EXPLORING HUMAN IMMUNODEFICIENCY VIRUS (HIV) STIGMA IN MEN WHO HAVE SEX WITH MEN (MSM) FROM A CRITICAL PERSPECTIVE

Zachary Tyler Marsh

A THESIS

Presented to the Faculty of Miami University in partial
fulfillment of the requirements
for the degree of

Master of Science in Kinesiology, Nutrition, and Health

Department of Kinesiology, Nutrition, and Health

The Graduate School
Miami University
Oxford, Ohio

2024

Dr. Paul Branscum, Advisor
Dr. Brandy Reeves-Doyle, Reader
Dr. Kyle Timmerman, Reader
Dr. Darren Cosgrove, Reader

ABSTRACT

The purpose of this study was to determine themes on the experiences and insights of Human Immunodeficiency Virus (HIV) stigma and queer stigma in men who have sex with men (MSM) aged 18-35 in a Freirean problem-posing education approach through a focus group. This project used a qualitative descriptive approach in thematic analysis. This study involved a focus group using Freirean education methods of coding, naming, and praxis to help the participants achieve critical consciousness and self-actualization on how to combat HIV stigma in their personal lives, and help those around them, as well as the greater MSM community. The transcript was coded via Dedoose qualitative software and underwent thematic analysis to get a better understanding of the research question. Based on previous research done on critical pedagogy and community capacity building in public health, it is expected that utilizing critical approaches more in public health on health behaviors and outcomes that involve systemic processes such as stigma can be empowering and effective in health education and promotion on a wide range of issues.

Table of Contents

List of Tables

Dedication

I dedicate this project to the millions of folks who have HIV/AIDS and to those who have died of AIDS-related complications, as well as their families and friends. I also dedicate this project to the whole LGBTQIA+ community.

Acknowledgments

This project could not have been done without the contributions of the following folks.

First, I want to thank my family and friends outside the department for their support in my health and wellness, and for giving me the motivation to complete this venture. I especially want to thank my parents for supporting me throughout my life and in my college journey.

Next, I want to thank the friends I have made in the KNH Department through the Master's program for being amazing people to go to for advice and making me be the best I can be. I especially cherish the times I have gotten to hang out with folks such as Wes Bogard, Jake Straub, Mackenzie Ellis, and Paula Concha Fernandez.

Next, I want to thank all the professors I have had in classes and the classmates I got to interact with. Your wisdom helped stimulate my learning and made me the best student I could be.

Next, I want to thank the students who served on my team. I want to thank Ginny Conner for helping me get access to funding for this study. I want to thank Fatiha Alam for her help with finding people to contact to participants. Sylvia Koenig deserves a huge thank you for her helping me with recruitment, conducting the focus group, data analysis, determining the results, and funding the participants as my research assistant. She has been the best research assistant I could have asked for and I could not have done this without her.

Next, I want to thank the contacts that we have contacted who have helped spread the word on this project. They have made our job a bit easier in promoting it.

I want to also thank the four participants for their participation and involvement in the study. This would not have been done without their contributions and insights.

Next, I want to thank Dr. Phil Smith for helping me get the ball rolling on my interests through writing a literature review and guiding me in the right direction with epistemology and how to construct a research question as my first advisor.

Next, I want to thank my committee, Dr. Timmerman, Dr. Reeves-Doyle, and Dr. Cosgrove for their guidance on this project, helping me review and edit this thesis, and helping me make this possible.

Lastly, I want to thank Dr. Geller and Dr. Branscum. Dr. Geller has been a huge help with me getting my project set with recruitment and IRB applications. Dr. Branscum has been a huge help with keeping me on track and reviewing my thesis, as well as serving as the chair of my thesis committee. They both gave me the resources to make this possible and I could not have done this without them.

Chapter 1

Introduction

Overview

The problems that were investigated are Human Immunodeficiency Virus and Acquired Immunodeficiency Syndrome (HIV/AIDS) in the men who have sex with men (MSM) population. This is regarding HIV stigma as a systemic part of increasing the HIV prevalence in this community and leading to other negative health outcomes for MSM.

HIV/AIDS is a problem that is often forgotten about and not talked about enough in the United States by the general public. The disease has killed over 700,000 people in the United States alone since the AIDS pandemic started in the 1980s (Sullivan et al., 2021). Even without looking at the mortality of this disease, its morbidity is still very high in the United States. Around 1.2 million United States citizens are positive for HIV, including an undiagnosed rate of around 13% (CDC, 2024a; HIV, 2023). That means those 13% of people do not know they have a positive status for the virus (CDC, 2024a; HIV, 2023). Some of the subpopulations in the United States disproportionately impacted by HIV include Black/African American MSM, Hispanic/Latine MSM, those who live in the Southern United States, and those aged 13-34 (CDC, 2024b; CDC, 2024c). MSM are a subgroup of individuals who face an even more significant problem concerning HIV. However, it is important to note that in 2021 when compared to 2017, the HIV incidence numbers in MSM dropped by 13.5% (HIV, 2023). This does reflect progress on addressing HIV in this community, but MSM are still at higher risk than the general population. Progress is also reflected in that total HIV infections dropped by 12% when comparing 2022 to 2018 with that being propelled by a 30% decrease in those 13-24, which are a high-risk category (CDC, 2024a).

MSM are a smaller subgroup of people in the United States that comprise 2% of adults in the population, but that does not mean they have lower overall rates of HIV/AIDS (Castel et al., 2015; Pitasi et al., 2021). They have the highest increase in HIV prevalence (Castel et al., 2015). According to the Centers for Disease Control and Prevention (CDC), ⅔ of the new cases of HIV were a result of the transmission of HIV in men having sexual contact with other men in 2022 (2024a).

With high mortality rates among MSM, they are a vulnerable population to HIV infection. They also face concerning levels of stigma regarding their sexual identity, sexual behaviors, and HIV in general. There are numerous research findings on the effect of stigma and access to care plus overall health. One research finding found a negative associative relationship between a person's perceived healthcare stigma and knowledge of HIV preventive efforts via pre-exposure prophylaxis (PrEP) (Babel et al., 2021). There even is research evidence that stigmatization leads to an increased risk for mental health disorders, increased fear of rejection, and also refusal to receive HIV care (Berger et al., 2001; CDC, 2020; Hedge et al., 2021; Valdiserri et al., 2019). This causes an intensity in this overall problem for the MSM population, especially with MSM being less likely to have open discussions with clinicians on HIV and other sexually transmitted infections (STIs) (Oldenburg et al., 2015; Valdiserri et al., 2019). This is not just a problem facing MSM, but those with increased risk for HIV in general. However, the HIV stigma problem in the MSM community is intensified by another form of stigma MSM face. MSM not only have to face HIV stigma, but this is compounded by their sexual identity or sexual behaviors, and the stigma associated with that.

This stigma can impact the daily lives of MSM due to their fears of certain effects caused by not only HIV stigma but also queer stigma. The effects of queer stigma on the queer individual documented via research findings include verbal harassment, gossip, fear of being out in public, exclusion by family, being rejected by friends, afraid of accessing healthcare services, and also a risk of assault (Stahlman et al., 2016; Valdiserri et al., 2019). The intersectionality of HIV and queer stigmas reflect a need for a critical qualitative approach to health intervention in the MSM community. This is because the experiences of these people need to be heard and validated to tackle this problem.

Also important to note is that few studies studying HIV have included transgender people as part of the study (Human Rights Campaign, n.d.b). This is concerning because a decent amount of transgender women in the United States (21.6%) are HIV positive (Human Rights Campaign, n.d.b). Even fewer studies have reported on transgender men and gender nonconforming individuals (Human Rights Campaign, n.d.b). This is problematic because HIV can significantly impact transgender and gender nonconforming individuals more than the general population (Human Rights Campaign, n.d.b). This cisnormative bias with a majority of research not being fully reflective of HIV in the transgender population reflects that there is more

action to be taken on studying this topic to be wholly inclusive. This study sought to mitigate this bias by being transparent on welcoming transgender men and gender nonbinary folks into the study.

This research followed a qualitative approach of having a focus group of four participants with the focus group following critical methods espoused by Paulo Freire in his seminal work on education: *Pedagogy of the Oppressed* (Freire, 1970). Freire's philosophy on education reflects the need for educators to break the power-oppression dynamic in education by having students discover problems facing them by themselves through collaborating to come to possible solutions to that problem (Freire, 1970). Freirean critical pedagogy is being used as an approach in public health education interventions with interventions done using this approach and also articles about how it can apply to issues such as health literacy or HIV being written (Dawkins-Moultin et al., 2016; Dearfield et al., 2017; Jarpe-Ratner & Marshall, 2021; Matthews, 2014; Wood, 2009). With its influence in critical theory which seeks to break down the barriers of power that cause oppression in those marginalized, critical pedagogy can be a perfect tool for health interventions versus those that relay knowledge to participants through the Banking Model of Education (Freire, 1970; Matthews, 2014). The Banking Model accounts for a lack of autonomy and individuality due to the instructor relaying knowledge on the student through lecture and expecting them to retain it (Freire, 1970). Freire likened this to inserting a coin in a piggy bank with the content being the coin and the piggy bank being the student (Freire, 1970). The instructor expecting this retention of knowledge the students have not developed themselves through collaboration is an example of the power-oppression dynamic, according to Freire (Aliakbari & Faraji, 2011; Freire, 1970). This Banking Model proposed by Freire does not allow students to have autonomy or individuality and does not allow them to come up with solutions to the problem themselves (Aliakbari & Faraji, 2011; Freire, 1970). Critical pedagogy is a vehicle to establish a dialogue between facilitators and participants on a certain issue affecting the participants which makes it a unique methodology on certain health topics involving marginalized peoples to establish praxis (action and reflection) (Matthews, 2014). This critical pedagogy is in hand with the topic of research to be investigated.

The goals of the focus group approach were to ask the participants about their perceptions of HIV stigma, their experiences with stigma regardless of if they are HIV positive or not, and their self-efficacy on bringing about transformative change. Throughout this process, participants

engaged with each other and the facilitator(s) through dialogue and coding to collaboratively develop conclusions on how to combat HIV stigma in public health.

The research dived into HIV stigma perceptions and consequences perceptions in MSM. This project sought to find themes as well as categories to better understand how MSM perceive HIV stigma and its impact on public health. After the transcripts were compiled and went through thematic analysis, another qualitative methodology was used. Coding through a qualitative descriptive approach was used to determine themes and categories that were considered the results of this project. The research sought to determine how MSM perceive HIV stigma and its consequences.

Research Question

1. How do men who have sex with men (MSM) perceive HIV stigma and its consequences?

Positionality Statement

The primary researcher of this project who is the writer of this thesis identifies as a queer, gay, cisgender man and uses he/they pronouns. These identities have influenced his interest in studying HIV stigma in this community. These have also influenced his interest in studying this from a critical approach to see how action can be taken to help empower individuals in the MSM community and allies to combat stigma.

Chapter 2

Review of the Literature

Introduction

The problem explored in this study is the Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS) stigma in the men who have sex with men (MSM) community. The theoretical lens of critical pedagogy was used as a methodology for a focus group on this problem. The following literature review examines the research done on MSM, HIV stigma, HIV prevention, and critical pedagogy to assess the extent of this issue in public health.

MSM Community and HIV in the United States

The MSM community has the highest increase in overall cases of HIV despite their relatively small size of 2% of adults in the United States (Castel et al., 2015; Pitasi et al., 2021). With that in mind, it is important to express that ⅔ of the new cases of HIV in the United States in 2022 were a result of HIV transmission by men who engaged in sexual contact with other men (CDC, 2024a). The total number of cases in this community has been dropping overall as reflected in approximately 32,100 new cases per year in the United States but a majority of them are still MSM (HIV, 2023). A disparity in youth regarding HIV is also reflected, especially since younger folks are more likely to engage in problematic behaviors that can increase the chances of an HIV diagnosis (Fisher et al., 2018).

Younger MSM are more likely to be involved in risky behaviors that are pleasurable at first but have negative consequences, such as unprotected sex and sharing needles for injectable drug use which can lead to HIV infection (Fisher et al., 2018). Fisher and colleagues (2018) also reported in their findings that MSM are less likely to get HIV tests, treatment, or prophylactic measures because of their fear of providers stigmatizing them and violating confidentiality over their sexuality (2018). HIV stigma is related to the virus' association with unsafe sex and drug use, and also its association with communities that already face stigmas such as MSM and non-MSM transgender people (Gunn et al., 2022). The impacts of HIV on MSM are related to the ongoing issue of HIV stigma in this community. As can be seen, MSM are more at risk for the

consequences of HIV due to the stigma behind their fear of treatment. This shows how stigma as a system needs to be addressed in HIV/AIDS education.

