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<u>Walden University</u>

College of Health Sciences

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Natasha Jeter

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Walden University
2016

Abstract

Experiences of Black MSM at an HBCU Regarding Stigma and HIV Risk Behavior

by

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MPH, University of North Carolina at Greensboro, 2005

BA, University of North Carolina at Greensboro, 1995

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Public Health

Walden University

February 2016

Abstract

Black men who have sex with men (MSM) on Historically Black College/University (HBCU) campuses face a unique set of challenges. In addition to being disproportionately affected by HIV, Black MSM are impacted by risk behavior, stigma, and environmental policies and practices that adversely influence their experiences. The purpose of this study was to explore the experiences of Black MSM at a HBCU and how stigma, culture, social practices and the collegiate environment impact HIV risk-taking behavior. Utilizing the ecological framework and qualitative analysis, the behaviors of 13 Black MSM on a HBCU campus were examined. Personal interviews and risk assessment questionnaires were analyzed utilizing the phenomenological inquiry method. Data were inductively coded and combined into themes using a qualitative data analysis computer software package. The findings revealed that these 13 participants perceived that HIV-related risk behavior is occurring. They also noted a stigma within the current culture and expressed feelings of marginalization and a negative campus climate from students in the sexual majority. Implications for improving social change from this research include opportunities to (a) establish a culture of social responsibility and consciousness related to the integration and socialization of Black MSM; (b) dialogue regarding the campus climate; and (c) address conscious, unconscious, individual, and environmental stigmas experienced by Black MSM attending this HBCU.

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Dedication

This dissertation research is dedicated to my parents Eddie and Celeste Harden. I am eternally grateful and humbled by all they sacrificed to provide me an opportunity to pursue my dreams. The love, encouragement, discipline, and relentless support have shaped me into the person I am today. I am everything I am because they loved and invested in me!

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Chapter 1: Introduction to the Study

In the United States, HIV/AIDS continues to be an epidemic with the Black community carrying the brunt of the impact (Hall et al., 2008). Over the course of the epidemic, information and data have been discovered and gathered on HIV and the changing face of the epidemic. Despite extensive behavioral research, current strategies have not resulted in a significant decrease of HIV/ AIDS cases among Blacks.

As it relates to incidence and risk groups, Meyer (2003) highlighted a host of social factors that impact and influence the behavior of individuals in the highest risk categories for HIV acquisition. These factors included stigma, prejudice, discrimination, stress, and hostile social environments that cause mental health problems. Rietmeijer, Lansky, Anderson, and Fichtner (2001) noted that behavioral surveillance has become an important strategy in determining effective evidence based prevention practices and strategies; however, certain demographics and subgroups continue to experience higher incidence of HIV. Among the subgroups impacted, men who have sex with men (MSM) continue to be the group comprising the largest proportion of new HIV infections (Centers for Disease Control and Prevention [CDC], 2013).

The main sexual risk behavior for HIV infection among MSM has been unprotected anal intercourse, with higher risk associated with receptive intercourse in comparison with insertive intercourse (Chmiel et al., 1987; Coates et al., 1988). For this group an independent association for HIV incidence has been found for increased numbers of sexual partners, substance use, sexually transmitted diseases (Darrow et al., 1987; Page-Shafer, Veugelers, Moss, Strathdee, Kaldor, & van Griensven, 1997) and lack

of circumcision (Buchbinder et al., 2005). A number of studies have been done on MSM in different settings; but, limited research has been conducted on Black MSM on Historically Black Colleges and Universities (HBCU) Campus (Payne et al., 2014). This study sheds light on a group of individuals that are underrepresented in the literature.

HIV/AIDS research is extensive and researchers have noted that rates of HIV are stable in some populations. However, in minority communities and amongst people who engage in nonheterosexual behaviors, the incidence continues to grow indicating that current interventions are not working for these cohorts. The complexities of behavior change or behavior modification draw from an interplay of many different variables. Understanding these variables is crucial in developing effective social change campaigns. Included in these social change models should be effective theoretical frameworks that address culture and the distinctive challenges faced by Black individuals impacted by HIV. Gaining insight into the behaviors and practices of these individuals is essential in determining effective social change models that address the current crisis facing Blacks.

Background of the Problem

HIV/AIDS has been a public health problem in the United States for the past 3 decades. What initially began as an unknown health problem thought to impact only a select group of individuals has become a nondiscriminatory disease impacting millions in all demographic categories. Even though HIV impacts individuals from all walks of life, it disproportionately affects minorities especially Blacks and has seen significant increases in incidence among 13-24 year olds and among the MSM subgroup (CDC,

2013C). Historically thought to be at relatively low risk for HIV infection, HIV among Black college students is on the rise (Hightow et al., 2005).

By sub group, MSM are still the group most heavily affected by HIV in the United States. While some research has been conducted on Blacks or Black students attending predominantly White institutions (PWIs), limited research has been conducted on Black MSM students attending HBCUs and their elevated risk for HIV acquisition (Payne et al., 2006) Younge, Corneille, Lyde, and Canady (2013) acknowledged that the public health establishment has understudied and underserved the African American student population.

Like so many other chronic and infectious diseases, minorities or people of color are often over represented in incidence and prevalence when compared with their nonminority counter parts. This notion is rooted is several variables that include individual, community, organizational, institutional, cultural, environmental, and political factors (Liao, Y., Tucker, P., Okoro, C. A., Giles, W. H., Mokdad, A. H., & Harris, V. B., 2004, and Williams, D. R., 1999). The result is a complex problem that requires an interdisciplinary approach to address the underlying causes for why minorities particularly MSM are experiencing high infection rates (Lane, S. D., Rubinstein, R. A., Keefe, R. H., Webster, N., Cibula, D. A., Rosenthal, A., & Dowdell, J., 2004).

The next generation of HIV prevention and risk reduction interventions must move beyond basic sex education and condom use and availability (Williams, Wyatt, & Wingood, 2010). Successful interventions targeting Blacks must optimize strategies that integrate sociocultural factors and address institutional and historical barriers to HIV risk

reduction behaviors. At the same time, these interventions must address factors in the environment that encourage high risk behaviors. Critically important is the development of paradigms that use innovative theories and conceptual frameworks that are culturally appropriate. Adaptations to existing theories are needed because the uses of traditional theories and frameworks have not resulted in significant decreases in HIV/AIDS among Blacks.

This study was needed because it provides a framework for understanding the unique dynamic experiences of Black MSM at HBCUs and provides some direction on how environment and culture shape behavior. Information garnered may aid in the development of future strategies to effectively address issues faced by this group. Younge et al. (2013) examined the paradox of risk for HBCU students and sexual health, and showed that the perceived risk HIV risk, religiosity, HIV testing condom use and substance use were as high or higher for Black HBCU students. Future researchers should examine institutional barriers such as stigma and other factors that might hinder administrators' ability to address sexual health at an institutional level. Results of this study emphasized the importance of moving past individual risk models and examining structural barriers that impacted the sexual health of students on HBCU campuses. LeBlanc et al. (2014) showed HIV Rates and STI rates at HBCUs to be higher than that of the national average. Further study is needed to examine and understand why this is occurring.

Culturally, the United States is experiencing a period of diversity and inclusion where culture, gender, race, ethnicity, differing sexual orientation, and other uniqueness

are all embraced. Despite the wide availability of information regarding HIV, there has been no notable decrease in HIV acquisition among minorities or in the MSM subgroup (Fenton, 2007). In 2011, Mustanski, Newcomb, Bois, Garcia, and Grov conducted a review of epidemiology, interventions risk, and protective factors. Mustanski et al. discussed behavioral, biomedical, structural, social contextual, psychosocial, social networking factors, and a lack of prevention and intervention strategies that adequately address this interplay of all of these variables, and the subsequent increased HIV burden of young MSM.

The experience of Black MSM on HBCUs has not been well documented. Along with the factors mentioned, environmental variables such as policy, culture, community, infrastructure, and campus climate are also issues of concern. While there are some similarities in HIV risk behaviors, socioeconomic factors, access to health care, mistrust of health care systems, discrimination, internalized heterosexism, and homophobia are other cultural variables that Blacks experience more frequently as compared to their White counterparts (Paradies, 2006).

Statement of the Problem

The research problem addressed in this study was the need to better understand the experiences of Black MSM attending HBCUs and how the HBCU environment and stigma influence HIV risk behavior. HIV continues to be a major health problem globally. Since its discovery, HIV has contributed to mortality and morbidly of millions of in the United States. By race, HIV continues to disproportionately impact minorities. Above all subgroups, MSM continue to see the highest incidence and prevalence of HIV.

Likewise they experience the highest mortality and morbidity rates. In the literature, research on MSM is widely available. Limited studies have been focused on Black MSM that are traditional college students on HBCU campuses.

Research Questions

1. What is the extent of stigma experienced by Black MSM (ages 18-24) attending an HBCU in North Carolina?
2. What impact or influence does the current HBCU environment (policy, practice, culture and stigma) have on the sexual behaviors of Black MSM attending the University?
3. What are the HIV risk behaviors of Black MSM attending an HBCU?

Purpose of the Study

The purpose of this study was to provide an understanding of stigma experienced by Black MSM who attended HBCUs. This study includes a description of the experiences of these students and the dynamic interaction of factors and variables that influence their sexual behavior. The literature review provides a foundation for current practices and behaviors of MSM and collegiate students in general. Results show how culture, practice, race and environment impact Black MSM and their collegiate experience. The experiences of the Black MSM were investigated through a phenomenological approach. The methodology for the investigation and specific interview questions is provided in Chapter 3.

Theoretical Framework

I used a phenomenological approach and the tenets of the ecological framework. The ecological framework considers the important dynamic occurring among individual, interpersonal, institutional, community, social/policy influences, relationships, and society. Bronfenbrenner (1979) saw the process of human development as being shaped by the interaction between an individual and his or her environment. The specific path of development was a result of the influences of a person's surroundings, such as their parents, friends, school, work, culture, and so on. In Bronfenbrenner’s model, behavior is viewed by being affected by and effecting multiple levels of influence. Many have expanded upon the early work done by Bronfenbrenner.

McLeroy, Bibeau, Steckler, and Glans (1988) described the ecological model in terms of health status and behavior as a function of public policy, community, institutional, interpersonal, and intrapersonal factors. The phenomenological approach to this study is largely shaped by the view of McLeroy et al. It treats the interaction between factors at different levels with equal importance to the influence of factors within a single level (Honjo, 2004). Utilizing the ecological framework, I explored social factors, economic factors, heterosexism, discrimination, stigma, policy, and campus culture/campus climate and their impact on Black MSM. Results of this phenomenological study revealed the complex interplay of factors that influence Black MSM risk behavior. Data were collected via demographic profile, risk assessment profile, and in-depth interviews.

Nature of the Study

A qualitative study design was selected because the research conducted was exploratory. I did not know or have knowledge of what information or experiences participants would share. The exploratory nature of qualitative research allowed participants to specifically define and outline their experiences; allowing them to reveal issues of interest and problems experienced. Within this qualitative framework, a descriptive phenomenological approach was elicited. This approach considered heavily the human experience and viewed those experiences without personal biases (Giorgi & Giorgi, 2003; Moran, 2000).

I explored stigma experienced and the role and influence that the HBCU environment played in the sexual risk taking behaviors of Black MSM. The study provides useful information on how to incorporate positive social change models to address psychosocial challenges experienced. Data were collected from Black MSM recruited via snowballing technique and marketing flyers. Each participant completed a demographic and risk assessment profile prior to in depth interview.

To ensure validity and reliability data was triangulated by method. Data was analyzed via coding and themes. Interviews were analyzed texturally and structurally. Coding was used to make sense of the essential meanings of the phenomenon that were revealed. From this process common themes emerged and were noted.

Operational Definitions

Bisexual: Man or woman with sexual and affectional or emotional orientation toward people of both sexes (Bradford, 2004).

Closeted: Gay man or lesbian woman who conceals their sexual orientation from social audiences or is not open about their sexual orientation (Herek, 2000).

MSM/W: Man who has sex with a man and a woman.

MSW: Man who has sex with a woman.

NGI-MSM: Nongay-identifying men who engage in sexual activity with other men but who do not self-identify as gay (CDC, 2005).

Out: An individual who openly engages in sexual relationship with an individual of the same gender where their sexual orientation is known and is not secret (Harry, 1993).

Nonresidential student: Student who lives off campus.

Nontraditional Student: Collegiate student that is entering college after the age of 24 (Kim. 2002).

Residential Student: Student who lives on campus in the residence hall.

STD/STI: Sexually transmitted disease/Sexually transmitted infection.

Unprotected Anal Intercourse (UAI): Engaging in anal intercourse without the use of a condom (Suarez & Miller, 2001).

Assumptions

It was assumed that participants would be honest because they self-select for the study. Participants would be open and honest because of the snowballing methodology and the referring individual. It was assumed that the study methodology would reveal or provide explanations of the phenomenon experienced by Black MSM and that demographic and risk assessment profiles would provide some insight into the

background of the participants. It was assumed that the individuals selected to participate in the study would be representative of the target population (Black MSM on HBCU campuses).

Limitations

A limited number of participants were included in study. Because of the limited number of participants in the study and the nonrandom selection, sampling bias had to be considered and results of the study may not be generalizable to all Black MSM attending HBCUs in the United States. Attitudes, behaviors, and experiences of participants included may not reflect the experiences of all MSM students attending this particular HBCU which could result in some selection bias. No comparison group (non-Black) MSM was included in the study. This exploratory study was designed to provide foundational or baseline information into the experiences of the subgroup. More expansive research is needed to draw comparison to other MSM college students in the United States. Study was designed to only include Black MSM; and thus some of the participants had previous sexual experiences with women.

Delimitations

Phenomenological inquiry may not provide the quantitative descriptions regarding specific HIV statistics within this population. The findings from this study are limited to interpretation based on qualitative themes rather than quantitative analysis. Each participant provided self-reported information about their HIV status and associated HIV risk behaviors via completion of the demographic and risk assessment profiles and during the interviews. Their experiences were based upon their interaction with the environment

and may not have accurately reflected the campus climate or the culture that that the organization espouses. Because of the use of self-reported data, information bias could have occurred.

Scope

The scope of this study was an HBCU in the South Eastern portion of the United States located in the Bible Belt. The study only included traditionally aged college students which are those individuals from 18-24. Only Black MSM were included in the study and the study relied on the participants to identify as a MSM. The research was designed to highlight the experiences of Black MSM at this particular institution not their general experiences in their hometowns or in the greater community at large.

Significance of the Study

This study adds to an existing body of literature on HIV and describes the experiences of traditional collegiate Black MSM students on an HBCU campus and what it is like to exists in a culture in which they are the sexual minority. These experiences include sexual risk taking and the phenomenon that influences their behavior. This is significant because limited research has been conducted on Black MSM students on HBCU campuses. Although much research has been conducted on Black and White MSM (Denning & Campsmith, 2005; MacKellar et al., 2005; Mansergh et al., 2002), the research that has been conducted has largely been completed outside of the collegiate realm and has focused on adult populations.

This research fills a gap in the literature and encourages other HBCU to explore the dynamics occurring within this demographic population in the HBCU collegiate

environment and sheds light on how stigma associated with being Black and MSM impacts or influences sexual risk behavior, and the overall experience of Black MSM. The results of this study provide insights into the experiences and behaviors of Black MSM collegiate students and lay some groundwork for the development of social change initiatives that have the potential to influence the landscape of HIV among minority collegiate students on HBCU campuses.

To understand the experiences of Black MSM, I first reviewed the literature regarding the experiences of collegiate students, Black collegiate students, MSW, MSM, and MSM/W. By exploring each of these subgroups, I examined similarities, behaviors, and experiences in an effort to determine if the experiences of MSM attending HBCUs are unique or the norm for 18-24 students attending college. Because MSM and Blacks are among those in the highest risk category for acquiring HIV infection, this phenomenological research project sheds light on behaviors currently being practiced by a select group of Black MSM on a selected HBCU campus.

This research provides some framework for others and will allow others to explore and offers some suggestions on appropriate interventions and strategies designed specifically to address this unique subgroup, moving them toward social and behavioral change. Utilizing the ecological model, I noted the individual experiences, the community experience, participants' view of the campus environment, and campus policies that shape their experience. This information allowed me to use the social change model to identify areas where improvements could be made. The literature review reveals that historically the Black culture is bias against non-heterosexual orientation and

expression (Herek, Gillis, & Cogan, 2009; Lewis, 2003; Majied, 2010). Gathering this information was important and shed light on sociocultural factors that contribute to HIV/AIDS risk behavior. Ultimately, the information helps to address the health challenges faced by those infected and the rest of society that is invariably affected.

For those currently infected with HIV, the US National HIV/AIDS Strategy emphasizes the connections between prevention and care and outlines key goals for prevention for persons living with HIV (PLWH), (The White House Office of National AIDS Policy, 2010). The goals include increasing the percentage of PLWH who know their status, reducing the HIV transmission rate, increasing the proportion of diagnosed person linked to care within 3 months of diagnosis, increasing the proportion of patients in continuous care, and increasing the proportion of infected individuals who to undetectable viral loads (Kilmarx & Mermin, 2012). For the remainder of the population who is affected, social change can help to reduce current stigma associated with the disease and create a culture that is more informed, that is, one that actively supports initiatives and programs aimed at the elimination of HIV/AIDS at all levels. To accomplish this, I sought to understand behaviors occurring in the collegiate and MSM populations.

Summary

Over the past 3 decades, the HIV epidemic has continued to impact millions worldwide. In the United States, HIV/AIDS continues to devastate and disproportionately impact MSM and minority populations. Consistent with other chronic diseases, minorities are among those most impacted by disease. In light of the current availability of

prevention information and the many reports that identify individuals and groups at most risk, minorities and MSM should be experiencing reductions in incidence and prevalence. However, these two groups continue to be disproportionately impacted. This dissertation reveals the experiences of Black MSM in their HBCU collegiate environment, with specific attention being given to stigma individual, community, environmental, practices and/or policies that influence their experiences; and more specifically their sexual risk behavior. This chapter is followed by a review of the pertinent literature in Chapter 2. Chapter 3 is a description of the study design, participants, procedures, assessments used, and how information gathered was assessed. Chapter 4 is a report of the original data and Chapter 5 is an analysis of those data.

Chapter 2: Literature Review

Currently HIV/AIDS is an infectious disease that contributes significantly to morbidity and mortality rates, and costs the United States millions of dollars in treatment, care, prevention, and interventions efforts (Hutchinson et al., 2006; Paltiel et al., 2005). Since its initial discovery, new cases of HIV have remained stable at approximately 50,000 annually (CDC, 2013b). The majority of new cases are comprised of MSM followed by Blacks.

Over the past 3 decades, some populations have seen a stabilization and/or decrease in incidence; however, MSM and Blacks continue to be disproportionately impacted by HIV. Similarly, the age demographic is seeing some shift with an increased incidence among the 13-24 age groups (CDC, 2008). Collegiate students who were once thought to be at relatively low risk are now heralded as the group in which incidence are increasing at alarming rates (Fergusen et al., 2006; Hightow et al., 2006; Lewis, Malow, & Ireland, 1997). Research on the risk behaviors of these individuals is well documented. Additionally, a wealth of literature is focused on MSM and the higher incidence of HIV that is often found among minority communities. Black MSM students on HBCU are underrepresented in the literature and strategies to address and reduce the incidence of HIV in this subgroup are limited.

The literature review serves as a baseline and foundation for current practices and behaviors among MSM and collegiate students. Information gained in the study was compared against these data. To do so, I began the literature review by providing a brief history regarding HIV in America. This is followed by an examination of risk behavior

associated with collegiate students, and Black college students. After which a profile of behaviors and practices of MSW, MSM/W, MSM, sexual culture of Blacks, and stigma the associated with being MSM in the Black culture was provided.

Research Strategy

Literature research was conducted using several sources of information. ProQuest Central, Science Direct, PubMed, and Google Scholar were accessed using the general search terms, *Black MSM, HIV*, *college students,* and *HIV risk behavior*. Articles found through these search engines, and by conducting a review of the references used by previous authors, I was able to locate a large volume of research. The Walden online library provided many of the needed articles for this review in addition to the host institution's library; publication included range from 1981-2015.

Ecological Model

Bronfenbrenner (1979) saw the process of human development as being shaped by the interaction between an individual and his or her environment. In Bronfenbrenner's model, behavior is viewed by being affected by and effecting multiple levels of influence. Bronfenbrenner's classic ecological model includes five systems or levels: The micorosystems, mesosystems, exosystems, macrosystems, and chronosystems. The microsystem included the immediate environment in which a person was operating. Mesosystems noted interactions of two microsystem environments. Exosystems include external systems to the individual that affect the individual. Macrosystems denoted larger cultural context of societal cultures, values, and expectations. Chronosystems are characterized by change or consistency over time in both the individual and the

environment. Bronfenbrenner's ecological model represented fluidity and depicted an ongoing dynamic interaction influenced by many variables on many levels.

When considering the this model in the context of HIV and MSM, the model suggest that HIV incidence and prevalence are a function of individual level risk behaviors (microsystem), but also considers systems in which the MSM individual work, lives, and engages (mesosystem), other's perceptions of the individual lifestyle or perceived notions about alternative sexual practice, inherent social sexual norms (exosystems), access to health care, stigma, discrimination, institutions and systems specifically designed to support the socio cultural norms of the community at large (macrosystems). These variables depict the fluid dynamic of the microsystem, mesosystem, exosystem and the macrosystem and how they converge together to fuel incidence and prevalence of Black MSM and HIV (Bronfenbrenner, 1979). The chronosystem variable is illustrated almost perfectly by the shift from the disease being one that primarily affected white MSM to one that disproportionately impacts Black MSM. The underlying causes for why this demographic was able to significantly mobilize and positively impact incidence is not just a function of individual behavior; but one of systems where many variables had to be addressed on multiple levels to impact change.

Since Bronfenbrenner's (1979) original model, many have expanded upon his work. McLeroy et al. (1988) described the ecological model in terms of health status and behavior as a function of public policy, community, institutional, interpersonal, and intrapersonal factors. The ecological model crafted by McLeroy et al. views health status

and behavior as outcomes of interest determined by public policy, community, institutional, intrapersonal, and interpersonal factors. In this framework public policy refers to local, state, national, and global laws and policies; community is inclusive of relationships among organizations, institutions, and informational networks within defined boundaries; institutional factors are rules and regulations for operation of social institutions and formal and informal organizational practices; interpersonal would encompass formal and informal social networks and social support systems, including family, work group, and friendship networks; and intrapersonal factors would include characteristics of the individual such as knowledge, attitudes, behavior, self-concept, skills, and developmental history.

Similar to the Bronfenbrenner (1979), interpersonal or individual risk and behavioral factors represent one piece of the ecological system of HIV incidence and prevalence. Intrapersonal factors such as social networks play a significant role in HIV exposure. Various social networks provide the opportunity for exposure to more partners with differing sexual practices. Within networks of MSM, there is typically drug use, sex work, heavy use of Internet for hooking up, and exposure to individuals with higher viral loads. Black MSM often feel marginalized and look to connect with via social networks, and may experience depression or other triggers that reinforce risk behavior. Dichotomously, supportive family, and friends can serve as a protective factor for seropositive or seronegative Black MSM.

At the ecological level of the community, Black MSM experience homophobia; heterosexism; and stigma and discrimination in health facilities, businesses, restaurants,

or when seeking housing. Community values and norms often stigmatize same sex practices and sexually diverse populations. This creates barriers in accessing services. Fear of discrimination and disclosure of sexual orientation or HIV health status creates and environment where MSM are forced to into marginalization (Parker & Aggleton, 2003). Marginalization can subsequently fuel risk behavior at the interpersonal and intrapersonal levels. Social and structural discrimination is common and widely accepted among the sexual majority (Parker & Aggleton, 2003). The resulting effect is often elevated risk. In the Black community, sexual diversity is not widely accepted and Black MSM are frequently alienated by family, community, church, school, and in the work place (Baral, Logie, Grosso, Wirtz, & Beyrer, 2013). Institutional factors such as campus climates, tolerance or intolerance, and safe spaces for sexual minorities impact Black MSM in the HBCU environment.

Public policies are often utilized to fund health and social programs for lower socioeconomic groups and can be a resource or a tool that denies access to needed services. For example, in many communities public policies and laws criminalize drug use and same sex relationships (Center for HIV Policy and Law, 2014). This poses significant challenges for funding of things such as needle exchange programs or condom distribution programs. Often what results are rates of infection that are 5 to 7 times higher than those in the general population (Center for HIV Policy and Law, 2014).

Using the ecological model for the theoretical basis for this study allowed me to consider of how multiple levels of health determinants affect Black MSM on HBCU campuses. The ecological model of HIV illustrates a shift from the traditional focus on

individual level risk factors and depicts a complex epidemiologic model that characterizes multiple levels of HIV risk factor for Black MSM (Baral et al., 2013).

HIV in America

The history of HIV and AIDS in America began in 1981, when researchers began to report cases of previously healthy gay men who had been diagnosed with Kaposi's Sarcoma (KS), and Pneumocystis carinii pneumonia (PCP) rare forms of cancer and pneumonia (CDC, 1981; Hymes, 1981). The unknown disease which was initially thought to affect only gay White men was named Gay Related Immune Deficiency (GRID). Later, the disease began to surface in other demographics such as hemophiliacs and IV drug users and became known as Acquired Immune Deficiency Syndrome (AIDS). The human immunodeficiency virus (HIV) was discovered to be the etiologic agent responsible for the AIDS.

Contrary to early reports, the disease which was thought to only impact White homosexual men was later found to be transmitted through intimate contact, blood, and via contaminated needles (CDC, 1983). Today it is accepted and widely known that HIV is transmitted via blood, semen, vaginal secretions, and breast milk. HIV behavioral transmission risks are ranked according to the following hierarchy: MSM, injection drug users (IDUs), MSM who inject drugs, heterosexual contact.

In the 3 decades since the beginning of the epidemic, the face of HIV has changed. Once thought to be a gay disease effecting primarily Whites, HIV is known to impact individuals regardless of age, sexual orientation, race, or ethnicity (CDC, 2012f). Even after 30 years, the group most affected by HIV is still MSM; however, the

racial/ethnicity of this group of MSM has changed significantly (Hall et al., 2008). Throughout most of the epidemic except in the late 1980s and early 1990s, MSM (not including MSM/IDU) had the largest estimated incident of HIV (Hall et al., 2008). From 1990 to 1999, MSM represented approximately 75% of AIDS diagnoses among males >13 years of age. During this period, the proportional distribution of AIDS cases by race/ethnicity among MSM shifted. In 1990 racial/ethnic minorities accounted for 33% of AIDS cases among MSM.

By 1999, MSM represented 54% of AIDS cases among MSM. In this period Black MSM with AIDS increased from 19% to 34%; Hispanic MSM increased from 12%-18% and the proportion of White MSM diagnosed with AIDS declined from 67% to 46%. In this 1990-1999 period, 22% of the MSM reported having sexual contact with a female partner; with Black MSM reporting 35% of such contact, American Indian and Alaska Natives reporting 29% contact, Hispanics 25%, and White MSM reporting 16%, the lowest amount of sexual contact with female partners (Hall et al., 2008). From 1996-1998, with the advent of highly active antiretroviral therapy (HAART), all racial/ethnic groups of MSM experienced declines in AIDS incidence. Over all AIDS incidence declined 22% among all MSM from 1996-1997 and slowed to 15% in 1998 compared with 1997.

Small declines in AIDS incidence among all MSM and within all racial/ethnic groups were observed from 1998 to 1999. During the years of decline AIDS incidence rates were highest for Black MSM and AIDS rates for both Black and Hispanic MSM were higher than rates for White MSM (Hall et al., 2008). Similarly, deaths among all

MSM with AIDS declined 49% from 1996 through 1997 with the rate of decline slowing to 22% in 1998 compared with 1997. From 1996-1998, AIDS deaths declined among all racial/ethnic groups of MSM. For each year death rates were highest for Black MSM and death rates for both Black and Hispanic MSM were higher than rates for White MSM (Hall et al., 2008). Smaller declines in deaths among all racial/ethnic groups of MSM with AIDS were observed from 1999-1999.

