Harder to reach population: High-risk MSM

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Introduction

Acquired immunodeficiency syndrome, or AIDS, has disproportionately affected men in the gay community in the United States since it was first observed in 1981. In 1984 scientists identified the virus that causes AIDS, the human immunodeficiency virus, or HIV. Today gay men as well as other men who have sex with men (together referred to as men who have sex with men or MSM) still comprise the largest number of HIV infections in the U.S. (Prejean et al. 2011). As the most highly-impacted risk group, it has seemed appropriate to design and make available HIV prevention services specifically for MSM.

Assessing prevention interventions requires obtaining good samples of MSM. That it is hard to sample MSM, in general, is self-evident; sampling high-risk MSM poses additional difficulties. These men comprise a hidden population defined by private sexual behavior that is still stigmatized in society in general, and especially so in particular subgroups within society, such as in some religious and minority populations. What makes high-risk MSM harder to identify is that the sexual behavior is so specific, i.e., it is not simply any sex with a man, but specifically unprotected anal intercourse (UAI, i.e., anal sex without a condom) where HIV transmission can occur. And while sex between men is stigmatized generally, anal sex in particular is itself far more stigmatized as an act, and UAI is weighted by judgment that a person is acting irresponsibly. Thus such multi-layered stigma associated with "high-risk MSM" makes this subgroup of MSM harder to reach than the general population of MSM. Since interventions targeting high-risk men would maximize their impact on HIV transmission and prevention, a specific goal of the President's National HIV/AIDS Strategy (White House 2010), it is critical to be able to identify and recruit this subgroup of high-risk MSM into HIV studies.

MSM comprise approximately 4% of the adult male population (Binson et al. 1995; Fay et al. 1989; Rogers and Turner, 1991). Studies using random-digit-dial telephone surveys of household probability samples of adult MSM living in San Francisco found that nearly two-thirds of MSM engaged in anal sex in the past year, but most of that behavior is not likely to lead to HIV transmission either because condoms were used or men chose seroconcordant partners (i.e., someone with the same HIV serostatus). The proportion of MSM who engaged in anal sex without a condom, with a partner of discordant or unknown HIV serostatus (i.e., truly high-risk behavior), was as small as 9% to15% of the MSM population (Osmond et al. 2007), which is approximately .004 to .006 of all adult males.

Recruiting MSM who have any anal sex in the past year can give the appearance of reaching high-risk MSM, but consider that a man whose only UAI in the past 12 months was due to a single slip-up, like a broken condom, would be included in such a sample. So too would a man who only has UAI with another person of the same serostatus. Including low-risk MSM makes it easier to recruit men into a prevention intervention study, but makes it more difficult to show that the intervention is effective in reducing high-risk behavior. Including low-risk MSM in a study can either increase the chance that any effect identified can be the result merely of regression to the mean, or that eligible study participants have such a low average level of risk that it can be difficult to show a significant reduction in risk behavior. Put another way, if only a subset R of the total intervention sample S engage in high risk behavior, then the behavior of S-minus-R men cannot be affected by the intervention. That remaining lower-risk portion of the sample is uninformative (provides no data) about the intervention's effect. In the interest of finding effective prevention interventions, we must begin to focus on recruiting truly high-risk MSM into HIV prevention intervention studies, that is, men who tend to consistently engage in risk behavior or who regularly put themselves in situations that could more easily lead to risk behavior.

Obviously, recruiting high-risk MSM presents sampling and recruitment difficulties. One straightforward way to simplify the task is to seek the target population in places they frequent in larger numbers and where low-risk MSM are less likely to go. Thus, sexual venues that attract MSM are more likely to attract higher proportions of high risk MSM than other social venues such as gay bars, street fairs and dance clubs. Much of the early literature on where-MSM-meet-to-have-sex categorized all places outside a home into one of two types of settings: "gay bathhouses" or "cruising areas" (Martin 1987; McKusick et al. 1985). The gay bathhouse category included both gay bathhouses and sex clubs because they are gay institutions that share a common primary purpose as a place to meet for sex. Cruising areas, on the other hand, can be any place where men go to find sex, but the purpose of the place was not primarily intended for sex. Examples of cruising areas are adult book stores and public toilets.

The Urban Men's Health Study (1997), a random-digit-dial (RDD) survey of household probability samples of MSM in four U.S. cities with high HIV prevalence, included items about visiting bathhouses and cruising areas. In a previous paper, we compared the health and sexual practices of men reporting being same-gender sexually active in the past year, grouping men by type of sex venues they attended (Binson et al. 2001). We compared men who had gone to a bathhouse in the past year but not to a cruising area, men who had gone to a cruising area but not a bathhouse, and men who had gone to both types of venues in the past year, what we called "multivenue users."