HIV Stigma

HIV stigma is a form of stigma that is problematic to the prevention of HIV in high-risk communities. Stigma is a systemic process that is linked to power, being able to dominate, and the stigmatized group facing inequality from other groups (Gunn et al., 2022). It differs from discrimination in that it is broader and includes labeling and stereotyping with discrimination being a part of stigma (Gunn et al., 2022). HIV stigma also has the impact of making groups who are not at high-risk for HIV distance themselves from the realities of HIV in terms of categorizing those who are at higher risk which contributes to stigma overall (Burkholder et al., 1999). The barriers that stigma causes are strengthened by those who do not support or at least accept sexual and gender minorities for who they are, despite support for the LGBTQIA+ community increasing in the United States (GLAAD, 2023).

Stigma is reinforced by the fact that around ⅓ of people from the United States do not support sexual and gender minorities, which only allows for ⅔ of them to be accepting of sexual and gender minorities with the total number of people accepting them increasing (Valdiserri et al., 2019). Even with acceptance increasing, stigma is still very prevalent through intentional and unintentional methods. These forms of stigma have permeated into the daily lives of MSM and other people at risk for HIV to create disparities. Stigma is also reinforced by the fact that as of June 2024, only 23 states and Washington D.C have explicit nondiscrimination laws in effect for LGBTQIA+ Americans that prohibit discrimination (Movement Advancement Project, 2024). This stigma overall creates a negative impact on the health outcomes and overall health behaviors of MSM.

According to the CDC from the Medical Monitoring Project, the median value for HIV stigma score in HIV-positive MSM from 0 to 100 was a score of 29 (Pitasi et al., 2021). The highest of the median scores was MSM who are 18-24 with a score of 39 (Pitasi et al., 2021). While it may be hard for one to interpret what these scores mean and whether or not these scores are severe per the scale used, it was a scale based on 10 questions asked to participants that were measured on a scale of 0 to 100 (Pitasi et al., 2021). The constructs help give a score that is reflective of the perceived stigma the individual answering the questions reported facing and the

median scores reported reflect that of the communities studied; the higher the score, the higher the level of perceived stigma (Pitasi et al., 2021). Even with these scores reported being in the 50th percentile of every score reported, these are still concerning levels of perceived HIV stigma since there are higher scores than 39 reported.

In terms of being able to measure stigma, Berger and colleagues (2001) also created a seminal psychometric HIV infection stigma scale that measured perceived stigma. The model had three categories: precursors, perceived stigma of having HIV, and possible responses (Berger et al., 2001). There were 40 items total in the survey after the original survey with 101 items was refined (Berger et al., 2001).

Negative Impact of HIV Stigma

MSM are facing a disparity of having more impact by HIV despite the advances in prevention and treatment since the 2000s (Babel et al., 2021). The CDC reported that the stigma, prejudice, and discrimination this community faces has an impact that causes mental, emotional, and physical health diseases and disorders in MSM which can also cause them to be hesitant to receive HIV treatment and prophylactic measures (2020). Related to this hesitancy is the fact that perceived stigma can cause people, especially MSM, to want to isolate and not get support from others because of an overwhelming fear of rejection (Berger et al., 2001).

Not only can stigma cause mental health issues due to fear of judgment, it also has medical repercussions to it (CDC, 2022). The finding that the MSM community fears that providers will violate their confidentiality due to their sexual preferences or sexual orientation shows how this is problematic (Qiao et al., 2018). This is problematic because disclosing one's sexual orientation or preference in MSM can make providers more likely to recommend their MSM patient to receive HIV and other sexually transmitted infection (STI) testing which is beneficial to their overall health (Qiao et al., 2018). The overall disclosing rate of MSM status to clinicians is in a range of 49% to 70% according to research findings (Petroll & Mosack, 2011; Qiao et al., 2018). These findings give a view of the provider-patient relationship and how one's sexual identity can cause both fear and willingness to disclose for health purposes. This is heavily related to MSM on whether or not they want to discuss HIV with medical staff or the level of sexual activity they partake in.

A survey done on HIV-negative MSM found that those living in states with higher levels of structural stigma against lesbian/gay/bisexual/transgender/queer or questioning/intersex/asexual and others (LGBTQIA+) people were more likely to engage in high-risk sexual activities and have less comfort discussing HIV or other STI prevention with clinicians (Oldenburg et al., 2015; Valdiserri et al., 2019). Another survey that surveyed American MSM in 2015 reported that the most common forms of perceived stigma were verbal harassment, family gossiping, and fear of being out in public (Stahlman et al., 2016; Valdiserri et al., 2019). Other trends from that 2015 survey were exclusion by family members, rejection by friends, being afraid of getting access to healthcare, and being assaulted (Stahlman et al., 2016; Valdiserri et al., 2019). Related is that hate crime statistics in 2012 conclude that 26% of reported hate crimes were against gender minorities and 13% of them were sexual minorities (Valdiserri et al., 2019; Wilson, 2014). These statistics give a frightening view of the impacts of stigma on MSM.

Critical Pedagogy and Participatory Action Research (PAR)

Critical pedagogy (also known as Freirean education) is the critical theory approach to education where power dynamics between student and teacher are disrupted to dissolve power in teachers and oppression in students. (Aliakbari & Faraji, 2011; Freire, 1970). This allows the cultivation of a community of teacher-students where all learn from each other and teach each other (Aliakbari & Faraji, 2011; Freire, 1970). This approach to education was popularized by Paulo Freire with his most famous work being *Pedagogy of the Oppressed* that was influenced by his experiences helping impoverished people in Chile while on exile from his native Brazil (Freire, 1970).

The objective of Freirean education is to halt the oppression of students as vessels of retaining knowledge that educators expect of them (what he called the Banking Model of Education) and give them back their autonomy to discover their critical consciousness (conscientização) (Freire, 1970). This is where they have an understanding of the structures of the world around them and, in general, the entire world that can lead to oppression (Aliakbari & Faraji, 2011; Freire, 1970). This critical consciousness is the highest state that critical pedagogy can achieve and it is done so through coding with objects to come to a consensus on the problem facing that group, naming through dialogue on their self and view of the world, and also praxis

(which involves taking action but also reflecting on that action afterward) (Aliakbari & Faraji, 2011; Freire, 1970). These three steps allow for one to develop the critical consciousness Freire theorized (Freire, 1970).

Critical pedagogy is based on Freire's problem-posing education. The Banking Model is the predominant system used in the United States where teachers, instructors, and professors are viewed as a bundle of knowledge that they lecture to their students for them to retain that knowledge (Freire, 1970). Freire likened this to a piggy bank (hence the name Banking Model) because the knowledge is being inserted into the student like a coin is put into a piggy bank (Freire, 1970). This process allows the student to have no autonomy or individuality and instead allows them to not discover their critical consciousness which makes them oppressed (Aliakbari & Faraji, 2011; Freire, 1970). Freire's philosophy is problem-posing education where students discover the knowledge themselves by getting involved to come to solution for the problem posed in order to take action and then reflect (Aliakbari & Faraji, 2011; Freire, 1970). The researchers or instructors assist the students as being the problem-posers to create a system of equality among the group but do not take the main role because that should be delegated to the students to ameliorate their oppression (Aliakbari & Faraji, 2011; Freire, 1970). This way the students still have their autonomy and individuality, are not oppressed, and are heading towards critical consciousness because they are discovering the knowledge of the problems plaguing them on their own (Aliakbari & Faraji, 2011; Freire, 1970).

Participatory Action Research (PAR) is a research approach that is dialectic towards research and action which allows for those affected by a research issue to be engaged in the research and contribute to the research topic on an equal note with the researchers (Minkler, 2000). This is through engaging with each other and assessing community strengths and weaknesses for action to be taken by increasing knowledge (Minkler, 2000). PAR blurs the lines between the researchers and participants to make them all involved equally in the research process conducted, and it also can be done quantitatively or qualitatively (Minkler, 2000). PAR involves the participants as part of the research team where they help develop research questions, hypotheses (if applicable), determine variables and measurements (if applicable), plan methods, and collect and analyze data, among other steps (Payne, 2017).

Freirean education can often be thought of as a form of PAR. This is due to how it is structured to have teachers/researchers be the problem-posers and the students/participants as the

group engaged together to get their knowledge toward critical consciousness (Freire, 1970). Freire was an influential figure in the development of PAR due to his seminal work and presentations on it in Tanzania (Orlowski, 2019). There is a form of PAR that is influenced by critical theory, critical participatory action research (CPAR). CPAR allows for participants involved in PAR to not only engage with researchers and each other but also to maintain their empowerment and get towards liberation (Fine et al., 2021; Morrow et al., 2001).

In terms of its history, PAR was developed in the field of social psychology by Kurt Lewin who coined the term "action research" (Payne, 2017). He researched the complex web of grievances between Black people and White people in one group and the other group being Jewish people and non-Jewish people (Payne, 2017). His research led him to believe that those oppressed (Black people and the Jewish) were part of a messy tangled system of tension that would require a constructivist approach with both of these groups (Payne, 2017). This interest led to the development of action research in general and PAR as a whole (Payne, 2017). Lewin's foundation of general action research is called the Northern tradition (Ferreira & Gendron, 2011). PAR which developed after Lewin founded action research and was influenced by Freire is known as the Southern tradition (Ferreira & Gendron, 2011). The Southern tradition is different from the Northern in that it is more progressive, political, and radical than the Northern tradition and was innovated by those in the Southern hemisphere (Breda, 2014). PAR developed into public health research decades later, but it would be called community capacity building. This form of public health-specific PAR is still being used today in qualitative public health research (Payne, 2017).

Critical Pedagogy in Public Health

The concepts behind critical pedagogy are a novel approach to public health intervention, but can be used in public health.

For example, a study provided a longitudinal case study of an Australian school's National Health and Physical Education curriculum that added an opportunity for critical pedagogy (Alfrey & O'Connor, 2020). The researchers chose to do a case study and it showed the efficacy of switching the methods and the process of change itself (Alfrey & O'Connor, 2020). The methods followed were of three phases each involving different workshops, teachers' perspectives, planning meetings, and lessons (Alfrey & O'Connor, 2020). The important findings

were that participation had gone up with the implementation of the critical curriculum and that the teachers had developed a more critical teaching style because of the implementation and having the resources for them to be more critical within reach (Alfrey & O'Connor, 2020).

Another case study approach using critical pedagogy documented the use of a comprehensive sexual health education (SHE) program in Chicago and how it could be improved to address health inequities, be inclusive to LGBTQIA+ people, and allow for discussion and dialogue (Jarpe-Ratner & Marshall, 2021). The researchers conducted interviews with teachers who also filled out a demographic questionnaire, several students went through focus group interviews and the lead researcher also kept contact with several student and community stakeholders throughout the study (Jarpe-Ratner & Marshall, 2021). They gave several important findings which were the necessity for student-centered learning approaches, using discussion and dialogue when discussing identities, the importance of a more holistic approach to sexual health and wellness, and also the importance of having discussions on inequities and intersectionality theory (Jarpe-Ratner & Marshall, 2021).

A significant amount of the research done on critical pedagogy methods in public health is theoretical by nature due to its novelty and the overall philosophy of challenging what can contribute to power and oppression in people's daily lives being a newer part of open discussion. An example of this is a research article that argued that health literacy interventions should go from the deficit level of patient-clinician relationships to a critical pedagogical and socioecological level to consider the social environment's impact on health literacy of people since education should be considered as and used as a form of social change (Dawkins-Moultin et al., 2016). They argued this is due to over 90 million adults in the United States having concerningly low adequacy in terms of health literacy and that incorporating the socioecological model and critical pedagogy can help implement individual, community, and society-based change (Dawkins-Moultin et al., 2016). Both lenses inherently involve different strategies for health literacy interventions, and both do help people figure out their problems at different levels of society (Dawkins-Moultin et al., 2016). This is a seminal article arguing for the use of critical pedagogy in public health that is of a theoretical nature and not a case study or primary data collection intervention.

Another theoretical-based article used a Freirean critical pedagogy approach to determine how critical pedagogy can be used in public health education and promotion (Matthews, 2014).

Matthews made note of using critical pedagogy as a way to foster critical health literacy in individuals and their communities (2014). The three phases Matthews examined in this approach are coding (listening and naming), dialogue and reflection, and promotion of action that is transformative (praxis) (2014). This is a foundational article on its overall implementation in public health research since it provides background on how to do this per the three steps used in critical pedagogy (Matthews, 2014).

A research article by Schoorman and colleagues (2012) is the closest to the research problem at hand but involves a different population with different needs for critical pedagogy intervention for HIV education. Nevertheless, this is arguably the most seminal piece on the importance of this type of research. Schoorman and colleagues (2012) detailed a critical pedagogical approach to health education for HIV/AIDS in a Guatemalan Maya immigrant community in South Florida through the Family Literacy Program (Schoorman et al., 2012). The area of the program had a high rate of HIV/AIDS so an approach to also increasing the critical literacy of this group was vitally needed since they could not read or write in any language (Schoorman et al., 2012). They talked about the importance of culturally responsive HIV/AIDS education to address the structural violence and sociocultural influences of increased HIV transmission (Schoorman et al., 2012). This study involved dialogue by nature through the use of critical participatory action research which found that a big trend was being invisible in this community which the researchers wanted to avoid at all costs (Schoorman et al., 2012).

