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Developing a partnership for HIV primary prevention for men at high risk for HIV infection in rural communities

Although the transmission patterns may be clear, the total number of HIV infections worldwide among men who have sex with men (MSM) remains unclear, for both urban and rural areas. The Joint United Nations Program on AIDS [UNAIDS] (2000a) indicates that sex between men is one of the major forces behind the HIV epidemic in many high-income countries such as Australia, New Zealand, the United States, and in some regions of Western Europe and Latin America. In these countries, prevalence remains highest among those infected through male same-sex sexual activity. In other places, transmission through a combination of sexual contact possibilities (i.e., homosexual, heterosexual, and commercial) and the use of intravenous drugs appears to dominate reasons for prevalence, although indicators suggest heterosexual transmission is the main cause. This is true for most developing countries.

Using health promotion and education to lower the incidence of this health problem, primary prevention for HIV disease has focused on promoting health among people at risk (Kroger, 1991). The distinct social and cultural characteristics of rural settings provide different challenges for the design and dissemination of methods to prevent the transmission of HIV through sexual contact between men. For example, in the United States, while the primary prevention and education efforts about the HIV epidemic have had a positive influence on the behaviour of MSM in general (Paul, Hays, & Coates, 1995), some suggest that MSM living in low HIV prevalence areas tend to engage in higher risk behaviours despite perceived risk (Hospers & Kok, 1995).

In describing the current incidence of HIV infection due to male same-sex sexual activity, UNAIDS (2000b) explains that in many countries around the world, same-sex sexual activity among men is not socially accepted. Male same-sex sexual behaviour exists in every society and in many countries. Men have sex with other men for many reasons (e.g., pleasure, economic, compulsion, from lack of availability of women, or for a combination of these reasons). In many countries, there are strong taboos about sex between men, and this can lead to risky behaviour. When MSM are likely to be stigmatised, they are far more likely to hide their sexual behaviour, have secret sexual alliances, or have rushed sexual encounters with other MSM. During such encounters there is little time for or interest in negotiating condom use. Male sexual behaviour sometimes involves penetrative anal sex, an act that carries with it a high risk of HIV infection.

This paper identifies a collaborative approach used to access a difficult-to-reach MSM population at risk for HIV infection in a rural area of the United States. To develop and implement an HIV prevention programme, an HIV prevention educator networked through social, political, and institutional structures by emphasising the involvement of a state government district health department, a community-based AIDS agency, MSM (gay and bisexual) gatekeepers, gay bars, and informal groups of rural MSM. The goal of the intervention was to lower unnecessary HIV incidence through building HIV-related support and partnership. Later, a university research team studying the effects of stigma became involved. The project reconsidered and redefined the role of the public health entity and university-based research in relation to conducting naturalistic (i.e., community, clinical, or institutional settings) social science programming and research.

Urban/rural psychosocial effects on MSM support and HIV-related action

In many urban areas, there are gay bars, restaurants, churches, and other community gathering places. In some cities there are complete neighbourhoods of gay people, which reinforces a sense of pride, supports gay identity, and makes it easier to develop support networks (Garnets & D'Augelli, 1994). The "more connected" urban gay community and "less conservative" general community allow for faster and more efficient mobilisation of resources. These are needed to develop strong primary prevention programmes to decrease risky behaviour and encourage one to seek testing for HIV antibodies, in part because the urban gay community is well organised and more aligned politically (UNAIDS, 2000b). In contrast, the structure for

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MSM support development in rural settings is distinctly limited (D'Augelli & Hart, 1987; D'Augelli, Hart, & Collins, 1987). Similar populations in rural communities are usually fragmented and disenfranchised which can make securing resources for HIV primary prevention education limited and difficult (Lindhorst, 1997; Mancoske, 1997; Smith, 1997; Sowell, 1996). In most rural areas, it is not possible to go to a neighbourhood gay bar or restaurant, determine which recreational or social group to join to affirm one's "gay identity", socialise with men who have extensive exposure to current HIV information, or learn where the next safer-sex workshop will be held.

Limitations for HIV support and prevention education for rural MSM are intensified by social characteristics that are traditional of rural areas. Rural community members tend to be more "tightly knit" and to know one another which makes it more difficult to maintain privacy and confidentiality (Rounds, 1988). Religion plays a larger role in shaping more traditional moral values. Religious beliefs may breed a lack of tolerance for diversity, enforce strong homophobic reactions and discrimination, preclude homosexuality as acceptable behaviour, and interpret homosexuality as a sin (Bell, 1991; Frierson, Lippman, & Johnson, 1987; Ginsberg, 1976; Heath, 1992). These characteristics have made it difficult for rural MSM to seek help from natural support networks including family, friends, and professionals who provide support (Frierson, Lippman, & Johnson, 1987; Rounds, 1988). Due to the fear of being ostracised within the community, many rural MSM may avoid seeking help; hide their illness; or delay seeking diagnosis, treatment or care in urban areas, mainly due to the stigma associated with the disease and their lifestyle (Carwein, Sabo, & Berry, 1993; Sowell, 1996). Since opportunities for support networks can be virtually non-existent, many MSM travel long distances simply for social contact with other MSM (Smith, 1997). The culture of intolerance and lack of confidentiality in rural areas can result in "watered down" HIV/AIDS education that has little value for MSM, and may make MSM reluctant to participate in educational programmes (Bell, 1991).

