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The Impact of HIV Prevention Education in School on Young Men Who Have Sex With Men

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Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

Sex education through the public school system has been identified by the Centers for Disease Control and Prevention as an excellent vehicle by which HIV prevention education can be presented to students, thereby decreasing the rate of HIV infection among young men who have sex with men (YMSM). However, YMSM continue to be at high risk for HIV infection in the United States despite educational efforts to prevent infection. The purpose of this qualitative study using a phenomenological approach was to explore what impact school-based HIV prevention education had on YMSM in the past, and what effect that education has had on their current sexual behaviors. The theoretical foundation for this study was the health belief model. Individual 1-hour interviews were conducted with 13 YMSM (ages 21-35) who received HIV prevention education in California. Interviews were analyzed for common themes using a phenomenological approach. Results of this study suggest that participants were not utilizing safer techniques taught in the school HIV prevention education because there was a lack of curriculum consistency, LGBTQ content, and classroom management, and the impact of stigma and homophobia on YMSM. These results support the health belief model. Findings support that positive social change can be achieved by providing standardized, all-inclusive, non-judgmental, HIV prevention education program, in a classroom environment where it is safe to receive same-sex sexual information. This should decrease the number of HIV+ test results among YMSM.

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Dedication

I dedicate this study to all the participants who gave so freely of their time to share their experiences receiving HIV prevention education while in middle school, high school, or both, with me. Although the experiences they related to me were poor, their honesty and candor should help to make the HIV prevention educational experiences of future generations of young men who have sex with men much more meaningful. This meaningful experience should help in preventing the future spread of HIV disease.

Acknowledgment

First of all, I would like to acknowledge the members of my doctoral dissertation committee: Drs. Tracy Marsh, Debra Wilson, and Yoly Zentella. Thank you for your continued encouragement and support. Without your help this would have been a much longer and arduous process.

Second, I would like to acknowledge my wife, Yolita Tachet, who also gave me continued encouragement and support. I cannot imagine what it takes to be the spouse of someone who is seeking a doctoral degree. Your patience is an inspiration to me. I love and thank you more than mere words can describe.

Third, I would like to acknowledge my friends and colleagues who gave me continued encouragement and support. Every time I thought I had reached a bump in the road, or an impasse, they helped me find ways to accomplish what I needed to do. I especially want to acknowledge Jesus Altamirano, a dear friend and colleague of many years, who passed away before I could finish my dissertation.

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Chapter 1: Introduction to the Study

Introduction

Young men who have sex with men (YMSM) continue to be at high risk for HIV infection in the United States despite educational efforts to prevent infection (Centers for Disease Control and Prevention [CDC], 2016b; Koenig, Hoyer, Purcell, Zaza, &Mermin, 2016; Pettifor et al., 2013; Phillips, Ybarra, Prescott, Parsons, &Mustanski, 2015). Sex education through the public school system has been identified by the CDC as an excellent vehicle by which HIV prevention education can be presented to students, thereby decreasing the rate of HIV infection among YMSM (CDC, 2010). According to Nieblas, Hughes, Andrews, and Relf (2015), the CDC reviewed 84 effective HIV prevention programs. Although two-thirds of all HIV infections are among MSM, only three of the 84 effective HIV prevention programs reviewed were developed for YMSM. The gap in the literature is that there is little research available that explores with YMSM what their lived experiences were with HIV prevention education they received in middle school, high school, or both, and how that has affected their current sexual behaviors, in particular, their risk for HIV infection.

The topic of this study was to find out why YMSM continue to be high risk for HIV disease in spite of the educational efforts of the public school system to prevent HIV infection. The purpose of this qualitative study using a phenomenological method was to explore the lived experiences of YMSM who received HIV prevention education in middle school, high school, or both, and how that lived experience has affected their current sexual behavior, specifically the risk of HIV infection. The findings gained by

interviewing YMSM 21-35 years of age who experienced HIV prevention education may be instrumental in adapting future HIV prevention education to be more user-friendly to YMSM. If HIV prevention education can be designed to be more user-friendly to YMSM, it might be influential in decreasing future HIV infections in this population. The social implications of decreasing future HIV infections in this population would be to increase the quality of life for the YMSM who do not become infected with HIV disease, as well as the lives of their sexual partners. A decrease in future HIV infections would allow resources currently utilized to treat HIV disease to be utilized researching and treating other medical conditions, such as Ebola virus and Zika virus.

This chapter consists of a brief discussion of the focus of this qualitative study using a phenomenological approach followed by a statement of the specific problem, the purpose of the study, and the research question. The next sections include the theoretical framework on which the study is based, the nature of the study, definition of terms, and assumptions. The final portion of this chapter contains a discussion of the scope of the study and its limitations and significance.

Background

According to the CDC (2016b), 34% of all new cases of HIV infection each year are among persons 13-24 years of age. Of that 34%, almost 91% are young men who identify as YMSMs and are either gay or bisexual (CDC, 2016b; Pettifor et al., 2013; Phillips et al., 2015). The CDC (2016c) estimates that only approximately 2% of the American population identifies as gay, bisexual, and other men who have sex with men. The CDC (2016b) also estimates that of all the YMSM 13-24 years of age who became

infected with HIV disease, over half became infected while still under the age of 18 years. Key questions are why the infection rate is so high in this population and what can be done to decrease this infection rate.

Since 1992, all public school students in the State of California have been required by law to receive HIV prevention education at least once in middle school/junior high school and once in high school (California Department of Education, 2016). The law states that HIV prevention education must be appropriate for students of all sexual orientations. By the time YMSM reach the age of 18 or graduate high school, they should be familiar with and able to implement HIV prevention education, thereby preventing infection with HIV disease. Despite the efforts being made by the State of California Department of Education to prevent HIV infections in this population, infection rates continue to be disproportionately high (CDC, 2016b).

Most of the data used to evaluate adolescent sexual behaviors come from the CDC Youth Risk Behavior Survey (YRBS). Although the CDC YRBS has been used since 1991 to evaluate youth risk, it was not until 2015 that the CDC started including questions about the survey respondents' sexual identity, as well as the sexual identity of their sexual partners (CDC, 2016g). This omission prevents researchers from examining the responses from YMSM. This study is needed to evaluate the sexual behaviors of YMSM so that HIV prevention education can be tailored to better meet the needs of YMSM, thereby lowering the rate of HIV infection in this population.

Problem Statement

Although much has been written about high infection rates in this population, none of the existing literature addresses the impact of the HIV prevention education message on YMSM. There is a need to understand better how the HIV prevention education is received and perceived in school by YMSM 21-35 years of age and whether, or how, that education affects their current sexual behaviors, particularly their risk for HIV infection.

Sex education through the public school system has been identified by the CDC (2010) as an excellent vehicle by which HIV prevention education can be presented to students, thereby decreasing the rate of HIV infection among YMSM. Despite educational efforts, however, HIV infection rates among YMSM continue to increase (CDC, 2016b). Much of the research done on the effectiveness of HIV prevention education comes from the CDC YRBS. Although the YRBS has been used since 1991, it was not until the 2015 YRBS that the CDC included questions asking the respondent their sexual identity and that of their sexual contacts (CDC, 2016g). Not including survey questions in the CDC YRBS that provide relevant information on the sexual behaviors of YMSM is where a meaningful gap in the current research literature can be found.

Evaluations of adolescent sex education programs make the following recommendations for improvements in the sex education being taught in schools:

- Sex education programs must be designed to effectively reach students (Pettifor et al., 2013).

- Sex education programs must be culturally appropriate, pragmatic, and inclusive of all students (Bay-Cheng, 2003; Brooks & Bridges,2015).
- Sex education programs must begin early (before sexual debut) and be repeated often to be most effective (Dinaj-Koci et al., 2014; Ma, Fisher, &Kuller, 2014).

Purpose of the Study

The purpose of this qualitative study using a phenomenological approach was to fill a significant gap in the literature by exploring the lived experiences of YMSM 21-35 years of age who received HIV prevention education in either middle school, high school, or both, and how that education has affected their current sexual behaviors, specifically their risk for HIV infection. Through individual, in-depth interviews of YMSM 21-35 years of age, I hoped to identify any unmet needs of YMSM so that future HIV educational efforts in middle school, high school, or both, may more completely meet the needs of YMSM. By better meeting the HIV prevention education needs of YMSM, the HIV infection rate in this population should decrease.

Research Question

The research question (RQ) for this phenomenological qualitative study was as follows:

RQ: What impact did the lived experience of receiving HIV prevention education, in middle school, high school, or both, have on YMSM in the past, and what affect has that education had on current sexual behaviors, specifically the risk of HIV infection?

In the individual interviews I askedthe following exploratory questions:

- Tell me about your experiences receiving HIV prevention education while in school?
- What did you like about the HIV prevention education you received while in school, and why?
- What did you not like about the HIV prevention education you received while in school, and why?
- How do you apply the HIV prevention education you learned in school to your life currently, and why?
- If you could change the HIV prevention education you received in school, what would you change and why would you change it?
- How risky do you believe your sexual behaviors today are, particularly unprotected anal receptive intercourse, based upon the HIV prevention education you received in school?
- Now that men who have sex with men may legally marry, have you given any thought about marrying another man?

Theoretical Framework for the Study

The theoretical framework for this qualitative study was the health belief model (HBM; Champion & Skinner, 2008). The HBM is based on the theoretical propositions that people make decisions about behaviors that affect their health by weighing the severity of the disease, their risk of becoming infected by their current behaviors, the benefit of modifying their current behaviors to protect them from infection, and obstacles

to modifying their current behavior to avoid chance of infection. There is a more detailed explanation of the HBM in Chapter 2.

To change high-risk behaviors and prevent HIV disease, the HBM predicts that a person must believe that they are engaged in behaviors that put them at high risk for infection with HIV disease and that they do not want to become infected with HIV disease. Because the HIV infection rate in this population remains high, YMSM may not be receiving sufficientinformation about the severity of HIV disease and the behaviors that put a personat higher risk for infection to effectively utilize the theoretical propositions of the HBM. By asking the RQ, What impact did the lived experience of receiving HIV prevention education, in middle school, high school, or both, have on YMSM in the past, and what affect has that education had on current sexual behaviors, specifically risk of HIV infection? this study shed more light on why the HIV infection rate in this population continues to be so high. The key questions concerned what HIV prevention information did these YMSM receive in middle school, high school, or both and whether that information was sufficient to help these YMSM make the decision that they wanted to modify their sexual behaviors to avoid the risk of HIV infection.

Nature of the Study

The nature of this study was qualitative using a phenomenological research method (see Creswell, 2014; Trochim& Donnelly, 2008; Wilson et al., 2015). Although roots of phenomenology can be traced to Kant and Hegel, Husserl (1859-1938), a German philosopher, is considered the “father” of the philosophical movement known as

phenomenology (Moustakas, 1994). Husserl believed that the personal world is reduced to personal experience.

Qualitative phenomenological research methods consist of gathering data from a specific population about a phenomenon experienced by that population.This is done by interacting with that specific population and developing results applicable to that particular population based on themes identified and analyzed from participant interviews (Creswell, 2014; Moustakas, 1994; Trochim& Donnelly, 2008). The central phenomenon of this study was the lived experiences of YMSM 21-35 years of age around HIV prevention education learned in middle school, high school, or both, and how that education has affected their current sexual behaviors. I chose phenomenology for this study because, rather than approach the subject of how HIV prevention education affected the current sexual behaviors of YMSM, specifically their risk of HIV infection, with a set of preconceived hypotheses, I wanted to hear how participants experienced the effect HIV prevention education had on their lives in their own words.

