

**ISSUES IN THE DEVELOPMENT OF  
HIV-PREVENTIVE INTERVENTIONS  
FOR MEN WHO HAVE SEX WITH MEN (MSM)  
IN RURAL AREAS**

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di:

- Deborah Bray Preston PhD, RN -School of Nursing The Pennsylvania State University University Park, PA 16802

- Anthony R. D'Augelli, PhD - Department of Human Development and Family Studies -The Pennsylvania State University University Park, PA 16802

- Richard E. Cain, PhD Department of Education and Physical Education Rhode Island College Providence, RI 02908

- Frederick W. Schulze, DEd, CHES - Public Health Educator - Pennsylvania Department of Health - Williamsport, PA 17701

**Abstract**

Interventions aimed at reducing HIV-related sexual risk behaviors among men who have sex with men (MSM) have been highly successful in urban areas in reducing the incidence of new cases of HIV infection. In rural areas, where the rates of infection are increasing, issues of culture, population density, isolation, and lack of access to health care services present different challenges for the design and dissemination of preventive interventions. In this paper, we will discuss the issues related to the development of preventive interventions for rural MSM, and propose a model of intervention based on preliminary findings from a recent study of rural MSM.

A paramount goal of the federal plan, Healthy Communities 2010, is to eliminate the transmission of HIV infection by helping communities mobilize to provide preventive interventions (U.S. Department of Health and Human Services, 2000). Nowhere is attaining this goal more important than in rural America, where the issues related to HIV/AIDS are critical in the face of increasing numbers of persons with HIV/AIDS and the restricted care that is available to them. Although HIV incidence rates in non-metropolitan areas declined slightly between June 1998 and June 1999 (from 7.4 to 6.2 per 100,000), the cumulative number of rural individuals who are seropositive represents nearly 6% (over 42,000) of all such individuals nationally (Centers for Disease Control and Prevention, 1999). These figures do not include the number of people who return to families in rural areas after being diagnosed with HIV elsewhere (Sowell & Christensen, 1996). Current estimates are that 18 to 50% of people who become infected in cities return to rural areas, whereas only 8% of those diagnosed in rural areas out-migrate (Davis, Cameron & Stapleton, 1992; Townsend, Suarez, & Reed, 1990). People who return to rural communities are often in the advanced stages of the HIV-related illnesses, and return to families for supportive care (Berry, McKinney, & McClain, 1996; Sowell & Christensen, 1996). Although the epidemiology of rural AIDS is not clear, informal indicators suggest an increase in the number of rural residents infected as a result of male same-sex sexual activity (Berry, 1993; Karon & Berkelman, 1991; Cohn, 1997) and intravenous drug use (Steel & Haverkos, 1992).

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. Both definitional matters relating sexual behavior to identity and the social position of same-sex activity in rural contexts make the articulation of principles of intervention complex. Whether there is a “rural” culture is surely as debatable as whether an “urban” culture exists, and such monolithic thinking may obscure within-setting variability related to gender, ethnic and racial background, socioeconomic power, and so on (Baer, Johnson-Webb, & Gesler, 1997). Yet population density, geographic isolation, and less tolerance of difference can distinguish urban from rural settings in powerful ways. Furthermore, the history of the HIV epidemic and responses to it have been heavily urban in nature, reflecting the prevalence and impact of HIV infection and disease. 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.

The integration of gay and bisexual men and their communities into the larger social fabric--however fractious it may be in cities--hardly occurs in rural settings. This is due in great part to the stigma associated with homosexuality. In most rural areas, it is not possible to go to a neighborhood gay bar or community setting, socialize with men who have extensive exposure to current HIV information, learn where the next safer-sex workshop will be held, and determine which recreational or social group to join to affirm one's "gay identity." Thus, the opportunity structure for lesbian and gay development in rural settings is distinctly limited (D'Augelli & Hart, 1987; D'Augelli, Hart, & Collins, 1987). Places for social and sexual contact are far fewer, the ability to develop close same-sex relationships in an open way is compromised, and the chance for the development of a gay community is undercut by the powerful force of invisibility.