Theoretical approach

Minority groups bring a different set of perceptions, needs and interests with them to health education. Therefore, health educators and planners may find it necessary to adjust programme planning, content or methods to the individual needs and interests of the specific minority community. From a health education perspective, the sharing of the mission and objectives among the institutions of a community and their leadership is key to the battle against HIV. There are a variety of community organisations that are appropriate for HIV prevention efforts and can provide input to effective programming (e.g., voluntary health agencies, government, educational institutions, health care providers, social groups and organisations) (Eng, 1993). Viewing and utilising the institutions of a community as a system can provide the platform that is crucial to planning and implementing preventive programmes. According to Butterfoss, Goodman, & Wanderman (1993), a collaborative, cooperative arrangement can do the following:

- Create more public recognition and visibility;
- Expand the scope and range of available services;
- Provide a more systematic orientation;
- Promote a comprehensive approach to planning, implementation and evaluation;
- Enhance the clout in advocacy and resource development;
- Improve opportunities for new pilot projects;
- Prevent the duplication of services while filling gaps in service delivery;
- Accomplish what single members cannot.

Programme planners relied upon a variation of the Program Evaluation and Review Technique (PERT) to develop the goal of the planning process and to list its sequences and activities (Breckon, Harvey & Lancaster, 1998). This applied planning model allowed planners to target the rural MSM community utilising principles of the "rolling ball" planning process. The process implies that programme development takes place in a stepwise fashion, similar to a ball rolling forward. The rolling ball concept also allows health educators and planners to utilise aspects of other popular planning methods. Planners engaged the PRECEDE model to establish priorities, identify the rural MSM community HIV prevention issues (epidemiological and social diagnosis as well as educational diagnosis), and allocate resources to achieve objectives (Green & Kreuter, 1991). The PROCEED model was used to develop a timetable for planning and implementation, assign responsibilities and construct a budget. Finally, a key element of the Planned Approach to Community Health (PATCH) model is local ownership (United States Department of Health and Human Services [USDHHS] (1993). This model assisted planners in examining enabling factors that may increase participation to HIV prevention and education by the rural MSM community in local gay bars and other prevention sites. The overall concept of this programme emphasised the multi-disciplinary nature of the health education field and the application of multiple approaches.

Project strategy and results

Principle 1 - Planning the process: Health education planners researched the rural MSM community regarding who should be involved in the project, when the best time was to plan such a project, and where the project planning should

occur. The approach centred on first identifying key gatekeepers for the informal and largely underground MSM population in the area. These gatekeepers were men who were well connected in several small gay groups and previously held positions of power by having been leaders of a gay group that had since dispersed. Another identified key player in this programming was a public health nurse. She had special HIV training through the Centers for Disease Control and Prevention. Her participation was essential to the success of the programme because she was well known to many of the MSM through her work at a local public health clinic providing HIV-related testing and services.

Principle 2 - Planning with people: Health educators have learned that consumers of the programme should be involved and/or consulted in the early stages of the planning process. The gatekeepers agreed to organise several focus groups of men they knew at two local gay bars. Both bars attracted heterosexual customers in the afternoon and early evening, and a gay clientele in the late evening. One bar attracted older, white, blue collar MSM, while the other catered to younger men, many of whom enjoyed cross-dressing. Ten focus groups were held in the bars over a period of three months. Among the questions men were asked were what educational interventions they thought were needed and what interventions they thought would work. The focus groups agreed that the most reasonable approach to reaching most men would be through the two local gay bars and that the two gay bars could work as specific targets for "themed" health education "parties" encouraging HIV risk-reduction. It was felt that the positive atmosphere of the bars would allow men to learn about HIV issues on their own "turf," in a way that would not be stigmatising nor require self-labelling.

Principle 3 - Planning with data: There is little published research about issues related to MSM and HIV/AIDS in rural areas. Furthermore, there is limited research available on characteristics of rural MSM, their psychosocial circumstances, their sexual risk behaviour, and few risk-reduction interventions have been documented that targets rural MSM. Nevertheless, the health education planners reviewed scant literature on rural MSM communities, local vital statistics on sexually transmitted diseases and HIV infection rates, as well as previous outreach efforts targeting the rural MSM community. This effort provided crucial baseline information and assisted in the planning process.