This educational approach brought forth their cultural norms about women having less power than men, poverty, and men being allowed to be promiscuous without repercussions (Schoorman et al., 2012). Due to generally not being aware of this topic, writings overall not being useful to them, and also that community understanding of this issue was a necessity, the researchers had to use a narrow approach with content delivered longitudinally (Schoorman et al., 2012). The program used dialogue, acting, drama, and cultural symbols to foster understanding and engagement (Schoorman et al., 2012). These sessions were impactful especially since the participants wanted these programs to be conducted and also attended them regularly because they found them useful and allowed them to reflect on and redevelop their gender roles due to HIV/AIDS (Schoorman et al., 2012). One impact of the intervention was that they got to start the process of reframing their culture's gender roles and norms given the rates of HIV in their community (Schoorman et al, 2012). Another was that they developed presentations

and determined potential audiences for future presentations including the teenagers in the community (Schoorman et al., 2012). And they also started to recognize that sex education in the home for their children was important and a start to addressing HIV (Schoorman et al., 2012).

Significance

In this chapter, the severity of HIV in the MSM community regarding mortality, health behavior, and stigma was discussed. The literature published that followed qualitative approaches had gaps due to not looking at HIV as systemic and influencing the power/oppression dynamic that HIV-positive folks go through concerning their status. Even with the critical pedagogy articles being mostly theoretical, the articles that had an actual intervention involved had positive results. Thus, with the severity of HIV being compounded by HIV stigma and overall involving other intersectional stigmas, this reflects the possibility of a critical approach working. The research questions of this study ask about the experiences and perceptions of MSM on stigma's consequences. This study addressed the gaps in the literature on how to implement critical methods in an intervention while also addressing the increasing HIV rates in this community despite their relatively small size in the United States. With these two addressed in tandem, it contributes to critical pedagogy being a less novel methodology and more accepted in public health for other issues that face stigma such as mental health.

Chapter 3

Methodology

Research Question and Specific Aims

The research question for this intervention was:

1. How do men who have sex with men (MSM) perceive HIV stigma and its consequences?

The following specific aims were compiled for this intervention. Specific aims are used in qualitative research to put forth the objectives and intentions for research projects.

1. Explore the overall perceptions of MSM aged 18-35 regarding HIV and how they put meaning to the associated stigma.
2. Identify MSM's perspectives on how HIV stigma can negatively impact HIV prevention and care in this group by letting participants engage with each other through critical coding.
3. Explore the participants' perspectives on how HIV stigma can impact self-efficacy in contributing to transformative change

Paradigm and Theory

The research can be considered under the transformative research paradigm. Transformative research is one of the four main research paradigms that allow for marginalized peoples' experiences and voices to be of the utmost importance as it combats injustice and promotes social justice, diversity, equity, and inclusion (Jackson et al., 2018). This paradigm of research is most often used for analyzing the effects of power dynamics, social structures, and systematic or systemic processes on marginalized groups (Jackson et al., 2018).

The research involved a group (MSM) who face marginalization based on their sexual behaviors overall regardless of whether or not they identify as part of the lesbian/gay/bisexual/transgender/queer or questioning/intersex/asexual and others (LGBTQIA+) community. Stigma is linked to power, social structures, and systems, and is oppressive to those who face it (Mitchell et al., 2021). Thus, transformative research has a critical theory aspect pertinent to its epistemological stance (Jackson et al., 2018). This aligns with the fact that the focus group methodology used a critical pedagogy approach in it. As such, critical pedagogy can

be thought of as how Freire developed it: as the application of critical theory to education to combat oppression.

The theoretical lens to be used in this project is Freirean education (critical pedagogy). The steps of naming, coding, and ultimately praxis (the end goal) were conducted by the participants to help them come to conclusions on the problem of HIV stigma and how it impacts MSM. The primary investigator and research team were on the sides to let the participants have more power through collaboration, community building, goal setting, and sharing of experiences without judgment, criticism, and ensuring confidentiality on the part of the researchers while also requesting participants to keep what other participants said inside the intervention space. However, side questions and further discussion probing were utilized during the focus group when appropriate.

When coding the transcripts collected, inductive coding and a qualitative descriptive research approach were used. A qualitative descriptive research approach allows for coding and thematic analysis to get the context of the problem at hand which in turn allows for more freedom in the coding process since the researchers are not restricted to a certain qualitative paradigm such as grounded theory or phenomenology (Doyle et al., 2020; Kim et al., 2017). This approach was used to validate the participants' experiences and to not allow the research team to come in with thoughts and ideas on possible themes. For a topic like this, it logically makes sense to let the data collected determine what themes are appropriate to the participants.

Sample and Recruitment

The sample for this study was a group who identified as MSM with three cisgender men and one gender nonbinary individual being involved in the study. The ages of the participants recruited were 18-35 since this range is adults with the most concerning rates of HIV in this population. Knowledge of critical pedagogy is not required for the participants since the concepts were broken down into pieces in the focus group that were easier to understand in terms of relating to power, oppression, and stigma. Participants were also not asked about their sexual orientation or HIV status because of how HIV stigma can impact all individuals in the MSM community regardless of sexual orientation or HIV status. Participants were also not asked to identify their race or ethnicity because the research team did not think to include this.

The sample size was four participants. With focus groups, too many participants and too few participants for a group will not give accurate themes to the problem due to decreased chances of not reaching saturation (Morse, 2000). Larger groups are too hard to maintain order and it also is hard to maintain the data collected in the transcripts with all of those participants since there is a large amount of usable data per participant (Morse, 2000).

These sample criteria do exclude those who identify as women (both cisgender and transgender) from participating. This exclusion is being used for the research not to exclude women since they face rates of HIV that have stabilized while men fluctuate but because MSM were found to be the population most impacted by HIV in the United States as of 2020 (HIV, n.d.). Other than that, MSM of other intersectional identities were welcomed and encouraged to participate and promotion was done heavily to recruit diverse groups of MSM across the Midwest.

To recruit MSM to participate in this study, the principal investigator (PI) and his research assistant contacted LGBTQIA+ organizations in the Midwest to promote this research project and spread the word to their MSM connections. Recruitment was also done via social networking and contacting on-campus organizations. Monetary incentives were promoted in the recruitment because each participant was given 75 dollars for participating in the focus group. This amount was determined to be the incentive because of how sensitive this topic is and can be potentially emotional or yield a negative reaction to some folks in this community as well as that recruitment in this community for studies can be challenging and hard-to-reach, as well as being underrecruited (Lucassen et al., 2017). The project started once approval from Miami's Institutional Review Board (IRB) was granted.

Methods and Procedure

This focus group took place via Zoom. The principal investigator (PI) and research assistant posed the problem to the four participants (the problem being HIV stigma in MSM) through the use of fictional scenarios written by the PI involving the research he has done for the study, trends, and experiences within this community in terms of HIV. The scenarios each involved an individual going through a struggle regarding HIV stigma and asked the participant to reflect on "what they would do if they were in his shoes". The topics in each scenario dealt with relevant facets and parts of the HIV stigma discussion to reflect and take into action the

critical approach used in the study. The scenario topics dealt with antiretroviral therapy (ART) for HIV treatment stigma, HIV stigma in transgender people, religion, social media, relationships, as well as stigma against those who use HIV pre-exposure prophylaxis (PrEP) prevention. The scenario concepts also had an influence on some of the codes that were used in thematic analysis. The PI and research assistant were on the sides observing and thinking of their responses. When appropriate and needed, the PI and research assistant posed follow-up questions to points of discussion to yield further discussion or to clarify on a point discussed. The research assistant led this process which helped allow for further engagement and discussion plus dialogue by the participants. The focus group was video recorded with participants' consent and was transcribed. Afterward, the transcription was examined by the PI and research assistant to check for accuracy and fix any errors due to the transcription process. Personal identifiers were de-identified.

The focus group was planned to take however long it needed to take, with it taking approximately 70 to 80 minutes with one five-minute break given. The focus group was structured for participants to take time to reach a mutual consensus on the scenario before moving on to the next one. Once all three scenarios were discussed and agreed upon, the participants were given the floor to share anything else they feel was pertinent to the topic to close out the focus group if they would have liked to. None of the participants did engage in the open floor discussion. The focus group concluded after this. The focus group overall went as planned. There were no moments where participants were emotional or experienced a negative reaction by the discussions and content of the focus group. The participants engaged in the focus group and with each other and gave significant insights and thoughts that allowed for the data collected to be reflective of the problem at hand in the thematic analysis portion.

Analytic Strategy

Once the transcript was collected, de-identified, and edited, then codes were added to it through Dedoose (Dedoose, n.d.). The codes were then used to determine themes. Coding was done throughout the project by transcribing the focus group.

A code is constituted by trends found in the transcripts that are broad that when combined can create themes for the overall problem. Codes for a topic like this could include education, mental health, and healthcare (these are a few examples from the data analysis; for full

codebook, look at the appendices) among other parts mentioned in a transcript. These codes were compiled in a code book and used to create themes to increase understanding of the experiences or perceptions of the problem at hand. As mentioned earlier, some of the concepts from the scenarios did get to contribute a code (e.g., social media, religion).

Consensus on codes was reached when there was agreement after transcripts had been thoroughly read and worked on together by the research team. Since inductive coding was used, codes were developed as the transcript was read, and a codebook was compiled with codes added throughout. The PI and research assistant split the transcript in halves to work on. The PI worked on the first half, and the research assistant worked on the second half. Consensus was reached by the team after one round of coding with the PI checking over the assistant's codes and editing as needed, and the research assistant also checking over the PI's code. The codebook was maintained and updated by the PI and research assistant through Dedoose. The definitions for the codebook were created by the PI after the categories and themes were determined based on the transcript.

Once coding was done through Dedoose, themes were determined and collected to be put in the results. Themes were determined by analyzing the relationships among codes and put together to represent the experiences of the whole group. The themes were constructed by the PI and agreed upon by the research assistant.

Categories were also decided upon by merging relevant codes to enhance the thematic findings. The research assistant to the PI for this project came up with the category idea, as well as led the construction of the four categories and what codes constructed these categories.

Overall, there were not any disagreements in the thematic analysis process besides any edits needed when engaged in the coding process. This reflected more of the PI's experience in coding and thematic analysis and the research assistant not having coded qualitative data before. The categories and themes were unanimously agreed upon by the PI and research assistant. It was known that consensus was reached when after checking the codes and determining their relevance to the categories and themes, the team determined that no further edits were needed pending the member checking process if engaged in by participant(s).

The possibility of side questions did make this more complex if there are significantly different responses. Thus, any side questions that occurred were noted and coded as part of the

transcript. These helped contribute to the themes determined to further assess whether or not the intervention affected the participants.

To ensure the trustworthiness of the data, all of the participants were recommended to be part of member-checking the themes and categories to ensure these were reflective of their perceptions and experiences and give any further insights or edits if needed. This allows for qualitatively credible findings that are parallel to their experiences and allows for more determinations of the findings in the research questions (Curtin & Fossey, 2007). Out of the four participants of this project, one did engage in the member-checking process and agreed that these were reflective and did not need further edits. This concluded the thematic analysis process and yielded the results of four categories and two themes.

Chapter 4

Results

Introduction

The primary research question for this study was*: How do men who have sex with men (MSM) perceive HIV stigma and its consequences?* To investigate this question, a focus group with four participants who identified as part of the MSM community was conducted via Zoom.

Participant Overview

The following table shows some characteristics of the participants of the focus group. Participants were assigned a letter to be their de-identified alias, as well as asked about what region of the United States they are from, their gender identity, their pronouns, and their age. Participants were not asked to disclose their sexual orientation, HIV status, race, or ethnicity. The characteristics of the participants can be found in Table 1 below.

Table 1: *Participant Characteristics*

Participant Name (de-identified)	Location	Gender	Pronouns	Age
M	Midwest	Genderfluid/ nonbinary Assigned Male at Birth (AMAB)	he/she	21
J	Midwest	Cisgender man	he/him	19
N	Midwest	Cisgender man	he/they	35
C	Midwest	Cisgender man	he/him	19

Results Overview

The results of the project after undergoing data analysis were four categories and two themes.

Categories were created after combining separate codes from the codebook created that when combined were relevant to the project. The four categories created were: health, resources, LGBTQIA+ Issues, and connection.

The data analysis also yielded two themes collected from the focus group transcripts. The themes can be found in Table 2 below.

Table 2: *Themes*

Several parts of our lives and our past still stigmatize us but, in some cases, they have been improving.
Heteronormative culture stigmatizes us structurally.

Categories

Categories were created from the merger of separate codes that when combined yielded part of the results. The categories created were health, resources, LGBTQIA+ issues, and connection. Table 3 shows the codes from the codebook that were used to create these categories, as well as further descriptions after. The full codebook with definitions that were used during the coding process can also be found in the appendices.

