated primarily with transient male residents. This unique set of circumstances may trigger participation in risky sexual behaviors. The work environments pose incredibly difficult barriers for conveying health messages, including those related to HIV prevention.

VI. Recommendations for the MSM HIV Prevention Strategic Plan

The following recommendations are presented within the context that funding is an essential component to building and sustaining programs and supporting staff in the delivery of HIV prevention and education programs for the MSM population. Further, it is important to consider that Alaska has unique challenges with recruitment and retention of medical and public health professionals to provide services in rural areas.

- **Promote an integrated model of care, where health care service providers conduct HIV testing, counseling, and education, and administer hepatitis vaccinations as needed, while the patient is being seen for any health care concern**

An integrated care model builds on opportunities whenever they are presented to the health care team. For example, if an individual presents for care related to an upper respiratory infection or for an employment physical, the clinician has the opportunity to explore if the individual's immunization status is up to date or if screening/testing has been conducted, as well as deliver educational messages. Further, if an individual presents with symptoms related to an STI, in addition to diagnostic activities, the identification of sexual contacts could serve as a means for disseminating health messages on HIV prevention and safe sex practices.

- **Provide a wide range of HIV testing options and available products and/or services. Universal testing is recommended, in that it would normalize testing and reduce stigmatization**

In 2006, the Center for Disease Control and Prevention revised its recommendations for HIV testing of adults, adolescents, and pregnant women. HIV screening is recommended for patients in all health care settings after the patient is notified that testing will be performed unless the patient opts out (declines) screening.⁶ In support of a recommendation by local providers, home HIV test kits are another possible option to pilot, since seeking medical services can be challenging when residing in smaller communities and remote areas.

- **Support health care professionals in tailoring prevention efforts with case management for individuals diagnosed with HIV**

Health care professionals involved in current case management activities may be able to use patient interactions surrounding treatment and care to tailor prevention messages. For example, with a new diagnosis, in addition to the medical issues to coordinate, there is often an opportunity for simultaneous education during contact identification. A new diagnosis may provide a “teachable moment.” Additionally, in a busy clinic setting, an adaptation of the National Patient Safety Foundation “Ask Me 3” framework could be implemented with the following questions: 1) What is my main

⁶ CDC. Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings. MMWR 2006;55(RR14):1-17

problem?; 2) What do I need to do?; and 3) Why is it important for me to do this? This could promote better communication between service providers and clients and help clients understand the importance of knowing their status and seeking appropriate follow-up and care. (<http://www.npsf.org/askme3>)

- **Tailor HIV prevention and related health message strategies in a broad context and to a general audience, *never* specifically targeting the MSM population**

HIV prevention messages must be general in content and non-threatening in tone. Materials with the messages such as *Safe Sex*, *Tools for Safe Sex*, *Respect and Care for Yourself*, or *Healthy Relationships* are more likely to be widely read and received, as noted by local providers. While alcohol is recognized as a seriously negative influence in HIV prevention, providing safe messages wherever alcohol is available (e.g., package stores, airports, bars) may strengthen prevention messages.

- **Continue and expand the use of electronic and digital communication to disseminate health and HIV prevention messages, including health information, testing events, counseling and support services, and appointment reminders**

With the widespread use of electronic/internet communications, the Internet, chat rooms, instant messaging are important vehicles for accessing health information. The expansion of digital/cell phone capabilities throughout Alaska offers a promising venue for delivering HIV prevention messages and other health communication. Currently, few villages have cell phone service, though cell phone coverage is being extended throughout the state. New electronic and digital capabilities, such as text messaging, Twitter, and Facebook, provide additional opportunities for delivering effective health messages to hard-to-reach populations.

- **Conduct further studies, including online studies, to better understand possible HIV prevention interventions in challenging populations and environments**

Suggested topics for future studies and pilot testing include: evaluate effectiveness of internet health communications in accessing hard-to-reach populations (such as MSM) in Alaska; assess the feasibility of multiple HIV testing methods for rural (remote) Alaska populations; replicate evidence-based best practices from other states; and assess capacity-building among local community health providers and advocates as change agents for HIV risk reduction.