CDC estimates of new HIV infections (HIV incidence) in the United States indicated that HIV remains a serious health problem, with an estimated 47,500 people becoming newly infected with the virus in the United States in 2010 (CDC, 2012). HIV incidence has remained relatively stable at about 50,000 infections per year since the mid-1990s (Hall et al., 2008). According to the CDC's 2012 supplemental report, in the new analysis, there were 53,200 infections in 2007; 47,500 in 2008; 45,000 in 2009; and 47,500 in 2010 (CDC, 2013). Among heavily affected populations, there was a decrease in new HIV infections among Black women, a 21% decrease between 2008 and 2010, a continuing increase in new infections among young gay and bisexual men, and 22% increase over the same time period (CDC, 2012; 2013). These data underscore the fact that certain groups, including Blacks, Latinos, and gay and bisexual men of all races/ethnicities, continue to be disproportionately affected by HIV. Similarly there are about 1.2 million people living with HIV in the United States. This represents an increase of over 60% over the past 15 years (CDC, 2011a).

HIV and Blacks

The CDC (2013b) estimated that approximately 50,000 people in the United States are newly infected with HIV each year. In 2010 (the most recent year that data are available), there were an estimated 47,500 new HIV infections; the estimated number of new HIV infections was highest among individuals aged 25-34 followed by individuals aged 13-24. Among racial/ethnic groups, Blacks bear the greatest burden of HIV in the United States, while Blacks represent approximately 14% of the total U.S. population, they account for almost half of all new HIV infections (CDC, 2013b). Likewise MSM account for approximately 4% of the population in the United States but are responsible for three-fourths (78% of HIV incidence among men and almost two-thirds 63%) of all new infections. In 2010, young Black MSM accounted for 55% of new infections among MSM, and now account for more new infections than any other subgroup by race/ethnicity, age, and sex. From 2008-2010, there was a 12% increase in HIV incidence among MSM overall (CDC, 2013b).

MSM represent approximately 4% of the US population; but, MSM have an HIV diagnosis rate more than 44 times that of other men, and more than 40 times that of women (Purcell et al., 2008). Black Americans rank second only to gay and bisexual men as the group most affected by HIV. Since the early 1990s, new infections among Black Americans remain at a higher level than any other racial or ethnic group.

The rate of new infections among Black men was the highest of any group by race and sex more than six times that of White men (103.6 v. 15.8 per 100,000; CDC, 2012d). The majority (72%) of infections among Black men were among MSM. The largest

percentage (38%) of new HIV infections among Black males in 2010 occurred in those aged 13-24 years (CDC, 2012d). Black women accounted for 13% of all new HIV infections in the United States in 2010 and nearly two-thirds (64%) of all new infections among women. Most Black women (87%) were infected through heterosexual sex. The rate of new HIV infections among Black women in 2010 was 20 times that of White women and nearly five times that of Hispanic women (38.1 v. 1.9 and 8.0 per 100,000, respectively).

Over the last 3 decades, HIV/AIDS has shifted from a disease which predominately affects White gay males to one that disproportionately affects Blacks. Black college students are at greater risk for contracting HIV than their White counterparts (Satcher et al., 2002). Half of all new HIV infections occur in individuals under the age of 25 years (CDC, 2002), with young MSM and Blacks being at particularly high risk (Valleroy et al., 2000). This is of particular significance in the Black community because fear, discrimination, stigma, and homophobia are prevalent. Researchers have underscored the challenges to prevention of HIV acquisition; many of which include social, physiological, and environmental factors influencing risk behavior and choices regarding sexual health.

The high incidence of HIV/AIDS in Black America is due to higher rates of late detection along with the challenges associated with other risk factors (Anderson et al., 2005; CDC, 2003, 2007, 2006; Diaz et al., 1994; Fleming & Wasserheit, 1999; Hart et al., 2004; Jordan, 2007; Leigh et al., 1993; Millet et al., 2005; Sharpe et al., 2004). These challenges include high risk sexual contact, high substance abuse which may lead to risky

sexual contact, lack of awareness of HIV status, higher rates of STDs, higher homophobia and tendency to conceal homosexual behavior, disproportionate ratio of available Black men to Black women, pressure on Black women to engage in risky sexual intercourse to maintain relationship, socioeconomic issues, limited access to high-quality health care, and dislike of condoms during sex (Bazargan et al., 2000; CDC, 2004a; Duncan et al., 2002).

In addition to the behavioral factors, biomedical factors such as STD/STI play a role in HIV acquisition. Blacks represent 14% of the U.S. population, yet account for one-third of all reported chlamydia cases, almost half of all syphilis cases, and two-thirds of all reported gonorrhea cases (CDC, 2012). Individuals who have an STD are at least two to five times more likely to become infected with HIV, if exposed to a partner who has HIV, than people who do not have an STD (CDC, 2012e). In the Black community higher rates of STDs are linked to untreated STD and subsequent selection of a sexual partner from this pool increases the likelihood of STD (Laumann & Youm, 1997). Lack of access to affordable quality health care impacts testing, prevention, and diagnostic services (Institute of Medicine, 1997). Concurrent relationships in the Black community result in higher rates of STDs (Hogben & Leichliter, 2008). These factors coupled with the fact that Blacks use medical services and treatments less than Whites accounts for higher rates of STDs and the increased risk of HIV infection.

Friedman, Cooper, and Osborne (2009) examined the social constructs that influence HIV and cited sexual and drug networks, segregation, racial policing, disparaging socioeconomics, and failure of the Blacks to address issues of substance use,

and sexuality as significant contributors of HIV incidence. These social constructs along with internalized homophophia (Herek, Gillis, & Cogan, 2009) and heterosexism (Szymanski & Gupta, 2009) further contribute to the complex interplay of behavioral, biomedical, and psychosocial factors that influence HIV acquisition.

Collegiate Students and Risk Behavior

The CDC (2004) noted that college students are a population that is particularly vulnerable to HIV infection. The CDC indicated that college students were at the epicenter of the HIV/AIDS epidemic. According to the Census Bureau (2013), in 2011, about 19.7 million students were enrolled in U.S. colleges. Gayle et al. (1990) estimated that one in 500 college students in the United States are infected with HIV. Since 1990, incidence and prevalence of HIV has increased so it is reasonable to assume that HIV rates among college students have also increased. Colleges and universities are places known as educational training grounds where learning, free thinking and exploration is encouraged. Colleges provide a rite of passage into adulthood; on college campuses this often involves consumption of alcoholic beverages, experimentation with drugs, and promiscuous sexual behavior (Duncan et al., 2002).

O'Malley and Johnson (2002) confirmed the extremely high prevalence of heavy drinking by college students. Alcohol use is highly prevalent among college students and is thought to contribute to elevated rates of sexual risk taking (Ceronka, Isbell, & Hansen, 2000; Hingson et al., 2002b; Wechsler et al., 2000). It is estimated 42% of college aged students engage in binge drinking (Wechsler et al., 2000), and as many as 400,000

college students have unprotected sex after drinking in a given year (Hingson et al., 2002b).

Men and women who consume excessive amounts of alcohol (four or more drinks at a time) are more likely to engage in unprotected or unplanned sex (Hillman et al., 2002; Hingson et al., 2002; Wechsler et al., 1995). The prevalence of marijuana use among college students has also increased (Rhodes et al., 2008). The new sense of independence and peer pressure results in students engaging in a variety of sexual behaviors, many of which are irresponsible (ACHA, 2012; CDC, 1999; Jemmott & Jemmott, 1991; Lewis et al., 1997; Prince et al., 1998). Collegiate students participate in risky sexual behavior and often do so while under the influence of drugs and alcohols. College students are likely to have multiple sexual partners and their use of condoms tends to be sporadic (Bazargan et al., 2000; Brien et al., 1994; Gillette & Lyons, 2006, Lewis, Malow, & Ireland, 1997). Yet, most collegiate students are unconcerned and feel that they are at relatively low risk for HIV.

Researchers on HIV/AIDS noted risk behavior in heterosexual college students. Bazargan et al. (2000) concluded that college students continue to engage in behaviors that place them at risk for HIV infection. Estimates showed that 35% of new HIV infections among males and 32% of new HIV infections among females in the United States occur among individuals below the age of 29 years (Lewis et al., 2000). The CDC (2012c) estimated that 19 million new STD infections occur annually in the US and nearly half are among individuals ages 15-24. This is significant because the presence of STDs increases the likelihood of HIV acquisition upon exposure.

Both homosexual and heterosexual college students engage in high-risk behaviors such as inconsistent condom use (D'Augelli, 1992; Lindley et al., 2003), use of drugs and alcohol during sex, (Clapper & Lipsitt, 1991; Keller et al., 1991), and sex with multiple partners (Lewis, 1997). Factors such as sexual abuse, alcohol and marijuana use, binge drinking, and failure to use condoms have been documented as HIV and STI risk factors for many college students (Jung, 2003, Mohler-Kuo et al., 2003; O'Malley & Johnson, 2002). For Blacks, these factors along with other social determinates such as higher prevalence of STIs, lack of access to health care, gender ratio imbalance, and poverty make HIV among Black College students a topic of concern. Research associated with HIV/AIDS and Blacks at both predominantly White and historically Black institutions suggested myriad complex factors that influence risk taking behavior and ultimately contribute toward risk behavior resulting in HIV. Developing effective interventions for collegiate students will hinge upon the customization of proven strategies and perhaps the discovery of new strategies designed to address subgroups that have historically been under represented within the literature.

Among college students, Adefuye et al. (2009) found that male students who used marijuana and alcohol were more likely to multiple sexual partners. Inconsistent condom use was associated with younger females, marijuana was correlated with inconsistent condom use, and alcohol was associated with lack of condom at last sex encounter. Students in the sample engaged in various HIV risk behaviors but reported low perceptions of HIV risk. In 2010, a national sample of US college students indicated that they participated in more oral and anal sex and were less likely to use condoms for anal,

vaginal, and oral sex and were less likely to have taken an HIV test when compared to their Black counterparts (Bui, Marhefka, & Hoban, 2010). In this same sample, Blacks reported more sexual partners, less use of hormonal contraceptives, more adverse health outcomes such as STDs, and unintended pregnancies. This study is consistent with other researchers that suggested a lack of condom use and increased incidence of STDs among college students.

In early 2003, acute HIV infection was diagnosed in two men attending college in North Carolina (Hightower et al., 2005). This sexual network was linked to 21 colleges, 61 students, and eight sex partners. Two of the most notable quantitative studies among Black MSM in college were the CDC (2004e) report which identified a significant increase in HIV among Black collegiate MSM in North Carolina, and the follow up epidemiological study conducted by Hightow et al. (2005). The North Carolina Department of Public Health identified two case of HIV among male college students in January 2000, and between January 2001 and May 2003 of the 56 cases reported, 49 were among MSM (CDC, 2004e).

Subsequent epidemiological studies conducted indicated an epidemic of HIV occurring among North Carolina collegiate students, primarily involving Black MSM and MSM/W (Hightow et al., 2005). A cross sectional comparison of risk behavior and demographic information of male enrollees with newly diagnosed college men with non-enrolled college men was conducted. Participants were gleaned from manual review of interview records of Disease Intervention Specialist. This CDC study was among the first that showed a significant increase of HIV among college students and specifically

amongst Black MSM in college. The overall rate of new HIV infections among Black men attending college in North Carolina increased from 15 per 100,000 persons in 2000 to 79 per 100,000 in 2002 and 2003 (Hightow et al., 2005). Data were analyzed using traditional statistical analysis for continuous variables and Mantel-Haenszel odds ratios. Findings indicated that these students were using the Internet to meet potential sex partners, meeting at bars, club, and using ecstasy and/or other club drugs (Hightow et al., 2005). This was notable because college students had not traditionally been seen as a risk group for HIV infection.

Among college students, hooking up, or physically intimate experiences occurring outside of committed relationships, occur more frequently when alcohol is involved. Hooking up is associated with frequency of sexually transmitted diseases (Grello et al., 2006; LaBrie, et al., 2005; Paul et al., 2000) and is associated more with Whites than students of color (Paul et al., 2000). Paul et al. underscored the risk behavior of collegiate students and the need for additional research and strategies to address the growing number of HIV infections among. In 2009, young persons accounted for 39% of all new HIV infections in the US (CDC, 2013d); persons aged 15-29 comprised 21% of the US population in 2010.

Black Collegiate Students and Risk Behavior

With the growing incidence rates of HIV infection among Black students on HBCU campuses (Hightow et al., 2005), research is needed to characterize sexual identity, sexual behavior, and condom use among this population. According the CDC (2004), HIV/AIDS is now considered the leading cause of death for individuals aged 15-

24 years of age. Within this group, the most affected individuals are college students (CDC, 2004). Among Black college students, knowledge alone does not predict safe sex practices, and researchers suggest that the use of sociocognitive theory driven strategies will help to predict such practices (Anastasia et al., 1999; Bates & Joubert, 1993; CDC, 2004c; Gupta & Weiss, 1993; Opt & Loffredo, 2004).

Researchers have focused on college student's attitudes, beliefs, and knowledge of HIV. Students are knowledgeable about HIV transmission routes and protection methods; however, this does not deter them from engaging in risky sexual practices and many believe themselves to be at low risk for contracting HIV and other STDs (Mongkuo, Mushi, &Thomas, 2010). Jemmott and Jemmott (1991) suggested that the link between knowledge and protective behavior is weaker for Black college students.

Factors such as sexual abuse, alcohol and marijuana use, binge drinking, and failure to use condoms have been documented as HIV/STI risk factor for many Black college students (Jung, 2003; Mohler-Kuo et al., 2003; O'Malley & Johnston, 2002). Research conducted on Black college students attending predominately White universities is consistent with the findings of the impact that alcohol plays in HIV risk taking behavior. Students who report condom use do not participate in heavy episodic drinking or marijuana use and do not have unprotected sex as a consequence of drinking alcohol, are less likely to report having HIV or other STI (Bazargan et al., 2000; Berkel et al., 2005; Burns & Dillon, 2005; Chng, Carlon, & Toynes, 2006; Sandelowski, 2006; Shegog et al., 2010; Wechler et al., 1995). Seth, Wingood, DiClemente, and Robinson

(2011) found that women who consumed alcohol were more likely to have multiple partners and risky partners.

Bui, Marhefka, and Hoban (2010) indicted in their National Sample of US College Students that Black students reported more sex partners and had higher rates of STDs. Similarly, Adefuye et al. (2009) observed that alcohol and marijuana use were related to low and inconsistent condom use among females and amongst males and use of these substances resulted in multiple sexual partners. Black males who used marijuana, alcohol, and other illegal drugs were significantly more likely to report multiple sexual partners at last sexual encounter.

HIV/AIDS in MSW (Heterosexual) College Students

In the United States, the proportion of HIV diagnoses attributed to heterosexual contact rose from approximately 12% of all cases in 1995 to 31% in 2009, making heterosexual contact for newly diagnosed cases of HIV more common than injection drug use as a means of HIV acquisition. MSW accounted for 25% of estimated new HIV infections in 2010 (CDC, 2012d), with about two-thirds of those infected through heterosexual sex being women. These increases represent a shift that is consistent with how the disease has evolved over the past few decades. Despite the evidence suggesting that the number of infected college students is increasing, most HIV related research has involved traditional high risk groups (Lewis, Malow, & Ireland, 1997).

For heterosexual collegiate students, the research is consistent and suggests high levels of HIV risk behavior in the form of inconsistent condom or no condom use, multiple lifetime sex partners, and alcohol and other drug use combined with sexual

activity (Bishop & Lipsitz, 1991; DiClemente et al., 1990; MacDonald et al., 1990; Mahoney, Thombs, & Ford, 1995). Most Black women are infected through high risk sexual contact and often they are unaware of their male partner's risk factors for HIV. These risk factors include unprotected sex with multiple partners, bisexuality and injection drug use (Hadler, Moore, & Holmberg, 2001; Millett, Mason, & Spikes, 2005). For Black men, sexual contact is the main risk factor with male to male sexual contact being a primary risk factor for 48% followed by heterosexual contact (CDC, 2005).

For college students, perceived susceptibility of HIV/AIDS is low. When examining HIV knowledge, attitudes, and practices among college students in the United States, results are consistent and they indicated that this cohort is in denial about the vulnerability of contracting HIV disease (Inungu et al., 2009). Inungu et al. conducted a study of a Midwestern university in the United States with a predominately White, heterosexual demographic and found that the while students reported being familiar with HIV/AIDS and transmission, 14% of students thought that mosquitoes transmitted HIV/AIDS and 19% were did not know one way or the other whether or not this was true. Additionally, they were unsure about maternal child transmission o and even though they had a high prevalence of risky sexual behaviors they did not perceive themselves to be at risk.

Of this cohort, 80.5% of the respondents had had sexual intercourse and of that number 40% of the students reported having intercourse with multiple partners (Inungu et al., 2009). Only 53% of the respondents reported condom use during the last intercourse and 10% reported having had an STD in the previous 12 months. Among the White

students, 17.5 was the average age at first intercourse (Inungu et al., 2009). In a similar study conducted among Black students at a Midwestern university similar results were found. Adefuye et al. (2009) found that students had a poor appreciation of their risk for HIV infection. Similarly, low condom use was reported with 75% of those reporting lack of condom use during last sex. Among the student respondents, the average age at first intercourse was 14 years or younger.

Multiple sexual partners were associated with individuals who used alcohol and illegal drugs with marijuana being associated with inconsistent condom use. Females reported lack of condom use when alcohol was a factor. Inconsistent condom use among college students is common among sexually active college students (DiClemente et al., 1990; McDonald et al., 1990; Strader & Beaman, 1989, 1991). DiClemente et al. found that knowledge of HIV did not result in consistent use of condoms during intercourse. Factors that impacted condom use among college students were comfort, convenience, and feelings that condoms inhibited sexual pleasure (Jemmott & Jemmott, 1990; McDonald et al; 1990). Negative attitudes toward condom use were associated with males more so than females; however, men were more amenable to using condom when it was suggested by their female partners (Maticka-Tyndale, 1991). For Black college students, the attitude of the male partner has been found to predict condom use (Jemmott & Jemmott, 1991) and generally speaking the attitude of the primary male partner has been found to be a significant predictor of condom use. For men, condom use has also been negatively associated with being in an exclusive relationship (Carol, 1991).

Cultural differences for condom use exist and despite positive attitudes toward condom use. White men and women consistently report less condom use. The belief that intercourse could still be enjoyable when condoms were used has been positively associated with intending to use condoms among Black female undergraduates (Jemmott & Jemmott, 1990). Barriers to condom use include embarrassment about purchasing and lack of condom negotiation skills with partner. Condoms were used primarily as a means of contraceptive versus as a mechanism for prevention of STD.

Bui, Marhefka, and Hoban (2010) examined the differences between White and Black college students using secondary data from the American College Health Association National College Health Assessment. Bui et al. found that both cohorts could benefit from interventions focusing on increasing condom use. When segregated, White students reported more experience in oral, anal, and vaginal sex were less likely to use condoms for oral, vaginal, and anal sex and were less likely to have been tested for HIV when compared with Blacks. Black students reported more sexual partners, lower use of hormonal contraceptives more sexually transmitted infections and more unintended pregnancies (Bui et al., 2010). Vaginal sex was common among both demographics. Among both races oral sex was the most commonly reported sexual behavior of the undergraduates. A greater percentage of Black students reported condom use for oral, anal, and vaginal sex acts when compared with Whites. Bui et al. underscored the differences in risk behavior among Whites and Blacks and provides some evidence for why we see increased incidence of STI, HIV, and pregnancies among Black versus Whites.

Hou (2009) found that patterns of HIV related behaviors for Black students attending HBCUs versus White students attending a traditionally White institution to be different; but, the findings mirrored those of Bui et al. (2010). Black students were almost two times as likely to engage in vaginal sex, were four times more likely to have had an STI and 3.6 times more likely to have been or gotten someone pregnant. Black students were less likely to use alcohol before sexual activity and more likely to use condoms during oral sex and all other sex types. Black students were 8.4 times more likely to report having been tested for HIV, 3.9 times more likely to ask about partner's HIV status, and 2.9 times more likely to be asked about their own status. Black students perceived themselves to be at higher risk for HIV (Hou, 2009). Black students perceived peer norms were lower for oral sex and higher for vaginal sex, and Black males perceived higher peer norms toward anal sex.

HIV among Black women is increasing (CDC, 2009) with rates of HIV that were 22 times greater than those for White women. The correlation between gender, power differentials, and HIV has been noted (Ferguson et al., 2006). The gender-ration imbalance among Black college students and the potential impact on HIV incidence is also a factor that contributes to the high incidence of HIV among Black women. For Black women the leading cause of HIVAIDS infection is heterosexual contact (CDC, 2009). For a variety of reasons, long-term monogamy among Black women is and concurrent sexual partnerships has become more common (Adimora et al., 2002). High rates of incarceration, unemployment, drug abuse, and bisexuality among Black men has

significantly decreased the pool of available men (Fullilove & Fullilove, 1999; Gilbert & Wright, 2003).

According to the Census Bureau (2013), in 2011, about 19.7 million students were enrolled in U.S. colleges. This is up from 2007 in which 17.9 million men and women were enrolled in institutions of higher learning. Of that number, 1 million were Black men. The American Council on Education (2006) noted that between 1993 and 2003 that the rate of Blacks enrolled in higher education program increased by 43% and college enrollment among Black high school graduates increased by 7%. During the same period among the same age group enrollment rates among Black women were twice those of Black men (8.8 .5 and 4.8%). At HBCUs Black women outnumber Black men six to one. Cose and Samuels (2003) reported that the consequences of under-representation of Black men on college campuses results in women knowing that they were dating a man who was also dating other women. As a result of the sex-ratio imbalance, Black women are more likely to tolerate their partner’s sexual indiscretions and be less likely to negotiate their condom usage by their partners (Ferguson et al., 2006; Wingood & DiClemente, 1997).

Ferguson et al. (2006) found that gender inequity on campus created a complex dating environment that led men to have multiple female sexual partners and women to be forced to decide whether to participate in man sharing. Women being less efficacious in condom negotiation and perceiving themselves as having limited or no power contributes to risk factors for STI and HIV (Wingood & DiClemente, 2000). Wingood and DiClemente further postulated that the more power men have in heterosexual

relationships, the more likely women will experience poor health outcomes. Man-sharing and the ability to control condom use are manifestations of the disparity in power that make women more vulnerable to contracting HIV infection (Ferguson et al., 2006). Gender power dynamics have also been chronicled among Black adolescent females because of their inability to refuse sex with males and to negotiate condom use.

College students have adequate to high levels of knowledge about HIV transmission and behaviors that reduce the risk of infection (Carol, 1991; Fisher & Misovich, 1990; Mahoney, Thomas, & Ford; 1995). However, this knowledge does not translate into safer sex practices. Researchers investigating HIV/AIDS related knowledge, attitudes, and behaviors among Black college students indicated that despite knowledge of HIV/AIDS risk most of them practiced inconsistent condom use and had two or more sexual partners over a 6 to 12 month period (Barazargan et al., 2000; Fennell, 1997; Jemmott & Jemmott, 1991; Johnson et al., 1992; Johnson et al., 1994; Lewis et al., 2000; Whaley & Winfield, 2003).

Increasing attention has been given to examining HIV-related issues among HBCUs, however, most of the studies focused on MSW HIV risk and safer sex behaviors (Bazargan et al., 2000; Braithwaite et al., 1998; Duncan et al., 2002; Ferguson, Quinn, Eng, & Sandelowski, 2006; Valentine, Wright, & Henley, 2003). To help capture and adequately access student risk taking behavior, Turkchik and Garske (2009) developed a sexual risk survey to clarify inconsistent findings in the literature and to access outcomes in programs designed to prevent and reduce sexual risk behavior among college students.

With the new strategies for decreasing HIV incidence, testing has become a priority in HIV prevention strategies. Not much attention has been given to the examination of HIV testing and HIV-related issues among both Whites and Blacks (Payne et al., 2006), and data suggested that Blacks test at a higher rate than Whites (Bui et al., 2010; Hou, 2009; Inungu et al., 2009). This is likely a result of their decreased perceived risk of HIV infection. As a general rule, individuals are more likely to be tested if they believe that they are at increased risk for HIV infection (Thomas et al., 2008). One of the goals of the US National HIV/AIDS testing strategy is to increase the number of people who know their HIV status via HIV testing (Kilmarx & Mermin, 2012; Kates et al., 2002). Testing is seen as an effective strategy for secondary preventions of HIV, and the research confirms that HIV positive individuals who are aware of their status take more caution to decrease transmission to other (Marks et al., 2005).

In addition to cognitive/behavioral risk taking, sensation seeking has also been postulated as a plausible reason for why collegiate students demonstrate high risk behaviors (Gullette & Lyons, 2005, 2006; Kalichman et al., 1994; Kalichman & Rompa, 1995). An individual who is sexual sensation seeking often attends parties, drinks to excess, is adventurous, seeks novel or different sexual experiences, may engage in unprotected sexual intercourse with multiple sexual partners, and may use illegal drugs (Cronin, 1995; Kalichman & Rompa, 1995; Reece, Dodge, & Cole, 2002). Among college students, sensation seeking and risky behavior has been under studied (Kalichman et al., 1994; Kalichman &Rompa, 1995). The research that has been conducted has been focused primarily on men and found that they score higher than women on sensation

seeking, have more sexual partners, and drink more alcohol (Arnold, Fletcher, & Farrow, 2002; Rolison, 2002; Gullette & Lyons, 2005). Gullette and Lyons found that students who scored high on the sexual sensation seeking scale, sexual compulsivity scale, and the college alcohol problem scale participated in more HIV risk behaviors and that sexual compulsivity, sexual seeking, alcohol use, gender, age, and Greek membership predicted HIV risk behaviors. The research on sexual seeking, alcohol, increased numbers of sexual partners, and the correlations to HIV risk behavior is yet another variable that underscores the complexity of understanding the complex dynamic that contributes to HIV risk taking behavior, behavior that seems to differ depending on the gender, race, and sexual identity.

MSM/W

Seroepidemiologic researchers have documented a change in the risk behaviors associated with new HIV infections (Hightow et al., 2006). Although MSM still account for the majority of reported HIV infections, the incidence of HIV is increasing among women and MSW. MSM/W are high risk for STDs/HIV (CDC, 2002b; Washington et al., 2009). The CDC conducted a review of HIV in the United States from 2000 to 2003, and it revealed that 80% of Black women acquired HIV through heterosexual contact, whereas only 27% of Black men acquired HIV through heterosexual contact; the majority of Black men (54%) reported being MSM as their transmission risk. Since that time several investigators have raised the possibility that MSM/W may serve as a bridge for infection between these groups (Dodge, Jeffries, & Sandfort, 2008; Hightow et al., 2006; Malebranche, 2008; Millett, Malebranche, Mason, and Spike, 2005). Millett et al.

explored this issue and determined that the high prevalence of HIV in the Black community and the greater likelihood of bisexuality among Black men placed heterosexual Black women at risk for HIV infection; they also noted that this was a complex issue that needed further exploration.

Millett et al. (2005) indicated that both heterosexual, MSM, and MSM/W reported having sex with a woman with the previous 5 year period. While some men hide their same gender sexual practices it is important to note that not all MSM/W do so. Likewise, bisexuality occurs in other racial groups; however, because of the high incidence of HIV infection among Black men and women the discussion has largely been focused on this demographic.

Bisexuality is reported as highest among Black men when compared to men of other racial or ethnic groups (Goodenow, Netherland, & Szalacha, 2002; Heckman et al, 1995; McKirnan et al., 1995). This is significant because research on this population is limited and some has been collapsed into research on MSM in general. Some information has been gathered regarding risk factors but not as much on protective factors creating gaps in knowledge about how this cohort operates in their sexual relationships (Dodge, Jeffries, & Sandfort, 2008). Nondisclosure has been linked to increasing HIV and other sexually transmitted infection incidence among female partners of Black MSM/W (Doll et al., 1992; Montgomery et al., 2003).