Table 1 shows the results of the analyses. HIV seroprevalence data was significantly higher in the bathhouse-only and multivenue groups than in the cruising area-only group. The numbers were similar for lifetime STD, although the cruising area-only vs. bathhouse-only comparison was the only one that was statistically significant. Sexual risk behavior was not only significantly more prevalent in the bathhouse-only group than in the cruising area-only group, but was also significantly more prevalent among multivenue users than in the bathhouse-only group. The prevalence for being in the highest quintile of number of sex partners and the highest sextile for number of one night stands basically doubles from the cruising area-only group to the bathhouse-only group, and then more than doubles again when comparing the bathhouse-only group to the multivenue group.

It should be noted that even though multivenue users are proportionally more likely than other groups to engage in high-risk behavior, not all of them engage in highrisk sex. However, a greater proportion of the multivenue group is significantly more likely to engage in a wider range of sexual behaviors, across a wider range of venues, and with more partners than MSM generally or MSM who tend to use one type of venue to meet men for sex. Consequently, multivenue use signifies a greater likelihood of engaging in behaviors associated with HIV transmission, and so can serve as an indicator behavior for identifying the high-risk MSM population.

Finding harder to reach high-risk MSM

We used recruitment from sex venues and screening for "multivenue use" to obtain samples of high-risk MSM for two different studies. In the first instance we used multivenue use to stratify a convenience sample prior to random group assignment for an experiment. In the second, we used questions in a probability sample survey of MSM exiting a bathhouse to identify multivenue users.

Study 1: The primary goal of this first study was to conduct an experiment to compare responses to survey questions on sexual behavior administered to MSM using

standard interviewing practices vs. conversational interviewing (Binson, R01HD056950). Conversational interview procedures allow the interviewer greater latitude in conducting the survey to assure that participants understand the meaning of items than is permitted in standard interviewing (Conrad and Schober 2000). While standard interviewing restricts the interviewer to the words specifically written in the survey, conversational interviewing employs very specific rules for what interviewers can do to help respondents correctly interpret the questions.

Since it was an experiment, we were not concerned with drawing a sample representative of a larger population. To be included in the experiment subjects had to be adult males who reported having anal sex with another man in the past 3 months. However, in order to avoid many "zero" and "one" responses, we wanted to get men with many sex partners and more complex sex lives, i.e., men with a range of sexual behaviors and multiple partners. Thus recruitment focused on venues where men with multiple sexual partners might be found, i.e., bathhouses/sex clubs and Internet cruise sites.

However, we also were concerned that, even with random assignment, by chance alone a greater proportion of low-risk men could be assigned to one group over the other. Since the survey was about sexual risk behavior, we preferred not to screen the men using too many items about sexual behavior that they would encounter as part of the experiment. So we settled on a few short screening items that identified multivenue use. To participate, men had to report having had anal sex in the past 3 months. The "high-risk subgroup" was defined as multivenue users, who had anal or oral sex in a bathhouse plus in at least one other public setting or with someone met via the Internet. Stratifying by multivenue use was expected to significantly improve our chances for an even balance between experimental conditions on proportion of high-risk subjects.

We first conducted 11 cognitive interviews to help finalize the survey instrument for the pretest. We recruited in this phase exclusively via the Internet using ads on Craig's List. Of the 18 men who contacted us about the study and were screened, 7 were not eligible for the study (i.e., no anal intercourse in the past 3 months; we did not screen for multivenue use for this phase). The cognitive interviews revealed that the majority of the remaining 11 only had anal sex or UAI with their primary partner. While this was adequate for finalizing the questionnaire, it raised concerns about our recruitment plans, as recruiting too many such men would undermine our ability to complete the experiment. Part of the problem was that recruitment on Craig's List was confined to the area where people were looking for studies to participate in. Thus for the pretest and main phases of the study we dropped Craig's List and limited our Internet recruiting to chat rooms used by men seeking sexual partners. We also sent recruiters to several San Francisco Bay area bathhouses. Some clubs allowed only passive recruiting, i.e., we could put up a flyer with tear-off strips or leave a stack of palm cards in the entry/exit area of the bathhouse. Some bathhouses also allowed active recruiting where the recruiter could approach men leaving the bathhouse to hand out palm cards. In active recruitment, the recruiters engaged patrons at the bathhouse, but they did not take contact information. Recruiters did not know the criteria for inclusion in the study.