Table 3: ***Categories and the Codes Used to Create Them***

Category	**Health**	**Resources**	**LGBTQIA+ Issues**	**Connection**
Codes	Medication	Education	Discrimination	Social Media
		Upbringing	Gender	
	Healthcare			Relationships
		Healthcare	Sexual Orientation	
	Mental Health			Employment
		Medication	HIV Status	

Health category

The health category was created through the merger of three codes.

One of the codes was medication which was used in any part of the transcript that referenced the use of medications (including pre-exposure prophylaxis (PrEP) and mental health medications) whether in the scenarios or the participant reflections. The reason for mental health medications being coded specifically in medications and not as much in mental health was due to

mentions of PrEP being referenced significantly more than mental health medications and combining the two refined the codebook. The use of PrEP did not fit the HIV status code and it was decided to keep those separate due to how holistic and complex HIV healthcare is.

The healthcare code also contributed to this category. This code was used for any references to medical care including doctor's visits and specialist visits whether talked about in the scenarios or the participant reflections.

The mental health code also contributed to this and was a general code on any topic dealing with mental health, including, mental health conditions, stress, and psychotherapy.

Resources category

The resources category was created through the merger of four codes.

The education code was used for any topic relating to educational settings and experiences whether used in the scenarios or the reflections of the participants on those scenarios.

The upbringing code was used when the participants of the scenario reflected on their upbringings, especially when talking about their experiences being raised in religious households, with spirituality also being a separate code.

The healthcare code contributed to the resources category as well.

The medication code also contributed to the resources category as well.

LGBTQIA+ Issues category

The LGBTQIA+ Issues category was created through the merger of four codes.

The discrimination code was used when the individuals in the scenario or the participants in reflection mentioned discrimination, hatred, or prejudice in their lives such as homophobia, transphobia, and anti-LGBTQIA+ hate.

The gender code was used when the individuals in the scenario or the participants in reflection referenced gender, including, gender identity, gender expression, gender norms, gender roles, gender variance, and gender biases, and when using the term men who have sex with men (MSM)

The sexual orientation code was used when the individuals in the scenario or the participants in reflection referenced sexual orientation, including homosexuality and bisexuality.

The sexual orientations of each participant were not requested to disclose if uncomfortable but there were instances of participants sharing their sexual orientation.

The HIV status code was used especially in coding the scenarios when the HIV status of the individuals in those scenarios was referenced and when the participants referenced the scenario. This code was not used for the HIV statuses of the participants since this was not requested for them to disclose if comfortable and none of the participants disclosed their HIV status openly in discussion.

Connection category

The connection category was created through the merger of three codes.

The social media code was used when the individuals in the scenarios or the participants reflected on social media use in general or specific apps, including typical social media apps but also dating apps.

The relationships code was used when the individuals in the scenarios or the participants reflected on those they know and their relationships with them. This included family, friends, colleagues, and others that can have an influence on their lives.

The employment code was used when the individuals in the scenarios or the participants reflected on jobs, being an employee, a culture of working, or employment as a queer person.

Themes

Themes were created through analysis of the transcript through coding and how these codes were used in relevant quotes taken from the transcript. Two themes were determined to be relevant results in this study in terms of the HIV stigma and other stigma MSM go through concerning their sexual relationships, behaviors, and preferences. The two themes collected from the transcript were:

1. Several parts of our lives and our past still stigmatize us but in some cases, they have been improving.
2. Heteronormative culture stigmatizes us structurally.

Theme 1: Several parts of our lives and our past still stigmatize us but in some cases, they have been improving

This theme is comprised of parts of the transcript that encompass numerous aspects of the participants' lives. These included religion and upbringing, healthcare, and relationships.

Religion and Upbringing

One of the predominant facets of this theme talked about was religion especially dealing with the participants' upbringing.

Participant M reflected on the second scenario about Gavin's transgender identity and religious upbringing by highlighting his experiences with religion. He talked about how he felt he was ousted from his religion, how it is tough to lose support from those around you, and how it is important to find what is right for you.

- "Personally, I grew up religious, and I feel like I was kind of pushed out, due to like bullying and pressures that were kind of similar to what was mentioned. And then, now, as I'm coming into adulthood and exploring like religious topics myself, I'm not… I have thought about looking for a queer-friendly church, or perhaps, like a Unitarian Universalist type of structure. I do understand what's written about, and how tough it is to not only lose your support system, but have that support system actively turn against you, and be part of what's tearing you down. It is pretty scarring to even venture back into like thinking about joining another religious community and not being sure of what their standards and beliefs are. But I think today, even in a town like (university city), there are like you mentioned, there's a number of churches that are somewhat openly pro-queer and pro-LGBT rights. I think it's really about sifting through the sand and finding what works for you."-M

Participant C also reflected on Gavin's story by highlighting his experiences growing up Catholic. C talked about how his church was not accepting of gay people and how the structure of masses was strange to him even if the church would be accepting of queer people.

- "Personally, I would be apprehensive. But I also grew up religious. I grew up Catholic and the thing about the Catholic Church is all the masses are the same wherever you go, pretty much. And just coming where I come from, my church was not accepting towards gay people, and I've kind of been… I've been programmed to kind of dislike the mass, the Catholic mass as a whole, because of the community that it was associated with and going to a church,

even if it is queer-friendly. If it had the same mass structure it would just be kind of weird to me. I just yeah, I wouldn't like it."-C

Another of the participants, J, reflected on the scenario about Gavin and how he could see him being disillusioned by the Church given his experiences while sharing he himself has also.

- "I would just become extremely disillusioned with the Church in general, I mean, I already am in my personal life. So, just, I can't imagine going through an experience like this and not being disillusioned by the church. I feel like… it'd be really easy to just get… pushed away in general. But assuming he wants to go to another church, I'd have to agree with C on that one like it's no one's business."-J

Participant C reflected on the scenario about Gavin by sharing out that it is no one else's business for churchgoers to know about Gavin being transgender, but that there are churches out there with folks who would support him.

- "First thing like I thought of when he, when you mentioned that he wanted to join another church is… but didn't want to come out to them as transgender… He doesn't really have to, to be honest… It's not really any of their business if he's transgender or not. But if he did really want to, there's plenty of like really, really nice churches out there… They're hard to find sometimes. But there, there are plenty."-C

Healthcare

Another of the topics within the focus group talked about that was part of the construction of this theme is healthcare in the MSM community.

One of the participants, N, reflected on the scenario about Gavin and brought up a point about holistic LGBTQIA+-friendly healthcare in the United States that queer people can use.

- "I think of… community-based resources that would be wonderful for him to take advantage of. So, I think about here in (big city) we have… which is a LGBTQ-centric healthcare system… That is holistic healthcare. Right? Everything from primary care, physicians to dental care, to mental health, social work, etc. And they have a number of affirming groups that meet

weekly based on different identities and specifically for trans folks with HIV, right? So, there could be wonderful resources for community building, for mentorship."-N

N also reflected on the third scenario about Charlie and his use of PrEP with a point about queer people and their access to healthcare.

- "It's like finding queer-affirming healthcare also really important, right? Like how? How you know, and maybe some of you have been through this situation, where you go into a doctor's office, and you try to explain; you have to explain to the doctor what PrEP is because they don't know what that is, right? And then, what does the stigma about that come from because they are people too. They're medical providers, but they're still people, right? So like, do they have preconceived notions of queer men, and how we have sex and what all comes with that?"-N

Sexual health was not the only predominant form of health talked about in the focus group. Mental health was also a big discussion and how it affects the queer community.

One of the participants, J, reflected on the scenario about Charlie and shared about his mental health.

- "I've tried therapy. Didn't like it, really, but I tried it. I'll switch, and I'm also on anxiety medicine. And that helps a lot, although that's not specifically for that. But in general, it helps with everything. So, it kind of bleeds into that and helps."-J

Participant M added to his point about his experiences with mental health medications and therapy and how they helped him during his transition from high school to college.

- "I'm on an anti-anxiety medication… antidepressant, and I found the therapy worked well for me. I did it, for I would say around 18 months consistently coming out of high school and entering college and now I'm no longer in it. But for me it was a great help and where available, I think that that could be something to try out."-M

Relationships

Another facet of the focus group that led to the development of Theme 1 was relationships.

Participant C reflected on the scenario about Charlie and talked about how queer people will always have to deal with those who do not want to change and are toxic.

- "There's a couple of ways you can go about it. So, the first one would be if it was a family member, especially, talk to them about it. But sometimes people are so stuck in their own beliefs that… they're not going to change. And at that point it's either you'd have to cut them off, unfortunately, or just deal with it… It's really, really hard to do. But it unfortunately, unless we change society as a whole… there's always going to be that person that you can't escape."-C

Participant J expanded his quote about Gavin and religion by talking about relationships.

- "But also… keep in mind, you know, like, how would these people feel if they did know? And are those people you want to even be hanging around in the first place?... If they knew and they treated you different, are they even worthy of being around?... I think that's something that you really have to consider. Because then why are you even there, if they don't accept who you are as a person?"-J

Participant C reflected on the first scenario about John and his social media and shared about how he should find new friends to support him.

- "It seems he needs to find new friends as well, because it said his former friends were part of the people stigmatizing him. And at this point I would assume that he's kind of lacking, since he probably got rid of them. He's lacking in friends… in a good group to support him… He needs people to support him, and that's probably next priority. After accepting himself for who he is."-C

Theme 2: Heteronormative culture stigmatizes us structurally

This theme is comprised of parts of the transcript that dealt with how queer people live in a society that promotes advantages for heterosexual people and having to deal with being viewed as abnormal, being dehumanized, and being viewed as 'less than'. These include homophobia,

bullying and peer pressure, and navigating a heteronormative society.

Homophobia

One of the discussions within the focus group that led to the construction of Theme 2 was homophobia and how gay people have had to deal with this their whole lives.

Participant J reflected on the scenario about Gavin by bringing up his experiences playing soccer and the feelings of not belonging he experienced in sport culture due to his sexual orientation.

- "So, before I even like really knew I was bi… I had always, you know… I was always queer, but like I didn't know it. And freshman year I played… I played soccer all the way up through my life.. up until freshman year of high school. And when I got to be a freshman, I was playing one high school team and there's nothing more toxic than high school sporting teams for queer people… I absolutely hated my time. I did not feel like I was part as gay, and you could tell like I was just completely isolated…. No one would pay attention to me to the age kind of structure of like sports and how they treat younger people… but yeah, there was definitely something there where I was pushed away, and that was a part of… made me realize like, Oh, I'm not like other guys."-J

Participant N reflected on the scenario about John by reflecting on the interconnections of homophobia and transphobia, and how they play into HIV stigma.

- "So yeah, I still think… that homophobia and transphobia is wrapped up, especially for a lot of people of a certain generation and anti-HIV or fear of HIV."-N

Bullying and Peer Pressure

Another of the discussions in the focus group that contributed to the development of Theme 2 is bullying and peer pressure.

Participant M reflected on the scenario about Gavin by mentioning his upbringing and the bullying he experienced and how he felt like it caused him to be "pushed out". This point relates to religion and upbringing and was the first part of a quote that helped develop Theme 1.

- “Personally, I grew up religious, and I feel like I was kind of pushed out, due to like bullying and pressures that were kind of similar to what was mentioned. And then, now, as I'm coming into adulthood and exploring like religious topics myself… I have thought about looking for a queer-friendly church, or perhaps, like a Unitarian Universalist type of structure.”-M

Participant J reflected on the scenario about Charlie by reflecting on how co-workers can make mean comments about their queer co-workers and how human resources (HR) and how the systems in place can help them handle these situations.

- “I'll also add that I feel like a lot of places nowadays, especially like if you have a co-worker or someone that's treating you in a way that they shouldn't, you can usually talk to someone about that in the company like human resources and stuff... I'd agree with C that at that point you have to just kind of step away, or you have to find some way to deal with it. But when it comes to like professional relationships, I definitely believe there's systems in place that help people deal with those situations.”-J

Navigating a Heteronormative Society

The final discussion that contributed to the development of Theme 2 is how queer people must consistently deal with a heteronormative society that has been built to advantage heterosexual and cisgender individuals.

Participant N reflected on the scenario about John by discussing how heteronormative society has made it normalized for folks to believe that AIDS prevention involves MSM to not have sex. This quote precedes his point about the interconnections of homophobia and transphobia.

- “It was very much like, well, if we want to stop AIDS, then gay men should just stop having sex. Right? It was a very simple answer from a very heteronormative cis-het perspective. Well, then, just stop having sex and AIDS will go away. It's like. Oh, okay, and yet, what? At what point is that denying the humanity of these people as well? Right? It's never been that simple it is a far more complex conversation. And, and, and, then you couple that with fear… It becomes, it becomes a daunting task.”-N

Participant J reflected on the scenario about John by sharing out how those with HIV/AIDS have been dehumanized due to heteronormative society while dehumanizing those with other diseases would be considered inappropriate.