Not only has bisexuality been linked to higher rates of STDs and HIV (CDC, 2002b; Washington et al., 2009), Black bisexual men have higher rates of substance use (Richardson et al., 1998), higher suicide rate (CDC, 1998), elevated levels of depressive

mood and anxiety disorders (Richardson, 1997), and have increased risk for HIV infection (Satcher et al., 2007) when compared to their heterosexual partners. Marginalized Black bisexual men have also been reported to have high levels of psychosocial distress (Crawford et al., 2002). Psychological distress among Black MSM/W has also been linked to risky sexual behaviors (Crawford et al., 2002; Peterson, 1998).

Black MSM/W are at relatively high risk for HIV transmission when compared to other risk groups (Brooks, Rotheram-Borus, Bing, Ayala, & Henry, 2003; Kahn, Gurvey, Pollack, Binson, & Catania, 1997; Leone et al., 2004; Prabhu, Owen, Folger, & McFarland, 2004; Wold et al., 1998). In North Carolina, a retrospective review of men aged 18-30 with HIV diagnosed during January 2000-May 2003 indicated that 49 of the 56 HIV cases were Black college males who had sex with men and women (Leone et al., 2004).

Fitzpatrick (2004) found that Black MSM/W college students, HIV positive and HIV negative, were less likely than were nonstudents to self-identify as gay, and were more likely to have had more lifetime sex partners. Washington et al. (2009) found that MSM/W students were less likely to use condoms, more likely to have had an STD infection and to have been tested for HIV than their MSW counterparts.

For college students the college/university campus is central to psychosocial development (Tomlinson & Fassinger, 2003) and it is suggested that men who identify as gay or bisexual may face unique challenges at HBCUs because of their sexual orientation (Patton, 2011). These challenges include how to make meaning of their gay or bisexual

identity, how to disclose aspects of their identity to others and their perception of their experience at HBCUs. Patton explored the dynamic between MSM and Bisexual men and the HBCU collegiate environment.

Patton (2011) focused heavily on sexual identity development of a small cohort of bisexual and gay Black men at an HBCU utilizing a phenomenological case study and the snowballing technique. Patton examined the social constructionist view of masculinities exploring the concepts of discrimination and institutional homophobia perceived by Black MSM. Patton used the model of multiple dimensions of identities to explore the experiences of Black MSM at this particular HBCU.

Malebranche (2010) conducted a qualitative study of risk behavior and disclosure of same sex behavior among bisexual men. Malebranche snowballing technique, web sites, fliers, and phone chat line services to recruit participants for the study. Data were collected via semi structured face-to-face interviews that ranged from 60-120 minutes. Interviews were audio recorded transcribed and NVivo 7. QSR international was utilized to determine codes, patterns, and themes for the interview and included rich narratives which did not delineate how many participants expressed the same themes (Patton, 2002). Coding patterns were compared to ensure intercoder agreement.

Aside from Washington and Wall (2006) and Harris (2003), both of whom focused on Black gay and bisexual men at PWIs, and Patton (2011), researchers have not focused on sexual identity experiences, much less sexual identity experiences at HBCUs. Washington and Wall explored identity development, spirituality, self-naming, and role models; whereas Harris focused on the dismal engagement of Black gay men at PWIs. At

PWIs, Blacks are both sexual and racial minorities; these students often experience feelings of isolation and marginalization (Connolly, 2000; Mobley, 2000; Schueler, Hoffman, & Peterson, 2009), and they sometimes struggle to find environments where they can feel comfortable and safe (Goode-Cross & Good, 2008).

The psychosocial development that they experience in college is complicated by the sociocultural practices of Black men which prohibit the expression of non-heterosexual behavior and identities (Mays, Chochran, & Zambudio, 2004; Millett et al., 2005; Stokes et al., 1996. For non-heterosexual Black students at both PWIs and HBCUs, racial identity superseded sexual identity and their need to feel a strong sense of connection to the Black community was more important to them than being or feeling connected to the gay community. In the Patton (2011) study, participants were not quick to disclose sexual identity. This is consistent with findings that unlike their White counterparts who view the coming out process as a positive experience in sexual identity development, Black gay and bisexual men construct the coming out process very differently and are less likely to disclose their sexual identity (Battle & Bennett, 2000; Mays et al., 1998; Ostrow et al., 1991; Rosario et al., 2004; Wall & Washington, 1991).

Negative attitudes about individual sexual identity and the coming out process have been associated with increased emotional distress and increased unprotected sexual behaviors for Black MSM/W (Rosario et al., 2001). Institutional homophobia (Walters & Hayes, 1998) has been discussed as a plausible reason for why Black MSM/W struggle with their coming to terms with their sexual identity and contributes to psychosocial factors that may influence risk taking behaviors. Sexual identities and the coming out

process have been explored; however, research on the role that stigma plays in HIV risk behaviors among Black MSM in the HBCU setting is needed.

Understanding the profile and the experiences of MSM/W is important because it helps in the development of new theory and interventions aimed at lowering incidence. Goldham et al. (1996) conducted a study and determined six groups of Non-Gay-Identifying MSM (NGI-MSM) with different profiles. The categorical profiles were hustlers, new age men or experimenters, incarcerated or formerly incarcerated men, people of color or cultural groups, and heterosexually identified bisexual men. This suggests the need for specific interventions that address the motivations for nondisclosure within these different profiles. Goldham et al. reported that masturbation and oral sex were common but that anal and vaginal sex was also occurring with condom use was rarely being reported. The majority of study participants reported unprotected anal intercourse and continued vaginal sex with wives or girlfriend, citing suspicion of the women as a reason why they did not use condoms (Goldbaum et al., 1996). For these men denial was a major risk factor and failure to identify with a certain group also indicates denial of the risk associated with the group. As a result, NGI-MSM are not typically receptive to interventions targeted toward gay or bisexual men. Likewise, they do not participate in non-sexual aspects of gay culture where information exchange could be useful (Goldbaum et al., 1996).

MSM/W keep their behaviors a secret because they fear for their safety and because they fear discrimination. This perceived stigma creates barriers toward disclosure and encourages secrecy. MSM/W experience both internalized and externalized

homophobia and as a result isolate themselves in a manner that allows them not to receive prevention messages targeted toward MSM or MSM/W. Sexual minorities such as MSM/W and MSM have been associated with higher prevalence of drinking, drug use, problematic drinking, and problematic drug use (Woodford, Krentzman, & Gattis, 2012). The increase use of alcohol and drugs is attributed to marginalization (Meyer et al., 2011), stress, discrimination, and mistreatment (Hatzenbuehler, Nolen-Hoeksema, & Erickson, 2008; Meyer, 2003) associated with their sexual orientation and the campus climate. The increased use of drugs and alcohol coupled with low condom usage found among MSM/W when compared with their MSW counterparts further underscores the need for HIV prevention strategies for marginalized populations (Washington et al., 2009) and helps to make the argument for why reducing stigma related to sexual orientation among people of color is so important for future prevention efforts.

MSM

As with the other subgroups discussed examining the profile, experiences, and practices of each subgroup helps to provide a foundation for this qualitative phenomenological study. Homosexual contact is the primary mode of HIV transmission in the United States. In the early years of the epidemic, the incidence of HIV infection among MSM in the United States peaked at 8-10% per year and then fell to below 1% by the late 1980s and early 1990s (Quan et al., 2002). Holmberg (1996) and Peterson et al. (1996) noted that the prevalence and incidence rates of AIDS among gay men was lower than it had been in the previous decade but the rates among men of color had continued to grow.

The main risk factor for HIV infection among MSM has been unprotected anal intercourse (UAI), with higher risk associated with receptive anal intercourse (Vittinghoff et al., 1999). Even after learning of their infection, some still MSM still engaged in UAI (Denning & Campsmith, 2005). In addition to high risk sexual behaviors HIV incidence among MSM has also been associated with increased number of partners, substance use, (Koblin et al., 2006) sexually transmitted infections, and lack of circumcision (Bushbinder et al., 2005; Kuiken et al., 1990). HIV Surveillance indicated that MSM are at elevated risk of contracting HIV and other sexually transmitted diseases (CDC, 2013).

In 2007, the CDC reported that about one third of HIV infections in the United States among MSM occurred in Black Men. In 2010, Black MSM accounted for 55% of new infections among MSM, and young Black men represented 45% of those infections. In 2013, White MSM accounted for the largest number of new HIV infections followed closely by Blacks (CDC, 2013b). This is notable because Blacks only represent 13% of the United States population versus 78 % represented by Whites. These statistics underscore the vast disparity of HIV infection for Blacks compared to Whites. Many studies look to explain the greater risk for HIV infection of Black men who have sex with Black men; however, research and data have been mixed with some studies being conclusively supported by evidence, some not being supported by scientific evidence and some in which there is insufficient or conflicting scientific evidence. Millett et al. (2007) conducted a literature review and suggested 12 hypotheses as a means of explanation for the disparity of HIV infection between Black and other MSM.

Upon examination of some of the theories postulated about Black MSM vs. other MSM it is sometimes suggested that Black MSM are more likely than other MSM to engage in high risk sexual behavior (Bingman et al., 2001; Heckman et al., 1999). UAI and multiple sexual partners are common sexual risk factors associated with HIV infection (Goedert et al., 1985). UAI is the single most important risk factor for HIV transmission among MSM (Vittinghoff et al., 1999). If Blacks are more likely to engage in UAI; then this would be a plausible explanation for the racial disparities in HIV infection rate of Blacks when compared to other MSM. However, since the beginning of the epidemic, studies have shown comparable rates and in some cases lower self-reported rates of UAI for Black MSM relative to other MSM (Bartholow et al., 2005; Bingham et al., 2003; Denning & Campsmith 2005; Doll et al., 1990; Harawa et al., 2004; Lemp et al. 1994; Samuel & Winkelstein, 1987; Ruiz, Facer, & Sun, 1998; MacKellar et al., 2005; Mansergh et al., 2002; McKirman et al., 2001; McKirnan et al., 1995; Ostrow et al., 1991; Stokes, Vanible, & McKirnan, 1996; Peterson, Bakerman, &Stokes, 2001; Purcell et al., 2005; Solorio, Swendeman, & Rotheram-Borus, 2003; Walleroy et al., 2002). Other researchers found no significant difference in racial or ethnic groups (Denning & Campsmith, 2005; MacKellar et al., 2005; Mansergh et al., 2002; McKirman et al., 1995; McKirnan et al., 2001; Lemp et al., 1994; Ruiz et al., 1998; Stokes, Vanible, & McKirnan 1996; Purcell et al., 2005; Solorio, Swendeman, & Rotheram-Borus, 2003), or found that Blacks were less likely than other MSM to engage in high risk-sexual practices (Bartholow et al., 2005; Bingham et al., 2003; Doll et al., 1990; Harawa et al., 2004). In a study conducted by Bingham in 2001, researchers reported higher rates of UAI for Blacks

MSM versus Whites. Studies of MSM also consistently report that Black MSM have the same number or fewer numbers of male sexual partners and this includes casual (Bingham et al., 2003; Doll et al., 1990; Harwa et al., 2004; Stokes et al., 1996), current (Bingham et al., 2001, 2003; Stokes et al., 1996), and lifetime partners (Harawa et al., 2004; Stokes, Vanable, & McKirnan 1996). As a whole, the research does not support the assertion that Blacks are more likely to engage in high risk sexual behavior regarding UAI, and numbers of sexual partners.

When examining sexual identity, Black MSM are less likely than other MSM to identify as gay or to disclose their sexual identity (Chu al., 1992; Doll et al., 1992; Goldbaum et al., 1998; Kramer, Aral, & Curran. 1980; McKirnan et al., 1995, 2001; Montgomery et al., 2003; Torian et al., 2002). Likewise, they are less likely to join gay related organizations (Kennamer et al., 2000; Stokes et al., 1996). The failure of Black MSM to identify as gay has implications for prevention interventions, and targeting messages toward this group is complex; but, that this has not lead to an increase in HIV Risk behavior. Failure to identify as gay or disclose MSM behaviors to others has not been found to be a predictor of HIV risk taking behavior for Black MSM.

Injection drug use and sexual activity while under the influence of substances have been associated with HIV risk behavior (Doherty et al., 2000). If Black MSM were more likely than other MSM to use mind-altering substances it could partially explain observed racial differenced in HIV prevalence (Millett et al., 2006). Researchers have found no differences among MSM of different races and ethnicities in the prevalence of alcohol use (Heckman et al., 1999), alcohol-related problems (Irwin et al., 2005; Stall et

al., 2001) or alcohol use during sex (McKirnan et al., 2001). In random samples of young MSM, Black MSM report comparable or lower rates of alcohol consumption and lower rates of substance dependence (Greenwood, et al., 2001) when compared to other MSM. Studies show that young Black MSM engage in lower illicit drug use than their non-Black peers (Valleroy et al., 2002; Torian et al., 2002). Studies regarding injection drug use by Black MSM have mixed results. Siegel et al. (2004) and Sullivan et al. (1998) both found injection drug use to be greater among Black MSM than among White MSM. Other studies suggest Black MSM are equally as likely or less likely to report injection drug use (Bingham et al., 2003; Easterbrook et al., 1993; Harawa et al., 2004; Reitmeijer et al., 1998). Black MSM were equally as likely (Easterbrook et al., 1993) or less (Harawa et al., 2004; Samuel et al., 1987) to report needle sharing. Crack Cocaine is the only illicit drug that Black MSM report using more often than other MSM; however, there has not been evidence that links increased crack cocaine use to HIV prevalence.

Further examination of the increased risk for HIV infection among Black MSM is supported by the fact that Black MSM are more likely than other MSM to contract sexually transmitted diseases that make the acquisition (Fleming et al., 1999) and transmission (Rothenberg, et al., 2000) of HIV easier (Fleming et al., 1999). High rates of coinfection among men with diagnosis of syphilis or gonorrhea have been reported (CDC, 2004). Black MSM are more likely than other MSM to report ever having current or previous STD (Heckman et al., 1999.

HIV testing and being aware of your HIV status is another area where Black MSM experience challenges. Despite researchers that showed Black MSM are equally

likely (CDC 2005; McKirnan et al., 1995; Heckman et al., 1999), or more likely (Dao, 1999) to have an HIV test and to have a history of HIV testing (Dao, 1999), others suggested that Black MSM are tested less frequently (CDC, 2005) and later in their HIV infection (Wortley et al., 1995) than other MSM. Infrequent or delayed HIV testing contributes to high HIV prevalence among Black MSM because men who are unaware of their HIV infection are more likely to engage in behaviors that transmit the virus to HIV negative partners (Colfax, 2002).

Genetics, circumcision, latent HIV infection, having sex with persons of unknown serostatus, incarceration, sexual networks, and anorectal douching have all been postulated as a reason for increased HIV risk among Black MSM (Millet et al., 2006). When considering genetic factors and susceptibility to HIV, it is known that some individuals remain HIV negative after repeated exposure to HIV and others become infected after a single exposure (Lopalco et al., 2000). Biological and genetic characteristics that affect HIV susceptibility have been studied and the CCR5 has been identified as a genetic factor that influences HIV infections. The CCR5 receptors are relatively rare in the general population (Samson et al., 1996).

Persons who are homozygous or heterozygous for the genetic mutation may be resistant to HIV infection. The genetic mutation has also been associated with decreased viral load, less rapid progression of HIV disease and increased survival (Berger, Murphy, & Farber, 1999; McNicholl et al., 1997). Globally, approximately 1% of Whites are homozygous for the genetic variant and 15% are heterozygous (Samson et al., 1996). Individual of African or Asian descent are homozygous or heterozygous <0.1% (Fowke

et al., 1998; Martinson et al., 2000; Williamson et al., 2000). The fact that CCR% occurs less frequently in populations of color suggest that there are genetic differenced in HIV infection among MSM (Martinson et al., 2000).

Circumcision is a cultural practice with biological consequences that may protect a man from HIV infection (Auvert et al., 2005; Quin et al., 2000). Historically, Whites are circumcised at a higher rate than Blacks or Latino men (Laumann, 1997); with newer data suggesting more similar rates of circumcision among Whites and Blacks (CDC, 2010). Latino men in general are less likely to be circumcised than Black men (Mansfield et al., 1995). Circumcised MSM are less likely than uncircumcised MSM to be HIV positive. Latino MSM are less likely than Black MSM to be circumcised resulting in expected higher rates of HIV infection among Latino MSM; however, more Black MSM have been diagnosed with HIV infection than Latino MSM since the beginning of the epidemic (CDC, 2004). Circumcision data regarding Black MSM is sparse and the role of circumcision plays in high rates of HIV infection among Black MSM is still undetermined.

HIV positive Black MSM being infectious for a longer time than other HIV positive MSM is another theory that seeks to explain higher rates of infections for Black MSM vs. other MSM. Factors that influence the duration of infectiousness among HIV positive Black MSM include access to and use of medical care for HIV infection and access and adherence to antiretroviral therapy (ART; Millet et al., 2006). Higher viral loads are attributed to inadequate health care access and /or suboptimal health care and higher viral loads (Millet et al., 2006). While no significant difference were found among

HIV positive MSM individuals regarding emergency department visits, inpatients visits (Kass et al., 1999), or recent hospitalizations (Zucconi et al., 1994), Whites were more likely than Blacks to report having health insurance (Kass et al., 1999). Conversely, Black MSM were more likely to access and receive care in public clinics (Halkitis et al., 2003), and less likely to have access to ART. Oster et al. (2011) found that Black MSM were more likely to have partners of unknown HIV status and among those previously diagnosed as HIV positive, Black MSM were less likely to be on antiretroviral therapy.

Black men report fewer sexual partners and similar rates of unprotected anal intercourse when compared with White men; however, to date behavioral risk factors for HIV infection do not explain elevated HIV rates among Black MSM (Harawa et al., 2004; Millett et al., 2007). It is theorized that Black MSM are more likely that other MSM to have sex with partners known to be HIV positive and that perhaps this is a plausible explanation for why we see greater risk for HIV infection among Black MSM. Mixed data on this hypothesis exist. Harawa et al. (2004) reported that Blacks were significantly less likely than other MSM to report having sex with a man who HIV positive further were stating that this would not have accounted for the disparate rates of HIV infection. Similarly, Easterbrook et al. (1993) found no association among Black MSM between HIV positive status and reported sex with an HIV positive partner. Heckman et al. (1999) reported that Black MSM were more likely than White MSM to know or suspect that a recent sexual partner was HIV-positive.

Researchers suggested but have not empirically determined that the sexual networks of Black MSM increase their likelihood of HIV infection (Easterbrook et al.,

1993; Harwa et al., 2004; Hightow et al. 2005). Bingham et al. (2003) published one of the only studies that tested the effect of sexual mixing on HIV infection among 400 Black MSM aged 23-29 years. They reported that proportionally more Black MSM were HIV positive than were MSM of any other racial/ethnic group. The further concluded that racial differences in partner selection partially explained elevated rates of HIV infection for Black MSM with Black MSM more likely than others to report having anal sex with and partner that was younger or older. The data regarding sexual mixing and Black sexual networks is strong; however, more studies are needed to properly evaluate this hypothesis.

It is hypothesized that Black MSM are more likely than other MSM to be incarcerated and that incarceration increases exposure to HIV as a result of homosexual contact while in prison (Fullilove, 2001; Wheeler, 2004). Black men represent the largest proportion of all incarcerated men in federal and state prisons (US Department of Justice, 2002). The HIV infection rate is five times higher in prisons that in the general population (US Department of Justice, 2001) and there are documented outbreaks of homosexual contact (Krebs & Simmons, 2002), HIV and STDs (Brewer et al., 1988; Mutter, Grimes, & Labarthe, 1994; van Hoeven, Rooney, & Joseph, 1990; Wolfe et al., 2001). While these are known statistics limited studies have explored incarceration and HIV infection among Black MSM.

Practices such as anorectal douching, have also been found to be associated with HIV status and Black MSM and it is another hypothesis used to explain the greater risk of HIV infection among Black MSM. MSM who engage in anorectal douching were five

times more likely to be HIV positive than those who did not (Millet et al., 2006; Millet et al., 2007). HIV prevention strategies such as serosorting, a practice of limiting unprotected sex to partners of the same serostatus and strategic positing in the insertive or receptive role during unprotected sex based upon HIV status is a practice or strategy utilized by White MSM. Similarly, selecting unprotected sexual partners thought to have the same HIV status, is also a strategy utilized by White MSM. Black MSM are less likely to have unprotected anal sex with presumed HIV- negative men and more likely to UAI with partners of unknown HIV status and less likely to adopt serosorting practice (Eaton et al., 2010). The serosorting strategy has been reported as a plausible explanation for the disproportionate number of HIV infections among Black versus White MSM (Eaton et al., 2010). Limited attention to MSM in HIV prevention services has left these men to creating their own strategies and serosorting has proven to be an alternative to condom use (Eaton et al., 2011) for White versus Black MSM.

For White MSM, personal acceptance of one’s identity is strongly associated with measures of social and emotional support (Turner et al., 1993), and interaction with a supportive community gay or otherwise is associated with more positive prevention messages, safer sex and more consistent condom use (Seibt et al., 1993). Prevention programs directed at White MSM may not be effective with Black MSM (Goldbaum, 1996). This lack of effectiveness among program for Black MSM has led researchers such as Malebranche in 2003 to suggest that a comprehensive understanding of HIV risk among Black MSM required a more thorough examination of sexual networks,

masculinity, sexuality, health care access, and the increased susceptibility related to social and environmental stressors.

Exploration of these areas has not included information related to stigma and the role it plays in Black MSM in the HBCU environment. Bing, Bingham, and Millett (2008) suggested that homophobia and AIDS stigma within families and communities of Black MSM may contribute to heightened HIV/AIDS risk. Homophobia from the church, feeling fear of family rejection, and the keeping of same-sexual activity a secret are also thought to contribute to risk behaviors among Black MSM (Miller, 2007; Seegers, 2007; Ward, 2005). Maulsby et al. (2013) found inconclusive evidence that incarceration, stigma, discrimination, social isolation, mental health disparities, or social networks explained the elevated rates of HIV among Black MSM.

Maulsby et al. (2013) expanded upon the findings of Millet et al., which suggested that differences in STI, undiagnosed serospositivity, late HIV testing, and late diagnosis contributes to the differences in rates of HIV of Blacks versus Whites. Maulsby et al. added that differences in access to care and treatment services and use of highly active antiretroviral therapy (HAART) also explain differences in rates of HIV between Black and White MSM. To date the results of the research on Black MSM suggest a complex play of behavioral, biomedical, structural, social, psychosocial, and social network factors that interweave; and in the absence of interventions that that address the basic tenets of these constructs HIV incidence among Black MSM continue to soar. In addition to these variables, stigma associated with being MSM should also be explored

and factored into this complex play of tenets that could possibly explain HIV risk taking behavior among Black MSM on HBCU campuses.

Black Culture, Sex, and Stigma

Black churches hold a central and influential position within the Black culture and society in the United States (Lincoln & Mamiya, 1990). Surveys indicated that four out of five Blacks belong to a faith tradition (CDC, 1999) and that 97% of Black people in the USA claim some sort of religious affiliation (Dawson et al., 1994). Church affiliation is a significant element in the social lives and networks of Blacks (Ward, 2005). For adults the ideology and the imagery with which they were raised influences their later beliefs and practices (Dyson, 2003). Historically, the Black church has been the spiritual ark that preserved and empowered Black people socially, psychologically and physically during and after slavery (Miller, 2001). The Black church has been a catalyst for communicating important and relevant information about issues impacting the people and the community. While, Black churches differ in their views on homosexuality, most teach that it is a sin and an abomination in the sight of God. On one hand, homosexuality is considered among the worst of all sins, and the denunciation of homosexuality is important among religious groups. On the other hand, for Black churches, these individual provide much of the creative energy necessary for the religious experience (Fullilove & Fullilove, 1999). Additionally, many clergy in the church are suspected of engaging in homosexual behaviors and they are thought to contribute to the hypocrisy that is often associated with religious institutions (Taylor, Chatters, & Levin, 2004). With homosexuality and HIV/AIDs the Black church has been silent and seemingly in denial about HIV/AIDS and

about the associated homosexuality occurring within the Black Community (Fullilove & Fullilove, 1999; Miller, 2007; Woodyard et al., 2007). Because of these factors the Black church is thought to indirectly and directly foster homophobia (Dyson, 1996).

Theologically driven homophophia has adversely shaped the lives of not only gay and bisexual men but has also impacted the lives of Black heterosexual male and females (Ward, 2005). Imbedded in Black homophobia is hypermasculinity. Hypermasculinity is characterized by assertion of power and dominance through physically and sexually aggressive behaviors (Mosher & Sirkin, 1984). Among heterosexual males, strength, aggression, sexual prowess the suppression of feelings and competitiveness fuels heterosexism and homophobia. Black men's conceptions of what it is to be a man have been shaped by racial stereotypes of Black men as athletes, criminals and sexual predators (Pieterse, 1992). Among Black culture being a man is dichotomous with being a homosexual. Homosexuals are considered feminine, sissies, or fags, but not manly; this ideology has contributed toward the hyper masculinity and homophobia seen with in the Black culture. Together theologically driven homophobia and hypermasculinity provide a platform for bullying, misogyny, and gay bashing that is legitimized by sociocultural, ideological and spiritual theological views (Ward, 2005).

Good Cake, an ethnographic study conducted by Christian (2005) involved in depth interviews with three self-identified gay men. The study was designed to gain a deeper understanding of how these men defined life satisfaction and levels of life satisfaction. The snowballing sampling strategy was used to identify respondents. Data were collected via semistructured interviews, audiotaped, transcribed and analyzed by

ATLAS.ti 4.2. In this study, participants expressed a range of behaviors from being in the closet and seeking to conceal sexuality by marriage to a lesbian woman to being out openly gay and comfortable. Participants also expressed issues surrounding the clash of black masculinity and their sexual orientation. The study explored many of stereo types and challenges surrounding racial and ethnic identities associated with being black and gay. Similarly, a qualitative study of masculinities, gender expression, and "Cool Posing" was explored by Harris, Palmer, and Sturve (2011). The conceptual framework for this study utilized the social constructionist view to explore the social construction of masculinities, male gender role conflict, and expression of masculinities among 22 black men enrolled at a private research university.

Along with homophobia and fear of femininity, participants ascribed toughness, aggressiveness, material wealth, restrictive emotionality, and responsibility to masculinity (Harris, Palmer, & Sturve, 2011). This study also speaks to need for further interventions that address sexuality and hypermasculinity. Malebranche, Fields, Bryant, and Harper (2009) explored masculine socialization and sexual risk behaviors among Black men who have sex with men. This qualitative study is consistent with the work of Christian (2005), Patton (2011), and Harris et al. (2011) in that the men involved are influenced by social, institutional, and cultural ideals of masculinity derived and manufactured by others. Their masculine socialization and beliefs influenced partner selection, sexual and HIV risk behavior. These perceived positive and negative attributes may hold particular relevance for the current HIV epidemic occurring among Black

MSM and the associated stigma experienced by these individuals (Malenbranche et al., 2009).

The stigma of homophobia creates psycho-social pressures for Black gay and bisexual men (Cohen 1999, Fullilove & Fullilove, 1999; Kennamer et al., 2000). Internalized homophobia may lead to lower self-esteem and psychological distress that results in these men engaging in sexual behaviors that place them at risk for HIV (Stokes & Peterson, 1998). Other findings indicated that these openly gay and bisexual men have higher levels of sexual risk-taking than those who are closeted (Crawford et al., 2002).

Many do not support antigay discrimination, and evidence from media based and empirical surveys indicates that a significant number of people in the USA, including Blacks people see homosexual relationships as unacceptable and morally wrong (Crawford et al., 2002). Of these individuals, Blacks tend to view homosexuality more negatively than Whites (Lewis, 2003). This is thought to influence the lack of open expression of Black gay and bisexual men. Lack of acceptance and stigma are thought to fuel the reasons why the Black Church, one of the most influential institutions in Black culture has not adequately addressed the issues surrounding the disproportionate impact of HIV/AIDS on member of their community.