I conducted individual, in-depth, 1-hour interviews with 13 YMSM 21-35 years of age exploring their lived experiences receiving HIV prevention education in middle school, high school, or both, and how that education has affected their current sexual behaviors, specifically the risk of infection with HIV disease. Iaudio-recorded interviews and transcribed them verbatim. I analyzed transcripts for common themes.

Definitions

Abstinence-only until marriage (AOUM): Abstinence-only until marriage (AOUM) is a form of sex education that is restrictive in that it only teaches that one

should remain abstinent until marriage and, once married, remain faithful to one's spouse. Until same-sex marriage was recognized as legal in the United States, sex education that emphasized AOUM did a disservice to lesbian, gay, bisexual, transgender, and questioning (LGBTQ) students because they never saw themselves as ever getting married (Bigelow, 2012; Lord, 2010).

Comprehensive sex education (CSE): Comprehensive sex education (CSE) is a form of sex education that teaches how to prevent sexually transmitted infections (STIs) and pregnancies. CSE teaches about birth control and the use of condoms. CSE does not require that individuals remain abstinent until married (Collier, 2007; Lord, 2010; Luker, 2007).

School-based sex education (SBSE): School-based sex education (SBSE) is a form of sex education that is taught to students in a classroom environment. In 2015, the CDC noted that approximately 37 million adolescents attended a public or private school 6hours a day and that school is the ideal place to teach adolescents about teenage pregnancy, STIs, and HIV prevention (CDC, 2010).

CDC Youth Risk Behavior Survey (YRBS): CDC YRBS is a survey the CDC has usedto monitor six categories of health risk behaviors that cause death or disability among youth since 1991 (CDC, 2016h). One of those risk behaviors is sexual behavior related to unintended pregnancies, STIs, and HIV disease. The CDC sends the surveys out to school districts across the nation. The school district is responsible for survey distribution to studentsand returning completed surveys to the CDC. Many researchers utilize data from the CDC YRBS. However, it was not until 2015 that the CDC asked

respondents to identify their sexual identity as well as that of their sexual partners, so there was no way to separate the responses of YMSM from heterosexual young men (CDC, 2016g).

HIV prevention education: HIV prevention education addresses what HIV disease is, how it is transmitted, and how to prevent becoming infected with HIV disease. The problem is there is no nationally approved HIV prevention education curriculum taught nationwide. What a student learns in one state or one school district might not necessarily be what is being taught in another state or school district (California Department of Education, 2016). Not all states are required to teach either sex education or HIV prevention education (National Conference of State Legislatures [NCSL], 2016).

No promotion of homosexuality laws (No promo homo laws): No promotion of homosexuality laws (no promo homo laws) restrict or prohibit schools from developing a sex education curriculum that presents homosexuality as a healthy or normal sexual behavior (Barrett & Bound, 2015). However, it can also be interpreted as banning teachers from saying anything about homosexuality unless it is negative. For example, if a student asks a question regarding homosexuality, the teacher is required to say homosexuality is against the law before it became legal (Kellinger, 2015).

Young men who have sex with men (YMSM): YMSM is the term I used to describe participants in this study rather than homosexual, gay, or bisexual young men.Although all four terms can be used to describe sexual behavior, homosexual, gay, and bisexual are frequently used as labels to indicate a man's sexual identity or orientation (CDC, 2016b). AYMSM 21-35 years of age may not have concluded during his time of sexual

experimentation that he exclusively has sex with men or is ready to identify as homosexual, gay, or bisexual. Some men have sex with men who, when asked for their sexual identity, will identify as a heterosexual man.

Assumptions

This qualitative study using a phenomenological approach included three assumptions. The first assumption was that all participants were young men 21-35 years of age who have sex with men and who lived in Alameda County, Contra Costa County,or San Francisco County, California. The second assumption was that participants understood the interview questions that were being asked in English. The third assumption was that participants were truthful in answering the interview questions.

These assumptions were necessary in the context of this study because I interviewed13 YMSM 21-35 years of age who lived in Alameda County, Contra Costa County, orSan Francisco County, California, who experienced HIV prevention education in middle school, high school, or both anywhere in the state of California. Participants needed to speak and understand English as that was the only language in which I conducted the interviews. It was also important that the participants answer the interview questions truthfully for the results of this study to have any value.

Scope and Delimitations

The scope of this study was an exploration of the lived experiences of 13 YMSM 21-35 years of age who received HIV prevention education in middle school, high school, or both anywhere in the state of California and how that education has affected their current sexual behaviors, specifically their risk for HIV infection. The risk for HIV

infection was chosen as the specific focus of this study because although HIV infection rates appear to have stabilized or decreased in other affected populations, the rate of HIV infection appears to be continually increasing in this particular population (CDC, 2016b). This continual increase in infection rates is despite this population havingreceived the most formalized HIV prevention education in middle school, high school, or both.

Although I considered just doing a survey of YMSM 21-35 years of age who had received HIV prevention education in middle school, high school, or both, and how that education had affected their current sexual behaviors, specifically risk of HIV infection, I felt that a Likert scale survey might not do justice to the lived experience of these YMSM. I believed that allowing these YMSM to describe their lived experience in their own words would produce deeper, richer information. That is why I chose to do a qualitative study using a phenomenological method.

Another research designthatI rejected was the case study design. The case study method often involves studying the complex relationship between people, a phenomenon, and a context (Creswell, 2013). I wasstudying a phenomenon experienced by people in the past and how that past lived experience had affected a current behavior.

Transferability refers to the ability to replicate a research study from one location to another (Lincoln & Guba, 1985). In a quantitative study, transferability establishes external validity. Qualitative research using phenomenological methods is limited in its transferability because it is a localized study of a specific group of individuals in a specific location. The results of this study may sound familiar to a reader from a different location dealing with similar participants. If this happens, it will lend credibility to this

study. However, credibility for this study is built into the details of how the study was conducted,including having participants check transcripts to ensure they reflected what the participant said.

Delimitations in this study included:

- Participants were YMSM21-35 years of age living in the Alameda County, Contra Costa County, and San Francisco Countygeographicalareas of California. Participants identified as homosexual, bisexual, or gay. Young men who hadnot been sexually active with men were excluded from this study.
- Participants must have received HIV prevention education in middle school, high school, or both, anywhere within the State of California. Participants who received HIV prevention education outside of thestate of California were excluded because the geographical area of focus was within the State of California.
- Participants underwent an individual, 1-hour, audio-taped interview.
- Participants must have spokenand understood English. Although non-English speaking participants may have valuable information to share, becauseHIV prevention education in California is restricted to English only, the data I collected involved those who received their HIV prevention education in English.

Limitations

There wereseveral limitations to this study. The first limitation had to do with design and methodological weakness. The design of this study was qualitative using a phenomenological method to explore and gain a deep understanding of the lived experiences of a convenience sampling of 13 YMSM who received HIV prevention education in middle school, high school, or both in the state of California. The information was not meant to apply to YMSM anywhere else.

Other design and methodological concerns included how well respondents were able to articulate how they experienced the phenomenon being studied. The richer and more descriptive the information provided, the more accurate the information collected was. Researcher bias was another concern. Phenomenological research is dependent upon the researcher's interpretation of the experiences the respondents described. Dependability addresses the accuracy and consistency of data collection, analysis, and theory generation (Lincoln & Guba, 1985). The dependability of the information garnered from participants depended upon the commonality of themes elicited from interviews.

The second limitation of this study was that it was limited to English-speaking participants. Although non-English speaking students might provide different information than English-speaking participants, becausethe State of California Department of Education only requires that HIV prevention education be taught in English, this study was restricted to English-speaking YMSM. Future studies may want to focus on YMSM who receive non-English HIV prevention education strategies.

The third limitation in this study was that participants received different HIV prevention education curricula in either middle school, high school, or both. This limitation impacted the lived experiences they brought to the individual interview and how they applied what they learned in school about HIV prevention to their current sexual behaviors. The way to correct for this limitation was to focus on where participant received his HIV prevention education and noting that as a possible reason for any inconsistent information gained in the interview process.

The fourth limitation in this study was the variation in the age of the participants, the length of time since they received HIV prevention education in middle school, high school, or both, as well as any HIV prevention education they may have received since leaving school.This limitation made it difficult to isolate the HIV prevention education they received in school from other sources of prevention information they brought to the individual interview. The way to minimize this limitation was to focus the participant on knowledge gained through the educational process while in middle school, high school, or both. I achieved this by asking participants to respond to the interview questions based solely on what was presented to them in the HIV prevention education they received in middle school, high school, or both.

Epoche, or bracketing, is the method by which researchers put aside theirpreconceived ideas or personal biases about a phenomenon(Creswell, 2013; Patton, 2015),in this case to best understand the lived experiences of the YMSM who received HIV prevention education in middle school, high school, or both. Although I conductedsome HIV prevention education in alternative high schools in Contra Costa

County in 1992 as an American Red Cross HIV education volunteer, I have no current experience in HIV education prevention curricula. Although I may have had or developed some preconceived ideas or biases while conducting these interviews, I paidparticular attention to acknowledging these ideas or biases and bracketed them so that I reported only on the information provided by interview participants. I analyzed the responses of participants according to the phenomenological literature.

Significance

Although much has been written about high infection rates in this population, none of the existing literature addressed the impact of HIV prevention education on YMSM. There was a need to understand better how the HIV prevention education received in school was perceived by YMSM 21-35 years of age and whether, or how, that education affected their current sexual behaviors, specifically their risk for HIV infection. By asking YMSM about their lived experiences around HIV prevention education received in school, I hoped to identify potential barriers that may be eliminated so that future efforts at teaching HIV prevention education will have a more positive impact on decreasing the HIV infection rate with this population.

I was appropriate for me to use qualitative research witha phenomenological method to interview YMSM 21-35 years of age, asking them for specific information about their shared lived experience of HIV prevention education they received while they were in school and how it is affecting their current sexual risk behaviors. The knowledge they shared about their lived experiences with school-based HIV prevention education

will help in the design of HIV prevention education programs that will better address their needs.

Summary

In Chapter 1, I identified the problem, provided background information on the problem, stated the purpose of the study, and posed the RQ. Following this, I discussed the theoretical framework for and nature of the study. I defined terms, identified assumptions, discussed scope and delimitations, presented limitations, and acknowledged significance.

Since the emergence of sex education in public school, there have been questions about the goal of sex education and what should be taught. Questions have included whether schools should teach children to abstain from sex until marriage or teach children how to prevent unwanted pregnancies and STIs. After the proliferation of HIV, other questions were asked such as whetherschools should teach only to the sexual majority students or to all students, including sexual minority students.

YMSM continue to be at high risk for HIV infection in the United States. The CDC (2010) has identified sex education in the public school system as an excellent way of presenting HIV prevention education and decreasing the rate of HIV infection in YMSM. However, when the CDC evaluated the effectiveness of 84 school-based HIV prevention education programs, only three were developed to meet the needs of YMSM (Nieblas et al., 2015).