Unfortunately there is little published research on issues related to MSM and HIV/AIDS in rural areas. In a study of psychosocial differences between rural and urban people living with HIV/AIDS, Heckman, Somlai, Kalichman, Franzoi and Kelly (1998) found that the rural respondents reported lower life satisfaction, less social support, reduced access to medical care, more community stigma, and more problems with confidentiality than urban residents. In addition, rural respondents reported decreased well-being, and more barriers to accessing health care, such as lack of trained health care providers and transportation problems. Some research suggests that men who live in low HIV-prevalence areas (such as rural areas) also tend to engage in higher risk behaviors (Hospers & Kok, 1995). This risk is increased by the migration of HIV-positive people to rural areas that was noted above. Unfortunately, there is no available research on characteristics of rural MSM, their psychosocial circumstances, or their sexual risk behavior. Moreover, few risk reduction interventions target rural MSM.

In this paper, we discuss issues related to the development of preventive interventions for rural men who have sex with men (MSM). In addition, we will propose a general model of intervention for HIV prevention for MSM in rural areas. Based on findings from a recent study of MSM in rural Pennsylvania and on our experiences working in communities in rural Pennsylvania, we consider how prevention programming might be designed to meet such men's needs.

## **Psychosocial Barriers Related to HIV Prevention in Rural Society**

Rural society differs from urban society in several significant ways relevant to HIV prevention. Rural people tend to be more supportive of conservative values and less tolerant of diverse populations. Strong religious beliefs play a major role in shaping the values, attitudes, and social norms of rural communities (Sowell & Christensen, 1996). Religion is viewed as a guide for acceptable behavior, and there is little appreciation for variations from the traditional family lifestyle (Smith, 1997). Moreover, because of the "small town grapevine," it is difficult to maintain privacy, and confidentiality is a major problem (Martinez-Brawley & Blundall, 1989). Many MSM living in rural areas cannot risk rejection or ostracism from friends and family, and therefore do not disclose their sexual orientation. Because of this, many rural MSM internalize feelings of social rejection, and internalized homophobia can develop (Smith, 1997). This form of cultural and social oppression has been shown to contribute to substance abuse (Kus & Smith, 1995).

Persons closely associated with rural MSM such as family members and personal friends are also at risk for social rejection (Mayne & O'Leary, 1993). This is termed *courtesy stigma* by Goffman (1963). For example, Anderson and Lane-Shaw (1994) found that stigma that included fear of social disapproval, a blemish on family identity, or loss of prestige in the community, were reasons given by family members for not disclosing the HIV status or sexual orientation of a relative. Rejection of rural MSM by their families (or at least, by some family members) is not uncommon (Heath, 1992; Sowell & Christensen, 1996; Weitz, 1991). In addition to the aforementioned issues, geographic isolation and a lack of networking opportunities with other MSM mean that gay and bisexual men may experience social isolation (Mancoske, 1997). Although stigma, rejection, and social isolation are also present in urban areas, the anonymity associated with higher population density means that gay and bisexual men are more likely to be "connected" to a local gay community and have much less fear about the consequences of the disclosure of their sexual orientation to families and friends. Most urban communities have lesbian, gay, and bisexual community centers, bookstores, clothing shops, bars, restaurants, places of worship, and other gathering places; indeed, in some cities, there are complete geographical neighborhoods containing high concentrations of lesbians and gay men and an infrastructure to serve them (Garnets & D'Augelli, 1994). Having these support networks reinforces a sense of pride and supports gay identity. In rural areas, these rich cultural opportunities and support networks can be virtually nonexistent, and many lesbians and gay men travel long distances simply for social contact with other gay people (Smith, 1997).