- “I feel like this is something; I mean, ultimately, he didn’t ask for this. This is not something he wanted… If we were to treat any other person who had a disease like that, like that would be considered negative or messed up in the eyes of most people. But I feel like there's a stigma just because it has to do with gay men or men who have sex with other men that it somehow has to do with those stereotypes… It's a negative thing, or it's bad, or like this upon themselves, which is simply, you know, not true.”-J

Conclusion

In conclusion, focus group brought about results reflecting heteronormative society and structural stigmatization through discussions on religion, healthcare, relationships, homophobia, bullying and peer pressure, and how queer people navigate these societies. The focus group also brought about different categories reflecting health, connection, LGBTQIA+ issues, and resources that are important to the MSM community as a whole.

Chapter 5

Discussion

Introduction

The research question for this project was: *How do men who have sex with men (MSM) perceive HIV stigma and its consequences?* After conducting and analyzing a focus group with men who have sex with men, four categories from the merger of different codes and two themes were constructed combining different discussions of the scenarios and personal reflections during the focus group.

Categories Interpretation

This section gives a reflection on the discussions in the focus group that contributed to the codes that built these categories, how these categories reflect the issue at hand, and also how these codes and categories relate to growing research done.

In the health category, the three codes merged reflect one's overall health and sense of well-being which was referenced heavily throughout the focus group scenarios and reflected on heavily by the participants. Especially important were the discussions on sexual health, mental health, and healthcare access to the contributions of this code. In terms of sexual health and stigma, Iott and colleagues (2022) found that stigma can cause MSM to delay getting HIV tests for numerous reasons, ranging from whether they should get an HIV test to differing opinions on how often to get tested. HIV stigma has also been found to be potentially associated increases in unprotected anal sex in both the receptive and insertive forms (Hatzenbuehler et al., 2011). In terms of mental health, they also found that HIV stigma is potentially associated with increases in depression and generalized anxiety symptoms (Hatzenbuehler et al., 2011). In terms of healthcare access, positive experiences with healthcare providers have been improving in terms of increased access to health insurance and increased acceptance of queer identities by providers but work in terms of cultural competency and reevaluating hospital policies need to be worked on (Quinn et al., 2015). Sexual health, mental health, and access to healthcare are important discussions within the queer community and this category reflects that.

In the resources category, the four codes merged reflect the focus group dealing with how the participants and the individuals in the scenarios have experiences, knowledge, and guidance

they have received that they have utilized in their day-to-day lives. This category also reflects the importance of those who have provided the scenario individuals and participants with those resources that they have used to navigate their lives. Especially important were the discussions on education, upbringing, healthcare, and medication. In terms of education, the amount of knowledge on sexual safety one has received from their healthcare providers and community organizations is important. Pre-exposure prophylaxis (PrEP) use is increasing among MSM in the United States and that along with knowledge of the importance of condoms reflect a possible normalization of PrEP for HIV prevention in the United States (Traeger et al., 2018). Increases in these reflect the importance of being informed. In terms of upbringing, a big part of this discussion was on religion and spirituality. Religion and spirituality in upbringing have been determined to be a big part of the holistic identity development of individuals, such as in MSM due to the differing messages religion has given them from acceptance to non-acceptance (Crockett et al., 2018). The discussions given in the interpretation of healthcare apply to the resources category as well. In terms of medication, growing research has been done on PrEP persistence which is defined as being on PrEP and using it over time (Laborde et al., 2020). This is important to study because those most at risk of contracting HIV tend not to be PrEP persistent (Laborde et al., 2020). A majority of PrEP users use it for between six months to a year which is often how persistence is viewed (Blackstock et al., 2017; Chan et al., 2016; Dombrowski et al., 2018; Krakower et al., 2019; Laborde et al., 2020; Liu, 2019; Rusie et al., 2018; Spinelli et al., 2019; van Epps et al., 2018; Zucker et al., 2019). In their study collecting patient and clinician perspectives on PrEP persistence, Laborde and colleagues (2020) found issues that affect PrEP adherence include follow up visits and laboratory test scheduling and attendance, patient-clinician communication, visiting the pharmacy for refills being an inconvenience to patients, and having to take it daily being a challenge. Those who reported the highest difficulties taking it daily were those who reported being homeless and those who have substance use disorders (Laborde et al., 2020). This study helps show how there are many contextual factors that can make taking PrEP and adhering to it over time difficult and that collecting these perspectives can uncover how providers can make it easier to support their patients' ability to adhere to it (Laborde et al., 2020). This study also found that the patients in the study reported a common theme that PrEP users did not focus as much on HIV risk as the clinicians nor PrEP as the only way to navigate chances of getting HIV (Laborde et al., 2020). A big portion of this could be due

to arguments that focusing extensively on risk and PrEP adherence could possibly contribute to HIV and PrEP-related stigmas and also the exacerbation of racial and ethnic disparities (Laborde et al., 2020).

In the LGBTQIA+ issues category, the four codes merged highlights the experiences of living as a man who has sex with other men. It reflects what the community goes through concerning MSM stigma, HIV stigma, homophobia, HIV testing, and sexual contact safety. With this project especially focusing on the experiences of MSM stigma and HIV stigma, the LGBTQIA+ issues category reflects the purposes of conducting this study and as such a decent portion of the findings of the study. This category is broader than HIV stigma and also includes others' perceptions of the LGBTQIA+ community. In terms of discrimination, these experiences are common for LGBTQIA+ adults in the United States. Research has shown that the most common forms are slurs, microaggressions, harassment, and violence and that these persist in numerous facets of life, including in healthcare encounters (Casey et al., 2019). In healthcare encounters, these are especially problematic because they can prevent queer folks from visiting their healthcare providers which can cause a range of problems in terms of health issues such as sexual health, mental health, and physical health (Casey et al., 2019). In terms of gender, gender identity is often thought of as fixed in terms of demographics but has fluidity and shifting elements to it, which reflects increased change and understanding in how people perceive gender and the LGBTQIA+ community (Ruberg & Ruelos, 2020). In terms of sexual orientation, sexual identity also has been found to have fluid and shifting elements to it, which also reflects how others perceive sexual orientation and the LGBTQIA+ community (Ruberg & Ruelos, 2020). In terms of HIV status, this further relates to how HIV stigma and thoughts plus opinions on testing can be an influence on one's HIV status if at risk (Iott et al., 2022).

In the connections category, the three codes merged reflect the importance of those around the queer community, how queer people meet others, how they connect with these people, and how they view their relationships with others. It reflects how queer people view connection with community and those outside their community as important. This category also highlights how relationships and others can also stigmatize MSM in terms of HIV and their sexual relationships, behaviors, or preferences. In terms of social media, it can be a tool used to deliver HIV interventions by building community, providing testing services, spreading health education information and awareness, and development of interventions (Cao et al., 2017). In

terms of relationships, one study found that younger MSM and HIV-negative men are preferred by other MSM for sexual contact and intimate relationships and in terms of race and ethnicity, White and Hispanic men were preferred over Black and Asian men across all the identities of the participants using the mobile app the researchers used for recruitment (Phillips et al., 2016). This can mean clustered cases of HIV in communities with higher incidence (Phillips et al., 2016). In terms of employment, one longitudinal study conducted found that HIV-positive MSM who are employed have a better quality of life in terms of physical and mental health (Rueda et al., 2012).

Themes Interpretation

This section gives an interpretation of the themes determined as the results of the study and discusses the quotes that gave light to these themes and how they can be interpreted in the real-world to the issue of HIV stigma in the MSM community.

Theme 1: Several parts of our lives and our past still stigmatize us but in some cases, they have been improving.

Theme 1 reflects how acceptance of MSM for who they are has been improving but that there is still stigmatization MSM go through about HIV and in general for their sexual behaviors and identity. The discussions from the focus group that constructed this theme dealt with religion and upbringing, healthcare, and relationships.

Religion and Upbringing

The quotes from participants M, C, and J on Gavin's scenario and reflecting on religion in general as MSM as well as on their experiences growing up in Christian households reflect how religion is an institution that can stigmatize and not fully accept MSM for who they are. It is important to note that in the United States, 47% of LGBTQIA+ adults are religious and that queer outreach has been increasing especially with the Universal Fellowship of Metropolitan Community Churches which is the largest Christian organization focused on queer outreach and membership (Conron et al., 2020; Human Rights Campaign, n.d.a). It has been found that being religious can lead to lower stress levels and increased fulfillment in life, and that being able to attend an accepting church can lead to lower stress levels, increased self-esteem, increased support, and less discrepancy in identity (Boppana & Gross, 2019; Hamblin & Gross, 2011;

Hancock, 2000; Koenig & Larson, 2001; Rodriguez & Ouellette, 2000; Rosmarin et al., 2009; Smith et al., 2003; Yakushko, 2005). The quotes from these participants reflect how religion as an institution can perpetuate stigma along with other institutional factors. Participants M and J in particular talk about how being a religious man who has sex with other men can be conflicting to the individual because of the perpetuation of this stigma, fears of lack of acceptance or being outed which can cause the disillusionment and feelings of being ousted. Participant C's discussion of how it is no one's business on Gavin's gender identity if he chooses to not come out also highlights an important point on how it is up to the individual when they want to come out to others if at all. Coming out to others can cause varying reactions in the individuals that the person came out to, with a great amount of this due to the stigma LGBTQIA+ individuals go through regarding their identity (Crocker et al., 1998; D'Augelli, 2002; Ryan et al., 2015).

Healthcare

The quotes from participants N, J, and M on sexual health and mental health reflect the importance of health in the LGBTQIA+ community and how healthcare interactions can unfortunately stigmatize queer folks. As referenced in the categories section, these can be problematic because providers are the ones who can provide PrEP for HIV prevention when MSM are sexually active and can also provide or refer them to treatment for mental health issues. MSM go through barriers to healthcare access such as providers who do not understand, cost, problems accessing health insurance, and identification systems that follow the gender binary of man or woman (Krehely, 2009; Quinn et al., 2015; Roberts & Fantz, 2014). The LGBTIQIA+ community (including MSM) also have reported facing anxiety issues due to coming out to their providers over their sexual orientation and behaviors where they fear not receiving care or being mistreated due to these (Mollon, 2012; Quinn et al., 2015; Roberts & Fantz, 2014; Stanton, 2013). Also problematic is that MSM and other LGBTQIA+ folks are less likely to seek healthcare due to a providers' lack of knowledge on LGBTQIA+ healthcare needs and an overall lack of outreach and support (Krehely, 2009; Quinn et al., 2015; Roberts & Fantz, 2014). Participant N talked about holistic healthcare and queer-affirming healthcare and how these are important in that they can eliminate the barrier of a non-understanding or unaware provider. Queer-affirming and holistic providers are important to the discussion of LGBTQIA+ health because they are more informed on LGBTQIA+ health issues and the need for PrEP in

groups such as MSM. Participants J and M talked about their experiences with mental health treatment, and these reflect how LGBTQIA+ people are more prone to facing mental health issues for a plethora of reasons ranging from stigma, and not being in an accepting environment, to internalized homophobia. Seeing a mental health provider for psychotherapy or medications can be a great tool for queer people to treat underlying mental health issues.

Relationships

The quotes from participants C and J on the relationships that MSM have reflect the importance of having relationships with supporting allies to combat stigma and the importance of MSM being able to have a community of folks in general. Allyship towards the LGBTQIA+ community has been found to promote education, belonging, fostering relationships, and feelings of living with purpose among allies (Rostosky et al., 2015). The ability for MSM to have positive interpersonal relationships with heterosexual allies such as family and friends is important to the discussion of combatting HIV and MSM stigma. Participant C talked about how queer folks deal with toxic people in their lives who are not accepting of their identities and that it is best for MSM to talk with them about it, then cut their relationships with them if that does not work. Participant J talked about those who treat MSM differently due to their identities and sexual behaviors if they know of them. All three quotes show the importance of those MSM surround themselves with as part of perpetuating HIV stigma, but also important to the acceptance, health, and wellness of the MSM community.

Theme 2: Heteronormative culture stigmatizes us structurally

Theme 2 reflects how society as a whole causes stigmatization toward MSM regarding their sexual behaviors, identity, and HIV due to heteronormativity and that this normalization of heterosexuality over other sexual orientations perpetuates HIV and MSM stigma. The discussions from the focus group that constructed this theme dealt with homophobia, bullying and peer pressure, and how MSM navigate a heteronormative society.

Homophobia

The quotes from participants J and N on homophobia that MSM and other queer folks go through reflect the stigmatization that this form of prejudice perpetuates in MSM. MSM are a

community at high risk with increased incidence with one reason being that they face double stigma through HIV and reinforced preconceived stigmas that already exist (Pulerwitz & Bongaarts, 2014). One intervention done in New York City (Project CHHANGE) tackled HIV stigma and homophobia and found that educating gay men on how stigma and homophobia impact HIV prevalence is important to anti-stigma interventions (Frye et al., 2017). Participant J reflected on how homophobia is rampant in sport culture by sharing his experiences playing soccer as a queer teenager in school. Participant N reflected on how homophobia and transphobia are different forms of prejudice but that they are interwoven to create a picture of anti-HIV and create fears of it that further stigmatize and "other" queer folks. In transgender populations, transphobia and stigma were barriers to PrEP use because people may assume those that take antiretroviral medication are HIV-positive and the social aspect to HIV stigma (Brooks et al., 2019; Chandler et al., 2021; Dang et al., 2022; Rael et al., 2018; Rowniak et al., 2017; Sevelius et al., 2016; Wilson et al., 2015; Wood et al., 2017). It is important to note that cisgender MSM can also face barriers to PrEP access and PrEP-related stigma (Pico-Espinosa et al., 2022).