Although much has been written in the literature about why the HIV infection rate continues to be so high in YMSM, no study has addressed how school-based HIV

prevention education has affected YMSM directly. Much of the information used to discuss the sexual behaviors of adolescents comes from the CDC's YRBS. Although the YRBS has been used by the CDC since 1991 to evaluate youth risks, it was not until 2015 that the CDC started including questions about the survey respondents' sexual identity or the sexual identity of their partners (CDC, 2016h).

The purpose of this qualitative study using a phenomenological approach was to fill a significant gap in the literature by exploring how YMSM 21-35 years of age experienced HIV prevention education they received in either middle school, high school, or both, and how that education has affected their current sexual behaviors, specifically their risk for HIV infection. Through individual, in-depth interviews of 13 YMSM, I hoped to identify any unmet needs of YMSM so that future HIV educational efforts in middle school, high school, or both may more completely meet the needs of YMSM. By better meeting the HIV prevention education needs of YMSM, the HIV infection rate in this population should decrease.

In Chapter 2, I describe my literature search strategy, followed with a discussion of thetheoretical foundation. Next, I present a literature review related to the key concepts of my study. I then present a summary and conclusions of Chapter 2.

Chapter 2: Literature Review

Introduction

According to the CDC (2019b), in 2017, 21% (8,164) of all new cases of HIV were among persons 13-24 years of age. Of that 21% of new HIV cases, 87% (7,125) were YMSM. Of those YMSM 13-24 years of age, Black and Hispanic YMSM were disproportionately affected by HIV disease.

Sex education through the public school system has been identified by the CDC (2010) as an excellent vehicle by which HIV prevention education can be presented to students, thereby decreasing the rate of HIV infection among YMSM. Unfortunately, there is no standardized national HIV prevention education curriculum; each state decides what it will teach (NCSL, 2016). Sex education focuses on heterosexual students, the sexual majority, to the detriment of lesbian, gay, bisexual, transgender, and questioning (LGBTQ) students, the sexual minority.

The purpose of this qualitative study using a phenomenological method was to explore the lived experiences of YMSM who received HIV prevention education in middle school, high school, or both, and how that lived experience has affected their current sexual behavior, specifically the risk of HIV infection. The insights gained by interviewing YMSM 21-35 years of age who experienced HIV prevention education may be instrumental in adapting future HIV prevention education to be more user-friendly to YMSM. If HIV prevention education can be designed to be more user-friendly to YMSM, it might be influential in decreasing future HIV infections in this population.

A synopsis of the current literature that established the relevance of this study includes the fact that HIV prevention education is not taught in all 50states (Ma et al., 2014; NCSL, 2016). In those states where HIV prevention education is being taught, there is no consensus about what will be included in the curriculum or who will teach HIV prevention education to the students (Bigelow, 2012; Borawski et al., 2015; Lord, 2010; Luker, 2007; May, 2010). The CDC has used the YRBS since 1991 to monitor sexual behaviors related to unintended pregnancies, STIs, and HIV, among other things (CDC, 2016h). Up until the 2015 YRBS, the CDC did not include questions asking respondents about their sexual identity or the sexual identity of their sexual contacts (CDC, 2016g). All previous YRBS data fail to represent risky LGBTQ sexual behaviors accurately. In spite of this fact, several studies have been based upon this incomplete secondary data provided by the CDC (Nieblas et al., 2015; Van Handel, Kann, Olsen, & Dietz, 2016).

This synopsis also includes the fact that a number of states refuse to present HIV prevention education that would be appropriate to LGBTQ youth, claiming no promo homo laws as the justification for withholding such information (Barrett & Bound, 2015; Kellinger, 2015; Kull, 2010; Lloyd et al., 2012). In those states, when students ask questions regarding same-sex sexual behaviors, teachers are instructed to describe same-sex sexual behaviors in negative or derogatory terms (Barrett & Bound, 2015). LGBT teachers who taught in these states never challenged the no promo homo policies for fear of losing their jobs (Kellinger, 2015).

Throughout most of U.S. history, sex education has been structured on conservative and religious values (Kull, 2010; Luker, 2007). Up until 2010, the Federal Government only funded sex education programs that emphasized an AOUM curriculum (Andrasik&Lostutter, 2012). Becausesame-sex marriage was only recognized on the federal level in 2014 (Yoshino, 2015), sex education and HIV prevention before 2014 held little, if any, relevance to LGBTQ youth. Even though parents and students asked for more CSEand HIV prevention curriculum, the federal government and those schools they funded persisted in only funding AOUM curriculum (Donovan, 1998; LaSala, Fedor, Revere, & Carney, 2015; Lloyd et al., 2012).

There is less information collected directly from adolescent MSM (Mustanski& Fisher, 2016). It has been suggested that institutional review boards (IRBs) are partially to blame for the lack of data directly from adolescents. Although adolescents can consent for STI testing and treatment without parental consent, most IRBs are hesitant to let adolescents consent to be interviewed about their sexual behaviors.

This chapter presents an introduction, literature strategy, literature review on the theoretical foundation, and literature review related to the concepts being studied. These concepts are listed here in the order in which they appear: chosen methodology, human immunodeficiency virus, stigma, homophobia, and sodomy laws. These concepts are followed by sex education, obstacles to researching with minors and LGBTQ youth, IRBs as a possible obstacle to researching adolescents and LGBTQ youth, no promo homo laws as a possible obstacle to CSE, critiques of sex education programs, and alternatives to school-based sex education. This chapter ends with a summary and conclusion.

Literature Search Strategy

To better understand how YMSM 21-35 years of age might have received HIV prevention education in school while an adolescent and how that education has affected his current sexual behaviors, I performed a Boolean search on the terms *HIV prevention education in the United States* and *young men who have sex with men*. I performed alternative Boolean searches substituting the search term *young men who have sex with men* with the search terms *adolescent men who have sex with men, teenage men who have sex with men, gay young men,*and *gay teens*. I performed searches in Google Scholar as well as the Walden Library, including PsycINFO, PsychARTICLES, SAGE/Premiere, CINAHL & MEDLINE simultaneous search, Science Direct, and ERIC. I also performed searches on government websites, including the CDC website, the NCSL website, and the California Department of Education website.

Theoretical Foundation

The HBM was the theoretical foundation for this qualitative study. The HBM was developed in the 1950s by social psychologists in the U.S. Public Health Service in an attempt to understand why people would not participate in a free program to detect and prevent tuberculosis (Champion & Skinner, 2008; Rosenstock, Strecher, & Becker, 1994). The HBM is based on the theoretical proposition that people make decisions about behaviors that affect their health by weighing the severity of the disease, their risk of becoming infected by their current behaviors, the benefit of modifying their current behaviors to protect them from infection, and obstacles to modifying their current

behavior to avoid chance of infection (Champion & Skinner, 2008; Collins et al., 2012; Kilmer, Cronce, Hunt, & Lee, 2012; Rosenstock et al., 1994).

With regard to HIV prevention education, the HBM predicts that in order to change high-risk behaviors, a person must believe that they are engaged in behaviors that put them at high risk for infection with HIV disease and that HIV is a disease they do not want to become infected with (Champion & Skinner, 2008; Rosenstock et al., 1994). The HBM is frequently used in the United States to modify behavior that puts a personat high risk for exposure for HIV disease (Li, Lei, Wang, He, & Williams, 2016). The HBM has also been successful working with reducing high-risk behaviors internationally. Li et al. (2016) used the HBM to increase condom use among MSM in China, and Tarkang and Zotor (2015) used the HBM to increase condom use among heterosexual women in Cameroon. In both studies, once high-risk behavior for HIV infection was identified, obstacles to using male condoms were identified and eliminated, behavior modification (increased condom use) was accomplishable, thereby reducing the risk for HIV exposure.

I chose the HBM as the theoretical foundation for this study because of its successful application in lowering high-risk behavior through education in individuals at risk for infection with HIV disease (Champion & Skinner, 2008; Rosenstock et al., 1994). The majority of the studies in my literature review identified HIV prevention education for YMSM as a failure (Adewuyi, 2015; Arrington-Sanders et al., 2015; Bay-Cheng, 2003; LaSala et al., 2015). According to Nieblas et al. (2015), the CDC reviewed 84 effective HIV prevention programs. Although two-thirds of all HIV infections are among MSM, only three of the 84 effective HIV prevention programs reviewed were developed

for YMSM. Some studies blamed the Federal Government's refusal to fund any HIV prevention education before 2010 other than an AOUM curriculum (Lloyd et al., 2012). Other studies blamed no promo homo laws as barriers to providing YMSM with appropriate HIV prevention education (Barrett & Bound, 2015; Kellinger, 2015). Still, other studies blamed the CDC for failing to identify LGBTQ youth in their YRBS until 2015 (CDC, 2016g). Researchers have been using the secondary data collected from the YRBS to gauge the success of HIV prevention strategies since 1991 (CDC, 2016h; Van Handel et al., 2016).

The RQ for this study was: What impact did the lived experience of receiving HIV prevention education, in middle school, high school, or both, have on YMSM in the past, and what affect has that education had on current sexual behaviors, specifically the risk of HIV infection? Using the HBM,I found in this study that HIV prevention education provided to YMSM in middle school, high school, or both failed to equip these youths with adequate knowledge and skills to protect themselves from becoming infected with HIV disease(see Champion & Skinner, 2008; Rosenstock et al., 1994). I have identified an obstacle to modifying YMSM current behavior to avoid the chance of infection. Based on feedback provided by participants of this study, I have made recommendations for improving the quality of HIV prevention education provided in middle school, high school, or both. Improving the quality of HIV prevention education so that it applies to all students may result ina decrease in the number of new HIV infection rates in this population.

Literature Review Related to Key Concepts

Chosen Methodology

The nature of this study was qualitative using a phenomenological research method (see Creswell, 2014; Trochim& Donnelly, 2008; Wilson et al., 2015). Although the roots of phenomenology can be traced to Kant and Hegel, Husserl (1859-1938), a German philosopher, is considered the "father" of the philosophical movement known as phenomenology (Moustakas, 1994). Husserl believed that the personal world is reduced to personal experience.

One strength of phenomenological research is that it provides a very rich and detailed description of the human experience (Creswell, 2014; Wilson et al., 2015). Another strength of phenomenological research is that information collected comes from the participants rather than being imposed by a structured statistical analysis (Lincoln & Guba, 1985). There are several limitations to using phenomenological research. One limitation is that the results are dependent upon the researcher's interpretation (Creswell, 2014; Lincoln & Guba, 1985; Patton, 2015).Another limitation is that the results are restricted to the participants involved in a specific location. The research may not be generalizable to another set of participants in a different location.

Qualitative phenomenological research methods consist of gathering data from within a specific population, about a phenomenon experienced by that population, by interacting with that specific population, and developing results that are applicable to that particular population, based upon themes identified and analyzed from participant interviews (Creswell, 2014; Moustakas, 1994; Trochim& Donnelly, 2008). The central

phenomenon of this study was the lived experiences of YMSM, 21-35 years of age, around HIV prevention education learned in middle school, high school, or both, and how that education has affected their current sexual behaviors. Phenomenology was chosen for this study because, rather than approach the subject of how HIV prevention education affected the current sexual behaviors of YMSM, specifically their risk of HIV infection, with a set of preconceived hypotheses, I wanted to hear how participants experienced the affect HIV prevention education has had on their lives in their own words.