Herek, Gillis, and Cogan (2009) studied lesbian, gay, bisexual and transgender (LGBT) adults and found that LGBT Blacks were more likely to score highly on internalized homophobia than respondents of other races and ethnicities. Internalized homophobia was linked to greater relationship problems among lesbians, gay men, and bisexuals (Frost & Meyer, 2009) and has been shown to be predict self-esteem and

psychological distress among LGBT Blacks (Szymanski & Gupta, 2009). African American youths may be more uncomfortable with others knowing about their homosexuality and disclose to fewer individuals than their White peers (Rosario, Schrimshaw, & Hunter, 2004). Stokes et al. (1996) found that Blacks were less involved in the gay community, had higher prevalence of bisexuality, and experienced less acceptance by friends and neighbors. These findings are consistent with stigma associated with being an openly gay Black. In a qualitative study conducted among heterosexually identified Black men who had sex with men, Valera and Taylor (2011) found that among a group of married heterosexual church going Black men that concealment and compartmentalizing their experiences was a major strategy utilized to maintain their religious traditions and their same sex behavior. The men in the study cited the need to conform to establish traditions, homophobia, deep religious beliefs, and heterosexism as reasons why they chose to live as married heterosexual MSM. The findings in this study are consistent with other researchers that suggested that Black MSM are reluctant to identify as MSM, gay, or bisexual because of perceived stigma from their families, the communities and the Black church (Jeffries et al., 2008; Malebranche et al., 2004 and Miller, 2005).

Evidence from other qualitative studies reported that most Black MSM experience high levels of perceived stigma around sexuality, masculinity and same sex behavior (Harawa et al., 2008; Kraft et al., 2000; Miller, 2005). Despite the stigma associated with being a Black MSM, Black MSM are well represented in the Black Church as parishioners, ushers, deacons, committee members and ministers (Douglas, 1999;

Woodyard et al., 2000). To date, the challenge remains as how to reduce stigma and develop research opportunities that focus on advocacy and capacity building initiatives with Black churches (Fitzpatrick, Sutton, & Greenberg, 2006). Historically, these institutions that have been instrumental in aiding in the management of social issues related to Black culture and now more than ever there is a need for churches to step up to address the needs of the Black community. While many researchers explored stigma, church, and Black MSM stigma as a variable has not been explored in the HBCU.

Review of Literature Related to Methods

In reviewing the literature related to methods, I explored quantitative, qualitative, and mixed method research studies. The majority of the studies reviewed were quantitative in nature and looked to establish correlations between one or many variables. Quantitative studies included experimental and nonexperimental designs (Eaton, Kalichman, & Cherry, 2010, Koblin et al., 2006, Raymond & McFarland, 2009). Studies reflected a variety of methodologies including experimental (Kalichiman et al., 2001; Wolitski et al., 2005), quasi experimental (Rhodes et al., 2011), correlation (Parsons et al., 2003), and descriptive research (Balan et al., 2009). The strength of quantitative research is that it uses large sample sizes to generalize findings to different population and subpopulations. Quantitative studies allow researchers to generalize findings when the data are based on random samples of sufficient size. The research can be generalized when the finding have been replicated on many different populations and subpopulations.

Koblin et al. (2006), Raymond and McFarland (2006), and Eaton et al. (2010) all conducted large quantitative studies with over 500 participants. These cross sectional and

longitudinal studies involved large cities and large sample sizes. Because of the breadth of the studies and the sample size researchers were able to generalize their findings. The statistical analysis was used to test various study hypotheses through deductive process.

Balán et al. (2009); Bingham et al. (2003); Bowleg, (2004); Goldsamt and Yi (2005); Malebranche (2008); Malebranche et al. (2009, 2010); Meyer and Champion (2010); Miller, Serner, and Wagner (2005); Rhodes et al. (2001); Wheeler (2005); and Wilton et al. (2005) are among the qualitative and mix method studies reviewed. Malebranche et al. (2010) conducted qualitative analysis and used a variety of recruitment techniques, flyers, social media, as well as snowballing technique. Semistructured interviews were used and demographic profiles rounded out the data collection process. All interviews were digitally recorded, transcribed, and uploaded into NVivo 7 (QSR International, Cambridge, MA), a qualitative management and analysis software package.

Similarly, Malebranche et al. (2009) conducted a qualitative study on MSM. Semistructured, one-on-one interviews were conducted with 29 self-identified Black MSM in Atlanta, Georgia, between May, 2003 and September, 2003. Participants were recruited through the Internet, intercept method at a local park, and snowball methods. Interviews were audio-recorded and transcribed verbatim using a professional transcription service. Transcripts were cross-checked for accuracy with the audio recordings as they were completed. Transcripts were uploaded into ATLAS.ti, a qualitative software package that aids in the organization, coding, and analysis of qualitative data.

Rhodes et al. (2011) conducted a qualitative research using community based participatory research and grounded theory to explore sexual risk among MSM utilizing focus groups. Rhodes et al. explored at risk among Black, Latino and White MSM. Focus groups were used to investigate participant responses to HIV risk and interventions. Focus group participants were recruited by AIDS Service Organization, and social and sexual networking, via snowballing techniques, and via list serves, chat rooms. Focus groups were audio recorded and a standardized moderator’s guide was used to introduce topics, guide the process and lead the discussion. Focus group were the selected methodology because reveal key perspectives and nuances that researchers are not able to foresee and participants are encouraged to ask questions exchange anecdotes and comment on one another’s experiences and perspectives (Patton, 2002). Sessions were audio recorded and transcribed. NVivo (QSR International, 2002) was used to code and establish themes.

Malenbranche (2010) conducted a qualitative study of risk behavior and disclosure of same sex behavior among bisexual men. Malenbranche used snowballing technique, web sites, fliers, and phone chat line services to recruit participants for the study. Data was collected via semi structured face to face interviews that ranged from 60-120 minutes. Interviews were audio recorded transcribed and NVivo 7. QSR international was used to determine codes, patterns, and themes for the interview and included rich narratives which did not delineate how many participants expressed the same themes (Patton, 2002). Coding patterns were compared to ensure intercoder agreement.

Wheeler (2005) used semistructured interviews and focus groups to understand the dynamic among HIV positive MSM. Wheeler used the sociocultural model to examine 12 themes associated with HIV risk. Jerome, Halkitis, and Siconolfi, (2009) used a phenomenological approach to explore and clarity the synergistic relationship between club drug use, risky sexual behavior, and seroconversion. Similarly, Balán et al. (2009) used a descriptive qualitative study to gain insight in to the phenomenon of barebacking from the viewpoint of the participants. Meyer and Champion (2010) conducted a phenomenological study to explore the lived experiences of Mexican Americans MSM in an effort to determine protective factors. In this study as with many mentioned previously semi-structured interview were utilized; data was coded and themes were determined.

Many of the researchers reviewed used snowballing techniques. Goldsamat and Yi (2005), Malebranche (2008), Malebranche et al. (2009), Malebranche et al., (2010), Serner and Wagner (2005), Patton (2011) used this technique in conjunction with other recruitment methods such as flyers or advertisements on social media. Balán et al. (2009); Jerome, Halkitis, and Siconolfi, (2009); Meyer and Champion (2010); and Wheeler (2005) used semistructured interviews and focus groups; most used demographic profiles to gain insight into participant's background.

While NVivo was used in many of the studies reviewed, Bowleg, (2004), Buseh and Stevens (2007), Elford et al. (2004), Rhodes, (2004), and Rhodes et al. (2007) used other qualitative software packages. Generally speaking, the central tenants for the qualitative phenomenological studies reviewed were the small sample sizes, recording of

interviews, transcription, coding, and thematic analysis of the data. Qualitative sample sizes differed from those in quantitative studies reviewed in that qualitative sample sizes were much smaller and individuals included in the qualitative studies had to fit strict criteria for study inclusion. The phenomenological studies were exploratory in nature and research gleaned was designed to gain insight and understanding into behaviors and experiences. All of the studies had mechanisms in place to ensure accuracy of the data collected.

Consistent with many of the researchers in the literature review related to methods, a phenomenological study will be used as an exploratory method to examine stigma and HIV risk behavior as experienced by participants that will be included in the study. The snowballing techniques will be utilized and consistent with the other studies reviewed flyers will also be used as a recruitment technique. One of the concepts researchers used in the studies reviewed was the theory of saturation. The main indicator of sample size in qualitative research is often the point at which redundancy, or theoretical saturation of the data, is achieved. A researcher should indicate how and when the decision was reached that there was sufficient depth of information and redundancy of data to meet the purposes of the study. However, there is lot of debate on sample size minimums and maximums and how one determines the notion of saturation (Mark, 2010). For this phenomenological study, I relied on the suggestion of previous research and sought to cap participants at the saturation point or nine, whichever was greater. In this study saturation was reached at 13 participants. Issues of trustworthiness were

addressed by triangulation of method and data analysis will be consistent with that of phenomenological study constructs.

Summary

In preparation for this research study, hundreds of studies on HIV among Black MSM, MSM/W, MSW, stigma, Black culture, and sex in various settings were reviewed. Research on differing group of collegiate students revealed myriad behaviors and factors that influenced HIV risk taking behaviors; some of which were extensively explored and other of which need further inquiry to determine relevance. In the research conducted stigma in the HBCU environment was one of the variables that warranted additional study.

In the literature review and the review of literature related to methods, most of the studies were quantitative in nature seeking to determine the relationship between an independent variable and either a dependent or outcome variable in a specific population on such as Black MSM. These quantitative research designs were both descriptive and experimental in nature. The descriptive studies were seeking to establish associations between variables. To ensure accurate estimation of the relationship between variables, the descriptive studies contained samples of hundreds and some thousands of subjects. The estimate of the relationship is less likely to be biased if you have a high participation rate in a sample selected randomly from a population. The experimental studies were seeking to establish causality and participants were often assigned randomly to treatment groups. To ensure that bias was minimized both subjects and researchers were blind to the identity of the treatment groups. Randomized control trials, self-identified

convenience sample-data analysis descriptive statistics with analysis of variance, bivariate analysis, SPSS, SASS are a few of the quantitative methodologies utilized to provide a mathematical model for scientific phenomenon.

In considering methodological inquiry, and based upon the qualitative research of other studies of HIV and Black MSM, a study grounded in the constructionist pedagogy was selected. In this methodology participants would be able to make meaning of their experiences within the context of their campus environment. In this paradigm reality is not discovered but socially constructed by the individual participants (Esterberg, 2001). Broido and Manning (2002) summarized four common themes that shape the constructionist paradigm: (a) relationships are subjective and mutually shaping; (b) realities are complex and finite; (c) values of the researcher, participants setting, theory influence the research; and (d) what emerges from the research is context driven. The phenomenological approach was selected because this descriptive method of inquiry provides insight on the lived experiences of participants (Creswell, 1998).

Phenomenological research focuses on commonalities across participants rather than focusing on the unique experiences of the individuals. The central phenomenon is the experiences of Black MSM on HBCU campuses. Phenomenological research enables the researcher to describe, interpret, and report data that informs how researchers approach their work with specific populations. In conducting the literature review, the qualitative studies explored included phenomenological case study approaches, many included in depth interviews and focus groups as the data collection method. Studies that used semi-structured interviews yielded rich data. These semistructured interviews

consisted of several key questions that helped to define the areas explored; but also allowed the interviewer and interviewee to delve in order to pursue an idea or response in more detail. Chapter 3 is a description of the phenomenological research methodology used in this study.

Chapter 3: Research Method

Introduction

The previous two chapters included a detailed the history of HIV in America and explored different subgroups adversely affected by the disease. In this chapter, I discuss the methodology that was selected to explore the experiences and behaviors of Black MSM at HBCUs and seek to determine what factors influence these experiences. Christian (2005); Davis et al. (2007); Eaton et al. (2011); Harris (2003); Harawa et al. (2004); Malebranche (2008), Malebranche et al. (2009); Semple, Patterson, and Grant (2000); Oster et al. (2011); Patton and Simmons (2008); Harris, Palmer, and Sturve (2011); and Patton (2011) studied MSM in different settings; but, limited research has been conducted on Black MSM on HBCU Campus. HIV/AIDS research is quite extensive and research reports note that rates of HIV are stable in some populations. Unexplained high HIV prevalence and incidence rates for Black MSM continue to be reported 17 years after the first published report in the scientific literature (Millet et al., 2006).

In minority communities and amongst people who engage in non-heterosexual behaviors HIV incidence continues to grow, indicating that current interventions are inadequate for these cohorts (CDC, 2013b; Elford & Hart, 2003). Previous researchers have suggested the need for studies that consider the role of sociocultural factors (e.g. racial discrimination, homophobia, and stigmatization) in the disparate rates of HIV infection among MSM (Eaton, Kalichman, & Cherry, 2010; Malebranche, 2003; Millett et al., 2006; Overstreet, Earnshaw, Kalichman, & Quinn, 2013). The complexities of

behavior change and/ or modification draw from a unique interplay of many different variables. Understanding these variables is crucial in developing effective social change campaigns and this provides the foundation for the research methodology selected for this study.

Research Methodology

Qualitative methodology was selected to explore this topic. Qualitative research is an inquiry process is used to gain an in depth understanding of human behavior and the reasons that govern this behavior. Qualitative methods investigate the why and how and seeks to gain a deeper understanding of an observed phenomenon (Creswell, 1998). Creswell further suggested that this is done to develop new theories and in these studies the researcher takes the role as an active listener versus the expert judging participants. Qualitative researchers are interested in understanding the meaning people have constructed, and how people make sense of their world and the experiences they have in the world (Merriam, 2009, p. 13). Such a method emphasizes an epistemological stance using methods such as participant observation or case studies which result in a narrative, descriptive account of a setting or practice.

Qualitative researchers heavily consider the observer in the world. The narrative descriptive account consists of interpretive materials that reflect the world represented in the form of field notes, interviews, conversations, photographs, recordings, and memos to the self. Qualitative research involves an interpretive, naturalistic approach to the world. The researchers study things in their natural settings, attempting to make sense of, or to interpret, phenomena in terms of the meanings people bring to them (Denzin & Lincoln,

2005, p. 3). Qualitative research involves working with nonordinal data (Nkwi, Nyamongo, & Ryan, 2001, p. 1). The research methodology defines what the activity of research is, how to proceed, how to measure progress, and what constitutes success.

Epidemiology is led by quantitative data. These data are utilized to study of the distribution and determinants of health-related states or events (including disease), and the application of this study to the control of diseases and other health problems (World Health Organization [WHO], 2013). However, while the frequency and distribution of determinants of health and disease do not provide insight as to why these phenomena occur. Qualitative data provide the why and the how of what is occurring. Together, quantitative and qualitative data provide a comprehensive representation of health events occurring in society. For at least three decades, we have understood the modes of HIV transmission.

Black MSM are disproportionately impacted by HIV. Today a lot of time, effort, and resources are focused on HIV prevention and designing intervention that address both primary and secondary prevention. Qualitative research helps us to gain a deeper understanding of the behavioral psychology and many of the tenets that influence the behavior of those at the highest risk for HIV acquisition. From this vantage point effective social change initiatives can be developed and instituted.

Role of the Researcher

In qualitative studies, the researcher is the instrument of data collection (Denzin & Lincoln, 2003). This means that data are mediated through the human instrument rather than through inventories, questionnaires or machines. To fulfill this role,

consumers of the research need to know about the human instrument. A qualitative researcher needs to describe relevant aspects of self, including any biases and assumptions any expectations and experiences to qualify his or her ability to conduct the research (Greenbank, 2003).

A qualitative researcher can be either emic (an insider) or etic (from an outside view). Good qualitative researchers ask probing questions, listens, thinks, and then ask more probing questions to get to deeper levels of eh conversation. An effective qualitative researcher seeks to build a picture using ideas, and theories from a variety of sources.

As an administrator at the university where the research was conducted, I have had the opportunity to interact and engage with all types of students. In years past, I have served as advisor and advocate for students associated with our gay straight student alliance. I have seen firsthand students arriving and facing the realization of discovering their sexuality. Likewise, I have seen the culture and the environment in which these students are expected to grow develop and thrive. Nonetheless, I had no vested interest with any group or individual that will be included in the study. I did not directly supervise or serve as instructor to any individual that fits the profile for research participants. Students whom I engaged with directly fit the exclusionary criteria and were not included as a study participant.

As researcher, my goal was to bring an unbiased perspective and voice to the experiences of Black MSM and how those experiences influence their behaviors in general, but more specifically their sexual and HIV risk taking behavior. I anticipated the

environment influences their behavior in some way; however, the data may suggest otherwise. As a current employee of the institution where the research was conducted there was concern about the information that would be revealed via the participant's stories and experiences. The research study was approved by the university IRB, and anonymity of the institution will be maintained. Incentives for individuals to participate in the study included refreshments during sessions and links to community and campus resources. The most important incentive to participation was the hope that their shared experiences will help to change the culture and campus climate for future student who do not identify, operate and or live as heterosexual.

Research Design

A phenomenological design was selected to examine the experiences of Black MSM on HBCU campuses. Two major approaches to phenomenological research include hermeneutic phenomenology and transcendental phenomenology and both represent philosophical assumptions about experience and ways to organize and analyze phenomenological data. In transcendental phenomenology meaning is at the core design for acquiring and collecting data which is used to explicate the human experience. Hermeneutic phenomenology requires reflective interpretation of a text or a study in history to achieve a meaningful understanding (Moustakas, 1994).

Transcendental phenomenology was chosen as the appropriate methodology for this research as I am looking to gain an understanding of the of participants' experiences. The transcendental emphasis includes epoch, a Greek work meaning to refrain from judgment. In this process, a researcher sets aside prejudgments as much as possible and

uses systematic procedures for analyzing the data. The process is called transcendental because the researcher sees the phenomenon “freshly, as for the first time” (Moustakas, 1994, p. 34) and is open to its totality. Using the transcendental approach, participants were selected based upon set criteria (Huley et al., 2013) and each was asked about their daily life experiences and about how the culture of the HBCU environment (policy, culture, and practice) has influenced their sexual risk taking behaviors experience. The following research questions were explored:

Research Questions

1. What is the extent of stigma experienced by Black MSM (ages 18-24) attending an HBCU in North Carolina?
2. What impact or influence does the current HBCU environment (policy, practice, culture and stigma) have on the sexual behaviors of Black MSM attending the University?
3. What are the HIV risk behaviors of Black MSM attending an HBCU?

The participants served as the experiential experts on the phenomenon being studied and other themes may emerge. Participants were required to meet both inclusionary and exclusionary criteria. The phenomenological study provided insight in the unique experience of a targeted group, but no attempts will be made to generalize to other specific populations. However, information gleaned provided understanding of the experiences faced by this group on their HBCU campus laying the foundation for others to explore the phenomenon.

Participant Selection

Participants were drawn from a public HBCU that is a part of the constituent institution of the University of North Carolina. In fall of 2012, the male/female graduate and undergraduate student ratios were 30%/70%. The undergraduate ethnic make-up was 75% Black, 16% White, 2% Hispanic, and 7% other. Ninety-one percent of undergraduates came from within the state and the remaining 9% were out of state students. In 2013, the total enrollment was 6,163 and 5,962 of these students were undergraduates. The campus has approximately 2500 residential students and the remaining are commuter, and or distance learners.

The institution is located in south eastern portion of the Bible Belt. The Bible belt is comprised of socially conservative evangelical Protestants and in this culture Christian church attendance is higher than the national average. Along with the religious conservatism comes a culture that is not open to diversity of sexual expression. The Bible Belt contains the second highest rates of HIV/AIDS incidence and within the geographic area >75% of HIV/AIDS infections are attributed to male-to-male sexual contact and Blacks account for 50% of new HIV infections (DCD, 2012f).

Procedures for Recruitment

From this population, six to nine Black MSM students were identified using the snowballing technique. The snowballing technique also known as chain referral sampling is a method of sampling in which participants or informants with whom contact has already been made use their social networks to refer a researcher to other people who could potentially participate in or contribute to the study (Heckathorn, 1997, 2002).

Snowball sampling is often used to find and recruit hidden populations, that is, groups not easily accessible to researchers through other sampling strategies (Atkinson & Flint, 2001). Two informants were identified by and selected based upon demonstrated advocacy work done with LGBT students on campus. The remaining participants were individuals who received flyers and referrals from two individuals.

Informant selection criteria were the following: self-identified as a MSM and being out or being openly MSM. Informants had to be Black, born having male gender expression; 18-24 years of age, currently enrolled, and must have been a residential student or a student living on campus for at least one semester since enrollment at the university. Potential informants were educated on the study and the purpose for the research and asked if they were interested in the role of informant. Informants shared information regarding the study with potential participants. After referral by the informant, I followed up will all potential participants informing them about the nature of the study and determining if they are interested in being included in the research study. This initial follow up contact was done via e-mail and subsequent phone call. Potential participants that were still interested after receiving information via email and after our initial phone call, met with the researcher in person to further discuss the project and any potential questions regarding the study. Subsequent participants were identified utilizing this technique. The initial goal is to recruit at least nine participants; however, when the data revealed that saturation had not been reached, the recruitment procedures were repeated until saturation occurred. All participants were required to meet inclusionary and exclusionary criteria to be selected for the study.

Inclusionary criteria for the study participants were identical to that of the informant. Participants were to be Black, born and having male gender expression, self-identified MSM, residential students currently enrolled at the institution, and between the ages of 18 and 24. Exclusionary criteria was being female, transgender, or transsexual, or being a gay male that did not identify as MSM, being over the age of 24 or under the age of 18, participants could be either residential or commuter students. This process was repeated for 2-3 weeks, and 13 participants were selected. The participant number was to increase if data revealed that saturation had not occurred. In this case the participant number increased to ensure data saturation. See Appendix D for detailed recruitment procedure

1. Two Black MSM students who met exclusionary and inclusionary criteria were identified from Gay/Straight Student Alliance to initiate and assist with the snowballing technique recruitment strategy.
2. Each student was provided information and a flyer regarding the study. The student informant provided the flyer to other students. Interested students contacted me the directly to get additional information regarding the study.
3. Student who contacted me via email or telephone were provided an e-mail and hard copy of the letter to participant which will provide basic information regarding the nature of the study.

4. The snowballing recruitment and flyers were used for 2 weeks and participants who self-selected for the study were asked to provide the flyer to other individuals they thought would be interested in the study.
5. In addition to the snowballing recruitment technique, flyers were used as an additional means of recruitment.
6. Once selected each participant met with the study conductor to complete consent forms, ask any other questions and to determine the time, date, and location of their interview.
7. During the first meeting, each participant was given a copy of the letter describing the proposed study and signed the consent form. The interviews included a three step process that began with completion of demographic profile, risk assessment profile followed by the interview. All assessments and profiles were completed electronically via laptop that I provided. Interviews were recorded for accuracy. A list of the demographic profile, risk assessment profiles and interview questions is included in Appendix B.
8. Audiotapes were transcribed verbatim and analyzed.
9. Interviews lasted approximately 45-60 minutes. At the end of each interview participants were provided hard copies of support resources as well as a small gift card for participating.

10. After participant information was collected and transcribed, participants were given the opportunity to review the information for accuracy. Clarifications were made and documented by me.

11. After the first nine participant information was analyzed additional participants were recruited utilizing steps 1-10 until saturation was reached.

12. At the conclusion of the study, participants received a summary of the findings of the research study.

Measures

Participants completed a demographic profile, risk assessment profile, and participated in an in depth interview with semistructured questions regarding or related to their experience as a Black MSM on an HBCU campus. The risk assessment profile was borrowed and adapted from the Forsyth County Department of Public Health and it is the tool that is used in the intake process for HIV counseling and testing. The instrument was designed to provide a glimpse of the HIV risk behavior in the past 3 to 12 months. Adaptation of the instrument included listing of various STDs in Question 10, listing of specific substances in Question 11n, and the addition of Question 21. The demographic profile questionnaire was used to gain insights into the experiences of participants and how demographics inform their behavior and experiences.

The demographic profile was adapted from the standard census data demographic profile. Adaption of the demographic profile included demographic variables relevant to the collegiate experience and the nature of the study such as classification, sexual

orientation, residential status etc. In addition to the demographic and risk assessment profiles six semistructured interview questions were used. General probing questions were asked to glean any information deemed significant by the participants. Observation of participants during the interview process and a reflection paper will also be utilized as measures (Appendix B).

Pilot Test

To ensure validity and reliability the risk assessment profile acquired from the Forsyth County Department of Health was pilot tested. Pilot testing of surveys offers a means of finding out if your survey or other data collection instrument will work in the real world. This was discovered by testing the tool on a specific number of people who fit the profile of your study target population (Center for Evaluation and Research [CE&R], 2011). The purpose of the pilot test was to make sure that everyone in the sample not only understood the questions, but understood them in the same way, that questions did not make respondents feel uncomfortable and it allowed for an opportunity to determine how long it would take to complete the survey in real time (CE&R, 2011).

The risk assessment profile was borrowed and adapted for the local health department. Although the risk assessment profile has been widely used, it had not been tested for reliability and validity. Prior to using the risk assessment profile as a data collection tool the instrument was piloted to ensure its validity and reliability. This was conducted in two phases or with two specific target groups. Group 1 was comprised of a group of professional and field experts. This group of professionals consisted of individuals who are experienced professionals or subject matter experts that work with

individuals similar to that of the target population. Group 1 reviewed the tool for content. During the review process professions in Group 1 was asked to consider the following questions:

1. Do you think that the survey captures all elements of a brief risk assessment profile?
2. Do the questions make sense or are some of them useless, redundant, etc.
3. With your current knowledge regarding behaviors associated with the target population, are there any questions that you would add or delete?

Pilot test of instruments was conducted on groups of volunteers who were similar to the target population (Peat, Mellis, & Williams, 2002). Suggestions for pilot testing of instruments include administering the questionnaire to subjects the same way it would be administered in the main study. Asking subjects for feedback to identify ambiguities and difficult questions, recording time taken to complete instrument and determine if its reasonable, discarding of all unnecessary or difficult or ambiguous questions, determining whether each question gives an appropriate range or responses, establishing that replies are interpreted in terms of the information required, checking that all questions are answered, reworking or rescaling question not answered as expected and shortening, revising the instrument (Peat et al., 2002). Contamination of data is a concern in pilot testing (van Teijlingen & Huntley, 2001). To ensure that there was not contamination of data, data gleaned from the pilot study were included in main study results and participants of from the pilot study were not allowed to participate in the main study. This was done so as not to introduce bias and compromise the validity of the study.

Consistent with the study protocol, student participants in group two who pilot tested the instrument were assigned a unique identifier and were excluded from participation in the study.

The second group of pilot testers consisted of representatives of the target group. Four Black MSM collegiate students were selected to pilot the instrument. The advantage of pilot testing the instrument was to provide advance warning about instruments and helps to determine if the instrument was appropriate or too complicated. (van Teijlingen & Huntley, 2001). Students in group two were asked to complete the survey the same way that it was administered in the actual project. Students pilot tested the instrument utilizing a laptop computer. They completed the consent forms and were given an opportunity to ask questions regarding the study, data collection and the process. To avoid bias, participants who agreed to pilot the instrument were excluded from participation in the actual study. Students were asked to provide feedback on content and logistical elements of the survey. Participants were observed for hesitancy and/or challenges experienced for different question in the instrument. Observations were made regarding logistical elements of the survey. For example, did check boxes work with ease? Did participants understand the instructions and how to identify their responses? After participants completed the pilot test of the instrument students in Group 2 were asked the following questions:

1. Were the questions and the language utilized clear and easy to understand?
2. Do the questions make sense or are some of them useless, redundant, etc.
3. Do you feel the survey covers all questions that should be asked?

After pilot testing the instrument on groups one and two, a debriefing took place with participants to look for patterns in the feedback. Data gleaned was used to revise the instrument and the revised instrument was used in the data collection process.

Data Collection

Before data collection began, each participant completed a consent form and statement of confidentiality (Appendix C). To ensure fidelity and structure, direct observation was taken via diary or journal of expression, reactions, and other significant events occurring within the environment. This was my responsibility. Participants completed all profiles electronically. The interviews were conducted in an office in the student center. The location was private and free from distraction. Each interview was recorded and transcribed. Member checking rounded out the data collection process. Profiles and interview transcripts were reviewed with each participant to ensure accuracy. With the approval of the participants and to ensure accuracy, clarification was made appropriately explained and documented by me. Data were organized by creating files for each item: risk assessment profile, demographic profile, and interview file. Creswell (1998) recommended "creating and organizing files" (p. 148) as the first step towards beginning the analysis process. Files and recordings are being e maintained in a locked filing cabinet in the researcher's home office.