Bullying and Peer Pressure

The quotes from participants M and J on the bullying and peer pressure that MSM can face even in adulthood reflect how MSM can be misunderstood and not accepted due to heteronormativity. Bullying, peer pressure and discrimination in adulthood are not often as talked about as in childhood and adolescence. One study done in the United Kingdom found that LGB employees are significantly more likely to report experiences of bullying with bisexuals reporting higher numbers than lesbians and gay men (Hoel et al., 2017). This study also reported that progress for LGB employees has been increasing in Western countries, but that prejudice and stigma due to heteronormativity still impact them (Hoel et al., 2017). Participant M talked about how bullying and peer pressure in his upbringing made him feel isolated from others which reflects the heteronormativity rampant in society and is an all-too-common experience that MSM and other queer folks go through. Participant J talked about bullying in adulthood at the workplace and how systems in the workplace including HR can help. This relates to the British study discussed (Hoel et al., 2017) and how heteronormative structures create a harder workplace environment for queer folks including MSM.

Navigating a Heteronormative Society

The quotes from participants N and J on how heteronormativity impacts HIV/AIDS awareness and education and how MSM go through their day reflect how HIV/AIDS awareness should also tackle homophobia, stigma, transphobia, and biphobia. The CHHANGE project was discussed as a project that implemented awareness efforts to eliminate homophobia and stigma as a part of the prevalence of HIV/AIDS cases in communities (Frye et al., 2017). More initiatives that deal with HIV/AIDS awareness and education while addressing systemic, systematic, and institutional structures that lead to increases in cases such as homophobia and stigma are needed. This project gives insight that addressing these as barriers to prevention can be effective and that more projects should follow suit (Frye et al., 2017). Participant N talked about how normalized it has become that the only way to prevent HIV/AIDS is for MSM to not have sexual contact. This contradicts the fact that all communities can become infected with the HIV virus and not just MSM. HIV.gov reported that in 2021, 22% of the HIV incidence in the United States that year was due to heterosexual sexual contact with females engaging in heterosexual contact and getting HIV being more than double that of males engaging in heterosexual contact (HIV, 2023). The epidemiological data reflect that the notion that to stop HIV/AIDS diagnoses that MSM should not engage in sexual contact is not true and further stigmatizes MSM. Participant J talked about how heteronormativity has resulted in queer folks with HIV being dehumanized while those with other diseases would not be dehumanized for it as it would be considered inappropriate. This reflects how heteronormativity has warped people's perceptions of HIV/AIDS and that HIV is still not fully understood even more than forty years after the start of the HIV/AIDS pandemic.

Future Research

Future research on HIV stigma and MSM stigma should also incorporate a critical approach since there are structural and institutional barriers that lead to increases in HIV cases in all communities. There are numerous ways to incorporate this approach and critical pedagogy could be a great vehicle to engage in critical research in the future on a wider, bigger approach. Future research on this issue should be done in both qualitative and quantitative regards. There is importance of having statistical findings for this issue but there also is importance in getting the experiences of MSM firsthand. If done in a mixed methods or qualitative approach,

phenomenology and grounded theory could be excellent qualitative theories used to guide a research study done in this community on HIV stigma. Future research should also involve participants 18 and older and not just 18-35 like this study did. Future research on HIV stigma and MSM should also be more representative of the queer transgender men population who have to not only navigate stigma and homophobia but also transphobia and how that can also impact their experiences as a member of the MSM community. Future research also should be intent on having a racially diverse as well as a socioeconomic status diverse sample in their research. These were not focused on for this project but also are important to the HIV stigma discussion.

Limitations

This study has several limitations to note. One of them is the size of the focus group. This focus group had four participants after ongoing recruitment due to issues with funding access. Thus, this study most likely has not reached the point of saturation which is important in qualitative research. Therefore, it cannot generally be said with certainty if this applies to other MSM aged 18-35 in one way. Future research should include more participants and more than one focus group conducted to accommodate increased participants.

Another limitation is that all of the participants were from the Midwest. Them all being from the same region could mean different results from those in different regions or across the United States. MSM from the West Coast could have differing opinions or insights than the participants in the focus group, for example.

Another limitation is that three of the four participants were on the younger side of the age range, 19-21. Thus, there was only one older participant that insights were collected from. Therefore, future research studies on this should include a healthy mix of younger and older participants in that range.

Another limitation from the study is that participants' sexual orientations and HIV statuses were not collected. Future research should collect this information if possible because someone who is HIV-negative may have a different opinion or insight than someone who is HIV-positive. HIV-positive folks have that lived experience and would have different experiences than HIV-negative people. Sexual orientations can also be a helpful in the data of participants but is not as important to the discussion as HIV status is.

Another limitation is that the participants' race, ethnicity, and socioeconomic status identifications were not collected either. Future research should also collect this information because these are important to this discussion and reflect access and other forms of stigma and prejudice that could give important insights on this topic. Using an intersectional approach as much as possible in this discussion is appropriate and can be impactful for future research.

A final limitation from the study is how the critical approach was used. The critical approach was used by guiding the participants of the focus group to attempt to reach consensus on what they would do if they were in the scenario through discussion, dialogue, and reflection. There are many ways to attempting a critical pedagogy approach and this may not have been the most effective or the most reflective of critical pedagogy. Therefore, future research should incorporate different approaches influenced by critical pedagogues such as Freire.

Conclusion

In conclusion, the focus group conducted on four MSM participants aged 18-35 yielded thematic results that reflect heteronormativity and structures of their lives that perpetuate HIV stigma and general stigma for their sexual behaviors and identity. The focus group also yielded four categories that reflect the importance of health, community, relationships, and day-to-day experiences in the MSM community that are also important to this question. Future research should also take on a critical approach in any way deemed appropriate, and should include higher numbers of participants, participants from different regions of the United States, participants of different ages, and should request participants' HIV status, sexual orientation, race, ethnicity, and socioeconomic status if possible.

References

Alfrey, L. & O'Connor, J. (2020). Critical pedagogy and curriculum transformation in Secondary Health and Physical Education. *Physical Education and Sport Pedagogy, 25*(3), 288-302. https://doi.org/10.1080/17408989.2020.1741536.

Aliakbari, M., & Faraji, E. (2011). Basic principles of critical pedagogy. *2nd International Conference on Humanities, Historical and Social Sciences, IPEDR, 17*, 77-85.

Babel, R. A., Wang, P., Alessi, E. J., Raymond, H. F., & Wei, C. (2021). Stigma, HIV risk, and access to HIV prevention and treatment services among men who have sex with men (MSM) in the United States: A scoping review. *AIDS and Behavior, 25,* 3574-3604.

Berger, B. E., Ferrans, C. E., & Lashley, F. R. (2001). Measuring stigma in people with HIV: Psychometric assessment of the HIV stigma scale. *Research in Nursing and Health, 24,* 518-529.

Blackstock, O. J., Patel, V. V., Felsen, U., Park, C., & Jain, S. (2017). Pre-exposure prophylaxis prescribing and retention in care among heterosexual women at a community-based comprehensive sexual health clinic. *AIDS Care*, *29*(7), 866–869. https://doi.org/10.1080/09540121.2017.1286287

Boppana, S., & Gross, A. M. (2019). The impact of religiosity on the psychological well-being of LGBT Christians. *Journal of Gay & Lesbian Mental Health, 23*(4), 412-426. https://doi.org/10.1080/19359705.2019.1645072

Breda, K. L. (2014). Participatory action research. In De Chesnay, M. (Ed.). *Nursing research using participatory action research (*pp.1-11). Springer Publishing Company.

Brooks, R. A., Cabral, A., Nieto, O., Fehrenbacher, A., & Landrian, A. (2019). Experiences of pre-exposure prophylaxis stigma, social support, and information dissemination among Black and Latina transgender women who are using pre-exposure prophylaxis. *Transgender Health*, *4*(1), 188–196. https://doi.org/10.1089/trgh.2019.0014

Burkholder, G. J., Harlow, L. L., & Washkwich, J. (1999). Social stigma, HIV/AIDS knowledge, and sexual risk. *Journal of Applied Behavioral Research, 4*(1), 27-44.

Cao, B., Gupta, S., Wang, J., Hightow-Weidman, L. B., Muessig, K. E., Tang, W., Pan, S., Pendse, R., & Tucker, J. D. (2017). Social media interventions to promote HIV testing, linkage, adherence, and retention: Systematic review and meta-analysis. *Journal of Medical Internet Research, 19*(11), e394.

Casey, L. S., Reisner, S. L., Findling, M. G., Blendon, R. J., Benson, J. M., Sayde, J. M., & Miller, C. (2019). Discrimination in the United States: Experiences of lesbian, gay, bisexual, transgender, and queer Americans. *Health Services Research, 54,* 1454-1466. https://doi.org/10.1111/1475-6773.13229

Castel, A. E., Magnus, M., & Greenberg, A. E. (2015). Update on the epidemiology and prevention of HIV/AIDS in the USA. *Current Epidemiology Reports, 2,* 110-119. https://doi.org/10.1007/s40471-015-0042-8.

Centers for Disease Control and Prevention. (2024a). *Estimated HIV Incidence and Prevalence.* Accessed June 29, 2024, via, https://www.cdc.gov/hiv-data/nhss/estimated-hiv-incidence-and-prevalence.html?CDC_AAref_Val=https://www.cdc.gov/hiv/library/reports/hiv-surveillance/vol-28-no-3/index.html

Centers for Disease Control and Prevention. (2024b). *Fast Facts: HIV in the United States.* Accessed June 30, 2024, via https://www.cdc.gov/hiv/data-research/facts-stats/index.html

Centers for Disease Control and Prevention. (2024c). *Fast Facts: HIV in the US by Age.* Accessed June 30, 2024, via https://www.cdc.gov/hiv/data-research/facts-stats/age.html

Centers for Disease Control and Prevention. (2020). *HIV Surveillance Report, 2018 (Updated), 31.* Retrieved from http://www.cdc.gov/hiv/library/reports/hiv-surveillance.html.

Centers for Disease Control and Prevention. (2022). *Let's Stop HIV Together.* Accessed June 29, 2024, via https://www.cdc.gov/stophivtogether/hiv-stigma/index.html#:~:text=HIV%20internalized%20stigma%20can%20lead,tested%20and%20treated%20for%20HIV.

Chan, P. A., Mena, L., Patel, R., Oldenburg, C. E., Beauchamps, L., Perez-Brumer, A. G., Parker, S., Mayer, K. H., Mimiaga, M. J., & Nunn, A. (2016). Retention in care outcomes for HIV pre-exposure prophylaxis implementation programmes among men who have sex with men in three US cities. *Journal of the International AIDS Society*, *19*(1), 20903. https://doi.org/10.7448/IAS.19.1.20903

Chandler, C. J., Creasy, S. L., Adams, B. J., Eaton, L. A., Bukowski, L. A., Egan, J. E., Friedman, M. R., Stall, R. D., & Whitfield, D. L. (2021). Characterizing biomedical HIV prevention awareness and use among Black transgender women in the United States. *AIDS and Behavior*, *25*(9), 2929–2940. https://doi.org/10.1007/s10461-021-03189-w

Conron, K. J., Goldberg, S. K., & O'Neill, K. (2020). Religiosity among LGBT adults in the US. Williams Institute. Accessed June 30, 2024 via https://williamsinstitute.law.ucla.edu/publications/lgbt-religiosity-us/

Crocker, J., Major, B., & Steele, C. (1998). Social stigma. In D. Gilbert & S. Fiske (Eds.), Handbook of Social Psychology (Vol. 2, 4th ed., pp. 504– 551). New York, NY: McGraw Hill.

Crockett, J. E., Cashwell, C. S., Marszalek, J. F., & Willis, B. T. (2018). A phenomenological inquiry of identity development, same-sex attraction, and religious upbringing. *Counseling and Values, 63,* 91-109.

Curtin, M., & Fossey, E. (2007). Appraising the trustworthiness of qualitative studies: Guidelines for occupational therapists. *Australian Occupational Therapy Journal, 54,* 88-94. https://doi.org/10.1111/j.1440-1630.2007.00661.x.