Individual, in-depth, 1-hour interviews were conducted with 13 YMSM, 21-35 years of age, exploring their lived experiences receiving HIV prevention education in middle school, high school, or both, and how that education has affected their current sexual behaviors, specifically the risk of infection with HIV disease. Interviews were audio-recorded and transcribed verbatim. Transcripts were analyzed for common themes.

Human Immunodeficiency Virus

HIV biology. Two lentiviruses, HIV-1, and HIV-2 cause HIV. Lentiviruses attack the immune system of human beings (AVERT, 2016b; Sharp & Hahn, 2011). Human beings are not the only species to be affected by immune system diseases (Aiello & Moses, 2016; Quammen, 2015; Sharp & Hahn, 2011). In dogs (canines), it is known as CIV; in cats (felines), it is known as FIV; in horses (equines) it is known as EIV; in cows (bovines), it is known as BIV; and in monkeys (simians), it is known as SIV(Aiello & Moses, 2016). It is important to note that different species have experienced immunodeficiency disease because HIV has been around since about 1920 (AVERT, 2016a). Scientists have been able to conclude that the first case of HIV took place around

1920 in Kinshasa in the Democratic Republic of Congo (AVERT, 2016a; Quammen, 2015; Sharp & Hahn, 2011). HIV is considered a zoonotic disease, a disease that can be spread between animals and humans (CDC, 2013; Sharp & Hahn, 2011). Scientists believe that SIV crossed the species barrier and infected humans with what is known as HIV (AVERT, 2016a; Quammen, 2015). The hunter theory is based on the belief that SIV crossed the species barrier because monkeys are eaten in Africa and SIV tainted blood came in contact with hunters when the hunters killed and dressed out monkey meat in preparation for cooking and eating it (Quammen, 2015; Sharp, & Hahn, 2011).

HIV transmission. HIV infection is transmitted through HIV contaminated bodily fluids, including blood, semen, vaginal fluid, and milk from an HIV infected mother to her child during pregnancy, birth, or breastfeeding (CDC, 2016b; CDC, 2016d). Unprotected sexual behaviors and number of sexual partners are factors that increase the sexual risk of being infected with HIV. Unprotected anal intercourse is the highest-risk sexual behavior with anal receptive anal intercourse (bottoming) higher risk than insertive anal intercourse (topping) (Andrasik, &Lostutter; Borawski et al., 2015; Brooks, & Bridges, 2015; Kull, 2010).

LaSala et al. (2015) researched to understand why YMSM continue to engage in risky sexual behavior even after receiving HIV prevention education. Using qualitative methods, they interviewed 44 parents and 37 gay and bisexual youth, 14-21 years of age. Participants discussed YMSM's sense of invulnerability, sexual arousal, parental disapproval, and lack of societal acceptance as contributing factors. Participants want gay sensitive sex education and community programs as well as increased societal acceptance

of their lifestyle. Participants recommended interpersonal and structural-level interventions to reduce stigma as a key component of HIV prevention to reduce stigma as a key component of HV prevention. Because this was a qualitative study, the one limitation acknowledged was that the results of this study might not be generalizable.

Ma et al. (2014) used data from the 2009 YRBS to analyze the responses of 16,410 U. S. high school students in 158 schools across the U. S. to assess the association between HIV education and risky sexual behaviors, and academic grades. Authors used survey regression modeling to assess for the association. Results found sex and HIV education was effective in delaying sexual debut, increased condom and other forms of contraception use, reduced STIs, and reduced pregnancies. Limitations to this study included it was a cross-sectional study. Cause and effect were undetermined. Although the study indicated students had received HIV education, there was no way to evaluate the quality of HIV education. There was no way of determining the effects of this study on YMSM.

HIV in the United States. HIV first came to the attention of North America with the June 5, 1981 issue of the CDC's *Morbidity and Mortality Weekly Report (MMWR)*that reported five active homosexuals in Los Angeles were treated at three different hospitals for Pneumocystis Carinii Pneumonia (PCP) (CDC, 1981). In June of 1982, the CDC briefly called the disease *gay-related immune deficiency* (GRID) because of the cluster of cases of Kaposi's Sarcoma (KS) and PCP among gay males in San Francisco, Los Angeles, and New York (CDC, 1982; Kull, 2010; Shilts, 2007). However, the CDC had to change the name from GRID to *Acquired Immune Deficiency Syndrome*

(AIDS) when a follow-up *MMWR* report identified that not only homosexuals but also injection drug users and hemophiliacs were becoming infected with HIV disease.

Stigma, Homophobia, and Sodomy Laws

Stigma. Stigma is defined as "a mark of disgrace or infamy; a stain or reproach, as on one's reputation" (stigma, 2016; Fone, 2001; Mondimore, 1996). In 1981, the CDC originally named HIV disease *Gay-Related Immune Deficiency* (GRID) disorder because the only people to become infected with it at that time were all identified by the CDC as being homosexual men (CDC, 1981; Masur et al., 1981; Merson, O'Malley, Serwadda, &Apisuk, 2008). In 1982, after people who were identified as other than homosexual men were becoming infected with HIV disease, the CDC quickly changed the name of the disease from GRID to *Acquired Immune Deficiency Syndrome* (AIDS) (CDC, 1982). The CDC even changed the terms *gay* and *homosexual* to the term *men who have sex with men (MSM)* because MSM was considered to be less pejorative and a more accurate term for the behavior that puts one at risk for HIV disease, rather than stereotyping a group of people (Andrasik&Lostutter, 2012; Merson et al., 2008). How a man identifies himself sexually is not a particularly appropriate way of categorizing his sexual behaviors (UNAIDS, 2006). Some men have sex with men who identify as heterosexual because of the stigma and homophobia attached to identifying as either gay or bisexual (Pathela et al., 2006; UNAIDS, 2006). Even though the CDC made all of these changes about HIV disease, the stigma of GRID as a homosexual disease had already caught on in American society.

Pathela et al. (2006) conducted a cross-sectional, random digit, dialed telephone survey of health status and risk behaviors with 4,193 men in New York City. The strength of their survey suggested that straight-identified men who have sex with men are married, have fewer male sex partners than gay-identified men, use condoms less frequently than gay-identified men with their male sex partners, and test less frequently than gay-identified men. A limitation of their survey is that it only included men who had residential telephone services.

According to the CDC (2016b), 84% of youth, 15-24 years of age, said there is a stigma around HIV in the United States. Stigma and homophobia around HV disease were given as reasons why only 22% of sexually active high school students have been tested for HIV. Stigma and homophobia were also given by the CDC as to why high school students engage in unprotected sexual behaviors.

Phillips et al. (2015) researched on Facebook with 302 adolescent gay and bisexual men (AGBM) to investigate HIV testing rates and barriers AGBM face. The results of their research indicated testing rates were low among AGBM. Barriers to testing included a lack of knowledge about the closest testing site, as well as the stigma and homophobia attached to being seen at an HIV testing site by others. The authors of this study recommended introducing HIV testing services into high schools. This study's limitations include that there was no way to ensure respondents were adolescents and that there were no repeat respondents.

Van Handel et al. (2016) conducted a study of HIV testing among U.S. high school students and young adults by analyzing secondary data from the YRBS and the

Behavioral Risk Factor Surveillance System (BRFSS), from 2011-2013. Logistical regression models found that only 25% of sexually active high school students and 33% of sexually active young adults had tested for HIV. Authors of the study recommend health services on-site for high school students.

There were several limitations with the Van Handel et al. (2016) study. First, I found no indication of how many surveys were included in the analysis. Second, the cross-sectional design of YRBS prevents temporal order between HIV testing and risk behaviors. Third, several biases could be involved with the results of the surveys: recall bias, nonresponses, and social desirability. Fourth, YRBS data only applies to youth who attend schools and are not representative of all persons in this age group.

Washington, D'Anna, Meyer-Adams, and Malotte (2015) conducted a study of 36 black MSM, 18-30 years of age, recruited through flyers and social media, for six focus groups to explore barriers to HIV testing. Findings from this study reiterated the need to address stigma to encourage increased HIV testing. BMSM also wanted more information on where to test. Limitations to this study include that BMSM were self-selected; a majority of BMSM had low levels of education (high school or less); many of the BMSM were substance users. These participants may not represent the BMSM community.

In their project, Fostering AIDS Initiatives That Heal (FAITH), Abara, Coleman, Fairchild, Gaddist, and White (2015) worked at establishing partnerships and collaboration with African American churches and other faith-based organizations (FBO) in South Carolina in an attempt to remove the stigma of HIV and other barriers, such as

homophobia, to HIV awareness, HIV testing, and reducing HIV risk behaviors. By demystifying HIV disease to the congregants of these churches and FBOs, Abara and colleagues were able to gain the support of these agencies in helping to educate people about how to avoid becoming infected with HIV and, at the same time, see the human side of those who were infected with the disease.

Homophobia. Homophobia is defined as an "unreasoning fear of or antipathy toward homosexuals and homosexuality" (Fone, 2001; homophobia, 2016; Mondimore, 1996). Homo-negativity is another way of describing homophobia. They can be used interchangeably (Andrasik&Lostutter, 2012). Homophobia can be described as external homophobia or internal homophobia.

Fields et al. (2015) conducted qualitative research on secondary data to explore gender role strain (GRS) arising from the conflict between homosexuality and cultural concepts of masculinity among black YMSM.They analyzed semi-structured interviews with 35 black YMSM, 18-24 years of age, in three New York cities and Atlanta, Georgia. Results of this study indicated that the greater the external homophobia exhibited by others, the greater the internal GRS in the black YMSM. The greater the internal GRS in the black YMSM, the greater the sexual risk behavior exhibited by the black YMSM. The greatest limitation of this study is the fact that the authors were using secondary data with samples from different primary studies with varying sampling strategies and potential selection biases.

External homophobia. External homophobia can be exhibited by people, families, communities, or society as a whole (Fone, 2001). External homophobia is a fear

exhibited by non-homosexual persons or groups of people, also known as the heterosexual community, the dominant sexual group, or straight community (Barrett & Bound, 2015; Bay-Cheng, 2003; Brooks& Bridges, 2015; Fields et al., 2015). The fear, or hatred, toward homosexuals was so adverse that in some parts of the country, especially in southern states, a man might be beaten or even killed merely for being a suspected homosexual (Fone, 2001; Kite, & Bryant-Lees, 2016; Mondimore, 1996). Sodomy laws were legislated to protect society from homosexuality.

Based on the belief there is limited same-sex education coming from the family and schools, Arrington-Sanders et al. (2015) conducted qualitative research with 47, 15-19-year old, same-sex, black adolescents on the role and function of sexually explicit material (SEM) in their sexual development and how SEM impacts sexual risk-taking behaviors during first same-sex sexual relations. Using the minority stress model and sexual script theory for framing the study's goals, the authors conducted 90-minute interviews with participants. Participants were recruited from clinics, social networking sites, and snowball samplings. Participants said they used SEM to develop their sexual self. SEM provided a safe, anonymous space to learn about gay sex. There are negative stigma and homophobia from home and school around same-sex relationships. The strength of this research is that adolescent black MSM are not receiving the information they need from parents, or school, due to stigma and homophobia. Therefore, they get the information they need from other sources, in this case, SEM. Limitations of this study are around the need for further research to ascertain whether viewing SEM is promoting sexual risk behavior. Participants may be viewing and mimicking risky sexual behavior.