VII. Resource Inventory

Below is an annotated bibliography of peer-reviewed journal articles from 2000 to present on HIV prevention topics related to the MSM population. These articles can serve as a basis for evidence-based strategies and practice. In addition, information on HIV education and prevention activities and other resources related to MSM that are likely to contribute to HIV risk reduction are also included. This inventory is designed to complement the information provided in the *Alaska HIV Prevention Plan 2007-2009*.

MSM in Rural Areas

Preston, D. B., D'Augelli, A., R., Kassab, C. D. & Starks, M. T. (2007). The relationship of stigma to the sexual risk behavior of rural men who have sex with men. *AIDS Education and Prevention*, 19, 218-230.

The authors, researchers affiliated with The Pennsylvania State University, sought to explore the relationship high-risk sexual behaviors and stigma for rural MSM. Participants, 414 rural MSM living in Pennsylvania, were recruited through one of three means: questionnaires mailed to the mailing lists of a nonprofit political action group and a social/recreation group; through the assistance of an AIDS service organization that works with rural MSM in Pennsylvania; and through the distribution of questionnaires at events and venues targeting homosexuals and bisexuals. The questionnaire was very similar to that used in the authors' previous publication (Preston et al., 2004) with the addition of a scale measuring sexual sensation seeking; no scale items were included in the article. The authors determined that community stigma, and not family stigma, "lay the foundation for sexual risk-taking behavior" in rural MSM (p. 227). Further, perception of community stigma was indirectly related to sensation seeking and high levels of sexual risk-taking through health care provider and family stigma as well as internalized

homophobia and self-esteem. Limitations of the study include a non-representative sample and cross-sectional design.

Preston, D. B., D'Augelli, A., R., Kassab, C. D., Cain, R. E., Schulze, F. W. & Starks, M. T. (2004). The influence of stigma on the sexual risk behavior of rural men who have sex with men. *AIDS Education and Prevention*, 16, 291-303.

The authors investigated the effects of mental health variables and stigma on the level of sexual risk engaged in by MSM. Rural MSM (n= 99) living in 50 census designated rural counties in Pennsylvania were recruited from local social networks and events targeting the gay community. Sexual risk behavior was assessed using previously established criteria, as was stigma. Findings indicate that level of sexual risk was related to self-esteem and stigma dependent on participant's level of risk. The authors call for educational programs aimed at rural MSM that are sensitive to concerns specific to rural MSM, such as fear of accessing educational information.

Internet Survey Methods and Interventions for MSM

Blas, M. M., Alva, I. E., Cabello, R., Carcamo, C., Redmon, M., Kimball, A.M., Ryan, R. & Kurth, A. E. (2007). Internet as a tool to access high-risk men who have sex with men from a resource-constrained setting: A study from Peru. *Sexually Transmitted Infections*, 83, 567-570.

The authors examined the use of the Internet as a tool for accessing high-risk MSM populations in Peru; a population underserved in the current peer education system for STI interventions. Participants accessed the survey by clicking on one of two banner ads on a Peruvian website targeting homosexuals; banner ads were identical except one offered the incentive of free HIV testing and condoms for participation while the other did not. The banner ad offering an incentive was clicked on more often and resulted in more completed surveys (n = 713) than the banner that did not offer incentives (n = 411). The authors discuss the demographic and risk differences of participants who clicked on the banner offering an incentive versus the one that did not, as well as differences among participants who followed up on the incentive and those that did not.

Bowen, A.M., Williams, M. L., Daniel, C.M. & Clayton, S. (2008). Internet based HIV prevention research targeting rural MSM: Feasibility, acceptability, and preliminary efficacy. *Journal of Behavioral Medicine*, 31, 463-477.