Data Analysis

Data were analyzed using NVivo, a qualitative data analysis (QDA) computer software package packaged and produced by QSR International. It is designed by qualitative researchers who work with rich text-based and/or multimedia information,

where deep levels of analysis on small or large volumes of data are required (QSR International, 2013). A three step process was used in analyzing the data. First, data were organized and prepared for analysis. This included transcribing interviews, typing any field or observation notes and arranging data into different types depending on the source information. All data were read to get a general sense of the information and to reflect on its overall meaning; for example, what are participants saying, as well as the depth and credibility of the information that is being shared would be reflected upon.

Phenomenological data analysis steps are generally similar for all psychological phenomenologists who discuss the methods (Moustakas, 1994; Polkinghorne, 1989). A detailed analysis of the information was conducted using Moustakas's approach to phenomenological inquiry. The research questions and the data analysis correlation matrix were as follows:

Research Question 1. What is the frequency extent of stigma experienced by Black MSM (ages 18-24) attending an HBCU inn North Carolina?

Research Question 2. What impact or influence does the current HBCU environment (policy, practice, culture and stigma) have on the sexual behaviors of Black MSM attending the University?

Research Question 3. What are the HIV risk behaviors of Black MSM attending an HBCU?

Listed below is Table 1 which is a data correlation matrix. The table pairs the research questions with the appropriate data collection tool.

Table 1

Data Analysis Correlations Matrix and Research Question Demographics

Research Question Demographics	RQ1	RQ2	RQ3	Demographics
Demographic Profile				X
Risk Assessment Profile		X	X	X
Interview Questions				
1. In terms of labels, how do you view yourself example; gay, bisexual, queer/questioning etc., and why?	X	X		
2. What is your understanding of stigma?		X		
3. Since becoming a student at the University, please describe the most significant experience that you can recall where you believe stigma influenced the way you were treated or where you believe stigma influenced the outcome of the situation.		X		
4. Taking into consideration your sexual orientation, since coming to the University, please describe in detail any positive or negative experience(s) that you have had on campus where you believe that your sexual orientation played a role?		X		
5. Since becoming a student at the University what impact has your perception of how others view you and your sexual orientation had on your HIV risk taking behavior?	X		X	
6. What impact if any has the University, and/or or campus climate had on your sexual risk taking behavior?	X		X	

The analysis started with horizonalization or building on the data from the first and second research questions. From this vantage, an analysis of all data occurred. Significant statements, sentences, or quotes that provide an understanding of how the participants experienced the phenomenon would be highlighted (Moustakas, 1994). From these significant statements, clusters of meanings would be developed into themes. These significant statements and themes were then be used to write a textural description of what the participants experienced. They are also used to write a structural description of the context or setting that influenced how the participants experienced the phenomenon. From the structural and textural descriptions, composite descriptions that present the essence of the phenomenon were crafted.

Moustakas (1994) added a further step. Researchers also write about their own experiences and the context and situations that have influenced their experiences. A detailed analysis of the information began the coding process and the organization of the material into chunks or segments (Rossman & Rallis, 1998, p. 171). Sentences were segmented, categorized, and labeled in the actual language of the participants. Data were analyzed for themes and chronicled. After the data were organized according to themes, I read each profile and the interview transcript in its entirety to gain a general sense of the information provided (Giorgi & Giorgi, 2003). Data analysis occurred through the etic versus an emic focus (Tashakkori & Teddlie, 2003).

Issues of Trustworthiness

In order to ensure trustworthiness of this qualitative research study several strategies as indicated in Chapter 3 were employed. Using Guba’s four criteria of

credibility, transferability, dependability and conformability evidence of trustworthiness was provided. To ensure credibility, both validity and reliability, I began by adopting a research methodology that has well been established in qualitative investigation. The phenomenological research methodology has been proven as a strategy for studies trying to glean information about the lived experiences of participants from their perspective. Instruments utilized were instruments widely administered by local Community based organization.

To ensure fit, permission was gained to modify the instruments pending the results of the pilot study. The revised plot tested instrument was utilized thus helping to establish credibility. Key informant was obtained and this individual assisted with use of the snowballing technique for participant recruitment. Thick descriptions and member checking strategies were also used to establish study credibility.

To ensure validity, three strategies were three were utilized, use of thick rich descriptions, member checking, and peer debriefing. Dependability was addressed by the use of overlapping methods (risk assessment profile and semistructured interview). To address the dependability issue more directly processes within the study were reported in detail to allow a future researcher the ability to repeat the study (Shenton, 2004).

Conformability was established. To do so, I took steps to ensure objectivity efforts were made to minimize any personal bias. In qualitative study conformability is akin to objectivity. Steps must be taken to ensure the objectivity of the researcher in an attempt to minimize bias (Patton, 2002). Triangulation will be used to confirm that the findings are the result of the ideas and experiences of the participants. Participant’s

experiences were recorded, transcribed, and reviewed. Participants were allowed to review and check data for accuracy, and clarify information.

Transferability, external validity or the extent to which the findings of this study can be applied to other situations is complex for qualitative research. The findings of a qualitative project are specific to a small number of particular environments and individuals, and it is impossible to demonstrate that the findings and conclusions are applicable to other situations and populations (Shenton, 2004). The background data, context of the study, and the detailed description of this study allows for future comparison to be made and for future studies of similar populations in similar settings.

Ethical Procedures

I had an obligation to respect the rights, needs, values, and desires of all participants. To do so, the research objectives were articulated verbally and in writing so that they were clearly understood by the participants. Participants were provided a description of how data would be used. Written permission to proceed with the study as articulated was received from the informant. A research application form was filed with the IRB for both the pilot survey and the larger study, and approval was acquired prior to recruitment of participants and data collection. Participants were informed of all data collection devices and activities prior to agreeing to be in the study. Verbatim transcription of interviews were provided for review to all participants. At the conclusion of the data collection, process written interpretations and reports were made available to all participants. The participants rights, interest and wished were considered first when choices are made regarding reporting of the data. The final decision regarding participant

anonymity will rest with the participants. The anonymity of participants was maintained utilizing unique identifiers, aliases and pseudonyms for individuals and places.

Participants did not fall within the category of vulnerable populations. However, individuals recruited for the study did fall outside of the societal norms regarding sexual orientation. As a result, extra sensitivity was taken with the participants included in the study. As such special consideration and/or accommodations were made to ensure that they are comfortable with the meeting location. The nature of the phenomenological study could have caused participants to sensitive subject matter discussed. Support resources were provided to all study participants considered for the study. Participants were given the option to withdraw early from the study and informed that they would not be penalized in any way for early withdrawal. Participants who decided to withdraw from the study would have received 24-48 hour follow up to address any issues arising as a result of the study. However, no participant chose this option.

Data from the study are confidential and kept electronically in my home office. With the exception of me, no one else had access to the data. In keeping with the statute on data, data will be stored for a reasonable period of time; Sieber (1998) suggested 5-10 years. Per Walden University procedure, these data will be kept for 5 years. After this period of time, data will be destroyed. Ownership of the data will reside with me.

Summary

To gain a better understanding of the stigma and associated HIV risk behavior of Black MSM attending an HBCU, a phenomenological qualitative study was conducted. LSR were selected to assist me in the use of the snowballing technique, and flyers to

identify research participants. Flyers were used as a means of recruitment, and LSR were able to use flyers to direct participants back to the researcher. Participants selected met exclusionary and inclusionary criteria. Originally, I planned to select six to nine participants for the phenomenological study. I planned to use in-depth interviews as it primary method of inquiry. However, data saturation was used as a measure for the inclusion of additional participants into the study which resulted in thirteen participants being selected for the study.

To provide some context and background for behavior of the participants each participant was required to complete a demographic and risk assessment profiles. Lastly, participants were provided the opportunity to review all data collected for accuracy. Procedures, profile, interview questions, audit trail pictorial, and consent forms are in Appendices A-E. Steps were taken to address issues of trustworthiness in the study. Consistent with the requirements for treatment of human subjects in research, compliance to all ethical procedures was maintained. All data and findings are recorded in Chapter 4.

Chapter 4: Results

Introduction

The purpose of this study qualitative study was to better understand the experiences of Black MSM attending HBCU and how the HBCU environment and stigma influence HIV risk behavior. The participants of this study were Black MSM who were currently attending a HBCU. Inclusion criteria for participation in this study were that informants must be Black, born having male gender expression, and 18-24 years old. The participants were required to be currently in school and have been a residential student or a student living on campus for at least one semester.

I conducted individual semistructured interviews to gather data for the study. In addition, the participants filled out a demographic questionnaire and a risk assessment profile. I designed the interview questions to extract the participants' views upon their experiences, relevant to the research questions. I recorded and subsequently transcribed all interviews. I employed NVivo 10 to organize interview data, and analyzed each interview textually and structurally. I also examined and narratively reported the demographics and risk assessment survey.

This chapter begins with a review of the research questions, and contains descriptions of the setting, participant demographics, and data collection processes. The chapter also includes the application of the research methodology to the analysis of the gathered data, and a presentation of the research findings. Narrative descriptions explain the themes that emerged from the data, and the chapter concludes with evidence of trustworthiness and a summary of all findings.

Pilot Study

I conducted a pilot study to assess the risk assessment profile for reliability and validity. I used two groups during this process. Group 1 included a panel of subject matter experts and my dissertation committee and chair, as well as a content expert, a supervisor from the county health department, the HIV testing coordinator for the local health department, and the Prison Re-Entry and Straight Talk Coordinator. Group 2 consisted of representatives of the proposed target group. The researcher selected four Black MSM students. I located the students who participated in the pilot with the aid of the president of the university's Gay/Straight Alliance.

I asked the students to complete the survey administered during the proposed study. This required the students to complete the survey utilizing a laptop computer. Students were asked for their consent and received information regarding the study. The participants read the consent form and had the opportunity to ask any questions regarding the study. I informed students about the confidentiality of the study. The students were asked to complete the survey honest and truthfully. Once the participants completed the survey, the researcher asked the students to provide feedback regarding the instrument and the directions he and she received.

I observed students for hesitancy or any body language that indicated difficulty with understanding and processing the questions during the survey. The participants provided feedback to me on a variety of aspects of the survey such as verbiage, ease of completion, survey clarity, and the like. Students were provided the opportunity to test check boxes on the electronic survey. Students then provided feedback on the ease of use

of the electronic data collection tool. In addition, I sought the participants' input regarding the clarity of the instrument.

If students had difficulty with questions, I asked him or her to think out loud regarding those questions. The participants were to inform me what part of the question contributed to their lack of understanding and clarity. To ensure all information was captured, I took notes. I also made observations regarding logistical elements of the survey. After participants completed testing of the instrument, experts in Group 1 considered the following three questions regarding the content of the survey:

1. Do you think that the survey missed any questions that should be asked in a brief Risk Assessment Profile?
2. Do the questions make sense or are some of them useless, redundant, etc.
3. Are there any questions that you would add?

I asked Group 2 the following three questions:

1. Were the questions and the language utilized clear and easy to understand?
2. Do the questions make sense or are some of them useless, redundant, etc.
3. Do you feel the survey covers all questions that should be asked?

The results of the pilot study enabled me to make changes to the instrument. The four students had no difficulty completing the questionnaire. Participants mentioned two suggestions for additional questions, with one of the suggestions (adding a question about sex parties) being incorporated into the questionnaire. The experts also recommended changes including alterations to questions and reducing time periods covered by the

questions from 12 months to 6 months. Appendix G includes all details regarding the results of the pilot test; Appendix H includes the revised risk assessment profile.

Research Questions

The broad overarching research questions were asked in order to better understand the experiences of Black MSM at HBCUs.

1. What is the extent of stigma experienced by Black MSM (ages 18–24) attending an HBCU in North Carolina?
2. What impact or influence does the current HBCU environment (policy, practice, culture, and stigma) have on the sexual behaviors of Black MSM attending the University?
3. What are the HIV risk behaviors of Black MSM attending an HBCU?

Setting

Individuals who chose to participate in this study came from an HBCU. The participants volunteered and were located using a snowballing sampling technique. I identified the two initial participants from the HBCU's Gay/Straight Student Alliance and met inclusionary criteria for the research study. These individuals disseminated the flyer to their peers and these students contacted the researcher to express interest in the study. With the consent of the participants, I conducted all of the interviews in an office in the student center. The location of the office was discrete and allowed for each participant to maintain privacy. All participants were able to do the interviews in person. All participants articulated no difficulty with answering the interview questions and posed no opposition to the research setting. No participants mentioned any stressors or life events

that could influence their responses to the interviews. Participants seemed to appreciate the interview process, and shared their stories, experiences, opinions, and feelings.

Demographics

I collected demographic information on all participants prior to the semi structured interview. Each participant's individual demographic profile is described narratively in the data analysis section of Chapter 3. All participants identified as Black, gay males. As a group, the participants have a mean age of 18.6, 100% identified as gay, and 85% described themselves as Christian. Only one participant never attended religious services. Religious activity ranged from not active to very active. The remainder attended religious services from a few times a year to once a week.

Of the 13 participants, two were freshmen, four were sophomores, two were juniors, and five were seniors. Participants' technology usage ranged from never to daily, and when answering questions about educational attainment plans, answers ranged from completing a bachelor's degree to planning to continue to doctoral-level studies. Only one student lived off campus, the remainder identified themselves as residential. Reported income ranged from < $25,000 to > $150,000, with nine of the respondents falling in the $25,000 to $75,000 range. Table 2 is a tabulation of demographic information for this sample.

Table 2

Sample Demographic Information (n=13)

Demographic	*n*	%
Classification		
Freshman	2	15
Sophomore	4	31
Junior	2	15
Senior	5	39
Residency		
Residential	12	92
Non-residential	1	8
Technology use		
Never	3	23
Hardly ever	5	39
A few times per year	1	8
A few times per month	1	8
A few times per week	2	15
Once or more a day	1	7
Educational attainment plan		
Some graduate work	2	15
Four year BA/BS	4	31
Masters	4	31
Advanced-PhD	3	23
Religious frequency		
Never	1	8
Few times	4	31
Few times per year	2	15
One or two times per month	4	31
Once a week	2	15
Religious preference		
Christian	11	85
No preference	2	15
Religious activity		
Not active	3	24
Somewhat active	8	62
Very active	2	15
Income		
25-39K	4	31
40-49K	2	15
50-74K	3	23
75-99K	1	8
100-124K	0	0
125-150K	1	8
Over 150K	1	8

Note. Due to rounding error, some percentages may not sum to 100%

Data Collection

I employed three methods of data collection in this phenomenological qualitative study. These included a demographic profile, risk assessment profile, and in depth semistructured interview questions. The demographic questionnaire measured volunteers' background information. Information gathered included age, gender, race, year in college, religion, level of religious activity, year in college, and income. In addition, other information gathered included sexual orientation, educational attainment plan, and technology use. Data gathered through the risk assessment profile included: HIV testing and status, sexual patterns in the previous 6-month period, type of substances used since entering college, use of substances while engaged in sexual activity, and number of partners in the previous 6 months. Other information collected described whether their partners were having sexual contact with other people, frequency of condom use, if they attended sex parties, if they had received any blood products in the previous 12 months, and any know HIV exposure in the previous 12 months.

I used semistructured interviews to gather participants' opinions on stigma, behavior that put the participants as risk for HIV exposure, and perception of campus involvement or support. I made initial contact with potential participants in person to explain the purpose of the study along with the requirements and expectations involved with participation in the study. All prospective participants were informed that their participation in the study was voluntary. Each individual selected for participation in the study signed a consent form that included information about the study procedures and participant protections. I assured participants that their names would not be used, and that

anything the participants shared was confidential. All participants received a copy of the consent form and I explained that they could withdraw from the study at any point with no repercussions.

I scheduled a meeting time and location that was convenient for each participant. To begin the data collection, I asked each participant to complete the demographic profile and Risk Assessment Instrument at the scheduled meeting time. Once the participant completed the demographic and risk assessment portions, the interview began. The interviews lasted between 30 to 60 minutes. I asked all participants the same questions and recorded their responses via tape recorder, which I later transcribed. Once the interviews were completed, I thanked the participants for their time and cooperation. I answered any questions asked by the participants, and provided contact information to address any future questions or concerns regarding the study. Students had an opportunity to examine and to verify their responses and the data. Two of the students did change and elaborate on some responses. These changes are reflected in the data analysis section.

Data Analysis

Student 1

Demographics and Survey Information. Student 1 reported that he was 21 years old and a junior in college. He did not live on campus. He identified as gay and had understanding of technology usage. He planned to complete a bachelor's degree. He attended church once or twice a month and self-identified as Christian. He described himself as somewhat active in his religious community. He was Black with an annual household income of $50,000-74,000. He had been HIV tested and reported negative. In

the last 6 months, he engaged in oral and anal sex. He engaged in sex for drugs or money, and had sex with persons of unknown STD status. He was involved in relationships with other MSM who had sex with other people. In addition, he reported having unprotected sexual encounters. He had not had an STD in the last 6 months. He used alcohol and marijuana and engaged in sexual activity while under the influence of substances. His partners have sex with other people and he has had 6–10 partners in the previous 6 months. He indicated that he sometimes used a condom, had not attended a sex party, and had not received blood or been exposed to HIV in the last 12 months.

Textual. Student 1 identified as gay stating, “Gay, because I like men and men only.” He said that he always knew he was gay but did not come out until ninth grade. He said that he did not recall any specific on-campus incidents of stigma, but described what happened when he and some friends decided to go to a house party. Student 1 reported:

> But like the one thing that comes to mind I don't know if it's [stigma] or not, but a house party that some students threw we went to. And we had -- we had went, me and a group of friends -- a group of gay friends, we all went and we were prepared to go party and everything like that. But when we got there, the guy at the door was like, well, no more dudes can come in. And we respected that in the beginning, kind of, you know, how guys -- all they want is as many girls to come to the parties as they -- as they…But when -- we stood out there for a little while and guys started going in and guys started going in, and that's when we realized it wasn’t because no more dudes can come in, it’s because we were gay and they didn't want to let us in because of that.

As the interview continued, Student 1 identified positive and negative experiences. He indicated that the opportunity to help the community through research and surveys was a positive experience. He also described how people assumed he would know about fashion and looking good because of his sexuality. He felt it was positive even if it was a stereotype because it gave him the opportunity to meet and interact with diverse people. Negative experiences he mentioned were specific incidents based on a combination of his own perception mixed with reality and personal experience. For example, Student 1 felt he needed to be careful where he sat. If he saw a group of heterosexual males sitting together on a bench, he stated that, “Like I could want to go sit on a bench, but I know that the guys beside the bench aren't going to like me sitting beside the bench, so it's like it kind of restricts you a little bit.” He went on to say, “straight dudes can do whatever they want on this campus, to me like they can do--they're not restricted to any single thing.” He remarked that he felt his orientation limited some of his opportunities. He wanted to run for Homecoming King but felt it was not possible because of his sexuality. Student 1 spoke of another gay student who had run for Homecoming King in the previous year who had difficulties. Student 1 felt that he was more flamboyant and easily identified as a member of the gay community and for that reason he assumed he could not run for Homecoming King. He believed that his status as a gay man precluded him from any type of campus-wide leadership role.

When asked about HIV risk-taking behaviors, Student 1 stated that he did not feel that the perception of others affected the choices he made, other than to make him more cautious as he did not wish to be the subject of campus gossip. He indicated that he was

out at home, but he also toned it down there out of respect for his mother. When his mother initially found out he was gay, she was very upset, but now that he is doing well and his straight brother is making bad choices, she is happy because he is making a future. His father has always been accepting. He and his father even had a conversation where he could educate his father about being gay and what it was like for him.

When asked to rate his college experience on a scale of one to ten, he chose five. Student 1 rated his experience a 5 because he felt that he was not completely free to be himself on campus. He said he had to watch what he did because he did not want straight men to accuse him of hitting on them. He felt that he struggled with being stereotyped and was not sure how to change that experience. He wanted people to see him as who he was and not as the “gay student.” When it came to faculty and administration Student 1 felt supported and accepted.

Structural. Overall, Student 1 expressed little emotion during the interview. He described how he enjoyed being known by others on campus. He liked the attention he received and was pleased to be known by many people. He appeared resentful that he was unable, in his view, to get any significant leadership experience, such as being Homecoming King because of his sexual orientation. One of the words he consistently used was *restricted*. It seemed as though he felt caged in and unable to completely relax and be himself, as he felt other members of the community would judge him. He mentioned it was easier to be friends and form close relationships with women rather than men. He said many straight men assumed he would hit on them rather than seek friendship. He also spoke about his relationship with his parents and coming out. He was

surprised with their reactions. His mother was initially upset and then calmed down and his father was very accepting.

Student 2

Demographics and Survey Information. Student 2 reported that he was 21 years old and a senior in college. He identified as gay and hardly ever used technology. He planned to complete a bachelor's degree and continue on to a master's degree program. He attended church a few times a year and self-identified as Christian. Student 2 self-described as somewhat active in his religious community. He was Black with an annual household income of $25,000-39,000. He had been HIV tested and reported negative. In the last 6 months, he engaged in oral and anal sex. He was involved in relationships with MSM who had sex with others. He had not reported ever testing positive for an STD. He used alcohol and marijuana and engaged in sexual activity while under the influence of substances. His substance use remained the same. His partners have sex with other people and he has had 2-5 partners in the previous 6 months. He indicated that he always used a condom, had not attended a sex party, and had not received blood or been exposed to HIV in the last 12 months.

Textual. Student 2 identified as gay because "I only have had sex with men, only date men, interact with men, you know, on that type of level, so I identify as gay." He had been out since high school and his parents and family were aware of his sexual orientation. He went on to speak about stigma and said he had never experienced any differences because of his orientation and feels that it is because of "who he is as a person." He did not have any negative experiences to report as a gay student on campus.

He stated that he did not necessarily come across as gay to others, so when people got to know him they realized he was gay. He said he was out and did not hide his sexuality and said,

> I would consider myself openly gay. I'm not -- you know I'm not just going to like prance around and say, oh, I'm gay, oh, I'm gay, but you know, it's not any -- it's not anything that I try to hide.

When asked about risk-taking behaviors, he said that how people viewed him had no influence on his personal choices. Being in school also had no influence on his level or choices on sexual activity. He felt professors and administrators had been warm and supportive. He had no issues with anyone employed by the university. Student 2 stated that his experiences on campus were wonderful and rated it as a 10 on a one to ten scale. He found his experiences at the college more positive than those at home and felt he was able to be himself.

Structural. Student 2 enjoyed his time as a student. He felt comfortable to be himself and accepted on campus by students, professors, and administrators. He reported being out and felt that no one he interacted with had an issue with his sexual orientation. Overall, he was happy with his college experience. Student 2 was confident in who he was and did not feel the need for external approval to validate his behavior, choices, or emotions.

Student 3

Demographics and Survey Information. Student 3 reported that he was 20 years old and a junior in college. He identified as gay and used technology several times in a

week. He planned to complete a bachelor's degree. He never attends church and has no religious preference. He was not active in any religious activity. He was Black with an annual household income of $25,000-39,000. He had been HIV tested and reported negative. In the last 6 months, he engaged in oral and anal sex. He had sex with persons of unknown STD status. He reported having sex with MSM who had sex with others and had sex without using a condom. He has not had an STD. He used alcohol and marijuana and engaged in sexual activity while under the influence of substances. His substance use increased in college. His partners had sex with other people and he has had two to five partners in the previous 6 months. He indicated that he sometimes used a condom, had not attended a sex party, and had not received blood or been exposed to HIV in the last 12 months.

Textual. Student 3 identified as a gay man. He said, "I don't like -- well, I like men sexually. I don't like females sexually and I don't see myself as a woman. I see myself as a man, so that's why I say that." He reported that he was out at school and home. He told his family he was gay after he turned 12 years old. He said that many people on campus looked down upon gay men. He stated that many straight men did speak with him and his friends. He attributed that to being well known and active in campus activities.

Student 3 stated that he felt judged because,

> what they think they know about, you know, being gay and all this stuff like gay guys, all they want to do is just touch on people. They're going to, you know, try

> to touch them, try to have sex with them, try to do all this stuff when that's really not the case.

He recounted an experience from his freshman year when he had a sexual experience with a straight male student. He shared information with a fellow student who he trusted. That student shared the information with other people and it spread all across campus. Students trying to identify the person he had sex with constantly approached him and people said he was talking about others. The rumors resulted in other men trying to provoke physical altercations and "he said/she said" moments for Student 3.

Student 3 shared a positive experience and described joining a modeling troupe on campus. He formed close friendships with other gay men and was able to find trustworthy people to confide in. These friends helped him study, taught him how to dress, and were available to talk. He attributes much of his current confidence and success to the group. He believed that what others think of him has had an influence on his HIV risk-taking behaviors. He spoke about going from being very casual and nonchalant to becoming aware. He had taken his second HIV/STD tests last month and was concerned with the results, as he had not been feeling well. He found out that he was healthy and did not have HIV. This episode convinced him that the needed to be more cautious.

Student 3 started college with the idea of partying being the norm, but had learned that it is better to cautious. He decided that he needed to move his sexual life away from campus as he felt the pool of potential mates was small and gossip flew around with relative ease. He did not want other people commenting on his private life. He said,

> I don't want to be a part of that perception of walking in the room and it's like everyone knows that I've had sex with this person and this person. And you know that's just -- I don't feel like that's cool.

Although he was being more careful, he also believed that he had opened up since being at college and become himself. He was able to access the local gay community and receive support. At home, even though he is out, he was not comfortable and had not made connections with the local gay community. When asked to rate the university, Student 3 gave the university a ten. He believed all experiences, good and bad, needed to be included and each experience was necessary and important.

Structural. Overall, Student 3 spoke of feelings of being judged by others. He believed that he was judged in the abstract as a gay man and judged by people who knew him because he was a gay man. He believed that people have a negative idea of what it is to be gay and projected those thoughts and ideas on to him. He found supportive friendships that helped him increase his self-confidence and provided support, as he needed it.

Student 3 also spoke about his fears. At one point, he was not feeling well and had been engaging in risky behaviors. He believed that he had an STD or HIV but was relieved to learn he was healthy. That made him realize that he needed to change his behaviors in order to protect his health. Student 3 did not like being the center of gossip and tried to avoid it as much as possible. Overall, he enjoyed his college experience and felt it was an important part of his growth as a gay man.

Student 4

Demographics and Survey Information. Student 4 reported that he was 21 years old and a senior in college. He identified as gay and never used technology. He planned to complete a bachelor's degree and continue on to a master's and a Ph.D. He attended church once a week and identified as Christian. He was somewhat active in religious activities. He was Black with an annual household income of $40,000-49,000. He had been HIV tested and reported negative. In the last 6 months, he engaged in oral sex and reported having sex with MSM who had sex with others and had sex without using a condom. He stated he had not had an STD in the past 6 months but contradicted this statement by stating he had syphilis. He used alcohol and marijuana and engaged in sexual activity while under the influence of substances. His substance use remained the same in college. His partners have sex with other people and he has had two to five partners in the previous 6 months. He reported attending a sex party. He indicated that most of the time he used a condom, and had not received blood or been exposed to HIV in the last 12 months.

The student later amended some of his responses to the risk assessment and the interview. He revealed that he was HIV positive in addition to having syphilis. He spent some time and spoke about the stress of managing his diagnosis. He found it challenging to manage his health and campus life activities.

Textual. Student 4 said "I view myself as gay, because I'm actively involved with men and I'm interested in men." He told me that he had been out for about 3 years and his family knew he was gay. When asked about stigma he replied that,

> A stigma that I’ve noticed on a daily basis is the way that straight heterosexual males view us gay men, by -- basically, you know, you can tell the difference between how they interact with other heterosexual men and how they interact with us. It's more of a shy away basis. They will speak to you when you're, you know, by yourself. They don't -- when they're with their homeboys, they don't speak to you. You also notice that straight men sometimes can jump with their friends when you like walk past, make comments and start to laugh about who you are, so I notice that's a stigma.”