Arrington-Sanders, Leonard, Brooks, Celentano, and Ellen (2013) conducted research to explore reasons black YMSM cite for being attracted to and seeking, an older partner, and the interpersonal needs met within older sexual partners. Authors conducted qualitative, in-depth interviews with 17 black YMSM. Due to the stigma and homophobia, many families and community members project on same-sex relationships in the black community, two themes emerged from this study. First, participants were attracted to the emotional maturity of older MSM. Second, older MSM exposed participants to more life experiences and introduced participants to the larger, same-sex community. The strength of this study demonstrates that it is more than just sex that attracts black YMSM to older partners. These young men are looking for mature, stable, emotional relationships with older MSM as well as entry into the larger MSM community. The limitation of this study is that it is qualitative and may not be generalizable to black YMSM everywhere.

Internalized homophobia. Internal homophobia is a response by homosexual men who take the fear, or antipathy, of non-homosexual people and turn it inward upon themselves (Fone, 2001). This, in turn, leads to self-destructive behaviors, such as substance use(CDC, 2016e), especially during sexual episodes (Borek, Allison, & Caceres, 2010; Kilmer et al., 2012; Kull, 2010; Marshall, Shannon, Kerr, Zhang, & Wood, 2010; Newcomb, Ryan, Greene, Garofalo, &Mustanski, 2014a; Newcomb, Birkett, Corliss, &Mustanski, 2014b), low rates of HIV testing (Bauermeister,Pingel et al., 2015; Phillips et al., 2015; Wilson et al., 2015), and risky sexual behaviors such as unprotected anal intercourse (Amola&Grimmett, 2015; Bauermeister, Eaton et al., 2015;

Hergenrather, Emmanuel, Durant, & Rhodes, 2016; Mustanski, Ryan, &Garofalo, 2014; Wilson et al., 2015; Zou et al., 2014). Gay men do not want to test for HIV disease because they are afraid that if they are seen at an HIV test site, they will be identified as being homosexual (Bauermeister, Pingel et al., 2015; CDC, 2016b). It can also lead to mental health disorders, such as depression and anxiety (Millar, Wang, &Pachankis, 2016; Nieblas et al., 2015; Puckett, Woodward, Mereish, & Pantalone, 2015). These mental health disorders, in turn, leads to barriers to HIV prevention education (Andrasik&Lostutter, 2012; Fields et al., 2015). For YMSM, stigma and homophobia are given as reasons why they do not ask for HIV prevention education that meets their specific needs (Brooks& Bridges, 2015). Stigma and homophobia can negatively impact YMSM health.

As previously discussed in this chapter, LaSala et al. (2015) researched to understand why YMSM continue to engage in risky sexual behavior even after receiving HIV prevention education. Using a qualitative method, they interviewed 44 parents and 37 gay and bisexual youth, 14-21 years of age. Participants discussed YMSM's sense of invulnerability, sexual arousal, parental disapproval, and lack of societal acceptance as contributing factors. Participants want gay-sensitive sex education and community programs as well as increased societal awareness of their lifestyle. Participants recommended interpersonal and structural-level interventions to reduce stigma and homophobia as a key component of HIV prevention. Because this was a qualitative study, the one limitation acknowledged was that it might not be generalizable.

Ma et al. (2014) used data from the 2009 YRBS to analyze the responses of 16,410 U. S. high school students in 158 schools across the U. S. to assess the association between HIV education, risky sexual behaviors, and academic grades. Authors used survey regression modeling to assess for the association. Results found sex and HIV education were effective in delaying sexual debut, increased condom and other forms of contraception use, reduced STIs, and reduced pregnancies. Limitations included it was a cross-sectional study. Cause and effect were undetermined. Although the study indicated students had received HIV education, there was no way to evaluate the quality of HIV education. There was no way of determining the effects of this study on YMSM.

According to the CDC (2016b), for YMSM who are just beginning to explore their sexuality, homophobia can pose obstacles to HIV testing and treatment. As previously discussed above (see Fields et al., 2015; Phillips et al., 2015; Van Handel et al., 2016; Washington et al., 2015), these YMSM do not want to test for HIV disease because they are afraid that if they are seen at an HIV test site they will be identified as being homosexual.

Using community-based participatory research principal and a randomized controlled trial, Bauermeister, Pingel et al. (2015), developed and tested a web-based program, “Get Connected!” seeking to promote HIV/STI testing with 130 YMSM between 15-24 years of age. Results of this study included participants not knowing where they could go to test for HIV/STIs and being concerned about the stigma and homophobia about being seen at a testing facility. This program took the first steps toward linking YMSM to HIV/STI testing services sensitive to their experience, close to

home, designed to meet their needs. Limitations of this program included: it was only a pilot program, the sample size was small, and there was a short follow-up period.

Internalized homophobia can also lead to mental health disorders, such as depression and anxiety (Millar et al., 2016; Nieblas et al., 2015; Puckett et al., 2015). This internalized homophobia can lead to barriers to HIV prevention education (Andrasik&Lostutter, 2012; Fields et al., 2015). For YMSM, stigma and homophobia are given as a reason why they do not ask for HIV prevention education that meets their specific needs.

Millar et al. (2016) conducted a study to investigate what effect internalized homonegativity (IH) had on the efficacy on the ESTEEM (Effective Skills to Empower Men) intervention, LGB-affirming psychotherapy. Participants in the study were 54 MSM, 18-38 years of age, in New York City. Participants were divided into two groups: the treatment group and the waitlist group. Moderation analyses showed participants rating higher in IH experienced a greater reduction in depression, anxiety, and past-90-day unprotected anal sex with casual partners as well as a reduction in past-90-day heavy drinking. The strength of this study was that YMSM who score high in IH might be particularly responsive to LGB-affirmative therapy. A limitation of this study included no comparison groups, so it was impossible to determine whether IH might also be effective in other types of treatment, regardless of LGB affirmative content.

A similar study was conducted by Puckett et al. (2015) with 257 LGB adults to explore the association between parental rejection to children's coming out, internalized homophobia (IH), social support, and mental health. Path analyses revealed that IH and

lower social support was associated with past parental rejection and current psychological distress. Their results and recommendations were similar to those of Millar et al. (2016).

Sodomy laws. Laws against LGBTQ persons, or persons engaging in homosexual activities, are classified as sodomy laws (Fone, 2001; Kane, 2003; Mallory, Hasenbush, & Sears, 2015). According to Kane (2003), up until 1961, all 50 of the United States carried laws criminalizing sodomy. Sodomy was defined as both anal sexual intercourse and oral sex. Although sodomy laws were supposed to be enforced uniformly against everyone in the United States, heterosexual or homosexual, the LGBT community was the primary target population of law enforcement agencies (Fone, 2001; Mallory et al., 2015). According to Fone (2001), by the end of 2002, 36 states and the District of Columbia had removed sodomy laws. Sodomy laws were so severe in some parts of the country that law enforcement officers were given the right to break down doors without a warrant to arrest people merely on suspicion of committing sodomy (Fone, 2001).

Homosexuality was condemned from the pulpit. Abara et al. (2015) used Project Fostering AIDS Initiatives That Heal (FAITH) to develop a rapport between the South Carolina HIV/AIDS Council and local black churches and faith-based organizations. The goal of the project was to establish and maintain, through education and training, HIV prevention interventions in black churches in South Carolina. This project was a non-scientific project that demonstrated, among other things, that when you put a face on HIV/AIDS, it is more difficult to condemn sodomy from the pulpit.

Garofalo et al. (2015) used a quantitative research method to prove the hypothesis that religious involvement and faithfulness may protect against sexual risk-taking for

HIV infection. They conducted their research using 450 YMSM, 16-20 years of age, in Chicago, Illinois. The results of their study suggest that religious involvement and faithfulness reduce high-risk sexual behavior. A strength of this study is that it is one of the first studies to provide empirical support that religion is associated with decreased HIV sexual risk-taking. Limitations of this study are that the sample is from one geographical area and may not be generalizable. Cross-sectional design does not allow for any interpretation related to causality.

According to Fone (2001) and Mondimore (1996), a person suspected of being a homosexual might be disowned by his family. Many young men living on the streets were kicked out of their homes when their families found out that they preferred relationships with men rather than women. This rejection by society has been used as one of the primary reasons why YMSM turn to alcohol and drug use (Kilmer et al., 2012; Newcomb et al., 2014a; Newcomb et al., 2014b), as well as survival sex, providing sexual favors in return for a place to stay, food, and clothes.

Marshall et al. (2010) used data collected by the At-Risk Youth Study (ARYS) to determine if street-involved drug-using sexual minority youth are at greater risk for survival sex work and are more likely to engage in riskysexual behaviors with clients. Authors used logistic regression to analyze data from 558 participants, 75 of whom identified as sexual minority and 63 reported survival sex work in the past six months. The results of the study indicated sexual minority youth were at significantly greater risk for survival sex work, as well as inconsistent condom use and a greater number of clients in the last six months. The strength of this study is that it demonstrated a significant

association between sex, sexual orientation, and self-reported engagement in survival sex work. Limitations include only a small number of participants identified as a sexual minority. The ARYS is not a random sample of street-involved youth. Generalizations to the entire street youth population may be limited. Survival sex work is stigmatizing behavior.

Newcomb et al., (2014a) conducted a study with 450 YMSM 16-20 years of age, living in and around Chicago, Illinois, to study prevalence and patterns of smoking, alcohol, and illicit drug use in YMSM. Recruitment used a modified form of respondent-driven sampling. Analyses were conducted with multivariate logistic regression and latent class analysis. The strengths of this study included that YMSM used marijuana more than 12th-grade males in the 2011 YRBS and similar prevalence of all other substances, and racial minorities tended to use substances less frequently than whites. Limitations included using a convenience sample that is predominantly urban and racial minorities, so the results may not be generalizable to all YMSM. There was no comparison with heterosexual males, so the authors were not able to determine whether sexual identity affected substance use. Future analyses should examine substance use as it relates to other health-related issues, such as HIV risk.

Newcomb et al. (2014b) conducted research evaluating the drug use differences between sexual minority and heterosexual students using the 2005 and 2007 YRBS data from the cities of Boston, Chicago, New York City and the states of Delaware, Main, Rhode Island, and Vermont. Strengths of this study include sexual minority youth continue to be at increased risk for drug use, likely due to socially based stressors like

homophobia and beliefs against sodomy. Critical intervention is necessary at both the institutional and individual levels to address these problems. This study is limited by the fact that it is not generalizable outside of the areas it included.

In 1986, the U. S. Supreme Court upheld the constitutionality of the sodomy laws of the State of Georgia in *Bowers v. Hardwick* decision (Donovan, 1998). In 2003, the U. S. Supreme Court reversed its 1986 decision in the law case Lawrence v. Texas (Lund & McGinnis, 2004), thereby invalidating sodomy laws nationwide. However, as of 2014, these unenforceable sodomy laws were still on the law books in 16 states, frequently as a protest against the decriminalization of sodomy by the United States Supreme court.