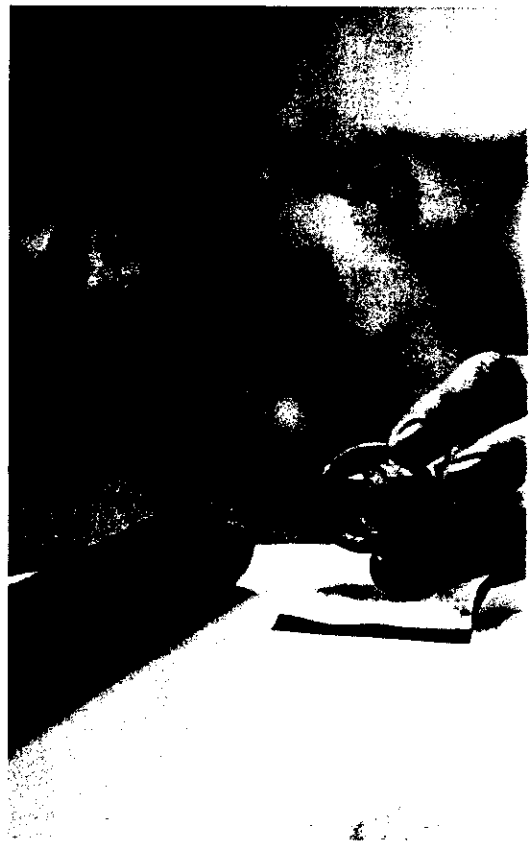
Principle 4 - Planning for permanence: The gatekeepers agreed that there were few formal venues for reaching local MSM in the rural area. There was no local social centre or even a local newsletter for the gay community. The bars were previously owned by gays but were now owned by heterosexual people. The gatekeepers met with and gained the support of the owners of the bars, as well as their managers and bartenders, with a proposal for a series of health "parties" at their establishments.

To attract participants, the parties featured free snacks, door prizes, sport bottles with the local AIDS hotline number, an HIV/STD roulette wheel game, a condom decorating contest, appearances by local drag entertainers, a lesbian comedian, a gay magician, and D. J. dance music. The health features of the parties included free on-site Orasure HIV testing, syphilis testing, influenza vaccinations, the first in a series of hepatitis B immunisations with appointments for follow-up shots, condoms, health materials and mini presentations by the local public health nurse. During the parties, she was introduced to the crowd by the local drag queens who provided entertainment (hence she was given legitimacy in that context and was seen to be a supportive resource), and she mingled among the men. She encouraged men to be tested on the spot, emphasising that testing could be confidential or anonymous. At each event, additional volunteers were recruited to help with subsequent events. For many of the men (as well as women who were also clients of the bars), this was their first experience of "volunteer" work for their own local gay community, and it fostered a sense of pride that had not often been experienced in this area. Over a period of 14 months, a series of "themed" parties were held at the bars titled "Hot'n Healthy", "Celebrate the Magic... of Safer Sex", "Latex Luau", and "Valentine Latex, Love and Life Party".

In addition, outreach was provided as part of previously planned summer events (i.e., a "Love Boat Cruise", a series of gatherings at a local amusement park, and informal gay summer picnics).

Principle 5 - Planning for priorities: The health education planners emphasised balancing the needs of the rural MSM community with the resources available from the "institutions" (i.e., community-based AIDS agency, public health department, bar owners, key gatekeepers). In addition to staff leadership (i.e., staff time for meetings during non-traditional office hours during evenings and weekends, coordination of events), resources for the programme also included funds for mailings, publicity, health promotional materials, and training for the public health nurse in counselling sexual minorities at the HIV test sites.

Principle 6 - Planning for measurable outcomes: The specific objectives of the current programme were to increase HIV awareness and access to HIV antibody counselling and testing services among the rural MSM community, and reduce the unintentional spread of HIV infection



through HIV primary prevention education. The development of the objectives was based upon Healthy People 2000 (USDHHS, 1990) and Healthy Communities 2000 (American Public Health Association, 1991) recommendations.

Principle 7 - Planning for evaluation: Evaluation should be systematically incorporated into the programme design. The process of planning for evaluation supports the role of health education planners in asking on-going questions of gatekeepers and participants as a team to determine ideas for outreach and whether the tools for evaluation are adequately assessing the programme goals and objectives. Health education planners regularly reviewed the programme with key gatekeepers and participants and examined the data regarding numbers screened for HIV and syphilis, and the number of participants receiving immunisations.

In 1999, planners networked with a local university and entered into a partnership with researchers who were beginning a pilot study to evaluate the impact of stigma and rural culture on HIV-related attitudes and risk behaviours of rural MSM. Researchers found it difficult to access the available sensitive MSM population for research. The "themed" parties allowed an opportunity for the researchers to gain access to this population for research purposes. The data gathered could then be used to augment the scant literature about rural MSM and to supply AIDS support agencies with needed documentation for policy and funding purposes.
The project was renamed "Country Boyz" to promote relevance for the rural MSM community and to promote a common link among the parties involved. The researchers utilised the previously identified gatekeepers to access study participants at the themed parties and summer events. Distributing surveys at bars and summer events, over 100 MSM completed the 40 - 50 minute survey and provided important data. In a preliminary analysis of the data, it is believed that mental health has a direct impact on male same-sex sexual behaviour in rural areas. In addition, stigma, as represented by the perception of attitudes among MSM of family and friends, health care providers, and community members, has an indirect impact on HIV-related attitudes and behaviours of rural MSM (Preston, D'Auguelli, Cain & Schulze, in press). Evaluation with key gatekeepers and

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