He spoke about his effort to run for Homecoming King. He felt that the stigma of being a gay male definitely prevented his election. He indicated that his past as a gay man was used against him and that students “didn't want to see a gay male in the position of a SGA, being the face of the school at the university.” Student 4 felt running for this position was positive in that he was able to be a role model to the gay community. He believed that his actions illustrated his belief, stating,

> Everything happens for a reason, so with me running, I get all the time from a lot of gay males that, you know, the inspiration that I brought to say that you can still be openly gay and still pursue your dreams.

When asked about HIV risk, Student 4 said that most people assumed he and other gay men were HIV positive. He did not speak about any behaviors he engaged in, rather he spoke about others’ perceptions. When reflecting on his own path, Student 4 indicated that he was very open with his partners. He believed that transparency and honesty were essential. In addition, he spoke about the lack of education on campus. He

felt that there were too few programs focusing on sexual health and general information regarding sex and sexuality. He spoke about how the school used to have a GSA and how currently it was not active.

Student 4 felt that his experiences with faculty and administrators were excellent. He remarked on how his quality of life has improved compared to being at home because he was able to be completely out and not hidden. Student 4 rated his experience at the university a 5. The main reason he gave it that score was for a lack of activities and programs for gay students. He stated that many students were struggling with issues around sexuality and were not getting the supports they needed. He felt an important question to explore that was not being covered by the study was how to deal with intersection of race and sexuality.

Structural. Student 4 struggled with issues of race and sexuality. He felt that it was difficult to learn how to juggle multiple labels that affected him in different ways. He believed that his options were limited because of his sexual orientation and indicated that services that would provide support for him and other gay students did not exist. He spoke about his struggles coming out in his freshman year and was upset to still see other freshmen grapple with similar issues. He felt that the campus lacked safe spaces for gay males to go when issues and challenges tested them. He believed that may people on campus were threatened by different sexualities. He stated that this lack of openness and judgment causes students to feel isolated and insecure leading to struggles with thoughts of suicide and depression.

Student 5

Demographics and Survey Information. Student 5 reported that he was 22 years old and a senior in college. He identified as gay and used technology at least once a day. He planned to complete a bachelor's degree and continue on to do some graduate work. He attended church once or twice a month and identified as Christian. He was very active in religious activities. He was Black with an annual household income of $75,000-99,000. He had been HIV tested and reported negative. In the last 6 months, he engaged in oral sex, anal sex, and reported having sex with MSM who had sex with others. He also indicated that he had sex without using a condom. He had not had an STD in the previous 6 months. He used alcohol and marijuana and engaged in sexual activity while under the influence of substances. His substance use had increased in college. His partners had sex with other people and he had had two to five partners in the previous 6 months. He indicated that he never used a condom, had not attended a sex party, and had not received blood or been exposed to HIV in the last 12 months.

Textural. Student 5 identified as gay saying "Gay for the simple fact that I just --- I like boys." Student 5 said he realized in high school that he was gay. He was out to only his immediate family and friends and at college. Student 5 felt that he was a victim of stigma in a variety of ways. He felt it negatively influenced his ability to assume leadership positions because many people associated being gay with "messiness" or drama. He also said that club advisors also support this stereotyping denying him leadership opportunities. He continued on to say more students, especially freshmen, are

coming out all the time and that the school does not offer services, programs, or support for these students.

When speaking about his sexual behaviors, Student 5 said that he limited sexual partners because he was careful and did not want to catch any STDs. He went on to say the gay community was more open and people tend to experiment more. He indicated that he was careful because of what he knew about HIV and STDs. He elaborated and said that in school with parties it was easier to be involved in the hookup culture because of alcohol or drug use. His overall impression of faculty and administration is positive except for a few advisors who he felt judged him because of his sexual orientation. He elaborated and said that he saw favoritism towards specific students that was based on the relationship between the student and faculty member.

Structural. Student 5 found attending college liberating. Away from home and a familiar environment, he was able to be himself. He did not hide who he was and felt this fact led to increased personal growth. He felt he could express himself and learn more about who he was as a person. Although he was upset by his perception of being judged because of his sexual orientation, he did not let his feelings get in the way of his participation in activities. He was also upset by the lack of programs, activities, and clubs directed towards gay students. He felt their needs were being overlook by campus officials. He was happy to be a part of the study because it made him believe that change could occur.

Student 6

Demographics and Survey Information. Student 6 reported that he was 23 years old and a senior in college. He identified as gay and used technology a few times a year. He planned to complete a bachelor's degree and continue on to get a Ph.D. He attended church a few times a year and identified with no religious preference. He was somewhat active in religious activities. He was Black with an annual household income of $40,000-49,000. He had been HIV tested and reported negative. In the last 6 months, he engaged in oral sex, anal sex, and reported having sex with MSM who had sex with others. He has not had an STD. He used alcohol and marijuana and has not engaged in sexual activity while under the influence of substances. His substance use has remained the same in college. His partners have sex with other people and he had one partner in the previous 6 months. He indicated that he always used a condom, had not attended a sex party, and had not received blood or been exposed to HIV in the last 12 months.

Textural. Student 6 said that he had identified as gay in high school but felt that he had rushed into that label too quickly. He was out to his family and has been since the age of 14. He came to college, fell in love with a woman, and today defines himself as queer. He primarily was attracted to men, but can occasionally find a woman attractive as well. When asked about stigma, he recounted how most of his straight male friends forget that he is gay, unless he reminds them, because he does not fit their preconceived image as a gay man. Because of this, he avoids stigma. He stated he noticed that his gay friends were treated differently. He reported no negative experiences and he attributes that,

"partially because I pass and people don't see me as gay for -- for whatever reason." He elaborated on his ability to pass.

> I used to -- I used to feel like I had to like be a little more feminine or flamboyant so that people knew that I was gay. Once I realized that that wasn't really who I -- who I was, and that most of my gay friends are not like that -- and the ones who are flamboyant are naturally flamboyant… [I] just continue living as myself.

As he continued to speak, he indicated that he did not see the perception of others influencing his behavior. He had always been more conservative when it came to dating and sexual activity and at this time, nothing has changed. He said that few options were available on campus and if there were more people available then he would date more. Overall, being in college did not change any of his behaviors and he acted the same at college as he did at home. He rated his experience at college as a three on a scale of one to ten. He rated it low because of the lack of a gay community. He stated that

> And I know that it's difficult to even have conversation or get people to come and do stuff like this, because we don't talk to each other. And it's hard to support each other like what happened last year when Student X ran for Homecoming King. There was not a community for him to pull on to support him through that. And I think that -- that's -- I think that's the biggest issue that we have here as gays at this HBCU is that we don't have a community, and we can't grow -- we can't grow because we don't know each other, we don't talk to each other.

He spoke strongly about how his professors had been supportive, but he felt lack of community is what hindered growth the most.

Structural. Student 6 felt badly that he cannot help his gay friends avoid stigma. He acknowledges his ability to "pass" makes his path smooth and feels guilty that he avoids the stigma many of his friends face. He is angry about the lack of community and believes that this absence makes it more difficult for gay students who attend the university. He would like to see change and have organizations like the Gay Straight Alliance be active again.

Student 7

Demographics and Survey Information. Student 7 reported that he was 19 years old and a sophomore in college. He identified as gay and used technology a few times a year. He planned to complete a bachelor's degree and continue to pursue a master's degree. He attended church a few times a year and identified as Christian. He was somewhat active in religious activities. He was Black with an annual household income of less than $25,000. He had been HIV tested and reported negative. In the last 6 months, he engaged in oral sex, anal sex, vaginal sex, and reported having sex with MSM who had sex with others. He also indicated that he had sex without a condom. He had not had an STD. He used alcohol and marijuana and had engaged in sexual activity while under the influence of substances. His substance use has remained the same in college. He does not know if his partners have sex with other people and had two to five partners in the previous 6 months. He indicated that he used a condom most of the time, had not attended a sex party, and had not received blood or been exposed to HIV in the last 12 months.

The participant later modified some of his responses to the Risk Assessment Questionnaire. He indicated that he has not been honest with his sexuality. He stated that he felt an internal pressure to identify as bisexual and highlighted a brief relationship with a woman. He continued stating that he truly self-identified as gay. He was worried about the perception of the interviewer and did not want to face judgment because of his sexual orientation.

Textural. Student 7 says he identified as bisexual because “I sometime have my tendencies on liking females, and I've been sexually active with a female in the past six months.” He has been actively out since he began college and was out to his family. He stated that he did face some stigma because of his sexual orientation. He reported that some men in his dorm did not like to be around him because he likes men. He believed that there “was like a lot of homophobia.” His positive experiences of being out enabled him to gain knowledge, experience, and make friends. The negative he reported is the judgement he faced from people who did not know him. He reported having sex under the influence of alcohol once but used a condom. He also said being at college did not change his behavior. He was aware that many people found college a forum for exploration; he found no changes in that setting. He found faculty and administration very supportive and felt they aided in his growth.

Structural. Student 7 loved his college experience. He was more comfortable with himself and liked how open he could be. He stated by being out he feels more free and open to experiences. He liked how he had a clean slate to be whom he wanted. The main struggle he faced was when he initially began to attend school, there were some

men in his dorm who said they were uncomfortable with him because of his sexuality. He was proud that he was able to stand up for himself and tell them not to judge him. Standing up for himself increased his self-confidence and strengthened his self-image.

Student 8

Demographics and Survey Information. Student 8 reported that he was 21 years old and a senior in college. He identified as gay and hardly ever used technology. He planned to complete a bachelor's degree. He attends church a few times a year and identifies as Christian. He was somewhat active in religious activities. He was Black with an annual household income of $50,000-74,000. He had been HIV tested and reported negative. In the last 6 months, he engaged in oral sex and anal sex. He used alcohol and marijuana and had engaged in sexual activity while under the influence of substances. His substance use had remained the same in college. His partners have sex with other people and he has had one partner in the previous 6 months. He indicated that he always used a condom, had not attended a sex party, had not received blood or been exposed to HIV in the last 12 months.

Textural. Student 8 identified as a gay male because he said he likes men. He had been out at home and school for several years. He had been active on campus and was a member of the marching band. He reported facing no stigma for being gay. He attributed this to the friends he made in the band who were also gay. He said, "I never really felt uncomfortable being gay here at Winston-Salem State, because -- I mean, there was a bunch of other people around me that was, you know, as comfortable in their skin as I was." They supported and empowered each other as a group.

Student 8 was slightly older than his peers are and has found himself in the role of mentor. He was willing to talk with anyone about his or her questions including how he caught a STD as a freshman. He believed it was important for him to share his experiences so that his friends did not make similar mistakes. His negative experience was his cautionary tale, catching an STD. He said that experience really made him focus on what he was doing and why he was doing it. He did not believe that others' perceptions affected his behavior and went into detail saying he did not care what others thought, he would always do what he felt was correct. He did not believe his sexual behavior changed because he was in college. He feels the change was because of maturity—as he grew older, he became more careful. Student 8 indicated that he was a bit more open at school than he was at home, and overall his experience in college was a 9 on the scale of 1 to 10.

Structural. Student 8 enjoyed going to school and found the environment supportive of his growth. He indicated that being a part of the band helped him form a circle of friends that created a supportive environment. He was older than many of his peers and used his experience to reach out and provide support and advice. His worst experience occurred when he was a freshman and caught an STD. At the time, he was very upset but he said it was easy to resolve because he was careful and knew his partners. Today, he regards it as a learning experience that he can share with others so they do not repeat his mistakes. Student 8 stated,

> You know, I'm a little older, so I don't mind, you know, opening up to people if they want to come to me and ask me questions. Like younger gays like coming

> into Winston, they'll come to me and ask me questions about my past experiences. Because -- I mean, I'm very open to a lot

He was proud to be able to reach out and provide support for others and like to be in a leadership role.

Student 9

Demographics and Survey Information. Student 9 reported that he was 18 years old and a freshman in college. He identified as gay and used technology few times a month. He planned to complete a bachelor's degree and continue on to a master's degree. He attended church once to twice a month and identified as Christian. He was somewhat active in religious activities. He was Black with an annual household income of $50,000-74,000. He had been HIV tested and reported negative. In the last 6 months, he engaged in oral sex. He had not had an STD. He had used marijuana and had not engaged in sexual activity while under the influence of substances. His substance use had remained the same in college. His partners do not have sex with other people and he had had one partner in the previous 6 months. He indicated that he always used a condom, had not attended a sex party, and had not received blood or been exposed to HIV in the last 12 months.

Textual. Student 9 stated that he was gay. He has been out for 3 years, but was not out to his family. When asked about a positive or negative experience he had on campus, he talked about an experience with a friend. He said,

> I was in my friend's room, and we had just started being friends like during New Student Orientation and the freshman thing and all that. And she just like, you

know, took off her bra and got fully naked and started changing. She was like you're gay. It's okay.

He reported that his female friends found him easy to talk to and came to him for advice about men. He did not believe perception of others influenced his HIV risk behaviors and said he acted the same way regardless of what others said about him. He said going to college made him more careful. He heard many rumors about STDs, which made him practice safe sex. He found faculty and staff to be helpful and welcoming. Student 9 liked being on campus. He found it easier to be himself and was pleased that he did not experience any gay bashing or bullying. He rated his experience as pretty good so far.

Structural. Student 9 loved the acceptance he experienced at school. He enjoyed not hiding his sexual orientation and the ability to express himself. He made friends who relied on him and enjoyed his company. He was able to come out to others and be accepted. He was careful in sexual encounters and credited that to being told by others what would happen if he was not.

Student 10

Demographics and Survey Information. Student 10 reported that he was 18 years old and a freshman in college. He identified as gay and never used technology. He planned to complete a bachelor's degree and continue on to a do some graduate work. He attended church a few times year and identified as Christian. He was not very active in religious activities. He was Black with an annual household income of $25,000-39,000. He had been HIV tested and reported negative. In the last 6 months, he engaged in oral

sex, anal sex and sex without a condom. He has not had an STD. He has used marijuana and has not engaged in sexual activity while under the influence of substances. His substance use has increased in college. He does not know if his partners have sex with other people and he has had one partner in the previous 6 months. He indicated that he never used a condom, has not attended a sex party, and has not received blood or been exposed to HIV in the last 12 months.

Textural. Student 10 identified himself as “gay because I like males and only males.” He had been out to his parents. He spoke about a negative experience he had when

> When I went---went to my friend's dorm room, his roommate, I guess, felt uncomfortable because we were both there at the same time and he kind of excused hisself [sic] out of there. So I felt like because we were gay he didn't want to be in the same room with us at the same time.

His overall experience has been positive. He felt many people like him because of his sexuality or did not have issues with it. He said that people did not influence his HIV risk behaviors; what he heard around campus made him extra careful about safe sex. Before he attended college, he thought he would be more open to partying and exploration. However, after he arrived he found that he valued his education and wanted to put it first. His relationships with administration and faculty were fine, and he felt many of them did not even know he was gay. His experience thus far has been an 8 on a scale of 1 to 10.

Structural. Student 10 loves attending college. Because he is not out to his family, he felt constrained at home. In addition, although he was out during high school,

he did not feel free as he was the target of bullying and harassment. After coming to college, he felt free and as if he could be his authentic self with other people. He felt he could do what he wanted and not be judged because he was no longer in a small town.

Student 11

Demographics and Survey Information. Student 11 reported that he was 19 years old and a sophomore in college. He identified as gay and hardly ever used technology. He planned to complete a bachelor's degree and continue on to a master's degree. He attended church once to twice a month and identified as Christian. He was somewhat active in religious activities. He was Black with an annual household income of 124,000-149,000. He had been HIV tested and reported negative. In the last 6 months, he engaged in oral sex, anal sex, and had sex with MSM who has sex with others. He also reported having sex without a condom. He had not had an STD. He had used alcohol and had not engaged in sexual activity while under the influence of substances. His substance use had increased in college. He did not know if his partners have sex with other people and he had two to five partners in the previous 6 months. He indicated that he sometimes used a condom, had not attended a sex party, and had not received blood or been exposed to HIV in the last 12 months.

Textural. Student 11 identified as gay because he has never been with a woman. He said that he has been out about three years to his friends and 2 years to his parents. Initially, when asked about stigma, he said he had not had experiences with it. After some thought, he described a pervasive miasma, that influences him.

> I guess people look at you like lower because you're gay. Like you can't do certain stuff because you're gay. Maybe they -- it's just -- it's just -- it's just different. They look at you like you -- you can't -- you just can't do certain stuff. You can't act -- you can't do certain clubs, you can't act a certain way. It's -- you know. You like lower because you're gay.

He continued on to say he felt his sexual orientation placed limits on activities on campus.

He stated that he was unable to join clubs or organizations because he was gay. Another issue he spoke about was dating, because the campus was small and had a limited number of students; there were very few people available for dating. He indicated that a great deal of drama did arise around relationships. He talked about how he was more cautious around campus because of others perceptions. He knew it was important to engage in safe sex and that people should be aware so they do not get into unsafe situations.

He did state that his behavior changed when he arrived at college. He experimented with alcohol and had had sex with a variety of partners. He attributed this to the freedom and acceptance he found at college. Even though he faced some discrimination, compared to home, it seemed like he had increased freedom to be himself. He had many positive relationships including friendships and good relationships with campus staff. He rated his experiences as a six or seven on a scale of one to ten, because of the negative drama around relationships.

Structural. Student 11 enjoyed his time at school. He was surprised by the freedom he experienced and pleased to make many friends. He did seem to be upset by the relationship drama that occurred on campus. He also felt excluded from some opportunities because of his sexual orientation. He felt it was unfair but did not see a way to change other people's perceptions. He remarked on the differences he experienced between home and school. He enjoyed the ability to be out and be himself at school. He learned from friends who were older than he was and appreciated the mentoring and advice. He was saddened by the death of a friend who had HIV, but was proud that he could be supportive for friend during the course of his illness.

Student 12

Demographics and Survey Information. Student 12 reported that he was 20 years old and a sophomore in college. He identified as gay and never used technology. He planned to complete a bachelor's degree. He attended church a few times per year and identified as Christian. He was not very active in religious activities. He was Black with an annual household income of $25,000-39,000. He had been HIV tested and reported negative. In the last 6 months, he engaged in oral sex, anal sex, sex with persons of unknown STD status, and had sex with MSM who have sex with others. He reported that he had sex without a condom. He has had gonorrhea in the past 6 months. He has used alcohol and marijuana and has not engaged in sexual activity while under the influence of substances. His substance use has decreased in college. He does not know if his partners have sex with other people and he has had 2-5 partners in the previous 6 months. He

indicated that he used a condom most of the time, had not attended a sex party, and had not received blood or been exposed to HIV in the last 12 months.

Textural. Student 12 identifies as openly gay, having been out to everyone but his family for 7 years. When asked about stigma at first he did not recall any incidents and then he spoke about an incident that occurred as he was walking out of a friend's dorm room.

> I really don't have a situation besides, you know, people have been rude because you -- I am a black gay male. So the situation was I guess two black gay males come out of a room together they automatically suspect something going on, so they came and said faggots. And that was the only thing that ever happened really.

He went on to say his overall experiences on campus have been positive. People have treated him well and he felt being gay actually helped him join an organization and even be noticed by people in leadership roles. He felt that his risk-taking behaviors had not changed and peoples' opinions did not affect that part of his life. He believed the stereotype of students partying all the time did not apply to him because he made his own decisions. He stated that he was able to relax and be himself on campus much more than he was at home. He rated his experience as an 8 on a scale of 1 to 10. When asked why an eight, he mentioned the incident when he was called a derogatory name. He expounded on his answer and stated there were some organizations that would not accept him because of his sexuality. When I asked him which organizations, he spoke about the campus fraternities. He was told by a fraternity member that formerly a gay male who had applied to a fraternity ruined it for all other gay students because of his behavior.

Structural. Overall Student 12 was happy with his experiences. He enjoyed the people he met and the opportunities he received. He felt that his experiences are generally positive. Student 12 relished the freedom he experienced at school. When he goes home to visit his family he must be careful with how he acts and what he says, as he is not out to his parents. When he was at school he liked how he was able to relax and be himself. He was upset by the fact people made assumptions about him based on his sexuality. He wanted to be able to join a fraternity, but was not able to do so. He felt the rejection was directly related to his sexuality. He also was unhappy with the name calling incident because he had done nothing to warrant that type of attention, and again, he was being judged based on his sexual orientation.

Student 13

Demographics and Survey Information. Student 13 reported that he was 19 years old and a sophomore in college. He identified as gay and hardly ever used technology. He planned to complete a bachelor's degree and continue on to get a Ph.D. He attended church once a week and identified as Christian. He was very active in religious activities. He was Black with an annual household income of more than $150,000. He had not been HIV tested. In the last 6 months, he engaged in oral sex, anal sex, sex with MSM who have sex with others, and sex without a condom. He has not had an STD. He has used marijuana and has not engaged in sexual activity while under the influence of substances. His substance use has remained the same in college. He does not know if his partners have sex with other people and he has had one partner in the

previous 6 months. He indicated that he never used a condom, had not attended a sex party, and had not received blood or been exposed to HIV in the last 12 months.

Textural. Student 13 labeled himself as gay. He explained that he chose that label because “I like men.” He told me that although he would tell people he was close to that he was gay, in his daily life he was “still not really out.” He elaborated and said “but to my friends how long I’ve been out, probably not even that long. Maybe a month or two ago.” He was not out to any members of his family. When asked about stigma, he reflected on an ongoing experience.

> I'm going to be really honest. I think -- I was interested in an organization here on campus, and I still am, but a decision hasn't been made if I'm going to be a part of that organization or not. I really don't know. But I do think if I don't get the chance to be a part of that organization it is because I'm a gay male.

When asked about the organization he indicated that it was one of the on campus fraternities. He continued and said that he knew of some fraternity members who were gay but hiding it by having girlfriends. He did not want to replicate their behavior and feared that it would prevent him from obtaining membership.

When asked about negative experiences he mentioned that the campus reputation of gay men being “whorish” bothered him. He wanted to be judged on his individual merits. He believed that the perception of others definitely affected his HIV risk-taking behaviors in that he was more careful. When talking about coming to college he mentioned how people think “you drink, you smoke, you have as much sex, and do as many of those things that you can.” He believed that those ideas influenced his behavior

but he was trying to focus on school and not be distracted. He reported having good relationships with faculty and staff and liked being at school. He felt fewer people were around to judge him and his behaviors. He was able to be slightly more open. In spite of this, he rated his overall experience a four because of the reputation gay students have on campus. He felt previous gay students had behaved in a manner that affected him in a negative manner. He was being labeled even though he had not engaged in behaviors that would draw censure. He continued and stated,

> What also makes it a four is the fact that I personally feel like I have no one here on this campus to look up to that is a gay male. Being anybody, younger or older, I – I feel like we don't have anyone to really look up to who is setting a good example for us to follow. Yeah, so that's why I really label it a 4, too

Student 13 indicated that he knew of Black faculty and staff but he did not believe that any of them had stood up and functioned as a mentor or advisor.

Structural. Early in the interview, Student 13 stated "I feel like we are all stereotyped to be this one way." The idea of being placed into a category based on the behavior of others genuinely angered him. He did not like feeling as if he was being penalized for the inappropriate behavior of other students. He also noticed the lack of older, more experienced role models on campus. He felt as though having a positive mentor on campus would make gay students' paths easier. He felt the negative reputation of gay students prevented him from enjoying membership in some organizations, such as fraternities. Although he was not out of the closet entirely, he was not willing to live a lie and date women to be accepted.

Themes

Once completing textural and structural analysis, I examined and coded data using NVivo. Reading and rereading the data led to the formation of clusters of data and eventually the clusters merged into themes. The process of data analysis resulted in the emergence of several themes relative to the research questions. In addition, all demographic information collected was compared against themes to see if any patterns emerged. I have organized the results of the study by themes. I will present them in the subsequent sections according to the research question to which the theme relates.

Research Question 1

The first research question in this study was: What is the extent of stigma experienced by Black MSM (ages 18-24) attending an HBCU in North Carolina? There were three themes associated with this question: (a) I feel no stigma, (b) stigma comes from fellow students, and (c) I would rate this.... Regarding responses to this research question, the majority of students did not know the meaning of stigma and needed to have the word defined. No demographic information was linked to this theme. An analysis of the data when compared to this theme, revealed no patterns which would indicate that the participants demographic background influenced this theme.

I feel no stigma. Student 2 said he did not have a single negative experience to report. He felt satisfied with his experience and happy to be at school.

> Well, I think it's been great simply because -- I mean, I've never had any like negative occurrences that had took place where I just felt as though, you know, someone was treating me badly just because I was gay. So overall, I think I've had

> a great experience. You know, I embrace it. You know, my friends embrace it. I feel like, you know, even people who don't know me, you know, once they find out that I am gay, you know, they kind of embrace it, too.

He went on to rate his experience at school as a 10. He felt empowered and supported, and loved his friends and teachers. He said stigma and anything associated with it did not apply to him because he was living his life and believes that people treat him as an equal because he walks into situations with that expectation.

Student 9 also reported no experience with stigma. When asked about it, he responded that he had an experience but it was not stigmatizing in his eyes. He felt it happened because he was gay but it was not negative or positive; it just was.

> Well, I was in my friend's room, and we had just started being friends like during New Student Orientation and the freshman thing and all that. And she just like, you know, took off her bra and got fully naked and started changing. She was like you're gay. It's okay. So I mean, that was an experience.

He did not feel singled out in a negative ways, the reaction he had was neutral. It was not good or bad in that context, it just was.

For Student 8, the experience was very positive. He made a group of friends from his first days on campus and had good relationships since then. He described his overall experiences as follows:

> Well, out of my 4 years here at "The University" and since, you know, being in the marching band there's been a whole host, you know, gays. So I never really felt uncomfortable being gay here at Winston-Salem State, because -- I mean,

there was a bunch of other people around me that was, you know, as comfortable in their skin as I was. So I don't know. I've never really had any, like, stigmas as far as me being gay. I mean, I -- people know me and they know I'm going to be myself regardless and they know that, so -- yeah.

He had no stigmatizing experience to report. He said he had negative experiences such as catching an STD when he was a freshman, however the experience was not stigmatizing, it was simply difficult for him personally.

Stigma comes from fellow students. When students reported feeling the effects of being stigmatized, they indicated that the stigmatization came from their peers and often involved stereotypes of gay males or actions of gay males in the past. An examination of the demographic data showed no link to this theme.

Student 13 spoke of his efforts to pledge a fraternity. When asked if he believed his sexual orientation would have bearing on his acceptance into the fraternity, he responded,

Uh-huh, and I think it is because…although I'm not openly gay, when you see me you know that I am gay There is no question about it. I mean, I'm in the Epiphany Modeling Troupe. I like Beyoncé.

Student 11 at first indicated that he could not think of a time when he was stigmatized, but then described,

I guess people look at you like lower because you're gay. Like you can't do certain stuff because you're gay. Maybe they -- it's just -- it's just -- They look at you like

> you -- it's just different… You can't act…can't do certain clubs, you can't act a certain way. It's -- you know.

He continued on to say, "it's mostly students [looking at you]." He felt excluded and pushed aside by his peers, but was so accustomed to this treatment that he regarded it as normal and not stigmatic until he sat back and assessed his experiences. Student 3 spoke about stigma but in a general manner initially. He said,

> Well, I know a lot of us being gay black men on campus are looked down upon, I would say. Now, a few of us, like me and my friends, most of me and my friends are, you know, well known on campus so, therefore, a lot of straight guys do, you know, they do talk to us. They do communicate with us. And then you know some of the activities that I'm involved in on campus, you know, I do -- I do interact with straight men a lot. So it's -- it's like I feel like they judge us off of what they know. Well, what they think they know about, you know, being gay and all this stuff like gay guys, all they want to do is just touch on people. They're going to, you know, try to touch them, try to have sex with them, try to do all this stuff when that's really not the case.

He continued and related an incident in his freshman year where he had a sexual encounter with a straight man. A friend he confided in spread rumors about the event all across campus and the participant had a very difficult time afterwards. Again, all the judgement and stigmatization he experienced was from his peers. Student 5 also spoke about stigmatization as an issue of perception and generalized his experiences before becoming a bit more specific.

> Well, the only thing I can say is like, you know, I mean, I know you make friends on who -- who you have -- who you have things in common with. But I know a lot of times most straight guys won't necessarily -- now, I'm not going to say befriend you, but hang out with you because you haven't had things in common, or they're quick to 16 think that just because somebody gay, they're going to try to hit on them. I know that -- well, I mean, I've experienced that before. It's -- it's not like a spoken thing, it's more so unsaid like, you know? You just know who you hang with.