Stigma and homophobia internationally. Even though the United States has decriminalized sodomy among consenting adults and the United States has recognized same-sex marriage with all the rights and privileges marriage provides (Yoshino, 2015), according to Bearak and Careron (2016) and Fenton (2016), there are still 77 nations worldwide where homosexuality is a crime punishable by imprisonment. In 10 countries, homosexuality may be punished by death. In five countries, homosexuality is punished by death. In countries where laws against homosexuality are more lenient, if that country has allowed Sharia Law to exist in certain regions, the penalty is always death in those regions governed by Sharia Law.

Sex Education

Sex education in schools has traditionally been a controversial issue (Bennett, 2007; Lord, 2010). Concerns about sex education have included such topics as who should teach sex education (Borawski et al., 2015); what should be included in a sex

education curriculum (Bigelow, 2012); at what age should sex education be taught to students (Dinaj-Koci et al., 2014; Lord, 2010), and how effective have sex education programs been at preventing unwanted pregnancies and STIs, including HIV disease.

Sex education in the 19th century United States. In 19th-century America, sex education was used to cure what was seen as a moral problem, a sin. One of the concerns of the 19thcentury was the issue of masturbation. Masturbation was considered such an offensive word in the 19thCentury America that other words were substituted for it, words like *the solitary vice, self-pollution,* and *Onanism*after Onan, son of Judah, who spilled his seed upon the ground rather than impregnate his dead brother's wife (Genesis 38:9).

The Reverend Sylvester Graham (1794-1851), a 19th-century Presbyterian minister, wanted to curb masturbation in young men, which he believed had reached epidemic proportions. He believed that sexual appetite could be curbed by eating bland food. Graham was also a member of the temperance movement and believed that a vegetarian diet could cure both masturbation and alcoholism (Tompkins, 2009). Graham is remembered for the graham cracker that he invented.

At the end of the 19thcentury, Dr. John Harvey Kellogg, a member of the Seventh-day Adventist Church, took the problem of masturbation one step further (Tompkins, 2009). He said that masturbation was "more than a moral failing but a physical and mental ailment that needed treatment and cures" (p. 327). In Kellogg's book, *Plain Facts about Sexual Life* and later *Plain Facts for Old and Young,* over 100 pages were dedicated to masturbation, which he termed "self-abuse." In those pages, he

identified the medical conditions masturbation could cause, and how to treat its effects. Kellogg believed that masturbation could be prevented, or cured, by a bland diet. Kellogg is remembered for the corn flakes he originally invented for reducing sexual stimulation.

Also, in the latter part of the 19thcentury, organizations appeared to combat pornography, prostitution, and STIs (Lord, 2010). For example, Anthony Comstock (1844-1915), a United States Postal Inspector and politician, who started the New York Society for the Suppression of Vice, was responsible for passage of the Comstock Act of 1873 by Congress, which prohibited the delivery of materials he considered to be obscene, lewd, or lascivious (Bennett, 2007; Lord, 2010; May, 2010). According to Lord (2010), The Comstock Act also prohibited the publication, distribution, or possession of information about abortion or contraception. A part of the responsibilities of the New York Society for the Suppression of Vice was to review sex education material to make sure it was not lewd or lascivious. The Comstock Act was so powerful and encompassing that in 1915, Margaret Sanger (1879-1966), American birth control activist and sex educator, was arrested by Anthony Comstock for distributing the book, *Family Limitations,* which contained a discussion about contraception, and again in 1916 for distribution of information on contraception (Bennett, 2007; Lord, 2010; May, 2010). Sanger worked as a nurse in the poorest immigrant neighborhoods of New York City.

Sex education in early 20th century United States. At the beginning of the 20thcentury, the primary concerns around sex education were pornography, prostitution, and STIs (Lord, 2010). Pornography was blamed for prostitution, and prostitution was blamed for STIs (Pierce, 2011). According to Lord (2010), the primary target of sex

education in America was combating STIs; what was then termed venereal diseases (Lord, 2010). Victorian values dominated the sex education scene. People were taught that STIs were the result of, and punishment for, immoral behavior. The whole subject of sex was so sensitive at the time that sex education was referred to as sexual hygiene and STIs were referred to as venereal diseases.

Sex education was a combination of religious morality and advances in medicine to combat STIs (Pierce, 2011). STIs were the result of sinfulness, and medicine had advanced to where STIs could be treated (Lord, 2010). Sex education was aimed primarily at young men over the age of 18 (Pierce, 2011). According to Lord (2010) and Pierce (2011), the basic premise of sex education was that if young mencontrolled their lustful passions, there would not be any STIs. Sex education was a lesson in morality.

Examples of sex education literature of the time are *Self and Sex for Young Men* written by the Reverend Sylvanus Stall (1897-1936), a Lutheran minister, and *What a Young Woman Should Know* written by Dr. Mary Wood-Allen, M.D. (1841-1908), a physician, and the World Superintendent of the Purity Department, Woman's Christian Temperance Union (Lord, 2010). Much of their writing was based on religious morals, such as people are God's creations, and they should strive to be pure in thought, word, and deed (Bigelow, 2012; Lord, 2010; Pierce, 2011). A strong belief in God and remaining pure would save young men from contracting an STI and passing it on to young women.

Sex education between 1918 and 1960 in the United States. According to Lord (2010), in 1918, the United States Public Health Service (USPHS) developed *Keeping*

Fit, its first attempt at providing a sex education program for the American Public.The program was targeted at young men, 14-21 years of age because the USPHS considered this population the most vulnerable for contracting STIs. The young men were taught that by exhibiting self-control, these young men could protect women and children from the ravages of STIs. Knowing how sensitive a subject sex education was and wanting their sex education initiatives to be successfully accepted by the more conservative Christian elements of American society, the USPHS partnered with the Young Men's Christian Association (YMCA).The YMCA was considered at that time to be an evangelical protestant organization.The YMCA delivered the content of *Keeping Fit* in a way that would not offend anyone. The basis of sex education was abstinence until marriage and, once married, fidelity toward the spouse. Abstinence and fidelity were what was taught in sex education up until about 1960.

Sex education between 1960 and 1980 in the United States. In the 1960s, although Americans said that they believed in abstinence until marriage and fidelity after marriage, they frequently indulged in sex outside of marriage (Lord, 2010). By 1960, there was a rise in STI rates and births outside of marriage. Thesewere attributed, at least in part, to advances in the treatment of syphilis and gonorrhea with penicillin (Collier, 2007), and a decrease in condom use due to the introduction of the birth control pill (BCP) as a form of contraception (Collier, 2007; May, 2010). In 1957, the BCP was approved by the Food and Drug Administration (FDA) for the treatment of severe menstrual disorders (Lord, 2010; May, 2010). In 1960, the BCP was approved by the FDA as a form of contraception for women (May, 2010). Condom usage declined

because sexually active people believed that doctors could easily cure all STIs, and the BCP prevented pregnancies.

If pregnancy did occur during the mid-1970s, a woman could also procure an abortion to terminate the pregnancy. On January 22, 1973, the United States Supreme Court ruled in the case of *Roe v. Wade* that, based on the right to privacy, a woman had the right to terminate her pregnancy in the early months without legal restrictions, and with restrictions in later months (Ely, 1973; Lord, 2010; May, 2010). This decision by the United States Supreme Court deemed unconstitutional laws established by any state forbidding abortions.

During this period, there was opposition to teaching sex education in the classroom. The Christian Crusade and other conservative groups called the sex education programs "smut" and "raw sex" (Luker, 2007, p. 205). The John Birch Society called sex education a communist plot to destroy American family values (Lord, 2010; Luker, 2007). Phyllis Schlafly, president of the conservative group, Eagle Forum, argued that sex education encouraged teens to become sexually active.

Kohler, Manhart, and Lafferty (2008) took the responses of 1,719 never married, heterosexual adolescents, 15-19 years, from the 2002 Cycle 6 National Survey of Family Growth, and utilizing multivariate logistics regression, concluded that teaching sex education did not increase risk of teen sexual activity or STIs. Teens who received CSE had a lower risk of pregnancy than those who received AOUM or no sex education. The strength of this study demonstrated that teaching CSE to youth did not initiate their sexual activities.

As a result of this opposition, there were two different types of sex education taught in schools during the 1960s and 1970s: CSE and AOUM. CSE included information on how to prevent pregnancy and STIs (Collier, 2007; Lord, 2010; Luker, 2007). AOUM sex education taught that people should remain abstinent from all sexual activity until marriage. AOUM did not include any information on contraception or STI prevention. The decision on which sex education program was taught in school depended on where the school was located. In locations where conservative and religious groups were in the majority, for example, the Bible belt of the southern United States, AOUM was the sex education curriculum chosen. In locations where conservative and religious groups were in the minority, for example, in the northern United States, CSE curricula were chosen.

Sex education between 1980 and 2010 in the United States. The debate over sex education continued to focus on which sex education curriculum was better for students: AOUM or CSE. The CSE group argued that if AOUM was sufficient, then why were teenage pregnancies and STIs still so high (Lord, 2010; Luker, 2007; May, 2010)? The AOUM group countered that signed virginity until marriage pledges worked at keeping youth safe from both teenage pregnancies and STIs, so there was no need to teach students about preventing pregnancy or STIs. Of all the industrialized nations in the world, the United States had the highest teenage birth rate in 1980.

In 1981, HIV disease appeared in the United States (CDC, 1981). However, the Reagan Administration remained mute on the subject of HIV until 1986 (Lord, 2010; Shilts, 2007). On October 22, 1986, C. Everett Koop, M.D., Surgeon General of the

United States, issued a 36-page report on AIDS: what it was, how it was transmitted, and what people could do to prevent becoming infected, including using condoms (National Library of Medicine, n.d.). Koop believed that "education was the best and only strategy of prevention against AIDS, and since AIDS was spread primarily through sex, school children from grade 3 on should receive sex education" (Lord, 2010; National Library of Medicine, n. d., Paragraph 4). By 1988, over 90% of all schools offered some sex education program: AOUM or a variation of CSE.

From 1981 through 2010, the Federal Government passed three pieces of legislation regarding federal funding for sex education programs in schools (Andrasik&Lostutter, 2012): in 1981, under Title XX of the Public Health Act; in 1996, under Title V, Section 510 of the Social Security Act; and in 2000, under Title XI, Section 1110 of the Social Security Act. All three pieces of legislation mandated abstinence-only sex education programs as the only programs to receive federal funding. Not all states accepted or received, federal funding, believing that CSE was more appropriate for students.

Even though there was no proof that AOUM was effective (Kull, 2010; Schalet et al., 2014), from 1996-2009 more than 1.5 billion dollars were spent by the Federal Government on AOUM programs (Coyle, Anderson, &Laris, 2016). At the same time, the federal government was pushing AOUM programs; there was research emerging that abstinence-plus sex education programs that included HIV prevention education were more effective in changing behaviors.

In an invited commentary in the Journal of Youth and Adolescence on broadening the evidence for adolescent sexual and reproductive health and education in the United States, Schalet et al. (2014) remarked that scientific research had made major contributions to adolescent health. However, U. S. adolescent sexual and reproductive health policies had not benefited from scientific research. As an example of this, the authors pointed to the fact that from 1998 through 2009, federal funding for sex education focused on ineffective and scientifically inaccurate AOUM.