Another major difficulty for MSM in rural communities is access to appropriate health care. Rural infrastructures that involve isolation, poor public transportation, shortages of medical and social services, fewer health care providers, limited technological resources, and higher proportions of people without medical insurance all are barriers to care (Graham, Forrester, Wysong, Rosenthal, & James, 1995; Sowell & Christensen, 1996). Other difficulties include problems with laboratory follow-up and diagnostic testing, insufficient numbers of personnel trained in advanced HIV/AIDS care, lack of outpatient and inpatient services, lack of availability of consultation services including social, mental, and case management services, and poor coordination of services (Graham, et al., 1995; Helms, 1993). Moreover, because fears of loss of privacy can be such a serious problem, some rural MSM travel to urban areas for testing and care (Foster, 1997).

Quality of care is an added concern. For example, sophisticated knowledge and skills are necessary to detect HIV infection to provide early intervention (Hinman, 1991; Roper, 1991). Dissemination of such knowledge into rural areas tends to be slower than in cities, adding to the difficulty of rural health care providers to deliver up-to-date care to HIV-positive individuals (Sowell & Christensen, 1996). Once individuals learn they are HIV-positive or have AIDS, aggressive biomedical and psychosocial interventions are necessary to limit morbidity (Osmond, 1994). Geographic isolation can also limit the participation of these individuals in experimental drug trials. In addition, drug treatment can be difficult, especially if people become sicker and have problems traveling to urban centers for specialized care (Berry, McKinney & McClain, 1996).

The negative attitudes of local rural health care providers toward MSM can be serious impediments to obtaining quality care and support. Professionals who are uncomfortable caring for gay and bisexual men (or men who acknowledge sexual contact with other men, regardless of their self-identification) are generally more unfamiliar with most aspects of gay culture, and often attribute homosexuality to learning or choice rather than to complex causation (Schwanberg, 1996). Homophobia remains common among physicians, nurses, and other health care workers. In a survey of MSM and lesbians, Schatz and O'Hanlan (1994) found widespread evidence of discrimination against MSM by physicians. Other researchers have found evidence of discrimination in care and unwillingness to care for both MSM and people with HIV/AIDS among physicians and dentists (Bennet, Weyant & Simon, 1993; Bernstein, & Rabkin, 1990; Clarke, 1993; Gerbert, Maguire, Bleeker, Coates & McPhee, 1991; Kelly, St. Lawrence, Smith, Hood, & Cook, 1987). Similar results were found for rural nurses (Preston, Forti, Kassab, & Koch, 2000) and social workers (Lindhorst, 1997). Gay and bisexual patients with AIDS are seen by some health care

providers as having a lower level of personal competence and moral worth, and are often viewed as responsible for their illness (Schwanberg, 1996). Moreover, rural health care providers who assist MSM who are “out” are often viewed by others in the community as behaving in a manner inconsistent with local values, and their reputations can suffer (Foster, 1997).

### **Stigma and Risky Sexual Behavior among Rural Men Who Have Sex with Men**

During the past decade many studies have examined the determinants of risky sexual behavior of MSM. Overall, results have shown that high-risk sexual behavior is related to a preference for receptive anal sex (McKusick, Coates, Morin, Pollack, & Hoff, 1990); having multiple sexual partners, inconsistent condom use, and high substance use during sexual encounters (Ostrow, Beltran, Joseph, DiFranceisco, Wesch, & Chmiel, 1993); demographic variables such as age and education (Kelly et al., 1992); and, several psychological variables such as self-efficacy (McKusick, Horstman & Coates, 1985), depression (Beltran, Ostrow, & Joseph, 1993), low estimation of perceived risk (Hospers & Kok, 1995), and sensation-seeking (Kalichman, Heckman, & Kelly, 1996; Kalichman, Nachimson, Cherry, & Williams, 1998). Most of the studies conducted to date have documented these risky sexual behaviors among urban MSM (Berry, 2000).