The overall relationship of eligibility hit rates by type of recruitment site (Table 2) is not statistically significant (p=.09), which may be due to the fact that the numbers are small for Internet and passive-only bathhouse recruitment. Nevertheless the rates are fairly comparable between Internet recruitment and bathhouse recruitment, but lower for men who heard about the study through a third party, basically the equivalent of "word of mouth" or a referral. However, looking among the proportion of eligible men who were "multivenue users" (Table 2), there is a statistically significant difference by recruitment site (p<.01). Interestingly, the highest hit rate for multivenue subjects was via passive-only recruiting, although the difference between passive-only and combined active and

passive recruiting was not statistically significant. The high-risk hit rate for Internet recruiting is significantly lower than that for the passive-only bathhouse recruiting and is a relative 20% lower than for mixed active and passive recruiting at a bathhouse. The multivenue hit rate for third party recruiting is significantly lower than for either type of bathhouse recruiting.

Study 2: We were interested in learning more about multivenue users and how it was that they would be in one venue on one occasion and then choose another venue on a different occasion, and, in particular, what difference the environment had on sexual risk behavior (Binson, R01MH71159). To accomplish this research goal we proposed to conduct individual qualitative interviews with multivenue users. Confronted with the fact that multivenue users would be difficult to identify and recruit, we devised a mixed methods approach, using a quantitative survey to identify the members of the target population and recruit them for qualitative interviews. The study design called for the use of time-location sampling to execute exit surveys at two bathhouses in Northern California. An individual's responses to key items on the exit survey were used to identify multivenue users who were then recruited for the in-depth interviews. The purpose here was to minimize self-selection bias in the interview cohort by having study staff approach qualified men drawn from randomly selected patrons exiting the bathhouses.

We used a two-stage cluster sample design in the study (Binson et al. 2007). In the first stage, 2-hour recruitment shifts were selected with probabilities proportional to the expected number of patron visits during the shift. In the second stage, a fixed number of patrons visiting during the selected shifts was randomly selected to participate in the exit survey. Respondent selection was based on a pre-specified procedure (the first person sampled in a shift was randomly selected from the first n men exiting; after that, every nth exiting man was sampled) and not left to the judgment of on-site recruiters.

A total of 477 surveys were collected in March through August of 2007. The survey instrument was administered using ACASI on a tablet computer set up in a small space that was part of the entry/exit lobby of the bathhouse. Surveys averaged 13 minutes in length. To be selected to participate in the qualitative interview, men had to report on the survey that in the past 3 months they had UAI and were multivenue users. A respondent was defined as a multivenue user if he reported that he had sexual contact (oral sex or anal sex) in either of three venues: by visiting a commercial adult venue (like an adult theater or bookstore), by visiting a public cruising area, or by hooking up with a man soon after meeting him via an Internet cruise site. Since all of these men were exiting a bathhouse, it was their visiting at least one of these other venues that defined them as multivenue users. Based on a participant's responses to the relevant survey questions, the computer program determined whether that participant met the eligibility criteria for the in-depth interview. The exit survey recruiters were blind to the criteria for selection.

Out of 477 exit surveys, 73 (15.3%) were found to be eligible for the in-depth interview of multivenue users. Table 3 shows how the eligible and ineligible compare to each other. The two groups did not significantly differ by race/ethnicity, education, or self-identification. However, a significantly greater proportion of eligible men were HIV-positive (41% vs. 16%). Since serostatus and risk behavior are correlated, this finding was expected. The eligible group was also significantly younger than the ineligible men, with group means of 38.7 vs. 42.6, respectively (p <.001, not shown in table). Sexual behavior over the past 3 months shows very large, significant differences between groups. The multivenue user group had a much higher average number of sexual partners during the prior 3 months. These variables are counts of numbers of partners and their distributions are rather severely positively skewed. Consequently, the reported p-values

come from negative binomial regressions. These differences between groups obtain regardless of whether it was insertive or receptive anal sex, and whether it was any anal sex or only unprotected anal sex. The means for frequency of club visits suggest that multivenue users also were more frequent bathhouse visitors, but those differences do not achieve statistical significance.

Of the 73 men identified as eligible, 3 were not invited to participate and 19 were invited but refused participation. Of the 51 men who agreed to participate, 14 provided contact information that ultimately proved to be inadequate, and another 7 men were not available during the required 2-week window (a criterion used because the interview was intended to cover the same 3 months of behavior covered in the exit survey). Of the 30 men who were scheduled for an interview, 6 did not show up at the scheduled time and could not be rescheduled. In the end, 24 (32.9%) of the 73 multivenue users identified by the survey completed the interview. Without the 2-week time constraint the interview rate might have been as high as 42.5%.