D'Augelli, A. R. (2002). Mental health problems among lesbian, gay, and bisexual youths ages 14 to 21. *Clinical Child Psychology and Psychiatry, 7*, 433–456. https://doi.org/10.1177/1359104502007003039

Dang, M., Scheim, A. I., Teti, M., Quinn, K. G., Zarwell, M., Petroll, A. E., Horvath, K. J., & John, S. A. (2022). Barriers and facilitators to HIV pre-exposure prophylaxis uptake, adherence, and persistence among transgender populations in the United States: A systematic review. *AIDS Patient Care and STDs, 36*(6), 236-248. https://doi.org/10.1089/apc.2021.0236

Dawkins-Moultin, L., McDonald, A. & McKyer, L. (2016). Integrating the principles of socioecology and critical pedagogy for health promotion health literacy interventions. *Journal of Health Communication, 21,* 30-35. http://dx.doi.org/10.1080/10810730.2016.1196273.

Dearfield, C. T., Barnum, A. J., & Pugh-Yi, R. H. (2017). Adapting Paulo Freire's pedagogy for health literacy interventions. *Humanity & Society, 41*(2), 182-208. https://doi.org/10.1177/0160597616633253

Dedoose. (n.d.). Home. Retrieved from https://www.dedoose.com/

Dombrowski, J. C., Golden, M. R., Barbee, L. A., & Khosropour, C. M. (2018). Patient disengagement from an HIV preexposure prophylaxis program in a sexually transmitted disease clinic. *Sexually Transmitted Diseases*, *45*(9), e62–e64. https://doi.org/10.1097/OLQ.0000000000000823

Doyle, L., McCabe, C., Keogh, B., Brady, A., & McCann, M. (2020). An overview of the qualitative descriptive design within nursing research. *Journal of Research in Nursing: JRN*, *25*(5), 443–455. https://doi.org/10.1177/1744987119880234.

Dubov, A., Galbo, P., Altice, F. L., & Fraenkel, L. (2018). Stigma and shame experiences by MSM who take PrEP for HIV prevention: A qualitative study. *American Journal of Men's Health, 12*(6), 1832-1843. https://doi.org/10.1177/1557988318797437.

Ferreira, M. P., & Gendron, F. (2011). Community-based participatory action research with traditional and indigenous communities of the Americas: Historical context and future directions. *International Journal of Critical Pedagogy, 3*(3), 153-168. Retrieved from http://digitalcommons.wayne.edu/nfsfrp/2.

Fine, M., Torre, M. E., & Oswald, A. G. (2021). Critical participatory action research: Methods and praxis for intersectional knowledge production. *Journal of Counseling Psychology, 68*(3), 344-356. doi.org/10.1037/cou0000445.

Fisher, C. B., Fried, A. L., Macapagal, K., & Mustanski, B. (2018). Patient-provider communication barriers and facilitators to HIV and STI preventive services for adolescent MSM. *AIDS and Behavior, 22,* 3417-3428. https://doi.org/10.1007/s10461-018-2081-x.

Freire, P. (1970). *Pedagogy of the oppressed.* New York, Seabury Press.

Frye, V., Paige, M. Q., Gordon, S., Matthews, D., Musgrave, G., Kornegay, M., Greene, E., Phelan, J. C., Koblin, B. A., & Taylor-Akutagawa, V. (2017). Developing a community-level anti-HIV/AIDS stigma and homophobia intervention in New York City: The project CHHANGE model. *Evaluation and Program Planning, 63*, 45-53. http://dx.doi.org/10.1016/j.evalprogplan.2017.03.004

GLAAD. (2023). Accelerating Acceptance 2023. Retrieved from https://glaad.org/publications/accelerating-acceptance-2023/

Gunn, J. K. L., Rooks-Peck, C., Wichser, M. E., Denard, C., McCree, D. H., Jeffries, W. L., DeLuca, J. B., Ross, L. W., Herron, A., Barham, T., Flores, S. A., & Higa, D. H. (2022). Effectiveness of HIV stigma interventions for men who have sex with men (MSM) with and without HIV in the United States: A systematic review and meta-analyses. *AIDS and Behavior, 26,* S51-S89. https://doi.org/10.1007/s10461-021-03358-x.

Hamblin, R., & Gross, A. M. (2011). Role of religious attendance and identity conflict in psychological well-being. *Journal of Religion and Health, 52*(3), 817–827. https://doi.org/10.1007/ s10943-011-9514-4

Hancock, K. A. (2000). Lesbian, gay, and bisexual lives: Basic issues in psychotherapy training and practice. In B. Greene & G. L. Groom (Eds.), Education, research, and practice in lesbian, gay,

bisexual, and transgendered psychology: A resource manual (pp. 91–130). Thousand Oaks, CA: Sage.

Hatzenbuehler, M. L., O'Cleirigh, C., Mayer, K. H., Mimiaga, M. J., & Safren, S. A. (2011). Prospective associations between HIV-related stigma, transmission risk behaviors, and adverse mental health outcomes in men who have sex with men. *Annals of Behavioral Medicine, 42*(2), 227-234. https://doi.org/10.1007/s12160-011-9275-z

Hedge, B., Devan, K., Catalan, J., Cheshire, A., & Ridge, D. (2021). HIV-related stigma in the UK then and now: to what extent are we on track to eliminate stigma?: A qualitative investigation. *BMC, Public Health, 21*(1022), 1-10. https://doi.org/10.1186/s12889-021-11000-7

HIV. (2023). *U.S. Statistics.* Accessed May 26, 2024, via https://www.hiv.gov/hiv-basics/overview/data-and-trends/statistics#:~:text=People%20who%20acquired%20HIV%20through%20heterosexual%20contact%20made%20up%2022,in%20the%20U.S.%20in%202021.

Hoel, H., Lewis, D., & Einarsdottir, A. (2017). Debate: Bullying and harassment of lesbians, gay men, and bisexual employees: Findings from a representative British national study. *Public Money and Management, 37*(5), 312-314. http://dx.doi.org/10.1080/09540962.2017.1328169

Human Rights Campaign. (n.d.a.). *Stances of Faiths on LGBTQ+ Issues*: *Metropolitan Community Churches.* Accessed June 30, 2024, via https://www.hrc.org/resources/stances-of-faiths-on-lgbt-issues-metropolitan-community-churches

Human Rights Campaign. (n.d.b). *Transgender People and HIV: What We Know. Accessed June 28, 2024 via https://www.hrc.org/resources/transgender-people-and-hiv-what-we-know*

Iott, B. E., Loveluck, J., Benton, A., Golson, L., Kahle, E., Lam, J., Bauermeister, J. A., & Veinot, T. C. (2022). The impact of stigma on HIV testing decisions for gay, bisexual, queer and other men who have sex with men: A qualitative study. *BMC Public Health, 22*(471), 1-17. https://doi.org/10.1186/s12889-022-12761-5

Jackson, K. M., Pukys, S., Castro, A., Hermosura, L., Mendez, J., Vohra-Gupta, S., Padilla, Y., & Morales, G. (2018). Using the transformative paradigm to conduct a mixed methods needs assessment of a marginalized community: Methodological lessons and implications. *Evaluation and Program Planning, 66,* 111-119. doi.org/10.1016/j.evalprogplan.2017.09.010.

Jarpe-Ratner, E. & Marshall, B. (2021). Viewing sexual health education through the lens of critical pedagogy: A case study in Chicago Public Schools. *International Journal of Environmental Research and Public Health, 18,* 1-16. https://doi.org/10.3390/ijerph18041443.

Kim, H., Sefcik, J. S., & Bradway, C. (2017). Characteristics of qualitative descriptive studies: A systematic review. *Research in Nursing & Health*, *40,* 23–42.

Koenig, H. B., & Larson, D. B. (2001). Religion and mental health: Evidence for an association. *International Review of Psychiatry, 13,* 67–78. https://doi.org/10.1080/09540260124661

Krakower, D., Maloney, K. M., Powell, V. E., Levine, K., Grasso, C., Melbourne, K., Marcus, J. L., & Mayer, K. H. (2019). Patterns and clinical consequences of discontinuing HIV preexposure prophylaxis during primary care. *Journal of the International AIDS Society*, *22*(2), e25250. https://doi.org/10.1002/jia2.25250

Krehely, J. (2009). How to close the LGBT health disparities gap. *Center for American Progress,* 1-9.

Laborde, N. D., Kinley, P. M., Spinelli, M., Vittinghoff, E., Whitacre, R., Scott, H. M., & Buchbinder, S. P. (2020). Understanding PrEP persistence: Provider and patient perspectives. *AIDS and Behavior, 24,* 2509-2519. https://doi.org/10.1007/s10461-020-02807-3

Liu A. (2019). Learning from oral PrEP care retention: rates, patterns, and interventions. NIAID-NIMH behavioral and social science meeting; May 13–14.

Lucassen, M. F. G., Fleming, T. M., & Merry, S. N. (2017). Tips for research recruitment: The views of sexual minority youth. *Journal of LGBT Youth, 14*(1), 16-30. https://doi.org/10.1080/19361653.2016.1256246

Matthews, C. (2014). Critical pedagogy in health education. *Health Education Journal, 73*(5), 600-609. https://doi.org/10.1177/0017896913510511.

Minkler, M. (2000). Using participatory action research to build healthy communities. *Public Health Reports, 115,* 191-197.

Mitchell, U. A., Nishida, A., Fletcher, F. E., & Molina, Y. (2021). The long arm of oppression: How structural stigma against marginalized communities perpetuates within-group health disparities. *Health Education & Behavior, 48*(3), 342-351. https://doi-org.proxy.lib.miamioh.edu/10.1177/10901981211011927.

Mollon, L. (2012). The forgotten minorities: Health disparities of the lesbian, gay, bisexual, and transgendered communities. *Journal of Health Care for the Poor and Underserved, 23*(1), 1-6.

Morrow, S., Rakhsha, G., & Castaneda, C. (2001). Qualitative methods for multicultural counseling. In J. Ponterotto, J. M. Casas, L. A. Suzuki, & C. M. Alexander (Eds.), Handbook of multicultural counseling (2nd ed., pp. 575–603). Thousand Oaks, CA: Sage Publications.

Morse, J. M. (2000). Determining sampling size. *Qualitative Health Research, 10*(1), 3-5.

Movement Advancement Project. (2024). *Equality Maps: Housing Nondiscrimination Laws.* Accessed June 30, 2024, via https://www.lgbtmap.org/equality-maps/non_discrimination_laws

Orlowski, P. (2019). Freirean conceptions of participatory action research and teaching for social justice - Same struggle, different fronts. *Canadian Journal of Action Research, 20*(1), 30-51.

Oldenburg, C. D., Perez-Brumer, A. G., Hatzenbuehler, M. L., Krakower, D., Novak, D. S., Mimiaga, M. J., & Mayer, K. H. (2015). State level structural sexual stigma and HIV prevention in a national online sample of HIV-uninfected MSM in the United States. *AIDS,* 29, 837–845.

Payne, Y. A. (2017). Participatory action research. *The Wiley Blackwell Encyclopedia of Social Theory.* https://doi.org/10.1002/9781118430873.est0272.

Petroll, A. E., & Mosack, K. E. (2011). Physician awareness of sexual orientation and preventive health recommendations to men who have sex with men. *Sexually Transmitted Diseases, 38*(1), 63–67.

Phillips, G., II., Birkett, M., Hammond, S., & Mustanski, B. (2016). Partner preference among men who have sex with men: Potential contribution to spread of HIV within minority populations. *LGBT Health, 3*(3), 225-232. https://doi.org/10.1089/lgbt.2015.0122

Pico-Espinosa, O. J., Hull, M., MacPherson, P., Grace, D., Gaspar, M., Lachowsky, N., Mohammed, S., Demers, J., Kilduff, M., Truong, R., & Tan, D. H. S. (2022). PrEP-related stigma and PrEP use among gay, bisexual, and other men who have sex with men in Ontario and British Columbia, Canada. *AIDS Research and Therapy, 19,* 1-9. https://doi.org/10.1186/s12981-022-00473-0

Pitasi, M. A., Beer, L., Cha, S., Lyons, S. J., Hernandez, A. L., Prejean, J., Valleroy, L. A., Crim, S. M., Trujillo, L., Hardman, D., Painter, E. M., Petty, J., Mermin, J. H., Daskalakis, D. C., & Hall, H. I. (2021). Vital signs: HIV infection, diagnosis, treatment, and prevention among gay, bisexual, and other men who have sex with men- United States, 2010-2019. *CDC Morbidity and Mortality Weekly Report, 70*(48), 1669-1675.

Pulerwitz, J., & Bongaarts, J. (2014). Tackling stigma: fundamental to an AIDS-free future. *The Lancet Global Health*, *2*(6), e311-e312.

Qiao, S., Zhou, G., & Li, X. (2018). Disclosure of same-sex behaviors to health-care providers and uptake of HIV testing for men who have sex with men: A systematic review. *American Journal of Men's Health, 12*(5), 1197-1214. https://doi.org/10.1177/1557988318784149.