Few studies have explored the effects of the stigmatization of same-sex sexual orientation on MSM’s sexual risk behaviors, although the stigma associated with sexual orientation and HIV/AIDS remains powerfully conflated, and this association presumably has important physical and mental health consequences. Findings from an exploratory study of 99 rural MSM aged 18 to 69 conducted by the authors (Preston, D’Augelli, Cain, & Schulze, 2000) indicate a relationship between stigma and levels of risky behavior. Categorizing respondents into differential risk categories using criteria suggested by Ostrow, DiFranceisco and Wagstaff (1998), we found that nearly half (47%) reported sexual behavior that could be classified as moderate to high risk. For example, over 50% reported they had receptive anal sex in the past six months, yet 37% used a condom only some of the time and 56% reported multiple sexual partners. Furthermore, almost 30% stated they had never been tested for HIV. Of the untested MSM, 15% were not tested because they felt they were at low risk, while 6% avoided testing because they were afraid to learn the results. In addition, although a direct relationship between stigma and rural MSM’s risky sexual behaviors could not be determined, stigma from families, health care providers, and their rural communities was related to low self-

esteem among the men. This was in turn related to high levels of risky sexual behavior. These results suggest an indirect relationship between stigma and sexual risk behavior of MSM that is mediated by feelings of self-worth. Although more complex analysis needs to be done on these issues, the findings to date indicate that rural MSM are a heterogeneous group, that some are at risk for HIV infection, and that the culture of rural society--especially reflected by the views of MSM's families and their communities--plays a role in how they live as gay and bisexual men, and may be indirectly implicated in risky sexual activities. Clearly, interventions directed at rural MSM must enhance self-esteem among men whose personal identity is deeply stigmatized by their social context.

### **A Model of Preventive Intervention For Rural MSM**

The proposed intervention model integrates Goffman's (1963) work on stigma, the Theory of Reasoned Action (Ajzen & Fishbein, 1980), and reference group theory (Kelley, 1952; Schuman & Johnson, 1976 ; Shibutani, 1955). As shown in Figure 1, the assumptions of the model are that: (1) there is a distinct rural culture and within that, a subculture of MSM, (2) MSM's risky sexual behavior is a function of social determinants (stigma and gay affirmation) and individual determinants (mental health) and (3) both stigma and gay affirmation are influenced by attitudes of reference groups (groups of significant others). The latter influence mental health indicators (self-esteem, depression, and internalized homophobia), which in turn are related to whether or not MSM practice high risk sexual behaviors. Consequently, rural MSM are members of two distinct, non-overlapping social systems, their local community and the "gay community", groups composed of different people holding strongly opposing attitudes and values some of which result in stigmatization.

Stigma is a complex concept that refers to prejudice, deviance, and discrimination (Alonzo & Reynolds, 1995). Stigma against lesbians, gay men, and bisexuals has long been prevalent in the United States. It has been exacerbated by AIDS because many with anti-gay views believe that the gay community is responsible for the epidemic. AIDS in the United States has been most prevalent among MSM, and most of the stigma associated with AIDS derives from its association with homosexuality (Herek, 1995; Herek & Capitano, 1999). Thus MSM are marginalized in society as a result of their "blemished" lifestyle (Grossman, 1991). For many MSM, the stigmatization resulting

from the negative attitudes of others results in a phenomena known as internalized homophobia, a form of self-deprecation which can erode self-esteem and cause depression (Garnets & D'Augelli, 1994; Shidlo, 1994). As such, the stigma associated with sexual orientation and AIDS is both a personal determinant of risk (reflecting a threat to the health and well-being of MSM) and a social determinant of risk (reflecting a threat to core social values concerning sexual behavior, morality, and religion) (Devine, Plant & Harrison, 1999). In summary, stigma reduces the social status of the person stigmatized because of judgments about the stigma held by significant others who provide or define standards of behavior (social acceptability) (Goffman, 1963; Merton & Kitt, 1950). Likewise, attitudes—both personal and social—are known to predict intentions to act as well as behavior. Thus MSM who have most strongly incorporated the stigmatized attitudes of their social contexts would be more likely to put themselves at greater risk for HIV infection, as a result of diminished self-esteem and enhanced self-criticism, which undercuts efforts to protect themselves for the future.