AOUM sex education has not worked in curtailing teen pregnancies, STI infections, or HIV disease (Kull, 2010; Schalet et al., 2014). Abstinence plus using condoms is a more effective sex education program (Andrasik&Lostutter, 2012). "Abstinence-only – one size fits all sex education can be disempowering" (Collins et al., 2012, p.24). People prefer positive interventions that empower them.

In addressing the question of whether CSE or AOUM is most effective for reducing teen pregnancies and STIs, Kohler et al. (2008) reviewed the responses of 1,719 heterosexual adolescents, 15-19 years of age, who had never been married, who participated in the National Survey of Family Growth (NSFG) in 2002. The NSFG is a nationwide survey conducted by the National Centers for Health Statistics. The results of their analysis showed that AOUM programs had no significant effect on delaying sexual debut or reducing the risk of teen pregnancy and STIs. They found that CSE did not increase adolescent sexual activity or STIs and reduced teen pregnancies. It is important to note that most research into sex education was conducted with heterosexual youth as this study did.

In 1998, 80-90% of adults who participated in state and national polls supported sex education in schools, not only AOUM sex education but also CSE. Despite what the polls indicated AOUM remained the only sex education curriculum that the federal government would fund (Schalet et al., 2014). In a critique of sex education taught in schools, Schalet et al. (2014) claimed that AOUM was ineffective and scientifically inaccurate and that, although evidence-based interventions (EBI) were a step in the right direction, they did not address issues important to LGBTQ students.

In the southern United States where African American youth are at high risk for HIV infection and AOUM continues to be the only option for sex education, Lloyd et al. (2012) conducted a qualitative portion of Project GRACE (Growing, Reaching, Advocating for Change and Empowerment). They conducted 11 focus groups with 55 African American adults and 38 youth on how to make HIV prevention education more inclusive in a rural community in North Carolina. Participants consistently identified public school sex education policies/practices as a major barrier. Suggestions for decreasing HIV infection risks included public schools providing access to health services and sex education. Participants believed that sex education should be taught by health educators, not just one of the teachers. Those health educators should be equipped to answer student questions, provide information about STI and HIV testing, and distribute condoms. In 1995, North Carolina law required that AOUM be the only sex education curriculum in the state. Most of the youth participants considered the AOUM curriculum to be ineffective as sex education and HIV prevention. A strength of this study is that it was conducted in a stable, rural town where the adults could recall what

sex education had been taught when they attended the same schools. Limitations of the study include that it was a convenience sampling and therefore not necessarily generalizable. There was a potential focus group bias for social desirability. There was a five-year delay between when the study was done and when results were published.

As previously discussed in this chapter, LaSala et al. (2015) found in their research that the needs of YMSM and their families for a more inclusive, CSE and HIV prevention curriculum were ignored by school authorities. They conducted qualitative interviews with 44 parents and 37 MSM students. The results of their study indicated that participants wanted gay sensitive sex education and community programs, as well as increased societal acceptance.

One reason school authorities ignored the wishes of YMSM and their families was that the Federal Government would only fund AOUM sex education programs and the school authorities depended on federal money to pay for sex education programs (Schalet et al., 2014). Another reason was that where politically conservative and religious principles were in control, political pressure was put on school authorities, especially those in elected positions, only to teach AOUM sex education.

Schalet et al. (2014) claimed that, although the federal government would only fund AOUM curriculums from 1998-2009, AOUM was highly ineffective and scientifically inaccurate. In 2010, the federal government started funding EBI. Although EBIs were an improvement over AOUM curriculums, EBIs did not include research on LGBTQ youth. EBIs concentrated on pregnancy and STI prevention. Schalet and

colleagues advocated for a more holistic approach that would include the needs of LGBTQ youth.

In an article published in the *Sex Education Journal* critiquing school-based sex education (SBSE) programs, Bay-Cheng (2003) made several points:

- Most sex education is taught from a fear perspective when it comes to talking about the dangers and risks of teen sex.
- Sex education focuses on heterosexual sex as normal sexual behavior to the exclusion of all other sexual behaviors.
- Sex education curriculum propagates sexist, racist, and classist notions of sexuality.
- Sex education projects a particular message of who teens are, how teens are, and how teens should be.

Bay-Cheng (2003) concluded with the recommendations that SBSE should be all-inclusive. That is, it should address not only the heterosexual majority of students but also those students who are in the sexual minority: LBGT youth. SBSE should not present stereotypes, such as the passive female role and the aggressive male role, because there are many different roles to sexuality. SBSE should not teach sex education from a fear basis of just presenting the negative consequences of teenage sexuality. It should also teach developing relationships and respect for each other.

Sex education since 2010. In 2011, 20% of states had fewer schools teaching HIV prevention education than in 2008 (Ma et al., 2014). As previously discussed in this chapter, Ma et al. (2014) conducted a study to ascertain if school-based HIV/AIDS

education programs were effective at reducing risky youth behaviors, including delaying initiation of sex, frequency of sex, number of new partners, and increased use of condoms and contraception. Using a cross-sectional study of the 2009 YRBS to analyze the responses of 16,109 students, grades 9-12, in 158 schools, they found that 87% of the students had received HIV prevention education. Male students who received HIV prevention education had delayed sexual debut, fewer sexual partners, reduced forced intercourse, and better grades.

In 2015, the CDC noted that approximately 37 million adolescents attended a public or private school 6hours a day and that school is the ideal place to teach adolescents about teenage pregnancy, STI, and HIV prevention (CDC, 2010). Despite this recommendation, there is no nationally approved sex education curriculum, including HIV prevention education, taught nationwide. What a student learns in one state, or one school district, might not necessarily be what is being taught in another state, or school district (California Department of Education, 2016). Not all states are required to teach either sex education or HIV prevention education (NCSL, 2016). According to the National Conference of State Legislatures, as of March 1, 2016:

- Only 24 states and the District of Columbia require that public schools teach sex education. Twenty-one of those states require sex education and HIV education.
- Only 33 states and the District of Columbia require HIV education.
- Only 20 states require that sex education and HIV education must include medically accurate information.

According to the California Department of Education (2016), where this current research was conducted, schools are not required to teach a CSE curriculum. However, since 1992 all schools in California are required to teach HIV prevention education: once in middle school and once in high school. A barrier to making HIV prevention education available to all students in the state is the fact that in California, these HIV prevention education courses are only required to be taught in English. According to the California Department of Education (2015), there are approximately 1.392 million students in California Public Schools, where English is their second language. There appears to be no provision for teaching HIV prevention education to students in any other language than English.

According to the CDC (2016a), although young people, 13-25 years of age are only 25% of the sexually active population of the United States, they are diagnosed with over 50% of all STIs reported in the United States (see also NCSL, 2016). The CDCreports that on an annual basis, adolescents, 15-19 years of age account for:

- 273,105 births (CDC, 2019a).
- 75,064 cases of chlamydia, gonorrhea, and syphilis (CDC, 2018a).
- 7,125 cases of HIV disease (CDC, 2018b).

It appears that, regardless of which method of sex education is implemented, AOUM or CSE, it is not having the intended effect of reducing teen pregnancies, STIs, and HIV infection. It also appears that sex education in the United States is intended mainly for heterosexual students to the exclusion of LGBTQ students. Zou et al. (2014) conducted a study of 200 YMSM, 16-20 years of age, in Melbourne, Australia.

Participants were recruited through community and other sources. Participants completed a questionnaire about their sexual behaviors and were screened for gonorrhea, chlamydia, syphilis, and HIV. Strengths of this study include it was one of the first studies to focus on sexual behaviors among teenage MSM. Most teenage MSM were already sexually active from an early age and engaging in high-risk sexual behaviors. There is a need for greater health promotion and prevention efforts to reduce the risk of STIs and HIV. Limitations of this study include that the results may not be generalizable. Younger teenagers were under represented in this study. Because some YMSM were referred from clinical sites, there may be a bias toward higher-risk men and men with STIs. Sexual partners were not categorized into regular or casual sex partners.

Sex education in the United States has always been about sex in heterosexual relationships, specifically heterosexual marriage. In the 19th century, sex education was concerned about the evils of masturbation. The predominant sex education message was to remain physically pure until marriage and, once married, stay faithful to your spouse. Throughout the first half of the 20th century, sex education was concerned about the rising rates of STIs. Again, the predominant sex education message was to remain abstinent until marriage and, once married, stay faithful to your spouse. In the 1960s, the sexual and gender revolution attacked traditional American values of remaining sexually pure until marriage and then staying faithful to your spouse. The AOUM was a kind of counter-revolution, an attempt to regain traditional sexual and gender roles and stabilize relationships. The 1980s saw the introduction of HIV disease into American Society. For the next 30 years, the only sex education curriculums the Federal Government would

financially subsidize were AOUM. In focusing attention on heterosexual relationships, specifically heterosexual marriage, sex education curricula do not appear to address the needs of LGBTQ students.

Obstacles to Conducting Research with Minors and LGBTQ Youth

Governmental surveys as secondary data. Much of the information used in research projects that discuss adolescents and their sexual behaviors are taken from governmental surveys administered to youth. Adewuyi (2015) conducted quantitative research on 1,933 African American eighth-graders on their knowledge of HIV. All of his information was taken from the 2012 District of Columbia Middle School YRBS. The results of his study were that students, especially male students, are still engaging in risky behavior that could put them at risk for exposure to HIV disease despite having taken HIV prevention education.Limitations of this study include not knowing what kind of HIV prevention education the students were receiving and how it was being taught since they attended different schools in the District of Columbia. The study also did not identify how many respondents identified as LGBTQ.

Governmental survey data is considered secondary data because the data is not collected by the researcher directly from the respondents. The researcher is using someone else's data to draw conclusions or results. A common survey used by researchers to gather research data is the CDC YRBS. As previously discussed in this chapter, Ma et al. (2014) used a cross-sectional analysis of the 2009 YRBS in their study to ascertain if school-based HIV/AIDS education programs were effective. As previously discussed in this chapter, Van Handel et al. (2016) used data from the 2005-2013 YRBS

and Behavioral Risk Factor Surveillance System (BRFSS) to assess HIV testing of 13-24-year-old individuals, from 2005-2013. One of the limitations of this study is that LGBTQ students are not identified as such from the survey data.

The CDC (2016h) has utilized the YRBS since 1991 to monitor six categories of health risk behaviors that cause death or disability among youth. One of those six categories is sexual behaviors related to unintended pregnancies, STIs, and HIV. The CDC sends out the YRBS to participating school districts. The school districts distribute the self-administered surveys to their students who complete them and return them to their teachers. The school districts then return the completed surveys to the CDC.

There are several problems with using this data for research information on LGBT youth. First, according to the CDC (2016h), not all schools in the nation participate in the survey, and not all students in schools that do participate in the survey are included in the survey. Schools participate in the survey voluntarily. Second, student participation in the survey is voluntary, and parents can opt-out their children from participating in the survey. Third, up until the 2015 YRBS, the CDC did not include questions asking respondents about their sexual identity or the sex of their sexual contacts (CDC, 2016g). Both of these new questions on the 2015 YRBS allow researchers to ascertain whether the respondent was an LGBTQ youth.