Quinn, G. P., Sutton, S. K., Winfield, B., Breen, S., Canales, J., Shetty, G., Sehovic, I., Green, B. L., & Schabath, M. B. (2015). Lesbian, gay, bisexual, transgender, queer/questioning (LGBTQ) perceptions and health care experiences. *Journal of Gay & Lesbian Social Services, 27*(2), 246-261. https://doi.org/10.1080/10538720.2015.1022273

Rael, C. T., Martinez, M., Giguere, R., Bockting, W., MacCrate, C., Mellman, W., Valente, P., Greene, G. J., Sherman, S., Footer, K. H. A., D'Aquila, R. T., & Carballo-Diéguez, A. (2018). Barriers and facilitators to oral PrEP use among transgender women in New York City. *AIDS and Behavior*, *22*(11), 3627–3636. https://doi.org/10.1007/s10461-018-2102-9

Roberts, T. K., & Fantz, C. R. (2014). Barriers to quality health care for the transgender population. *Clinical Biochemistry, 47*(10), 983-987.

Rodriguez, E. M., & Ouellette, S. C. (2000). Gay and lesbian Christians: Homosexual and religious identity integration in the members and participants of a gay-positive church. *Journal for the Scientific Study of Religion, 39*(3), 333–347. https://doi.org/10.1111/0021-8294.00028

Rosmarin, D. H., Krumrei, J. E., & Andersson, G. (2009). Religion as a predictor of psychological distress in two religious communities. *Cognitive Behaviour Therapy, 38*(1), 54–64. https://doi.org/10.1080/16506070802477222

Rostosky, S. S., Black, W. W., Riggle, E. D. B., & Rosenkrantz, D. (2015). Positive aspects of being a heterosexual ally to lesbian, gay, bisexual, and transgender (LGBT) people. *American Journal of Orthopsychiatry, 85*(4), 331-338. https://dx.doi.org/10.1037/ort0000056

Rowniak, S., Ong-Flaherty, C., Selix, N., & Kowell, N. (2017). Attitudes, beliefs, and barriers to PrEP among trans men. *AIDS Education and Prevention: Official Publication of the International Society for AIDS Education*, *29*(4), 302–314. https://doi.org/10.1521/aeap.2017.29.4.302

Ruberg, B., & Ruelos, S. (2020). Data for queer lives: How LGBTQ gender and sexual identities challenge norms of demographics. *Big Data & Society, 7*(1), 1-12. https://doi.org/10.1177/2053951720933286

Rueda, S., Raboud, J., Plankey, M., Ostrow, D., Mustard, C., Rourke, S. B., Jacobson, L. P., Bekele, T., Bayoumi, A., Lavis, J., Detels, R., & Silvestre, A. J. (2012). Labor force participation and health-

related quality of life in HIV- men who have sex with men: The multicenter AIDS cohort study. *AIDS and Behavior, 16,* 2350-2360. https://doi.org/10.1007/s10461-012-0257-3

Rusie, L. K., Orengo, C., Burrell, D., Ramachandran, A., Houlberg, M., Keglovitz, K., Munar, D., & Schneider, J. A. (2018). Preexposure prophylaxis initiation and retention in care over 5 years, 2012-2017: Are quarterly visits too much?. *Clinical Infectious Diseases : An Official Publication of the Infectious Diseases Society of America*, *67*(2), 283–287. https://doi.org/10.1093/cid/ciy160

Ryan, W. S., Legate, N., & Weinstein, N. (2015). Coming out as lesbian, gay, or bisexual: The lasting impact of initial disclosure experiences. *Self and Identity, 14*(5), 549-569. http://dx.doi.org/10.1080/15298868.2015.1029516

Schoorman, D., Acosta, M. C., Sena, R. & Baxley, T. (2012). Critical pedagogy in HIV-AIDS education for a Maya immigrant community. *Multicultural Perspectives, 14*(4), 194-200. https://doi.org/10.1080/15210960.2012.725317.

Sevelius, J. M., Keatley, J., Calma, N., & Arnold, E. (2016). 'I am not a man': Trans-specific barriers and facilitators to PrEP acceptability among transgender women. *Global Public Health*, *11*(7-8), 1060–1075. https://doi.org/10.1080/17441692.2016.1154085

Smith, T. B., McCullough, M. E., & Poll, J. (2003). Religiousness and depression: Evidence for a main effect and the moderating influence of stressful life events. *Psychological Bulletin, 129(4),* 614–636. https://doi.org/10.1037/0033-2909.129.4.614

Spinelli, M. A., Scott, H. A., Vittinghoff, E., Liu, A. Y., Gonzalez, R., Morehead-Gee, A., Gandhi, M., & Buchbinder, S. P. (2019). Missed visits associated with future preexposure prophylaxis (PrEP) discontinuation among PrEP users in a municipal primary care health network. *Open Forum Infectious Diseases, 6*(4), 1-8. https://doi.org/10.1093/ofid/ofz101

Stahlman, S., Sanchez, T. H., Sullivan, P. S., Ketende, S., Lyons, C., Charurat, M.E., Drame, F.M., Diouf, D., Ezouatchi, R., Kouanda, S., Anato, S., Mothopeng, T., Mnisi, Z., & Baral, S. D. (2016). The prevalence of sexual behavior stigma affecting gay men and other men who have sex with men across sub-Saharan Africa and in the United States. *JMIR Public Health and Surveillance, 2*(2), e35. https://doi.org/10.2196/publichealth.5824

Stanton, M. M. (2013). Perspectives on lesbian, gay, bisexual, transgender (LGBT) older adults' decision to disclose their sexual orientation or gender identity to healthcare and social service providers. [Master's Thesis, Smith College].

Sullivan, P. S., Johnson, A. S., Pembleton, E. S., Stephenson, R., Justice, A. C., Althoff, K. N., Bradley, H., Castel, A. D., Oster, A. M., Rosenberg, E. S., Mayer, K. H., & Beyrer, C. (2021). Epidemiology of HIV in the USA: Epidemic burden, inequities, contexts, and responses. *The Lancet 2021, 397,* 1095-1106. https://doi.org/10.1016/S0140-6736(21)00395-0.

Traeger, M. W., Schroeder, S. E., Wright, E. J., Hellard, M. E., Cornelisse, V. J., Doyle, J. S., & Stoové, M. A. Effects of pre-exposure prophylaxis for the prevention of Human Immunodeficiency Virus infection on sexual risk behavior in men who have sex with men: A systematic review and meta-analysis. *Clinical Infectious Diseases, 67*(5), 676-686. https://doi.org/10.1093/cid/ciy182

U.S. Statistics. (n.d.). HIV.gov. Retrieved from https://www.hiv.gov/hiv-basics/overview/data-and-trends/statistics

Valdiserri, R. O., Holtgrave, D. R., Poteat, T. C., & Beyrer, C. (2019). Unraveling health disparities among sexual and gender minorities: A commentary on the persistent impact of stigma. *Journal of Homosexuality, 66*(5), 571-589. https://doi.org/10.1080/00918369.2017.1422944.

van Epps, P., Maier, M., Lund, B., Howren, M. B., Beck, B., Beste, L., Skolnik, A., Vaughan-Sarrazin, M., & Ohl, M. E. (2018). Medication adherence in a nationwide cohort of veterans initiating pre-exposure prophylaxis (PrEP) to prevent HIV infection. *Journal of Acquired Immune Deficiency Syndromes, 77*(3), 272–278. https://doi.org/10.1097/QAI.0000000000001598

Wilson, E. C., Jin, H., Liu, A., & Raymond, H. F. (2015). Knowledge, indications and willingness to take pre-exposure prophylaxis among transwomen in San Francisco, 2013. *PloS One*, *10*(6), e0128971. https://doi.org/10.1371/journal.pone.0128971

Wilson, M. M. (2014). Hate crime victimization, 2004–2012, statistical tables. Washington, DC: U.S. Department of Justice, Bureau of Justice Statistics. Retrieved from www.bjs/gov/index.cfm?ty=pbdetail&iid=4905.

Wood, L. (2009). 'Not only a teacher, but an ambassador': Facilitating HIV/AIDS educators to take action. *African Journal of AIDS Research, 8*(1), 83-92.

Wood, S. M., Lee, S., Barg, F. K., Castillo, M., & Dowshen, N. (2017). Young transgender women's attitudes toward HIV pre-exposure prophylaxis. *The Journal of Adolescent Health:Official Publication of the Society for Adolescent Medicine*, *60*(5), 549–555. https://doi.org/10.1016/j.jadohealth.2016.12.004

Yakushko, O. (2005). Influence of social support, existential well-being, and stress over sexual orientation on self esteem of gay, lesbian, and bisexual individuals. *International Journal for the Advancement of Counselling, 27*(1), 131–143. https://doi.org/10.1007/s10447-005- 2259-6

Zucker, J., Carnevale, C., Richards, P., Slowikowski, J., Borsa, A., Gottlieb, F., Vakkur, I., Hyden, C., Olender, S., Cohall, A., Gordon, P., & Sobieszczyk, M. E. (2019). Predictors of disengagement in care for individuals receiving pre-exposure prophylaxis (PrEP). *Journal of Acquired Immune Deficiency Syndromes, 81*(4) e104-e108. https://doi.org/10.1097/QAI.0000000000002054

Appendices

A: Scenarios for Focus Group

1. John is a man who has sex with other men. He used to take pre-exposure prophylaxis (PrEP) to prevent HIV transmission. He stopped taking it and ended up testing HIV-positive after having sexual contact with a now ex-boyfriend. He ended up taking zidovudine (Retrovir) as antiretroviral therapy (ART) to help reduce his viral load. After a few years on this medication, he got a test result of an undetectable viral load. John said in an interview on social media that he faced stigma from his former friends regarding his sexual behaviors and sexual identity. He also said that he felt perceived stigma while on Retrovir. He elaborated saying others spread hateful rumors about him and even that his boyfriends refused to have sexual contact with him due to these rumors. He said he did not know what to do to combat this stigma and educate those around him on HIV and being a man who has sex with other men during an interview broadcast on social media. What would you do if you were in his shoes?

2. Gavin also identifies as a man who has sex with other men. He identifies as a transgender man, having transitioned in his early twenties. Like John, he also felt perceived stigma due to being HIV-positive by his friends and even family members. Being born into a highly religious family who did not like that Gavin identified as transgender and gay led to his family kicking him out when he was eighteen. This led Gavin to leave his church and start to identify as spiritual but not religious since several of the other church attendees started to harass him. Gavin does not know what to do about the stigma associated with HIV and identifying as transgender. He wants to resume some form of church activity at a different church but is afraid to come out to other people about being transgender due to stigma. What would you do if you were in his shoes?

3. Charlie also does identify as a man who has sex with other men. He is currently HIV-negative but due to his sexual relationships, does use pre-exposure prophylaxis (PrEP) before sexual contact and right before switching partners. He also regularly gets HIV tests at his local clinic. Due to his use of PrEP, he has faced stigma from non-MSM folks who criticize him for his sexual relationships, amount of sexual contact he has had since

starting PrEP, and also due to using PrEP in the first place. He does not know how to combat this stigma because the amount of criticism he gets from people he knows has made him start to struggle with anxiety and a fear of being around others. He is very conscientious of his health and wellness, and knows PrEP is a way to help him prevent getting HIV from his relationships. What would you do if you were in his shoes?

B: Codebook

Code	Definition
discrimination	Includes mentions and discussions of feeling discriminated against including forms of hatred and prejudice such as homophobia, racism, and transphobia
education	Includes mentions and discussions of educational background or fostering, nurturing, or gaining knowledge on topics such as HIV/AIDS awareness and LGBTQIA+ awareness
employment	Includes mentions and discussions of having a job, being an employee, or systems in the workplace
gender	Includes mentions and discussions of gender identity and expression
healthcare	Includes mentions and discussions of receiving physical healthcare such as doctor's visits, and treatment, etc.) Does not include medications such as mental health and HIV prevention and mental health is reflected in a different code.
HIV status	Includes mentions and discussions of HIV status (positive, negative, or undetectable)

location	Includes mentions and discussions of a place or area such as a city, urban, rural, town, etc.)
medication	Includes any mentions and discussions of medications for any purpose such as HIV prevention and mental health
mental health	Includes any mentions and discussions of mental health such as mental health disorders and psychotherapy. Medications are reflected in the medication code.
relationships	Includes any mentions and discussions of relationships such as friendships, parent-child, romantic, sexual, etc.)
sex	Includes any mentions and discussions of sexual contact
sexual orientation	Includes any mentions and discussions of one's sexual identity such as gay, bisexual, straight
social media	Includes any mentions and discussions of social media such as dating apps and popular social media sites
spirituality	Includes any mentions and discussions of religion and feeling spiritual whether or not religious
stigma	Includes any mentions and discussions of related stigmas such as HIV stigma and MSM stigma
upbringing	Includes any mentions and discussions of upbringing

C: Committee Members

Paul Branscum, Ph.D.
Professor
Department of Kinesiology, Nutrition, and Health
Miami University

Brandy Reeves-Doyle, Ph.D.
Assistant Professor
Department of Kinesiology, Nutrition, and Health
Miami University

Kyle Timmerman, Ph.D.
Associate Professor
Department of Kinesiology, Nutrition, and Health
Miami University

Darren Cosgrove, Ph.D., MSW
Assistant Professor
Social Work Department
Marist College