The most salient research on the relationship between attitudes and behavior to date has been that of Ajzen and Fishbein (1980). They modeled behavior and behavioral intentions as a function of attitudes toward behavioral acts or objects of behavior, the subjective norms governing the behavior, and an individual's compliance with these norms. Subjective norms are defined as the individual's perception of the expectations of significant others. The model has been used to predict safer sex behavior (Lewis & Kashima, 1993; Moore, Rosenthal, & Boldero, 1993) and condom use (Nucifora, Gallois, & Kashima, 1993; Ross & McLaws, 1993). The theory has also been useful in the design of HIV preventive interventions (Catania, Coates, & Kegeles, 1994; Fisher & Fisher, 1992). A focus on MSM's attitudes about HIV is a critical component of any prevention program.

In a meta-analysis of past research, Sheppard, Hartwick, and Warshaw (1988) found strong evidence for the predictability of the Ajzen-Fishbein model. However, in the studies assessed by these researchers, measures of normative influences on behavior were restricted to the influence of significant others (friends and family) and did not include the influence of the larger social context. This occurred even though researchers and theorists have long known that attitudes have their foundation in one or more social groups, generally referred to as reference groups (Kelley, 1952). Thus, extension of the model to include the influence of the attitudes of other social groups, as well as rural society, on the behavior of rural MSM is warranted to generate more accurate predictions. These additional attitudes are defined in the proposed model as social determinants of MSM's behavior.

Social determinants are best operationalized by MSM's reference groups, some of which contribute to stigmatization, and some of which contribute to the affirmation of sexual identity. In their seminal overview of research and theory concerning attitudes and behavior, Schuman and Johnson (1976) cited reference groups as sources of social pressure that influence peoples' attitude formation. Reference groups are significant others in the social settings of individuals who provide or define standards for behavior (Merton & Kitt, 1950). These groups are directly responsible for the internalization of social norms (Shibutani, 1955). Reference group pressure can directly influence behavior or can mediate attitude-behavior relationships.

Three types of reference groups have been identified by social theorists: normative, comparative, and generalized (Kelley, 1952; Shibutani, 1955). Normative groups are those closest to the individual which help him or her define and evaluate personal actions (Kelley, 1952). These groups, generally family and close friends, have strong affective ties to the individual, and can have a strong influence on individual behavior. For rural MSM, family attitudes towards homosexuality and HIV can influence an individual's feelings of self-worth. Conservative family attitudes may mean that an MSM would not reveal his sexual orientation; if sexual orientation were revealed, alienation might result. Another normative reference group for MSM is a gay network: friends, sexual contacts, and primary partners who are gay or bisexual. For rural MSM, however, this group may be fragmented, hidden, and non-cohesive because of the risk of exposure due to stigma. Comparative reference groups are those that influence standards of behavior, but are not necessarily emotionally linked to the individual. They do, however, exert pressure on an individual to behave in a prosocial way by providing comparison points whereby an individual can make judgments about his behavior (Kelley, 1952). One such group for rural MSM would be health care providers who provide advice about sexual risk reduction behavior as well as education, screening, and counseling about HIV issues. Unfortunately, the negative attitudes of some of these providers are barriers to adopting and maintaining safer sex behaviors. In many urban areas, MSM would receive such education from other MSM who serve in AIDS prevention programs. In rural areas, there are few, if any, peer educators who are themselves MSM. Finally, generalized reference groups reflect the opinions of the larger social system or community (Shibutani, 1955). These groups provide a frame of reference for whether or not a behavior is socially acceptable. For rural MSM, one generalized reference group is the people in their communities, many of whose views are antithetical to the open expression of a gay identity. Another generalized reference group for rural MSM, albeit a more

geographically distal one, is the larger “gay community”, whose affirmation of identity stands in contrast to the values of the local community.

Thus, intervention models need to be aimed at developing a strong sense of a gay subculture within rural communities. This means that risk reduction strategies must be directed at supporting gay affirmation through strengthening MSM networks, gaining support from health care providers, and promoting gay pride.