The authors sought to examine the feasibility, acceptability, and initial efficacy of the Wyoming Rural AIDS Prevention Project (WRAPP); a project based on iterative research and the Information-Motivation-Behavioral skills model as a theoretical framework. Participants were recruited for the three-module intervention (all three modules can be viewed at <http://www.wrapphome.net/>) through banner ads placed on a gay men's website. Once eligibility was determined participants were randomly assigned to one of six module orders. Pretest data were collected before module access, posttest after module completion, and following each module participants had access to tailored printable messages based on their responses. Issues related to incentives, internal validity, demographic differences of participants, and attrition are discussed. The authors call for future research to expand on and support the findings of the current study and encourage dissemination of the WRAPP intervention.

Bowen, A. (2005). Internet sexuality research with rural men who have sex with men: Can we recruit and retain them? *The Journal of Sex Research*, 42, 317-323.

The author, a professor at the University of Wyoming, examined the efficacy of online banner ads in recruiting rural MSM for completing an internet survey. Participants, self-identified as either gay or bisexual, accessed the online survey (located at <http://www.wrapphome.net/>) by clicking on a banner ad located on a popular internet dating site. Participants in the "expected pay, paid" group and the "expected pay, not paid" group who rolled over a banner ad indicating a "Rural Men's Sex Survey" received the message, "Click here to see if you qualify to earn \$25." Participants in the "no pay expected, not paid" group responded to, "new banners in which no money was advertised" (p. 318). A total of 1,045 rural MSM - defined as minimum 60 minutes from an urban center- clicked on the banner ads; 314 participants initiated but did not complete the survey and 731 participants completed the survey. The author was able to identify correlates of HIV risk survey initiation and completion for rural MSM. Recommendations for future research include identifying efficient methods for recruiting and retaining minorities and non-gay identified MSM.

Bowen, A., Williams, M., & Horvath, K. (2004). Using the Internet to recruit rural MSM for HIV risk assessment: Sampling issues. *AIDS and Behavior*, 8, 311-319.

The authors compared demographic characteristics of rural men who have sex with men (MSM) recruited online with rural MSM recruited using conventional sampling methods. To compensate for differing definitions of rurality and to gain a better understanding of rural MSM in the north central region of the United States, the samples were stratified by city size, "to determine whether behaviors in frontier areas differ from those in rural areas" (p. 312). Participants ($N= 327$) were recruited via: traditional

sampling methods (56%) such as face-to-face contact, referral from friends in the study, or advertising in public places; or online (44%) through the use of banner ads placed on the www.Gay.com home page. Many characteristics, such as patterns of internet access and use and sexual risk behaviors, showed similar patterns across city sizes. In some ways, however, such as number of internet sex partners, the Internet sample engaged in more high-risk sexual risk behaviors. Overall, the Internet appears an advantageous tool for recruiting rural MSM.

Chiasson, M. A., Parsons, J. T., Tesoriero, J. M., Carbeallo-Diequez, A., Hirshfield, S. & Remien, R. H. (2006). HIV behavioral research online. *Journal of Urban Health: Bulletin of the New York Academy of Medicine*, 83, 73-85.

The authors present information specific to conducting internet-based research on sexual behavior with MSM populations. Topics of discussion include information on MSM and sex online, demographic and behavioral characteristics of MSM online, and internet-based outreach and prevention for MSM. A large portion of the paper is dedicated specifically to methodological and ethical challenges of internet-based research (e.g., recruitment and retention, public versus private behavior, and technical considerations). Finally, the authors encourage researchers to adapt “evidence-based HIV interventions” to the Internet-distributed self-help programs based on cognitive behavioral therapy that have proven successful for treating depression (p. 82).

Ross, M. W., Tikkanen, R. & Mansson, S.A. (2000). Differences between Internet samples and conventional samples of men who have sex with men: Implications for research and HIV interventions. *Social Science & Medicine*, 51, 749-758.