Table 4 shows the comparison of the 24 cases who were interviewed to the 13 cases with whom we made contact but failed to interview and the 33 cases where we failed to make contact or they refused participation outright. Very few statistically significant differences obtain because of small subsample sizes. The group that we did manage to contact but failed to interview is less white, less gay-identified, and less likely to be HIV-positive than either the interviewed group or the non-contact/refusal group. They are also younger (mean age 37.0 vs. 39.3 for the interviewed group and 38.9 for the non-contact/refusal group, not shown in table). The non-contact/refusal group was better educated than the other two groups.

The non-contact/refusal group consistently reported the lowest average number of partners (with the sole exception of unprotected receptive anal intercourse), although, once again, none of these differences are statistically significant. Of course, the numbers for the non-contact/refusal group are lower in the relative sense, not in the absolute sense. The non-contact/refusal group visited the bathhouse where they were recruited less frequently than either of the other two groups, and visited other Bay Area bathhouses less frequently than the interviewed group; this may be due in part to the fact that eligible men from outside the Bay Area would be less likely to be available to participate in an interview.

Data from this study also add to the body of information that is useful in addressing the question of recruiting high-risk MSM through the Internet. While the overall prevalence of UAI in the past 3 months was 31% and 24% in private settings (i.e., private homes or hotels), it was 7% with a partner they had just "met" online. That compares with 13% in public settings, and 6% during the just completed bathhouse visit (Kerr et al. 2011).

Discussion

The experience with the two studies indicates that multivenue use can serve as an effective indicator of high-risk behavior among MSM and increase the proportion of high-risk individuals included in the study sample. We began with the premise that high-risk MSM were a small subgroup within the MSM population. These data support this premise. Similar to the size of the high-risk population seen in the Osmond et al. data (2007), we found about 15% of the men exiting the bathhouses were multivenue users. Recruiting a sample from sites where men meet for sex increases the odds that the sampling will generate a group of sexually-active MSM, but also a greater proportion of men who are likely to engage in behavior associated with HIV transmission. But as the data showed, taking the additional step of screening for multivenue use makes identifying a sample of high-risk subgroup of MSM more assured.

We postulated that HIV prevention study eligibility criteria should be reconsidered, specifically in narrowing the window within which any anal sex or UAI last occurred in order to filter out men who may have already reduced their risk behavior subsequent to a temporally remote risk event. The experience with the Craig's List recruitment for the cognitive interviews in Study 1 suggests that such a strategy will not necessarily solve the problem. The eligibility criteria narrowed the window to "any anal sex in the last 3 months," as we proposed, and still resulted in a sample that only had anal sex and UAI with their primary partner. This is not to suggest that these men have no risk for HIV infection, but they do not reflect the behavior of high-risk MSM. Thus, using a strategy that limits eligibility by narrowing the time window in which eligible behavior can occur should be evaluated further.

Data from the two studies indicate that recruitment via the Internet may have significant challenges. In Study 1 there was the failure, primarily due to self-selection bias, to recruit high-risk MSM through Craig's List. The change to recruiting through Internet chat rooms did not greatly improve our attempt to recruit online, as evidenced in the minimal number of participants we obtained, as well as the smaller proportion of men likely to engage in high-risk sexual behavior. These problems may be due in part to a lack of experience with Internet recruitment within our team, even though we followed procedures laid out from other studies that recruited men online (although we did not screen for multivenue use in this phase of Study 1). Furthermore, while the overall rate of UAI in the Study 2 sample was quite high, and higher than might be expected even in public settings, UAI with men met via the Internet was not a primary contributor to those numbers. And these data showed that many of the multivenue users and other men who reported high-risk activity in the past 3 months did not report using the Internet to meet men. Thus, sole reliance on the Internet for recruiting MSM into any HIV study is likely to be problematic for generalizability not only because of extant issues such as the limits of convenience sampling and self-selection bias, but also because high-risk MSM are less likely to be accessed that way. Further study of the use of Internet recruitment is needed with a particular focus on better understanding how meeting sex partners online differs from meeting at bathhouses and cruising areas. This seems particularly important given the rise in the use of social media websites like the cruise sites GRINDR and Scruff, or even Facebook and Twitter, as a source for recruitment (Landovitz et al. 2012).

Although not part of our recruitment plan for Study 1, we had a number of referrals to the study from third parties. It was interesting to note that these referrals tended to produce a lower proportion of multivenue users than the planned recruitment procedures. This supports the results in a study by Martin and colleagues (2003), which found that among young MSM ages 18-29, HIV-positive men were less likely to refer other respondents to the study, and the men they did refer were less likely to be HIV-positive themselves. We take this as another confirmation that a referral-based recruitment process is unlikely to deliver substantial numbers of high-risk MSM.