### **Developing HIV-Preventive Interventions for Rural MSM**

As we enter the third decade of the HIV epidemic, the challenge of preventing additional infections remains paramount. Primary prevention remains the only effective way to slow the rate of infections, and for nearly two decades now social and behavioral scientists have developed and evaluated HIV preventive interventions. Significant reductions in casual sexual activity have occurred among gay men in large cities (Fox, Ostrow, Valdisseri, Van Raden & Polk, 1987; Martin & Dean, 1993; McKusick et al., 1985). Neglected during these years has been the development of interventions for men who live in rural areas. The development of preventive interventions for rural MSM must take into account the personal and social determinants that influence MSM’s behavior. Some models used extensively in urban settings simply will not work. An educational program on safer sex or on new medical treatments held in a well-known community setting (such as a school or a public library) will likely reach very few people. Rural MSM would be unlikely to appear in a public setting in which their gay identity could be known. Indeed, many rural MSM would not even wish other MSM to know of their identity, as they might fear that this would lead to unexpected disclosures through tightly-knit local networks, some members of which might share the information with family or friends of the MSM. The reinforcement value of community bonding and gay identity affirmation so powerful in large metropolitan areas (where anonymity and distance from families of origin, employers, etc., can be arranged) is overshadowed in small towns and rural areas by the powerful stigma of acknowledged homosexuality. Thus, traditional educational programs offered in public settings, however effective in past evaluations, will likely draw very few attendees. This would suggest that it will be difficult to modify the personal determinants of rural MSM high-risk behavior directly through traditional educational programs.

On the other hand, methods that are targeted to the social determinants of MSM high-risk behavior are likely to succeed. Efforts to modify reference groups in ways that allow MSM to develop attitudes consistent with risk reduction should be considered. In essence, rural MSM have two major sets of social influences: the mainstream rural communities in which they live and the “gay communities,” with which they identify. There may be little that can be accomplished in attempting to change the stigma endemic in rural society, although over time attitudes may slowly change to be more supportive, if not affirming. It is possible, for example, to provide training to rural health care providers that might diminish their anti-gay attitudes. Such individuals, because of their embeddedness in local communities or in the rural culture, can have a major impact if their attitudes become more positive. If their views are more positive, they will convey more positive attitudes as they do health education and screening in their communities.

More practical goals for prevention activities are to strengthen or develop reference groups for rural MSM. However, this is difficult due to issues of privacy, confidentiality, and the stigma associated with homosexuality in rural culture. For example, in the survey conducted by the authors, only 9% of the respondents said that “everyone knows I’m gay,” and another 41% said that most people know. Nearly one-quarter (23%) were “closeted,” and were thought to be heterosexual. About sixty percent said they were very or extremely close to their families. Yet, only one third (37%) had discussed their sexual orientation with fathers, and one-half (53%) had discussed it with mothers. Over one-third (36%) said their fathers suspected or did not know about their sexual orientation; 29% said their mothers suspected or did not know. Few (7%) said their families were intolerant of gay and bisexual people, and 64% said families were somewhat tolerant; however, only 29% said families were very tolerant. The men saw their communities as being more negative than their families, with 27% saying that people in their communities were intolerant. This could partly explain why only 42% had discussed their sexual orientation with co-workers (Preston et al., 2000).

Many rural MSM have local gay networks composed of small numbers of lesbian and gay friends (D’Augelli & Hart, 1987). Often, however, these social groups are hidden and fragmented, and can therefore be difficult to access for support. Helping to organize informal networks may be necessary in many communities. Using existing reference groups can bring people together for prevention programming. Increasing the support potential of normative and generalized reference groups can increase a sense of community and decrease internalized homophobia. This serves to reduce the effects of stigma from the dominant reference groups.

