

EXECUTIVE SUMMARY

In 2004-2007, the HIV Alliance conducted an in-depth community assessment to gather more information about the risk and protective behaviors of local men who have sex with men (MSM) in relation to the transmission and acquisition of HIV. This formative evaluation, referred to as the Community Identification Process (CID) lays the foundation for the implementation of the evidence-based intervention model known as PROMISE. The HIV Alliance reviewed research literature and existing local data, and conducted interviews and focus groups with Lane county professionals knowledgeable about HIV and/or MSM, gatekeepers (such as owners of gay bars or adult bookstores), and men from the target population. This evaluation employed several methods to answer two significant research questions:

- What is the context in which men who have sex with men participate in risky behaviors?
- What motivates these men in our community to change their behaviors?

These questions required the collection and analysis of both empirical and interpretive data. Quantitative or empirical data helped us understand how many people engaged in risk behaviors and to narrow our target population to those at highest risk, whereas interpretive data helped us understand why people chose to engage in risk behaviors and how and why they sought to reduce their risks. Each provided important information with which to build and modify this intervention.

Research literature and the local epidemiological profile provided us with a foundation of information about HIV infection in our area and described who in our community was at highest risk. We looked at incidence and prevalence within sub populations divided by race, ethnicity and age. Rather than narrow our population based on these criteria we looked instead at risk behaviors that were putting MSM at risk. Unsurprisingly, across the literature and in data collected throughout the state of Oregon, including Lane County, **unprotected anal sex with partners of unknown or assumed HIV status** was correlated with new infections. We found however, that most men used condoms some of the time or took other steps to reduce the risk of transmitting or acquiring HIV. To get a better picture of what was happening in Lane County we began by asking community partners and our own staff about our target population and how to best reach them to gather further information. Based on information gathered through these surveys, we approached “gatekeepers” in our community: those individuals who were close to the population and who could either allow or deny us access to our target population. These qualitative interviews produced more details about the venues where MSM meet each other and helped us map sexual and social networks in Lane County. We then recruited men from these sexual and social networks who were willing to participate in interviews. These interviews described (1) the context in which MSM had unprotected anal sex with partners of unknown or assumed status, (2) what they were doing to reduce their risk and (3) how far along they were in adopting protective behaviors. We discovered consistent themes across interviews that helped us understand which factors contributed to risk and what motivated MSM to change their behaviors.

An analysis of the all data suggested that when MSM in Lane County participated in unprotected anal sex with partners of unknown or assumed status one or more of the following was a contributing factor.

Men reported a **lack of communication** before and during sex, including discussion of HIV status, condom use and how they planned to reduce their risk. Many men also indicated that cultural and behavioral norms in venues like adult video stores and bars were barriers to clear communication.

The majority of men reported using **alcohol and/or drugs** before or during sex. Many men reported participating in risky behaviors they would otherwise avoid if sober.

Men shared common beliefs and attitudes that contributed to risk. **Primacy of pleasure** is the prioritization of pleasure, sometimes physical or emotional, over other emotions or thoughts. This pleasure was a consistent barrier to employing a risk reduction strategy like condoms for many men.

In addition, **assumptions about the status of their sexual partners and their risk** contributed significantly to unprotected anal sex. Men assumed status based on a sexual partner's appearance, sexual identity and/or the sexual history of their partners.

When men reported changing their behaviors, they discussed several motivating factors which contributed to successful change and maintenance of new behaviors. These factors were consistent with theories which describe how and when people change their behaviors. For some, an **increased perception of risk** resulting from new information about a sexual partner or the acquisition of another STD spurred behavior change. When partners, family and friends wanted MSM to change their behavior (**subjective norms**), men were more likely to report successful behavior change. In addition, when men thought that their peers (**social norms**) were using condoms, disclosing their status or communicating openly about sex, they were more likely to do the same. The majority of men discussed **decreased negative consequences** as the most significant motivating factor for change, including decreased anxiety and guilt as a result of unprotected anal sex.

There was a large variance in how far along men were in adopting protective behaviors: some MSM were not thinking at all about changing their behavior and some were performing the protective behavior but having occasional relapses. For each participant we evaluated their progress towards three goal behaviors (**safer sex negotiation, status disclosure and condom use**) and we found that men had complicated risk reduction strategies that were often employed differently depending on the unique context of each encounter.

Using this information we will develop media materials, called **role model stories**, that will encourage and support behavior change and which will be distributed by MSM recruited as **peer advocates**.

Through community observations and interviews, we mapped sexual and social networks where we will begin to recruit peer advocates and monitor the distribution of role model stories. We will focus on three networks where MSM reported high-risk behaviors and a high incidence of the contributing factors discussed above: **(1) online, (2) adult video stores and (3) the glass bar island nude beach**. Because these networks might not be directly accessible to outreach staff, we will also recruit peer advocates who belong to these networks and others which are more accessible (e.g. bars, LGBT related groups).

This information provides us with a solid foundation on which to build the core elements of this intervention and succeed in reducing new infections in our community.