Student 4 seemed to have the most active experience with stigma and its effects.

> The biggest one is when I was running for a SGA position for Homecoming King, I feel as though that was the biggest stigma, where I see how by sexuality and what I chose to do with my lifestyle of me being gay affected the outcome of what I wanted to do in the future. Basically when I ran for the position a lot of things came out about my sexuality, things I did in my past, of being gay. And it was more so they didn't want to see a gay male in the position of a SGA, being the face of the school at the University for what I got from it.

In this instance, he was unable to attain a leadership position because he was being stigmatized for being a gay male and for incidents in his past associated with being gay.

I would rate this…. All students were asked to rate their experience on a scale of one to ten. Answers ranged from a low of three to high of 10. Student scores varied with several students reporting experiences with scores of seven to eight. Exploring the demographic data showed that student background had not effected the rating level.

Student 6 scored his experience a three because of a lack of a solid gay community and organizations.

> Because there's no sense of community among the LGBT group. We don't have -- the community amongst the LGBT people here on campus is not very strong if at all, it's just -- I know we have -- I know there is a registered organization for the Gay Straight Student Alliance, PRISM, but I know that they're not active. And I know that it's difficult to even have conversation or get people to come and do stuff like this, because we don't talk to each other. And it's hard to support each other like what happened last year when Student X ran for Homecoming King not a community for him to pull on to support him through that. And I think that -- that's -- I think that's the biggest issue that we have here as gays at this HBCU is that we don't have a community, and we can't grow -- we can't grow because we don't know each other, we don't talk to each other.

Student 13, who scored campus a 4, was angry about the actions of previous gay students. He felt their actions reflected poorly on the community and made things more difficult for current students. He also said the campus lacked solid adult professional gay role models for students. He believed that was necessary for their growth. Student 13 stated,

> There have been guys who have come before me and they've made us all look bad. Made -- With being messy, you know, with -- you know, engaging in sexual activities with people who are supposed to be straight and gossiping and just being messy. I – I think they have made a bad name for us all, and it's really hard

> to show people that you're not that person because everybody puts a label on everybody. It's like -- it's hard to run away from that.
>
> What also makes it a 4 is the fact that I personally feel like I have no one here on this campus to look up to that is a gay male. Being anybody, younger or older, I -- I feel like we don't have anyone to really look up to who is setting a good example for us to follow. Yeah, so that's why I really label it a 4, too.

Some students were having a wonderful experience and scored the school a 10. Student 2 stated nothing but praise for his experiences. He scored the university as highly as possible because he could not recall a single negative experience. Student 2 stated,

> Well, I think it's been great simply because -- I mean, I've never had any like negative occurrences that had took place where I just felt as though, you know, someone was treating me badly just because I was gay. So overall, I think I've had a great experience. You know, I embrace it. You know, my friends embrace it. I feel like, you know, even people who don't know me, you know, once they find out that I am gay, you know, they kind of embrace it, too. So it's -- it's never been a bad experience that I would say that I have had.

Students' experiences were mixed, with some reporting strong positives and others strong negatives. However, each student had praise for the school and no single interview was completely negative. Students cited strong supportive faculty and administration as a strength and all seemed to have some peer support.

Research Question 2

The second research question in this study was: What impact or influence does the current HBCU environment (policy, practice, culture, and stigma) have on the sexual behaviors of Black MSM attending the University? Two themes were associated with this question. Those themes were: (a) no impact, and (b) it had an impact.

Little to no impact. A majority of the respondents indicated that the environment had little to no impact on their sexual behaviors. Several of the participants said they were confident in themselves and did not look to outside influences to see how to behave or act. The demographic information collected from the students showed no evidence of patterns that would affect student responses. Student 2 summed up the mainstream view and said,

> So it doesn't really have like an impact on me simply because -- I mean, I'm the type of person I'm going to live my life according to how I would like to live my life… Yeah, I don't think it has any influence at all on my life, actual like having like sex or, you know, sexual activity. And so I -- I mean, it doesn't have any like impact on my sexual activity at all.

Student 10 thought about increased freedom associated with being in college; but, that did not influence his behavior.

> I would say that hasn't But I did have that thought, like this is college, I can, you know, do more, be more free. But you know, me wanting to put my education first, not really being too wild, it hasn't really impacted me.

Student 12 also said that he saw no change in his behavior.

> Well, it really didn't have an effect because, you know, I don't -- I don't party. I don't go out to party. So everything that I do is basically on myself, so it's not really the university. It's something that I've already known or I already talked with people about, you know.

The students were confident and believed that they could make their own decisions. They reported that external information did not impact their decision making. The students had internal barometers that they utilized to assess what to do or how to react in diverse situations.

It had an impact. A few students said they became more cautious after coming to school. The caution was caused by what they saw other people go though. The participants did not mention any one program or intervention that affected their decision making. Student demographic information showed no patterns linked to this theme.

> But just looking at other people and what they may have gone through, it really affects me, their -- their situations. Like with condoms, usually use them all the time. I know people that are positive and I know people that were -- get raped on campus. So you've got to be real careful, and that really affects me and the stuff I do.

Student 13 also agreed and said,

> It has definitely There is a lot of temptation. You know, when you have friends who getting it in and you in your room by yourself studying, I mean, you do feel like, I wish I had somebody or, you know, whatever the case may be.

> Well, it has had an impact, because I am well aware of, you know, the risk of having sex, whether gay or straight or whatever the case may be. But --- Yes. And I guess the impact that it has made is me having, you know, not multiple sex partners and only sticking to one.

For some students the campus interventions did work and were helpful. The students became more cautious in choosing partners and some were tested for STDs. One student mentioned the free STD testing that happened on campus and how helpful he found it.

Research Question 3

The third research question in this study was: What are the HIV risk behaviors of Black MSM attending an HBCU? I achieved the information for this research question on the Risk Assessment Questionnaire. During the interviews, the most commonly mentioned HIV risk-taking behavior was inconsistent use of condoms during sexual activity. Several of the MSM were unaware of the fact that oral sex without a condom is an HIV-risk behavior.

The answers to the risk assessment were enlightening. Students engaged in high-risk behaviors that they did not consistently report during the interviews. Four of the students indicated that they always used condoms; with one of those four indicating that he did engage in sexual acts under the influences of substances. Six of the 13 students reported having sexual activity under the influences of a substance. Of those four students who reported always using condoms, three had only one partner in the past 6 months. Two of the students reported never using condoms, with one having the same partner in the past 6 months and the other having two to five partners. Twelve of the 13 participants

reported having HIV testing completed in the past 6 months with negative results. One of the participants had not been tested. All participants reported some substance use. Seven students reported no change in substance use, five reported increased use, and one student indicated his usage had decreased. The two substances reported were alcohol and marijuana.

The participants reported a wide range of sexual behaviors, which included oral sex, anal sex, sex with persons of unknown status, sex for drugs or money, sex with MSM who have sex with others, and sex without a condom. All students reported engaging in oral sex and 10 reported engaging in anal sex. Ten of the 13 participants reported having sex without a condom, while four of the 13 stated they always used a condom. Tables 3 and 4 contain the results for the risk assessment profile.

Table 3

Risk Assessment Profile Participant Data Summary Chart Q1-Q6

Participant	**Q1**	**Q2**	**Q3**	**Q4**	**Q5**	**Q6**
	HIV Test & results	**Last 6 months** 1-Oral Sex 2-Anal Sex 3-Vaginal 4-Sex w person of unknown status 5-Sex for drugs or money 6-Sex with MSM who has sex with others 7-Sex w/o condom	**STD last 6 mon.** N-No Y-yes	**Substance use since college**	**Sex & substances**	**Use of substances since college**
1	Yes negative	1, 2,4,5,6,7	N	Alcohol Marijuana	Yes	Increased
2	Yes negative	1,2,6	N	Alcohol Marijuana	Yes	Remained the same
3	Yes negative	1,2,3,4,6,7	N	Alcohol Marijuana	Yes	Increased
4	Yes negative	1,6,7	N Syphilis	Alcohol Marijuana	Yes	Remained the same
5	Yes negative	1,2,6,7	N	Alcohol Marijuana	Yes	Increased
6	Yes negative	1,2,6	N	Alcohol Marijuana	N	Remained the same
7	Yes negative	1,2,3,6,7	N	Alcohol Marijuana	N	Remained the same
8	Yes negative	1,2	N	Alcohol Marijuana	Y	Remained the same
9	Yes negative	1	N	Marijuana	N	Remained the same
10	Yes negative	1,2,7	N	Marijuana	N	Increased
11	Yes negative	1,2,7	N	Alcohol	N	Increased
12	Yes negative	1,2,4,6,7	Y Gonorrhea	Alcohol Marijuana	N	Decreased
13	No	1,2,6,7	N	Alcohol Marijuana	N	Remained the same

Table 4

Risk Assessment Profile Participant Data Summary Chart Q7-Q12

Participant	Q7	Q8	Q9	Q10	Q11	Q12
	Partners have sex w/people other than you (last 6mo)	**# partners last 6 mo.**	**Freq. of condom use** S-Sometimes N-Never M-Most of time A-Always	**Sex Party** Y-Yes N-No	**Received Blood Prod. Last 12 mo.** Y-Yes N-No D-Don't know	**HIV Health Exposure Last 12 mon.** Y-Yes N-No
1	Yes	6-10	S	N	N	N
2	Yes	2-5	A	N	N	N
3	Yes	2-5	S	N	N	N
4	Yes	2-5	M	Y?	N	N
5	Yes	2-5	Never	N	N	N
6	Yes	1	Always	N	N	N
7	Don't know	2-5	Most of the time	N	N	N
8	Yes	1	Always	N	N	N
9	N	1	Always	N	N	N
10	Don't know	1	Never	N	N	N
11	Don't know	2-5	Sometimes	N	N	N
12	Don't know	2-5	Most of the time	N	N	N
13	Don't know	1	Never	N	N	N

Evidence of Trustworthiness

In order to ensure trustworthiness of this qualitative research study several strategies were employed. Using Guba's four criteria of credibility, transferability, dependability and conformability evidence of trustworthiness was provided.

To ensure credibility, both validity and reliability the researcher began by adopting a research methodology that has well been established in qualitative investigation. The phenomenological research methodology has been proven as a strategy for studies trying to glean information about the lived experiences of participants from their perspective. Instruments utilized were instruments widely administered by local Community based organization. To ensure fit, permission was gained to modify the instruments pending the results of the pilot study. The revised plot tested instrument was utilized thus helping to establish credibility. Key informant was obtained and this

individual assisted with use of the snowballing technique for participant recruitment. Thick descriptions and member checking strategies were also utilized to establish study credibility.

To ensure validity, three strategies were three were used: use of thick rich descriptions, member checking, and peer debriefing. Dependability was addressed by the use of overlapping methods (risk assessment profile and semi-structured interview). To address the dependability issue more directly processes within the study were reported in detail to allow a future researcher the ability to repeat the study (Shenton, 2004).

Conformability was established. To do so, I took steps to ensure objectivity efforts were made to minimize any personal bias. In qualitative study conformability is akin to objectivity. Steps must be taken to ensure the objectivity of the researcher in an attempt to minimize bias (Patton, 2002). Triangulation was used to confirm that the findings are the result of the ideas and experiences of the participants. Participant's experiences were recorded, transcribed, and reviewed. Participants were allowed to review and check data for accuracy, and clarify information.

Transferability, external validity or the extent to which the findings of this study can be applied to other situations is complex for qualitative research. The findings of a qualitative project are specific to a small number of particular environments and individuals, and it is impossible to demonstrate that the findings and conclusions are applicable to other situations and populations (Shenton, 2004). The background data, context of the study, and the detailed description of this study allows for future comparison to be made and for future studies of similar populations in similar settings.

Data Summary

The purpose of this qualitative study was to better understand the experiences of Black MSM attending HBCU and how the HBCU environment and stigma influence HIV risk behavior. The participants of this study were Black MSM who currently attend an HBCU. I used individual semi structured interviews to gather data. The participants filled out a demographic questionnaire and a risk assessment profile prior to the interview. The researcher selected 13 participants using snowball sampling. Analysis of the interviews resulted in several themes.

Three themes were found relating to Research Question 1. The themes included: (a) I feel no stigma, (b) stigma comes from fellow students, and (c) I would rate this.... Research Question 2 produced two diametrically opposed themes. Those themes were: (a) no impact, and (b) it had an impact. The demographic information was compared to the uncovered themes. No demographic patterns were linked to student responses. Research Question 3 was answered by data from the Risk Assessment Survey with some support from the interviews. The MSM were found to engage in risk-taking behaviors. The participants reported more HIV risk-taking behaviors in the risk assessment profile than were mentioned during the semi structured interview. During the interview, the students underreported or seemed to brush aside any in-depth responses to the questions most associated with HIV risk-taking behavior. In addition, some answers on the individual risk assessment profiles were contradictory.

Summary

The chapter began with a brief introduction and the questions that guide the study. The researcher described the research setting and the demographics of the participant group. The following sections listed procedures employed to gather data, data analysis methods, and the ensuing results. The results of the data analysis in this phenomenological study were themetized and each participant's interview and demographic data were analyzed. Each participant's individual textural and structural descriptions are also included. The end of chapter displays the composite textual and composite structural descriptions (Table 2). In the next chapter, I will briefly recapitulate the results of the study and then present a discussion of the implications of the study findings within the context of the existing literature. The chapter will conclude with suggestions for future research.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

Black MSM is the subgroup most heavily affected by HIV in the United States. While some research has been conducted on Blacks or Black Students attending PWIs, limited research has been conducted on Black MSM students attending HBCUs and their elevated risk for HIV acquisition. Historically thought to be at relatively low risk for HIV infection, researchers suggested that HIV among Black college students is on the rise (Hightow et al., 2005). Like other chronic and infectious disease minorities or people of color are often over represented in incidence and prevalence when compared with their non-minority counter parts. This issue stems from variables that include individual, community, organizational, institutional, cultural, environmental and political factors. The result is a complex problem that requires an interdisciplinary approach to address the underlying causes for why minorities particularly Black MSM are experiencing high infection rates.

I sought to understand Black MSM, stigma, and HIV risk behavior as described by Black MSM students currently attending an HBCU. In addition to HIV risk behaviors, I sought to understand individual, institutional, and cultural constructs that influenced their experience. The purpose of this chapter is to discuss how phenomenological inquiry was utilized to understand the experiences of Black MSM attending HBCUs and how stigma and the HBCU environment influenced the experience and HIV risk behavior of these study participants. The research reflects textual, structural, and thematic responses for participants.

This chapter begins with a summary of the findings and then interprets results in light of information previously presented in the literature review. Stand out themes and observations are also reviewed. The chapter concludes with limitations, recommendations, and most importantly implications for social change.

Thirteen Black MSM students participated in the phenomenological study. The participants filled out a demographic questionnaire and a risk assessment profile prior to completing their semistructured interview. Thirteen participants were selected using snowball sampling. Analysis of the interviews resulted in several themes.

Themes

Three themes emerged relating to research question one about stigma. Initially many students were unclear as to the meaning of stigma. Their experienced relating to stigma ran the gamut from no significant experience to very impactful lasting experiences. For Research Question 2, generally speaking student did not feel that the HBCU environment had any impact on their sexual behaviors. However, many expressed that the permissive nature of the environment allowed them to more freely explore and engage in behaviors that they did not participate in when in their home environments. Research Question 3 was answered by data from the Risk Assessment Survey with some support from the interviews. Consistent across all instruments, Black MSM were found to be engage in risk taking behaviors. Conversely, they reported more HIV risk taking behaviors in the Risk Assessment Profile than they mentioned during the semi structured interview. There was lots of underreporting and lack of depth when asked to responses to HIV risk taking behavior, and contradictory responses were noted.

Of the major themes gleaned from interview was that the few students who felt no stigma were students who were very well connected to the campus community and benefited from exclusive elitist programs that the average student is unable to access due to academic and/or social standing. Students who are a part of these programs unknowingly enjoy status and a privilege that is out of reach to most of their MSM peers. This privilege served as a protective factor and these students felt less marginalized than their peers who expressed they felt ostracized by the sexual majority. Participants expressed a lack of community among their peers in the sexual minority. This phenomenon drew a parallel to the work of Parker and Aggleton (2003) who discussed how social and structural discrimination are common and widely accepted among the sexual majority.

Stigma and Marginalization

The majority of participants expressed the need for change in culture. They expressed a desire for more programs, services, support, and other resources for themselves and other students in the sexual minority. Students described feelings of marginalization and felt that the programming, services, and resources were geared toward the majority. Conversely, the participants expressed that stigma they experienced did not come from faculty or staff, but from fellow students. As a result they provided low ratings for their overall experience. These participants expressed a culture of homophobia, lack of acceptance, and preconceived notions about their sexual intent toward their non-MSM male peers. Students expressed that they felt no stigma from faculty and staff but spoke candidly about a campus culture that did not include, promote

or offer enough programs and activities for MSM students. This finding is consistent with the literature which notes that in the Black Community fear, discrimination, stigma and homophobia are prevalent (Bing et al., 2008; Patton, 2011; Ward, 2005). This is also consistent with the findings of Connolly (2000), Mobley (2000), and Schueler et al. (2009) who stated that at PWIs Black MSM experienced feelings of isolation and marginalization as a result of being in the sexual and racial minority. Black MSM student that attend HBCUs are not in the racial minority; however, they are part of the sexual minority and they described experiencing stigma and marginalization from their peers. This institution does have an EEO/Diversity policy that includes gender identity and sexual orientation. Neither the policy nor the associated language is explicitly stated in the student code of conduct. This could provide some explanation as to why student report that faculty and staff were more accepting.

The participants expressed that marginalization by other students impacted their overall experience and in many cases provided the motivation for them to seek out experiences, encounters, and socialization outside of the collegiate environment. Researchers suggested but did not empirically determine that the sexual networks of Black MSM increase their likelihood of HIV infection (Easterbrook et al., 1993; Harwa et al., 2004; Hightow et al. 2005). Students suggested that the environment encouraged them to seek experiences outside of campus, and the literature suggests that the expanded sexual network could place MSM collegiate students at increased risk for HIV infection. However, more research is needed in this area to determine whether or not an association exists.

Participants in the study expressed that they did participate in organized religious activities with the majority identifying as Christian. I did not explore how they reconciled their lifestyle with spiritual or religious affiliations. This is worth exploring.

Heterosexism and homophobia were themes that participants expressed from their peers. They were aware of and had experienced homophobia and even expressed that being more feminine flamboyant perpetuated stereotypes perpetuated by the sexual majority. Dichotomously, participants did express that once an individual or group got to know them personally and discovered that they were ok it was better. They expressed this but acknowledged that as a body they were still judged by the sexual majority and felt that even though they did not feel marginalized by faculty and staff that the culture of the institution was not supportive and did not offer enough initiatives, activities and resources for the sexual minority. Conversely, some initiatives offered were thought to be out of reach to individuals because they were in the sexual minority. No participant expressed that this was openly communicated; but described this manifested through how explicitly the campus supported the interest of the sexual majority without thought to sexual minority.

Participants expressed support from administrators, faculty, and staff, and expressed marginalization from their peers but this support did not translate into program and/or services. This was an interesting point because ultimately administration could implement initiatives and programs for the sexual minority; but, it cannot mandate peer acceptance. Even still creating a culture that educates and promotes inclusion is imperative. The university setting mirrored that of the community and just as the African

American community has been largely silent in acknowledging and addressing issues surrounding Black MSM. Black MSM described having to assimilate to an environment that clearly did not support the minority. Participants expressed the need for more services geared toward the minority, and the need for active administrative involvement in the process not simply passive acceptance.

Risk Behavior

Participants expressed a concern regarding STIs/STDs; however, this concern did not result in consistent reduction of risk behaviors among the students who admitted to being sexually active. The fear or concern of contracting an STI/STD seemed to be over shadowed by the notion that they were in an environment where they could “be themselves” and environment that was more permissive and accepting than the environments they experienced at home. All expressed use of alcohol, marijuana, or both and only four of the participants expressing that they always used condoms. This was consistent with findings on college students and risk behavior from (Brien et al., 1994; Bazargan et al., 2000; Gillette & Lyons, 2006, Lewis et al., 1997), these college students like many of their peers engaged in behaviors that placed them at risk for HIV infection. Consistent with research conducted on MSM by Koblin et al. (2006), these participants revealed an increased number of partners and substance use. Participants did not describe any injection drug use but acknowledged alcohol, marijuana use, as well as the exchange of sex for money. The risk assessment profile data suggest that they were unsure of the HIV status or sexual behaviors of their partners. Students reported having experienced STIs/STDs including HIV.

Most of the participants reinforced findings from previous studies suggesting that the permissiveness of collegiate environment encouraged exploration and risk taking behavior. Almost half of the students who reported substance use expressed an increase in substance use since entering college. The participants reported a wide range of sexual behaviors, which included oral sex, anal sex, sex with persons of unknown status, sex for drugs/money, sex with MSM who have sex with others, and sex without a condom. All students reported engaging in oral sex and 10 reported engaging in anal sex. Ten of the 13 reported having sex without a condom; while four of the 13 stated they always used condom. Student expressed that the collegiate environment provided them the freedom to express and explore in a way that the home environments did not allow. Students expressed that the environment allowed for exploration but did not state that the environment explicitly promoted the risk behavior. Consistent with findings form the literature review, this suggests that collegiate environment provides a rite of passage into adulthood that often involves consumption of alcoholic beverages, experimentation with drugs, and promiscuous sexual behavior (Duncan et al., 2002).

Participants expressed concern about contracting STDs; but, this concern did not appear to influence risk taking behavior. Participants expressed that testing on campus occurred with some frequency; however, they did not recall being engaged in other awareness efforts surrounding sexuality, health, or risk taking behavior.

The participants expressed thoughts surrounding feeling marginalized but did not indicate or make a connection between this marginalization and their sexual promiscuity.

Participants did indicate that the freedom of the collegiate environment increased their sexual exploration.

Theoretical Considerations

Participants' experiences as viewed through the Bronfenbrenner's ecological model revealed fluidity among the levels as well as a dynamic interaction influenced on multiple different levels. Students described unique microsystem or individual experiences with stigma and risk taking behavior and took ownership of their choices, and expressed that they were uninfluenced by other individuals or systems. However, this is difficulty to distinguish as many interpersonal factors often influence individual choice and there is fluidity within the ecological model with micro and mesosystems overlapping. Mesosystem interactions are interactions in which the MSM individual work, lives, and engages. Mesosystem interactions largely shaped the individual and overall experiences of participants in the study. In this study, participants were aware of other's perceptions of the individual lifestyle or perceived notions about alternative sexual practice, and the inherent social sexual norms (exosystems); however, participants stated that this did not impact their sexual risk taking behavior.

Macrosystem variables such as stigma, discrimination, institutional cultures and systems specifically designed to support the socio cultural norms of the student community at large were particularly troubling. Data suggested a need for shift in both the macrosystem and the chronosystem. The chronosystem, which is characterized by change or consistency over time in both the individual and the environment, could also use further exploration. While our study did not allow us to explore the chronosystem

pathway, the lack of tolerance at the peer level suggests cultural and societal values that were inherent in the psyche of the students. This should be furthered explored as it has direct impact and influence on the experience of those in the sexual minority. Exploring this phenomenon may help us to gain a greater understanding of the attitudes and beliefs that result in students discriminating against other students in their peer group based upon sexual orientation. I did not explore the mental well-being of the participants and how this might influence behavior. Bronfenbrenner's early model, and the expanded work done by McLeroy et al., (1988) is still relevant and this research reinforces the need for more research and interventions at the ecological level of the community.

Limitations

This study included participants from one of many HBCUs versus including aggregate data from many institutions and this is a limitation. Views expressed by participants at this institution may not reflect the views of other Black MSMs attending HBCUs. When conducting studies that involve self-report data, there is always the concern regarding the quality of self-report data. The concern is regarding over reporting or under reporting depending upon the nature of the study. When conducting research that requires an individual to disclose risk behaviors or other information that could result in stigma or discrimination, participants could have been less than truthful because they were concerned about the perceptions of the researcher. Data reported did reflect some inconsistencies as it related to information that was reported surrounding STD/STIs. The nature of this exploratory study did not allow the researcher multiple interactions with the participants. Multiple interactions could have increased the level of comfort between me

and the participants and perhaps resulted in more freedom of expression or greater recollection of experiences.

In research quality sampling has direct implications for validity and generalizability of results. The prevailing thought is that a large sample size is more representative of the population and that larger sample sizes limit the influence of outlier or extreme observations. In qualitative studies the goal is to "reduce the chances of discovery failure," and a large sample size broadens the range of possible data and forms a better picture for analysis (Depaulo, 2000; Marshall & Rossman, 2014).

In this study, I was seeking to understand a hidden population. To date, there are not concrete figures on the numbers of Black MSM attending this HBCU; and thus it is difficult to gauge what percentage of the Black MSM participated in either the pilot study or actual study. A recent review of qualitative study research showed the mean sample size was 31 and noted that the distribution was non-random, and suggested that this be utilized as a starting point for sample sizes in qualitative research (Mason, 2010).

Samples for qualitative studies are generally much smaller than those used in quantitative studies. This is because qualitative research can be labor intensive, analyzing a large sample can be time consuming and often simply impractical (Mason, 2010). No matter what the number, the goal of qualitative research is to make sure that the qualitative samples are large enough to assure that most or all of the perceptions that might be important are uncovered or that data saturation is reached.

The concept data saturation entails bringing new participants continually into the study until the data set is complete, as indicated by data replication or redundancy.

Saturation is reached when a researcher gathers data to the point of diminishing returns, when nothing new is being added (Malterud, 2001; Marshall & Rossman, 2014; Mason, 2010; Pope et al., 2000). While this study had a small sample size (*n*=13) saturation was reached in the participant pool.

This study also involved no comparison group. The nature of the phenomenological research approach focuses on individual experiences, beliefs, and perceptions. The primary focus of this research was the experiences and perceptions of Black MSM and as a result no comparison group was utilized. The literature review provided some background regarding the experiences of students in the sexual majority; some of which are similar. Students in the sexual minority and sexual minority participate in high risk behaviors while in college. This study did not explore the extent of drug and alcohol use and mental illness on the behaviors of Black MSM; these variables could have provided expanded information and/or another vantage point for interpreting the experience of these students.

Recommendations

More studies on HBCU campuses concentrated on efforts on building community among African American Gay Male students and other students in their peer group are needed along with researchers who chronicle the experiences of Black MSM on HBCU campuses. Participants expressed a wide range of experiences that were both positive and negative. Despite knowledge of risk behaviors participants described a culture in which they actively engaged in risk behavior. Colleges and universities have long been aware of the association between the collegiate environment and the culture of risk behavior.

Institutions should active push against that typecast and actively work to encourage and promote social responsibility among all students. More resources and support for the sexual minority are needed. Participants indicated that they did not feel stigma or marginalization from faculty, staff or administrators. However, this could be better demonstrated by actively seeking to understand the unique interest and needs of this demographic and by providing programs and services to support their interest and their needs. The leadership should consider evaluating programs, activities, and organizations to ensure that they do not unconsciously encourage exclusion. Participants expressed having more negative interactions with peers versus administrators, faculty, and staff. Students are products of their community and their behaviors and actions imply that there is still a great deal of angst in the African American community as it relates to issues of non-heterosexuality. This suggest that more efforts should be concentrated on educating and understanding how to get students to actively participate in creating an environment that advocates for social justice and fosters inclusion.

To improve upon weaknesses in this study a comparison group could be used. The comparison group could include students who comprise the sexual majority. Adding specific constructs on belief and culture would help a researcher in trying to determine how individual beliefs influence prejudice, bias, and impact how the majority engages (accepts or oppresses) students in the sexual minority.

Another suggestion for improvement or future study would be expanding the scope of the study. Conducting this research within a larger geographic area could possibly yield greater depth and more generalizable results. Involving all of the HBCUs

in the system and or the region would allow for researchers to determine the similarities of experiences at other HBCU and would allow some level of comparison across institutions.