The authors, funded by the Swedish National Institute of Public Health, conducted a review of cybersex literature and compared data collected from identical online and traditional paper questionnaires. Participants were recruited for online survey, accessed via the Swedish federation for lesbian and gay rights webpage, from online chat rooms targeting men who have sex with men. Participants were recruited for online survey, accessed via the Swedish federation for lesbian and gay rights (RFSL) webpage, from online chat rooms located on the RFSL webpage that target MSM. Participants were recruited for paper surveys from different RFSL branches and key homosexual people in different areas of Sweden. Results of the study demonstrate that internet and paper samples differ in several demographic ways (e.g., age and rural versus urban residency) indicating modal biases in self-selected samples of MSM. The authors emphasize the ability to recruit large samples of MSM using internet questionnaires.

HIV Prevention and Intervention

Baldwin, J. A., Johnson, J. L., & Benally, C. C. (2009). Building partnerships between indigenous communities and universities: Lessons learned in HIV/AIDS and substance abuse prevention research. *American Journal of Public Health, 99*, 77-82.

The authors examined challenges specific to HIV and substance abuse prevention studies with American Indian and Alaska Native (AIAN) communities. Issues related to AIAN and HIV/AIDS including rates of HIV/AIDS and cofactors in the spread of HIV/AIDS, such as poverty and transiency between urban and rural areas, are discussed. Challenges regarding collaboration with AIAN populations and suggestions for building and sustaining successful partnerships with these populations are also considered. Recommendations for building a trusting partnership focus on active collaboration with the indigenous community at every step of the process- from the initial planning and designing of the program to data analysis, interpretation of results, and dissemination of findings.

Balsam, K. F., Fieland, K. C., Simoni, J. M., & Walters, K. L. (2004). Culture, trauma, and wellness: A comparison of heterosexual and lesbian, gay, bisexual and two-spirit Native Americans. *Cultural Diversity and Ethnic Minority Psychology, 10*, 287-301.

The authors compared cultural participation, trauma, physical and mental health, and substance abuse in a sample of two-spirit urban American Indian and Alaska Native (AIAN) participants with a sample of heterosexual urban AIAN participants. Two-spirit is a term meant to signify diverse gender and/or sexual identity in an AIAN or Canadian First Nations individual; in the current study participants self-identifying as lesbian/gay, mainly bisexual, or unsure were categorized as two-spirit. Participants were interviewed primarily by a Native American interviewer using a standardized protocol. AIAN participants were more likely to have experienced trauma, such as childhood physical abuse, in their past and to utilize psychological services and illicit drugs as adults. Implications for providing culturally sensitive services to two-spirit AIAN populations are discussed.

Bull, S. S., Lloyd, L., Rietmeijer, C., & McFarlane, M. (2004). Recruitment and retention of an online sample for an HIV prevention intervention targeting men who have sex with men: The Smart Quest Project. *AIDS Care, 16*, 931-943.

The authors analyzed recruitment and retention rates for MSM participating in an internet-based randomized control trial. MSM (n = 36) helped develop and test the online longitudinal prevention intervention project Smart Sex Quest, based on a project used in the AIDS Community Demonstration Projects that was proven successful in community settings. Participants were recruited in one of five ways: passive recruitment from a chat room, possible participants clicked the researchers screen names to access study site links; paid banner advertising on websites targeting MSM; paid advertising in print media directed at MSM; flyers sent to health departments and social service agencies in all 50 states; and messages sent to list serves targeting MSM. Eligible participants, individuals over 18 living in the US who spoke English, took a baseline risk assessment (no assessment questions were included in the article) and were randomly assigned to the control group- participants received generic didactic safe-sex information, similar to what is found on health related web-pages- or the intervention group- participants received tailored messages generated by computer algorithms based on baseline assessment information. Following completion of the initial assessment participants were sent an email asking them to return to the site in three months for a follow-up risk assessment. The authors explore which recruitment strategy was most successful and examine possible solutions for future reductions in attrition (the current study had an attrition rate of 84%). Methods of internet interventions that have proven successful in recruitment and retention as well as online methodological challenges are also discussed.