Use of an exit survey in Study 2 to identify our target group provided us with considerable information on men who did not qualify for the in-depth interview as well as for men who did qualify but were not interviewed. This allowed for some assessment of self-selection bias in the qualitative interview phase of the study. A venue-based approach offers other advantages as well. Correct application of time location sampling will minimize investigator bias in participant selection as well as respondent self-selection bias. The correct application of sample weights produces sample estimates that can be generalized to the venue patron population. Embedding eligibility criteria in a short survey reduces the chances that knowing the study's purpose and its intended target population will contribute to self-selection bias. Moreover, data obtained in the survey permits the investigator to evaluate what biases occurred during sample selection.

Obviously, recruiting a sample of high-risk MSM is a challenge in HIV research because the behaviors that define risk are both private and stigmatized, and they are not factors around which social groupings necessarily occur. The typical criterion of any anal sex or UAI in the recent past, usually defined as 3 or 6 or 12 months, is broad and captures a large segment of the population that is not at particularly high risk for HIV infection. By identifying an "indicator" for membership in the high-risk target population, we can enhance screening for study participation to ensure that the sample will result in a higher proportion of the target population. Our data show that it is possible to ask about multivenue use as an indicator of high-risk sexual behavior.

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	Cruising Area Only (N=515)	Bathhouse Only (N=326)	Multi- venue (N=481)
Characteristic/Behavior	%	%	%
HIV-positive	13.1	21.2	24.9
Ever had an STD	49.5	61.3	58.2
UAI with non-primary partner	20.0	33.9	50.5
UAI in public setting	4.3	10.1	21.6
>26 partners in past year	8.1	14.8	33.2
>21 one-night stands in past yea	ur 5.7	12.3	30.7

Table 1: UMHS 1997 - HIV-status and STD History by Venue Use

Binson et al., AJPH, 2001

	Screened	Eligible	Eligible	MVU*
	Ν	%	Ν	%
Recruitment Approach				
Bathhouse active & passive	226	80.5	182	66.5
Bathhouse passive only	24	75.0	18	83.3
Internet	24	75.0	18	50.0
Third party	106	67.9	72	48.6

Table 2: Study 1- Eligibility & Multivenue Use Status by Recruitment Approach

*Multivenue User

	Ineligible	Eligible	
	(N=404)	(N=73)	
Demographic characteristics	%	%	
Nonwhite	38.5	36.6	
< college degree	32.0	36.1	
Gay-identified	86.9	93.1	
HIV-positive	15.9	41.1***	
Sexual behavior	Mean	Mean	
# men sexual contact	9.3	25.7***	
# men oral sex	8.4	20.0***	
# men anal sex	3.8	16.9***	
# men insertive anal sex	2.8	11.8***	
# men insertive UAI	10.4	6.9**	
# men receptive anal sex	1.9	7.7***	
# men receptive UAI	10.3	3.4***	
Club visitation in the past 12 months	Mean	Mean	
# visits to this bathhouse	11.4	16.2	
# visits other bathhouses	5.6	15.0	
# bathhouses visited	0.7	1.1*	
			* p <

Table 3: Study 2 - Ineligible vs. Eligible

p < .05** p < .01 *** p < .001

		Refusal /
Interviewed	Contacted	No Contact
(N=24)	(N=13)	(N=33)
%	%	%
26.1	53.8	37.5
41.7	46.2	28.1
95.8	84.6	93.8
45.8	30.8	45.5
Mean	Mean	Mean
27.7	34.6	21.1
25.1	21.9	15.4
18.1	25.2	13.0
11.9	20.1	8.5
7.0	13.1	4.4
10.8	6.9	26.1
2.7	4.2	3.7
Mean	Mean	Mean
22.6	28.6	7.5
32.8	9.1	5.2
1.1	0.8	0.9
		* p < .05
		** p < .01
	Interviewed (N=24) % 26.1 41.7 95.8 45.8 Mean 27.7 25.1 18.1 11.9 7.0 10.8 2.7 Mean 22.6 32.8 1.1	Interviewed $(N=24)$ Contacted $(N=13)$ $\frac{9}{6}$ $\frac{9}{6}$ 26.153.841.746.295.884.645.830.8MeanMean27.734.625.121.918.125.211.920.17.013.110.86.92.74.2MeanMean22.628.632.89.11.10.8

Table 4: Study 2 - Comparisons among Those Eligible for Qualitative Interview