One method of building normative reference groups is the training of social leaders who are presumed to hold positions of power in social networks of MSM and who can be used to create norms for cautious sexual behavior. Based on diffusion theory, these interventions have used men who are social leaders in gay bars, whether in large cities (e.g., Miller, Klotz, & Eckholdt, 1998) or in small cities (e.g., Kelly et al., 1992). In many rural areas, however, there are simply no major focal gay settings such as bars or community centers. For instance, in rural southwestern Pennsylvania, there are only two very small bars, which draw MSM from areas very far away. While some local MSM might know one another, most patrons are strangers, diminishing the potential credibility that social leaders would emerge from patrons. Even within the local group of regular bar patrons, knowledge of each other can be limited, with many MSM not revealing their community identities or linkages to others. Also, and importantly, there are few, and very small, community-based AIDS organizations that serve these large geographical areas. With agency resources dedicated to case management services for people with HIV/AIDS, these organizations are unlikely to mount a social diffusion prevention effort, which tends to be relatively labor-intensive.

Using reference group theory, one of the authors (Dr. Schulze) developed a prevention program designed for rural MSM in north central Pennsylvania. The purpose of the intervention was to build social support by providing opportunities for social interaction, HIV prevention programming, and HIV testing for rural MSM. The approach centered around 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 had been leaders of a gay group that had since dispersed. They were approached by the HIV outreach professional from the state department of health. The gatekeepers became part of an informal planning group that considered how to best approach outreach to MSM. In focus group meetings, the gatekeepers agreed that there were few formal venues for reaching local MSM in north central Pennsylvania; no local center or even a local newsletter existed for the gay community. They decided to pull together several focus groups of men they knew at two local gay bars. The bars were previously owned by gays but were now owned by heterosexual people. Both attract heterosexual customers in the afternoon and early evening, and gay clientele in the late evening. One bar attracts older, white, blue collar MSM, while the other caters to younger men, many of whom enjoy cross-dressing. Ten focus groups were held in the bars over a period of three months. In each group men were asked: what they thought of the problem of AIDS, what educational interventions were needed, and what interventions they thought would work. They agreed that the most reasonable approach to reaching most men would

be through the two local gay bars. 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 stigmatizing nor require self-labeling (either as gay or as interested in HIV). The gatekeepers then contacted the owners of the bars, as well as their managers and bartenders, with a proposal for a series of health “parties” at their establishments.

The parties included on-site free oral HIV tests, blood screenings for syphilis, and influenza and Hepatitis B immunizations. HIV education was presented through condom games and condom distribution. The key player in this programming was a public health nurse who had special HIV training through the Centers for Disease Control and Prevention. She was well-known to many MSM through her work at a local HIV clinic and had been introduced to the gatekeepers during the planning sessions. The nurse had introduced herself prior to the parties to the bars’ staff. 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, emphasizing that testing could be confidential or anonymous. The parties had snacks, door prizes, sport bottles with the local HIV/AIDS hotline number, and condom decorating contests. 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. Approximately 500 MSM attended the series of bar parties.

In addition to the bar parties, a series of summer picnics were held at a local amusement park, and similar programming was offered. These picnics attracted 150 participants. Screening and testing were also offered at a summer Gay Pride Festival held in Harrisburg, PA, the state’s capitol, to which many rural MSM traveled for an afternoon of music and socializing.

Input from gatekeepers and participants of these programs was highly positive and a need for continued momentum directed at further programming was identified. Other suggestions were:

1. A need for more focus groups, especially those containing more racial diversity.
2. Accessing and involving more health care agencies and providers.
3. Educating and training more nurses to provide support and programming.

4. Identification and training of more peer educators.

5. A need for a long-term plan to continue networking and programming, and strategies to pursue sources of funding.

The model proposed in this paper provides a basis for understanding the individual and social determinants of high risk sexual behavior among rural MSM. In addition, it suggests an approach to planning and developing practical interventions aimed at reducing sexual risk by supporting and strengthening the gay identity of men who reside in rural communities. The barriers to developing effective interventions are considerable, as they are grounded in powerful stigma and in fundamental characteristics of rural communities. Nonetheless, innovative approaches taking advantage of the nature of rural culture (concern about one's friends and neighbors, bonding together to pool limited resources, resisting solutions from outsiders) must be attempted as the spread of HIV continues beyond metropolitan areas.

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