Bull, S. S., McFarlane, M., & King, D. (2001). Barriers to STD/HIV prevention on the Internet. *Health Education Research, 16, 661-670.*

The authors examined challenges to online interventions targeting STD/HIV that are not conducted as supplementary or adjunct to a clinic visit. Participants (n = 4601) were recruited for the survey (located at www.SexQuiz.org) from chat rooms and bulletin board sites where online partner solicitation was common. Reasons why individuals will and will not utilize internet education materials by method of delivery (i.e., E-mail, website, or chat room) are discussed. Men who have sex with men (MSM) were more likely to endorse E-mail, chat rooms, and websites as methods of delivering of STD/HIV prevention information they would use. This indicates that the Internet may be an effective way of delivering information on STD/HIV to MSM populations not utilizing clinics.

Bull, S. S., McFarlane, M., & Rietmeijer, C. (2001). HIV and sexually transmitted infection risk behaviors among men seeking sex with men online. *American Journal of Public Health, 91*, 988-989.

The authors report on data from an online sex quiz assessing demographics and HIV/STD risk behaviors conducted in 2000. The survey was posted on www.SexQuiz.org and 3248 males participated. The MSM participants are compared to non-MSM participants on demographic information (such as age at first sexual encounter) and sexual risk behaviors (such as having sex with partners met on the Internet). The authors encourage public health professionals to use the Internet in interventions for reducing HIV/STI risk, emphasizing that internet sex seekers vary demographically in key ways from the populations that STI/HIV programs generally target.

Chae, D. H. & Walters, K. L. (2009). Racial discrimination and racial identity attitudes in relation to self-rated health and physical pain and impairment among two-spirit American Indians/Alaska Natives. *American Journal of Public Health, 99*, 144-151.

The authors investigated the associations between actualization and racial discrimination and self-rated health and physical pain and impairment for a sexual minority American Indian or Alaskan Native (AIAN) sample. Participants (n = 451) were recruited to participate in the computer-assisted interview via one of three ways: targeted, partial-network, or respondent-driven sampling. Evidence indicates that for two-spirit AIAN individuals discrimination has a negative impact on health, varying by the individual's level of actualization. The current study, having been conducted on an urban population, "may not be generalizable to...two-spirit American Indians/Alaska Natives in rural areas" (p. 8).

Garrett, M. T. & Barret, B. (2003). Two spirit: Counseling Native American gay, lesbian, and bisexual people. *Journal of Multicultural Counseling and Development, 31*, 131-142.

The authors trace the history of the phrases two spirit and berdache as applied to Native American sexual minorities. The traditional views of sexual minorities in Native American cultures are discussed, as are contemporary views on the subject. Two profiles of two spirit individuals are included and implications for counseling this population are conferred.

Heckman, T. G., Silverthorn, M., Waltje, A., Meyers, M., & Yarber, W. (2003). HIV transmission risk practices in rural persons living with HIV disease. *Sexually Transmitted Disease, 30*, 134-136.

The authors sought to classify patterns of continued high-risk sex practices for a cross-sectional sample of HIV positive individuals living in rural areas. Participants were recruited from nongovernmental health care and social service organizations to complete the mail delivered survey. Most of the male participants had sex only with men (60 %) and over 50 % of all the HIV positive participants reported engaging in unprotected intercourse. The authors indicate that while past research has demonstrated that HIV positive urban participants reduce risky sexual behaviors after interventions delivered in face-to-face group settings, such interventions are not appropriate for rural populations; therefore, internet videotape, or telecommunication delivery modalities should be explored for rural HIV infected populations.

Johnson, W. D., Holtgrave, D. R., McClellan, W. M., Flanders, W.D., Hill, A. N., & Goodman, M. (2005). HIV intervention research for men who have sex with men: A 7-year update. *AIDS Education and Prevention, 17*, 568-589.