Recommendations for larger more expansive study would include a mixed method campus climate study that gathered statistical data on the sexual identities, risk behaviors, and factors such as substance use, mental wellness/illness. Focus groups could be utilized to get a general sense of the attitudes and behaviors of the majority versus the minority. Data could be analyzed utilizing multivariable regression analysis. This type of study would allow for the analysis of data from those in sexual majority and majority and would allow comparison between the groups and provide some explanation as to influencing factors and outcomes. A benefit from this type of study would be gathering information regarding the number of students who identify as LGBTQ

Implications for Social Change

Among the findings of this study was a confirmation of what the literature states regarding colleges and universities and risk behavior. The research confirmed the phenomenon of risk behavior within the target audience. Participants expressed that the collegiate environment allowed them freedom to explore and be themselves. While this did not come as a surprise; this finding definitely illustrated the need to establish a culture of social responsibility and possible solutions that will encourage Black MSM to enjoy their rite of passage into adulthood; but to do so in a manner that is responsible individually and culturally. Students were aware of risk behavior; however, many failed to bridge the gap between knowledge and sustained consistent behavior change. The

study suggested that reflection on previous behaviors and actions helped to increase their readiness for sustaining change behaviors. When exploring risk behavior among the students, one of the anticipated social change outcomes was a consideration of the environmental and cultural factors that promote risk behavior among marginalized groups. Study results suggst that these factors were not separate or distinct from factors that the average collegiate experience. Risk behavior was inherent in the collegiate culture and this study suggests that being marginalized did not promote more risk behavior.

The study results did not reveal institutional constructs that needed to be addressed; but rather revealed the need for more constructs to be put into place to decrease risk behaviors and promote more social responsibility. The need for more education around diversity and inclusion and participants were willing to use their voice to enlighten their peers. This leads me to the next implication for social change. The study helped to further expand the consciousness regarding the integration and socialization of Black MSM and will spark more conversations with the administration about things that could be implemented to support and encourage the sexual minority to more fully engage with the campus at large. The study highlighted many positive things and revealed areas for potential improvement.

The Black MSM who participated in this study expressed that they felt honored that someone cared to inquire about their experience as students. Many articulated that using their voice to express their experience positively contributed to their self-value and their self-esteem. The study encouraged the participants to actively reflect on their

collegiate experience and to intentionally ponder the nature of that experience and its impact on them as an individual/student.

The study also contributed to literature confirming some of the findings of previous researchers and laying the foundation for future research on other HBCU campuses. I suggested more work needs to be done with the student body and suggests that students entered the institutions with values and beliefs that created a hostile experience for their peers who were in the sexual minority. Many of the participants commented and shared that constructs within the HBCU environment contributed to them not being able to fully take advantage of all opportunities available within the collegiate environment. Conscious, intentional efforts must be initiated to ensure that Black MSM are able to participate in any program or activity of their choosing without stated or implied exclusion based on their sexual orientation. For students, there is a need for campaigns, public service announcements, and other educational awareness initiatives, to address conscious and unconscious student behaviors that contribute to Black MSM feelings of marginalization. Lastly, it is my hope that this research encourages other HBCU campuses to consider similar studies in their environments.

Conclusions

I sought to gain an understanding of the experiences of Black MSM attending an HBCU and explored how stigma and environmental variables such as infrastructure, policy, culture, community, campus climate, risk and protective factors influence the general behavior and HIV risk behavior of Black MSM. This research study sought to gain an understanding of the experiences of Black MSM attending an HBCU and

explored how stigma and environmental variables such as infrastructure, policy, culture, community, campus climate, risk and protective factors influence the general behavior and HIV risk behavior of Black MSM.

Participant responses regarding stigma ranged from none experienced to very detailed examples that illustrated the impact of stigma experienced. Not understanding the concept of stigma definitely impacted students perceptions regarding the motivation or underlying cause of different behaviors experienced. Students who experienced stigma (understood the concept and recognized the behavior) provided very detailed recollection of the event that occurred. However, of those who did not understand the term stigma once it was explained most were able to vividly recall experiences where stigma was a factor. Students felt that the HBCU environment did not have much impact on their sexual behaviors. Yet they expressed that the environment allowed greater freedom of expression and allowed for sexual exploration specifically when they compared the collegiate environment to that of their home environment.

Of the research questions explored, the third question regarding risk behavior provided the most data which included some inconsistent responses across tools. This question was explored via risk assessment profile and in the in-depth interviews. During the interviews, the most commonly mentioned HIV risk behavior was inconsistent use of condoms during sexual activity. Several of the MSM were unaware of the fact oral sex without a condom was an HIV risk behavior. The participants reported a wide range of sexual behaviors, which included oral sex, anal sex, sex with persons of unknown status, sex for drugs/money, sex with MSM who have sex with others, and sex without a

condom. This research supports the findings of many others and suggests that HIV prevention and risk reduction intervention must continue to evolve beyond education and condom use and must address other variables that influence risk behavior.

These variables include but are not limited to, stigma experienced, opportunity, attitude, availability, social norming, depression, hypersexuality, and notions of rites of passage. Many of these concepts are part of the institutional culture of the collegiate environment, and others of which are concepts seen and experienced in African American culture and society. Attitudes, behaviors and beliefs of the peers in the sexual majority created an antagonistic environment for Black MSM, and could have influenced risk behavior of participants in the sexual minority.

HIV risk behaviors of the participants indicated a high level of risk behavior taking place among Black MSM which was consistent with the literature which indicates that collegiate students in general frequently engage in high risk behaviors. We know that for HIV acquisition that MSM is the group which experiences the highest incidence of infection and that Black MSM 18-24 is a group that is disproportionately impacted.

The study confirmed that marijuana and alcohol use, unprotected anal and oral sex, sex while under the influence, and sex with many different partners without knowledge of HIV status was occurring. The results showed that participants were aware of risk behavior but the freedom offered by the collegiate environment to them as individuals in the sexual minority overshadowed all else and they articulated that college was a place where they could be themselves and enjoy freedoms not experienced in their

home environments. This suggests that further study on the HBCU collegiate environment and its influence on risk behaviors is warranted.

Stigma and marginalization experienced by Black MSM at this HBCU was consistent with the experience with Black MSM at PWIs. Results suggest that the administration/leadership needs to do more to create an environment that considers the needs of marginalized students in the sexual minority. Results showed that the peer group was largely responsible for the culture which the sexual minority found oppressing. The findings of this study indicate and support the literature regarding collegiate students and risk behavior, how the African American community including the church shapes the views of its people and how those views contribute to stigma, discrimination, marginalization, heterosexism, and homophobia. The research clearly indicated a need for macro level changes to address stigma, discrimination and institutional systems and cultures that reinforced socio cultural norms demonstrated by students. In addition to macro system level changes, changes were also needed at the chronos or individual and interpersonal system levels. This research confirms that risk behavior is occurring, that stigma exists within the current culture, and that students are helping to foster a climate where individual and collective bias is negatively impacting more vulnerable students. More research is needed surrounding how to create collegiate environments that decrease risk behaviors while promoting responsibility. More work is needed on how to foster a campus climate that actively assess and address conscious and unconscious individual and environmental stigmas experienced by Black MSM at HBCUs.

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Appendix A: Letter to Participant

Date:

Name of Participant

Address

Dear (Name),

My name is Natasha Jeter and I am a doctoral candidate at Walden University. I am conducting dissertation research on Black MSM on an HBCU campus. There are a vast number of studies regarding MSM, and collegiate students and risk behavior; however the studies that focus on Black males on non PWI are limited. The purpose of this study is to gain insight on the experience of Black MSM on HBCU campuses and to determine if and how stigma influences their sexual risk taking behavior. This research will provide insight into these experiences and provide a framework for how we address the needs of Black MSM in an effort to reduce the overall incidence of HIV among African Americans.

I realize that your time is important to you and I appreciate your consideration to participate in this study. In order to fully understand your experience we need to meet on two separate occasions for approximately one hour each meeting. Meetings can be held at a location of your choosing and will not require you to do anything you don't feel comfortable doing. The meetings are designed to simply get to know you and learn about your experience of being a Black MSM on an HBCU campus. All information gathered during our meetings will be kept strictly confidential.

Please contact me at your earliest convenience to schedule a date and time that we can meet. My telephone number is [redacted] You can also email me at natasha.jeffreys2@waldenu.edu. I look forward to hearing from you.

Natasha Jeter

Doctoral Candidate Walden University

Appendix B: Interview Protocol

Date: TBD

Location: TBD

Name of Interviewer: Natasha Jeter

Name of Interviewee: Student 1

Interview Number: One

Please take a few moments to complete the demographic and risk assessment profiles. After which we will conduct the interview which contains 6 semi-structured interview questions.

Unique Identifier________________ {(DOB)-month/dd/last 4 of social} e.g. 10/05/8897

Demographic Profile

Gender

1. What is your gender? Male Female

Age

2. In what year were you born? 19_____________

Classification

3. What is your classification this semester? ___________

- Freshman
- Sophomore
- Junior
- Senior

4. Are you a residential or a non-residential student?

Sexual Orientation/Sexual identity
5. Generally speaking, do you consider yourself to be

- Gay
- Bisexual
- Transgender
- Transsexual
- None/Neither
- Unsure

Technology Use
6. How often do you use the Internet for the purposes of dating or hooking up?
- Once or more a day
- A few times a week
- A few times a month
- Hardly ever
- Never

Education
7. What is the highest level of education you plan to complete?

- Four-year college degree / B.A. / B.S.
- Some graduate work
- Completed Masters or professional degree
- Advanced Graduate work or Ph.D.

Religiosity/ Religious Preference
8. Apart from events such as weddings and funerals, how often do you attend religious services?

- More than once a week
- Once a week
- Once or twice a month
- A few times a year
- Never

9. What, if any, is your religious preference?
- Protestant
- Catholic
- Christian
- LDS / Mormon
- Jewish

- Muslim
- Other
- No Preference / No religious affiliation
- Prefer not to say

10. How active do you consider yourself in the practice of your religious preference?

- Very active
- Somewhat active
- Not very active
- Not active
- Does not apply / Prefer not to say

Racial/Ethnic Identity
11. Would you describe yourself as:

- White
- Black or African American
- American Indian and Alaska Native Asian
- Native Hawaiian and Other Pacific Islander
- Some Other Race
- Two or More Races

Income
12. What was your 2013 family income from all sources before taxes?

- Under $25,000
- $25,000 - $39,999
- $40,000 - $49,999
- $50,000 - $74,999
- $75,000 - $99,999
- $100,000 - $124,999
- $125,000 - $149,999
- Over $150,000

Risk Assessment Profile

Note: Here the word "sex" means oral, vaginal, or anal sex

Question			
1. Have you ever had an HIV test?	Yes	No	Don't Know
2. Do you have HIV?	Yes	No	Don't Know
Have you ever tested positive for HIV?	Yes	No	Don't Know
3. Do you have sex with men?	Yes	No	Don't Know
Have you had sex with a man in the past year?	Yes	No	Don't Know
4. Do you have sex with women?	Yes	No	Don't Know
Have you had sex with a woman in the past year?	Yes	No	Don't Know
5. Have you ever had sex with an HIV+ person?	Yes	No	Don't Know
Have you had sex with an HIV+ person in the past year?	Yes	No	Don't Know
6. Have you ever injected (shot-up) drugs?	Yes	No	Don't Know
Have you injected drugs in the past year?	Yes	No	Don't Know
7. Have you ever had sex with someone who injected drugs?	Yes	No	Don't Know
Have you had sex in the past year with someone who injects drugs?	Yes	No	Don't Know
8. Have you ever had sex with a man who has sex with other men?	Yes	No	Don't Know
Have you done this in the past year?	Yes	No	Don't Know
9. Have you ever had sex in exchange for drugs or money?	Yes	No	Don't Know
Have you done this in the past year?	Yes	No	Don't Know

10. Have you had a sexually transmitted disease in the past year?

Yes No Don't Know

If yes, check all that apply

☐Syphilis (bad blood) ☐Genital/Sex Warts ☐Gonorrhea (clap) ☐Herpes
☐Chlamydia ☐Trichomonas (trich) ☐Hepatitis A ☐Hepatitis B
☐Hepatitis C ☐Men-burning or drip from penis (not gonorrhea or chlamydia)
☐HIV

11. Have you ever had sex while using drugs (i.e., cocaine, crack speed, heroin, ecstasy, and methamphetamine) Yes No Don't Know

Do you regularly have sex while using alcohol? Yes No Don't Know

12. Have you received any blood or blood products in the past year?

Yes No Don't Know

13. Have you had health care exposure to HIV within the past year?

Yes No Don't Know

14. Do you have sex with more than one person? Yes No Don't Know

15. Do any of your sex partners have sex with people other than you?

Yes No Don't Know

16. Have you had sex without a condom in the last three months?

Yes No Don't Know

17. How many sex partners have you had within the past year?

None one 2-5 6-10 more than 10

18. How many sex partners have you had in the last three months

None one 2-5 6-10 more than 10

19. How often do you use condoms with your sex partners?

Never Sometimes Most of the time Always

20. Since coming to college has your substance use (eg., cocaine, crack speed, heroin, ecstasy, methamphetamine alcohol, marijuana,)

Increased Decreased Remained about the same

Semistructured Interview Questions

1. In terms of labels, how do you view yourself eg. gay, bisexual, queer/questioning etc., and why?

2. What is your understanding of stigma?

3. Since becoming a student at the University, please describe the most significant experience that you can recall where you believe stigma influenced the way you were treated or where you believe stigma influenced the outcome of the situation.

4. Taking into consideration your sexual orientation, since coming to the University, please describe in detail any positive or negative experience(s) that you have had on campus where you believe that your sexual orientation played a role?

5. What impact has your perception of how others view you and your sexual orientation had on your HIV risk taking behavior?

6. What impact if any has the University, or campus climate had on your sexual risk taking behavior?

Probing:

What question or information have I not asked that is critical or significant to your experience as a Black MSM on this campus?

*Interview Protocol will be duplicated for all participants

Appendix C: Participant Consent Form

Experiences of Black MSM at an HBCU exploring stigma and HIV risk behavior.
Walden University

You are invited to participate in a research study of Black MSM on HBCU. As a key informant or participant, you were identified because of your advocacy work with LGBT populations or you were identified because one of your peers felt that you fit the profile/ criteria for this study. Please read this form and ask any questions you may have before acting on this invitation to be a key informant or participant for this study.

This study in being conducted by Natasha Jeter, a Doctoral Candidate at Walden University. You may already know the researcher as an Administrator in the Division of Student Affairs, but this study is separate from that role.

Background Information:
The purpose of this study is to better understand the experiences of Black MSM on HBCU campuses and how those experiences impact and or contribute to HIV risk taking behavior.

Procedures:
If you agree to be in this study, you will be asked to complete a demographic profile and risk assessment profile which should take approximately one half hour to complete. After completion of the two profiles you will be asked to participate in a one on one interview in a campus location of your choosing. The interview will take approximately one hour in length each time.

Here are a couple of sample questions:

1. Since attending "The University" what has been your experience as a Black MSM student?

2. Describe your perception of how others view you and how this has impacted your sexual risk taking behavior

Voluntary Nature of the Study:
This study is voluntary. Everyone will respect your decision of whether or not you choose to be in the study. No one at the Institution will treat you differently if you decide not to be in the study. If you decide to join the study now, you can still change your mind during or after the study. You may stop at any time.

Risks and Benefits of Being in the Study:
Being in this type of study involves some risk of the minor discomforts that can be encountered in daily life, such as recollection of past experiences, and possible stress associated with those memories. Being in this study would not pose risk to your safety or wellbeing.

Study benefits include helping the researcher to recognize and understand things and experiences that contribute to HIV risk behavior among Black MSM at HBCUs. This data will aid in the development of social change models aimed at reducing HIV incidence among Black MSMs attending HBCUs.

Payment:
Participants will receive no monetary compensation for their participation in the study. Participants will be provided a light meal after completion of the demographic profile, risk assessment profiles, and in depth interview.

Privacy:
Any information you provide will be kept confidential. The researcher will not use your personal information for any purposes outside of this research project. Also, the researcher will not include your name or anything else that could identify you in the study reports. Data will be kept secure by in a locked cabinet in the home office of the researcher. Electronic profiles will be password protected and stored on an external hard drive. Data will be kept for a period of at least 5 years, as required by the university.

Contacts and Questions:
You may ask any questions you have now. Or if you have questions later, you may contact the researcher via cell phone at [redacted] or via e-mail at Natasha.jeffreys2@waldeu.edu. If you want to talk privately about your rights as a participant, you can call Dr. Leilani Endicott. She is the Walden University representative who can discuss this with you. Her phone number is 1-800-925-3368, extension 1210. Walden University's approval number for this study is # 09-17-14-0189392 and it expires on 09/16/15.

The researcher will give you a copy of this form to keep.

Statement of Consent:

I have read the above information and I feel I understand the study well enough to make a decision about my involvement. By signing below I understand that I am agreeing to the terms described above.

Printed Name of Participant ______________________

Date of consent ______________________

Participant's Signature ______________________

Researcher's Signature ______________________

Appendix D: Detailed Study Protocol

1. One –two Black MSM students who met exclusionary and inclusionary criteria were identified from Gay/ Straight Student Alliance to initiate and assist with the snowballing technique recruitment strategy.

2. Each student was provided information and a flyer regarding the study. The student informant provided the flyer to other potential students. Interested students contacted me the directly to get additional information regarding the study.

3. Students who contacted me via email or telephone were provided an email and hard copy of the Letter to participant which provided basic information regarding the nature of the study.

4. The snowballing recruitment process took place for 2 weeks and participants who self-selected for the study were e asked to provide the flyer to other individuals they thought would be interested in the study.

5. In addition to the snowballing recruitment technique, Flyers were utilized as an additional means of recruitment.

6. Once selected each participant would met with Study conductor to complete consent forms, ask any other questions and to determine the time, date and location of their interview.

7. During the first meeting, each participant was given a copy of the letter describing the proposed study and sign the Consent Form. The interview included a three step process that begins with completion of demographic profile, risk assessment profile followed by the interview. All assessments and profiles were completed electronically via laptop provided by the researcher. Interviews were recorded for accuracy. A list of the demographic profile, risk assessment profiles and interview questions are included in Appendix B.

8. Audiotapes were be transcribed verbatim and analyzed.

9. Interviews lasted 45-t 60 minutes. At the end of each interview participants will be provided hard copies of support resources as well as a small gift card for participating.

10. After participant information was collected and transcribed, participants were given the opportunity to review the information for accuracy. Clarifications were made, and documented by the researcher

11. After the participant information was analyzed additional participants were recruited utilizing steps 1-10. This continued until saturation was reached.

12. At the conclusion of the study participants will receive a summary of the findings of the research study.

Appendix E: Audit Trail Course of Research

A. Proposal and IRB approved
B. Post recruitment flyers for research study
C. Approach 2 individuals regarding being Lead Student Recruiters (LSR)
D. Present with information regarding the nature of the study
E. Ask if they are interested in working as LSR

If Yes

1. LSR asked to identify research participant that meets inclusionary and exclusionary criteria.

2. LSR will provide potential participant with basic study info and ask permission for researcher to email them information?

3. Research makes email contact with potential participant requesting number if still interested

4. If yes then follow up call make to potential participant

5. Consent gained

6. Resources provided

7. This participant asked to identify potential participant that meets inclusionary and exclusionary criteria steps 1-7 repeated until either 6-9 people identified

8. Participants receive study schedule which details times, dates, and location or data collection process

9. Data Collected

10. Data transcribed and coded for themes and content

11. Member checking, participants review transcribed interviews for accuracy and content and approve

12. Data analyzed themes transcribed and rich description created

13. Data summarized and reported.

14. Study concluded and participants receive copy of research

If No

1. Resources provided and confidentiality ensured step C is repeated another LSR is selected

Appendix F: Data Correlation Matrix

Research Questions

RQI 1.What is the frequency extent of stigma experienced by Black MSM (ages 18-24) attending an HBCU inn North Carolina?

RQII 2. What impact or influence does the current HBCU environment (policy, practice, culture and stigma) have on the sexual behaviors of Black MSM attending the University?

	RQI	RQ II	Demographics
Demographic Profile			X
Risk Assessment Profile		X	X
Interview Questions			
1. In terms of labels, how do you view yourself eg. gay, bisexual, queer/questioning etc., and why?	X	X	
2. What is your understanding of stigma?		X	
3. Since becoming a student at the University, please describe the most significant experience that you can recall where you believe stigma influenced the way you were treated or where you believe stigma influenced the outcome of the situation.		X	
4. Taking into consideration your sexual orientation, since coming to the University, please describe in detail any positive or negative experience(s) that you have had on campus where you believe that your sexual orientation played a role?		X	
5. Since becoming a student at the University what impact has your perception of how others view you and your sexual orientation had on your HIV risk taking behavior?	X		
6. What impact if any has the University,	X		

and/or or campus climate had on your sexual risk taking behavior?			

Appendix G: Pilot Test Results and Commentary

Group I (Field Experts) {Dissertation Committee Chair, Content Committee}

HIV/STI Prevention Supervisor, HIV Testing Coordinator, Prison Re-Entry and Straight Talk Coordinator. All of the afore mentioned professional work for our local (Forsyth County) Department of Health

Field Expert	Professional Affiliation
1	HIV/STI Prevention Supervisor*
Comments/Suggestions: 1. Consider shortening the time frame to 6 months because people have a hard time remembering a year. Clinically, we typically only discuss the last 90 days-6 months unless something has been on-going. 2. For a research survey, two pages is definitely good and I wouldn't make it any longer 3. As you know we used to use a similar format for our risk assessment but we have since updated our form. Some of the feedback in the outreach setting was that the questions were too wordy and redundant (asking "have you ever" and "in the past year"). I understand how this is useful in both risk counseling and research, but we often got skewed answers because people were tired of reading/answering questions.	

Field Expert	Professional Affiliation
2	HIV Testing Coordinator*
Comments/Suggestions: 1. Consider shortening the time frame to 6 months 12 months is a long time in the life of a college student. 2. Simply format to reduce number of questions.	

Field Expert	Professional Affiliation
3	Prison Re-Entry and Straight Talk Coordinator
Comments/Suggestions: 1. For Question 4 to make inquiry comprehensive add sex with transgendered man or female; perhaps utilizing a checkbox format that will reduce the number of Questions from 4 to 1. 2. For Question 5, consider shortening to the following: Have you ever sex with someone whose HIV status was unknown?	

3. For Question 8- I recommend formatting the question like this to avoid confusion) Have you had sex with a man in the past 6 months?
4. For Question 9-I recommend formatting the question like this to avoid confusion. In the past year have you had sex in exchange for drugs, money, or another incentive?
5. For Question 10 in addition to sexually transmitted disease add infection.
6. For Question 18 and 19 change one to 1

Group II (Students)

Student	Unique Identifier	Classification	Residential Status
1	06-06-5727	Sophomore	Non-residential*
2	08-01-3573	Junior	Non-residential*
3	02-27-0904	Sophomore	Non-residential*
4	10-26-1105	Sophomore	Non-residential*

*All of these non-residential students had previously lived on campus

Student 1	Unique Identifier	Classification	Residential Status
	06-06-5727	Sophomore	Non-residential
Comments/Suggestions Questions were clear and relevant. No issues with the survey as printed.			

Student 2	Unique Identifier	Classification	Residential Status
	08-01-3573	Junior	Non-residential
Comments/Suggestions Questions were clear and relevant. No issues with the survey as printed.			

Student 3	Unique Identifier	Classification	Residential Status
	02-27-0904	Sophomore	Non-residential
Comments/Suggestions Questions were clear and relevant. Suggestion: Add the question Have you ever had sex with more than one person in a day?			

Student 4	Unique Identifier	Classification	Residential Status
	10-26-1105	Sophomore	Non-residential
Comments/Suggestions Questions were clear and relevant. Suggestion: Have you ever attended a sex party? If yes, did you actively participate at the party?			

Pilot Test Information Commentary

As indicated in the manuscript the risk assessment profile was borrowed and adapted for the local health department. Although the risk assessment profile had been widely utilized to my knowledge it had not been tested for reliability and validity. To do this the survey was evaluated/piloted with two groups. Group 1 include a group of experts and included (dissertation committee, chair, content expert, Supervisor from the County health department, HIV testing coordinator for local health department, and non-traditional traditional HIV testing coordinator.

The second group consisted of representative of the target group. Four black MSM students were selected to pre-test and pilot the instrument. Participants were referred by the President of the Gay/Straight Student Alliance. Four Black MSM were involved in pre-testing and pilot testing of the instrument. Students were asked to complete the survey the same way that it would be administered in the actual project; as such students pre-tested the survey utilizing a laptop computer. Students were provided information regarding the study and asked for their consent to participate. Students read consent form and had the opportunity to ask question regarding the study. Students were advised of the confidentiality of the study and asked to complete the survey being honest and truthful. After completing the electronic survey students were asked to provide feedback regarding the instrument and directions they received.

As students were completing the survey they were observed for hesitancy or body language that suggested difficulty with understanding and processing the questions. Students were also asked to provide feedback on contact and ease of completion of survey. For ease of completion students were asked if check boxes worked and if instructions were clear, and about the clarity of the instrument. If students had difficulty with questions students were asked to “think out loud” regarding those questions. They were told to share with me what aspect of the question contributed to their lack of understanding and clarity. Notes were taken to ensure that all information was captured. Additionally participants were observed for hesitancy and/or challenges experienced for different question in the instrument. Observations were made regarding logistical elements of the survey. For example did check boxes work with ease? Did participants understand the instructions and how to identify their response? After participants completed testing of the instrument experts in Group 1 considered the following three questions three regarding the content of the survey:

1. Do you think that the survey missed any questions that should be asked in a brief risk assessment profile?
2. Do the questions make sense or are some of them useless, redundant, etc.
3. Are there any questions that you would add?

Group 2 was asked the following three questions:

1. Were the questions and the language utilized clear and easy to understand?
2. Do the questions make sense or are some of them useless, redundant, etc.
3. Do you feel the survey covers all questions that should be asked?

Appendix H: Risk Assessment Profile

1. Have you ever had an HIV Test? □ Yes □ No □Don't Know
If yes was your test □ positive or □ negative

2. Within the last **6 months**, have you had… (mark all that apply)
□ Sex with a man… If yes, which type? □Oral sex □ Anal sex
□ Transgendered men If yes, which type? □Oral sex □ Anal sex
□ Transgendered women If yes, which type? □Vaginal sex □ Oral sex □ Anal sex
□ Sex with a woman… If yes, which type? □Vaginal sex □ Oral sex □ Anal sex

□ Sex with someone whose HIV status you did not know
□ Sex with an HIV+ person
□ Sex in exchange for drugs/money
□ Injected (shot up) drugs
□ Sex with someone who injected drugs
□ Sex against your will (rape)
□ Sex with a man who has sex with other men
□ Sex with more than one person in the same day
□ Sex without a condom

3. Have you had a sexually transmitted disease or infection in the six months year?
□ Yes □ No □ Don't know

If yes, check all that apply
☐Syphilis (bad blood) ☐Genital/Sex Warts ☐Gonorrhea (clap) ☐Herpes
☐Chlamydia ☐ Trichomonas (trich) ☐Hepatitis A ☐Hepatitis B
☐Hepatitis ☐HIV or drip ☐ Burning or dripping from penis (not gonorrhea or chlamydia)

4. Since coming to college have you used any of the following substances
□ cocaine □crack □speed □heroin □ecstasy □methamphetamine □ alcohol □ marijuana

5. Have you had sex while using these substances?
□ Yes □ No □ Don't know

6. Since coming to college has your use of these substances
□Increased □Decreased □Remained about the same

7. Do any of your sex partners have sex with people other than you?
□ Yes □ No □ Don't know

8. How many sex partners have you had within the 6 months?
None 1 2-5 6-10 more than 10

9. How often do you use condoms with your sex partners?
Never Sometimes Most of the time Always

10. Since coming to college have you attended a sex party?
□Yes □ No □ Don't know If so did you participate? □Yes □ No

11. Have you received any blood or blood products in the past year?
□ Yes □ No □Don't know

12. Have you had health care exposure to HIV (e.g., needle prick) within the past year
□ Yes □ No □Don't know