The authors conducted a review and meta-analysis of 54 behavioral HIV prevention interventions targeting men who have sex with men (MSM); 26 small group interventions, 18 individual level interventions, and 10 community-level interventions were evaluated. Results for interventions contrasted against minimal to no HIV prevention control conditions are presented independently from those where interventions are contrasted against standard or other HIV prevention conditions. For small group and individual-level interventions the most favorable effects were found when perceptions of risk and losses were addressed (i.e., “unsafe sex exposes you” emphasis rather than “safer sex protects you”), for community-level interventions those that emphasized personal skills (e.g., self-reinforcement) had the most favorable effects. The authors encourage the use of individual-level interventions when targeting highest risk clients.

Noar, S. M., Clark, A., Cole, C., & Lustria, M. L. A. (2006). Review of interactive safer sex web sites: Practice and potential. *Health Communication, 20*, 233-241.

The authors, researchers at the Department of Communication at the University of Kentucky, examined how web sites that focus on safe sex and target e-health information seekers are promoting safer sexual behaviors. Specifically the authors examined: how web sites are directing their messages to specific population sub groups, such as MSM; what safe sex messages and theoretical strategies are being

employed by web pages; and the degree to which web pages are utilizing interactive and technical features. A total of 21 safe sex websites met the inclusion criteria and were coded on several features. Results indicated that almost half (48%) of all web sites contained content specific to gay, lesbian, bisexual, and transgender individuals and over two thirds (67%) of web sites had STDs as the primary focus. Discussion topics include the need for more tailored/targeted information, more information regarding reducing the number of partners, and the missed opportunities for interactivity of web sites.

Poon, C. S., & Saewyc, E. M. (2009). Out yonder: Sexual-minority adolescents in rural communities in British Columbia. *American Journal of Public Health, 99*, 118-124.

The authors examined a population-based sample of lesbian, gay, or bisexual (LGB) adolescents (weighted n= 6905) taken from respondents to the British Columbia Adolescent Health Survey of 2003. Rural LGB adolescents were compared to their urban counterparts; age was controlled for and analyses were conducted by gender. Results were mixed, however, sexual minority boys were more likely to consider suicide, be the victim of dating violence and physical sexual harassment, and engage in binge drinking. The authors discuss the need for future interventions to consider the rural-urban status of sexual minority youth in the future and specifically call for interventions to be adapted for the needs of rural individuals.

Silenzio, V. M. B. (2003). Anthropological assessment for culturally appropriate interventions targeting men who have sex with men. *American Journal of Public Health, 93*, 867-871.

The author, a physician with the Department of Family Medicine at the University of Rochester, discusses the importance of considering social factors for public health professionals working with prevention of HIV in MSM populations. General social organizational frameworks of same-sex phenomenon are discussed and examples are given; for example the Native American concept of the berdache is provided as an example of a gender-defined pattern of MSM. The author proposes that public health workers utilize rapid ethnographic approaches to design or evaluate interventions targeting MSM. Action steps and objectives for rapid ethnographic assessment for MSM are outlined.

Information, Projects and Websites

AIDS Committee of Toronto (n.d.). Retrieved July 10, 2009, from <http://www.actoronto.org/>.

The AIDS Committee of Toronto (ACT) hosts a highly informative webpage detailing their work and services for gay and bisexual men, youth, and women at high risk for HIV/AIDS. ACT partners with Portuguese-speaking communities so many pages and links offer bilingual information. Links include a “research with a purpose” tab that includes, among other things, an HIV/AIDS library and findings from their research projects. The Information tab links to such information as a safer sex page and educational campaigns.

Centers for Disease Control and Prevention (2008). Replicating effective programs plus. Retrieved July 9, 2009, from http://www.cdc.gov/hiv/topics/prev_prog/rep/index.htm.

Replicating Effective Programs (REP) Plus is a site that outlines REP programs and offers other related resources. REP programs are, “tested, science-based behavioral interventions with demonstrated evidence of effectiveness” for reducing risky sexual behaviors or increasing safer sex practices (pp. 2). Programs have been packaged in such a way as to be delivered in different settings (e.g., health clinics, shelters, etc.) or to different populations.

Centers for Disease Control and Prevention (2007). Fact Sheet: HIV/AIDS among men who have sex with men. Retrieved July 6, 2009, from <http://www.cdc.gov/hiv/topics/msm/resources/factsheets/msm.htm>.

While this webpage, posted by the Centers for Disease Control, was last updated in 2007, the most current data discussed are from 2005. Information detailed in the webpage is broken into several sections: statistics, including such subcategories as HIV/AIDS in 2005 and transmission categories of male adults and adolescents with HIV/AIDS diagnosed with 2005; risk factors and barriers to prevention, which includes sexual risk factors and substance use; and prevention. The concept of rurality is not discussed as an issue. However, social discrimination and cultural issues are addressed in the risk factors and barriers to prevention section.

Centers for Disease Control and Prevention (2007, May 17). HIV prevention among men who have sex with men: Cross-cutting challenges and multiple health threats. *Centers for Disease Control and Prevention Podcast* retrieved from www2a.cdc.gov/podcasts/media/pdf/hiv_04_051707.pdf

Moderator Dr. Rob Janssen interviews Mary McFarlane of the CDC's division of STD prevention and Mary Ann Chaisson and colleagues from the medical and health research association in New York City. Discussion focuses on the impact of the Internet in HIV risk for men who have sex with men (MSM) and specific issues for rural MSM are discussed. The successful use of the Internet in reaching MSM populations that are hard-to-reach via traditional recruitment- such as non-gay identified MSM, and MSM in rural areas- is also discussed. Further, the intersection of psycho-social health conditions and HIV in MSM is discussed, as are ways to incorporate partnerships with agencies serving health needs of MSM in interventions.

Colorado State University (2008). Commitment to action for 7th-generation awareness & education: HIV/AIDS prevention project. Retrieved July 8, 2009, from <http://www.happ.colostate.edu/index.html>

The Ethnic Studies Department at Colorado State University, with funding from the Centers for Disease Control, developed the Commitment to Action for 7-th Generation Awareness & Education: HIV/AIDS Prevention Project (CA7AE:HAPP). CA7AE:HAPP uses the Community Readiness model to assist communities in developing community specific interventions. The webpage offers downloadable community readiness model downloads- including presentations and training materials.

Lgbthealthchannel (2001). Safer sex & STD prevention for gay & bi men: Overview. Retrieved July 7, 2009, from <http://lgbthealth.healthcommunities.com/stdmsm/index.shtml>.

Lgbthealthchannel is a webpage where authorities on LGBT health issues dispense information relevant to the health of lesbian, gay, bisexual, and transgender individuals. The overview page on safer sex and STD prevention for men who have sex with men (MSM) gives an overview on which STDs can be transmitted through which specific sexual behaviors. For example, the author outlines seven STDs that one can transmit/contract through penis-to-anus penetration without a condom, with or without ejaculation. For each specific sexual act the author also details how to engage in the sexual act in a safer manner. Pages linked to include: specific sexual behavior; fetish & alternative sexual behavior; sexual paraphernalia; drug use; STD prevention; living with STDs; and find a doctor.

Managing Desire (n.d.). Gay sex without regret: What's safe for you. Retrieved July 6, 2009, from <http://www.managingdesire.org/GaySexWithoutRegret.html>.

ManagingDesire is a webpage developed by a doctorate student in medical anthropology at the University of California Berkeley in conjunction with the HIV Prevention Section of the Berkley Free Clinic. *ManagingDesire* is based on four principles two of which are: one, "We learn best through talk with peers rather than through top-down instruction"; two, "Humor and controversial analogies encourage creative thinking about HIV prevention." Based on these principles some of the language and images used on this web page may be construed as graphic and/or inappropriate. Topics covered on the page include what safe sex is, how to be safe while engaging in a number of specific sexual behaviors, and "condom hints."