Institutional Review Boards as a Possible Obstacle to Researching Adolescents and LGBTQ Youth

In an article published in the American Journal of Preventative Medicine, Mustanski and Fisher (2016) indicated that the number of researchers who use secondary

data from the CDC YBRS to analyze adolescent sexual risk behaviors do so, in part, because IRBs do not approve research studies involving minors, particularly those who are LGBTQ. IRBs do not approve research studies involving minors in an attempt to protect vulnerable research subjects. Mustanski and Fisher (2016) did a systematic review of 93 HIV prevention programs in the CDCs compendium of EBI. They were only able to identify four that were evaluated for YMSM over 18 years of age and none that were evaluated primarily or exclusively with YMSM under the age of 18.

These disapprovals have been over the question of whether or not an adolescent can self-consent to be part of a research project without involving his parents in the research project or consent process. In all 50 states, adolescents, 13-18 years, can consent for STD testing and treatment, including HIV testing (Guttmacher Institute, 2016). However, IRBs appear to be leery of approving adolescents for self-consent without parental approval to answer questions on a researcher's survey.

No Promo Homo Laws as a Possible Obstacle to Comprehensive Sex Education

No promo homolaws are in effect in nine states and several school districts (Barrett & Bound, 2015; Kellinger, 2015; Lloyd et al., 2012). No promo homo laws are frequently found in the southern United States where HIV infections are particularly high. According to Barrett and Bound (2015), no promo homo laws "restrict or prohibit any school-based instruction, counseling, discussion, or activity that could be construed as being positive about or promoting homosexuality" (p.267). However, it can also be interpreted as banning teachers from saying anything about homosexuality unless it is negative. For example, according to Kellinger (2015), if a student asks a question

regarding homosexuality, the teacher is required to say homosexuality is against the law. Although proponents of no promo homo laws claim they keep sex education neutral (see also Barrett & Bound), what this law does is continue to maintain the stigma and homophobia that alienates LGBTQ students (Shelton, 2015).

Barrett and Bound (2015) used the secondary data from the 2011 National School Climate Survey (NSCS) of 8,584 students. 84.9% of the LGBTQ respondents experienced gay used as a derogatory term. 91.4% of the LGBTQ respondents felt distressed as a result of this. In her critical article on no promo homo attitudes in the Educational Form, Kellinger (2015) stated that when she taught high school English in Georgia in the 1990s, she remained in the closet out of fear that identifying herself as a lesbian, or making any positive comments about the LGBTQ lifestyle, would get her terminated from her job.

As previously discussed in this chapter, Lloyd et al. (2012) conducted a study on how to make HIV prevention education more inclusive in a rural community in North Carolina where AOUM was the only sex education students received. As a part of the Project Grace (Growing, Reaching, Advocating for Change, and Empowerment), Lloyd et al. conducted 11 qualitative focus groups with 55 African American adults and 38 youth. Participants consistently identified public school sex education policies and practices as a major barrier to making HIV prevention education more inclusive. Ideas for decreasing risks included public schools providing access to health services and CSE.

Shelton (2015) conducted qualitative research to understand how the social, cultural, and political elements of schools and their communities influence what

participants can accomplish on behalf of LGBT students. The two-year study started with 17 participants in focus groups and individual interviews. At the end of two years, there was only one participant left in the study. The no homo promo laws were such that most of the participants chose to teach in other parts of the country.

Critiques of Sex Education Programs

HIV infection rates among YMSM, 13-25 years of age, continue to increase every year. According to the CDC (2016b), from 2005-2014, HIV infection rates among black and Hispanic YMSM, 13-24 years of age, increased by about 87%. HIV infection rates among white YMSM, 13-24 years of age, increased by 56%. Evaluations of adolescent sex education programs make the following recommendations for improvements in sex education being taught in schools:

- Sex education programs must be designed to effectively reach students, particularly multi-faceted programs (Pettifor et al., 2013).
- Sex education programs must be culturally appropriate, pragmatic, and inclusive of all students, particularly LGBTQ students (Bay-Cheng, 2003; Brooks & Bridges, 2015).
- Sex education programs must begin early (before sexual debut) and be repeated often to be most effective (Dinaj-Koci et al., 2014; Ma et al., 2014).

Arrington-Sanders et al., (2013) evaluated SBSE programs to be so poor at fulfilling the needs of LGBT students that African American YMSM sought out relationships with older African American MSM to educate them about their sexuality. According to Nieblas et al. (2015), the CDC reviewed 84 effective HIV prevention

programs. Although two-thirds of all HIV infections are among MSM, only three of the 84 effective HIV prevention programs reviewed were developed for YMSM. A more holistic approach to sex education is necessary to include LGBTQ youth in sex education (Schalet et al., 2014). Existing HIV prevention efforts have failed to decrease HIV infections in YMSM.

Alternatives to School-Based Sex Education

A number of HIV prevention programs have been developed for LGBTQ youth as alternatives to school-based sex education programs because SBSE programs are not meeting the sex education needs of YMSM (Arrington-Sanders, Harper, Morgan, Ogunbajo, Trent, &Fortenberry, 2015; Mustanski, Garofalo, Monahan, Gratzer, & Andrews, 2013; Mustanski, Greene, Ryan, & Whitton, 2015). As previously described in this chapter, Arrington-Sanders et al. (2015) did 90 minute, qualitative interviews with 47 black MSM, 15-19 years old, on why they used sexually explicit material (SEM). Respondents said they used SEM to develop their self-image. SEM provided a safe, anonymous space in which to learn about gay sex. There is a negative stigma around same-sex relations at home and school, and schools are not providing them with information about same-sex relationships.

Mustanski et al. (2014) did a study with 202 YMSM, 16-20 years of age, on the feasibility, acceptability, and initial efficacy of Queer Sex Ed (QSE), in an online sexual health promotion program. All participants completed pre- and post-test surveys online and an online sexual health curriculum of five modules. This study was a mixed-methods design. The strengths of this study were that participants indicated they learned more than

in a school-based sex education program, and they appreciated the comprehensive LGBT specific approach. Limitations included using a pre-post change design rather than a randomized control trial so results may have come from factors unrelated to the intervention. Future post-intervention outcomes should be longer than two weeks.

Mustanski, Garofalo, Monahan, Gratzer, and Andrews (2013) studied the feasibility, acceptability, and preliminary efficacy of "Keep It UP! (KIU), an online HIV prevention program for YMSM. The method was a randomized clinical trial with 102 sexually active YMSM, 18-24 years of age. The KIU intervention included seven modules, completed across three sessions. Strengths of the study were a positive response from participants on both quantitative and qualitative responses. Limitations of the study included the design of the study did not allow authors to conclude what elements of the intervention led to the lower rate of unprotected anal intercourse.

Lightfoot, Taboada, Taggart, Tran, and Burtaine (2015) reviewed the pilot study of AMP! (Arts-based, multiple interventions, Peer education), an interactive theatre production for HIV prevention. AMP! was developed in Los Angeles, California and adapted for testing in North Carolina. HIV and STD rates are higher among youth in the Southern United States, basically due to their abstinence-based approach to sex education (Lloyd et al., 2012). The program utilized interactive theatre to educate students about sexual health. The goal of the AMP! Program was to supplement school sex education around HIV transmission and reduce stigma around people living with HIV. Participants were 317 ninth graders in two public high schools. The researchers used mixed methods with a "pre-test, post-test surveys and focus groups." The strengths of this study were that

there was a significant increase in HIV knowledge and a decrease in HIV stigma. Limitations of this study include it was a convenience sampling and may not be generalizable.

Whereas most CSE programs approach teaching sex education to students as individuals in a classroom environment, a multicomponent sex education program approaches teaching sex education to students as part of influential networks, such as parents, peers, and sexual health services. A particularly effective multicomponent sex education program was developed for high school students that integrated a classroom curriculum, parent education, a peer advocate program, and sexual health services at 10 urban high schools (Berglas et al., 2016). The study was conducted over two years and included 1,779 students, 243 parents and, 86 peer advocates, and Planned Parenthood of Los Angeles provided the sexual health services. Eighty-six percent of the students were Hispanic, and only 14.7% had been sexually active compared to an average of 22% sexually active elsewhere. The multicomponent intervention was deemed successful, in part, because students reported greater use of sexual health services and carrying a condom. There were no other significant behavioral changes found in this study. Parents provided positive feedback on their participation in classes on how to talk about sex with their children. One drawback to this program is that it did not address how many LGBT students and their parents were involved in the program.

Summary and Conclusions

Existing literature regarding HIV prevention education and YMSM demonstrates several things. First, there is no standardization regarding what constitutes an HIV

prevention program in the United States (California Department of Education, 2016; NCSL, 2016). Each state decides whether or not it will have an HIV prevention education program. If a state decides to have an HIV prevention education program, that state decides what information will be included in the curriculum and how it will be presented.

Second, not all states have HIV prevention education programs (Ma et al., 2014; NCSL, 2016). There are still states that have no promo homo laws on their books and states that refuse to implement all-inclusive HIV prevention education programs that address the needs of LGBT students (Arrington-Sanders et al., 2013; Bay-Cheng, 2003; Brooks & Bridges, 2015; LaSala et al., 2015). The vast majority of HIV prevention programs do not meet the unique needs of YMSM. Sex education is being taught to the sexual majority: heterosexual youth, while avoiding sexual minorities: LGBTQ youth. Not meeting the unique needs of YMSM tends to alienate sexual minority youth, which can lead to high-risk sexual behavior, as well as substance use and mental health issues.

Third, even though AOUM programs were not effective at curtailing HIV infections, the federal government continued to fund these programs from 1996-2009 in the amount 1.5 billion dollars (Andrasik&Lostutter, 2012; Kull, 2010; Schalet et al., 2014). Not only do AOUM programs not work, but CSE programs also do not address the needs of LGBTQ youth (Lloyd et al., 2012).

Fourth, most of the data used to evaluate adolescent sexual behaviors come from the CDC YRBS, which is handed out to schools to administer to students. This data is secondary data. Although the YRBS has been used since 1991, it was not until 2015 that the CDC included questions about the respondents' sexual identity as well as the sexual

identity of their sexual partners (CDC, 2016g). Not knowing the respondent's sexual identity, as well as the sexual identity of their sexual partners prevents researchers from examining the responses from LGBT youth (Ma et al., 2014; Van Handel et al., 2016).

Fifth, there is less information collected directly from adolescent MSM. It has been suggested that IRBs are partially to blame for the lack of data directly from adolescents. Although adolescents can consent for STI testing and treatment without parental consent, most IRBs are hesitant to let adolescents consent to be interviewed about their sexual behaviors (Mustanski& Fisher, 2016).

The gap in the literature exists for several reasons. Although much information has been collected from the CDC YRBS to address the effectiveness of HIV prevention education among young people since 1991, by its admission, the CDC (2016h) admits that, until the 2015 YRBS, the CDC did not seek to identify the sexual orientation of the survey participant or the sexual orientation of their sexual partners. Therefore, the YRBS cannot be properly used to address either the effectiveness or needs of YMSM.

Second, the gap in the literature is exacerbated due in part to IRB hesitation to allow researchers permission to question adolescent MSM. There is scant information from adolescent MSM about the effectiveness of HIV prevention education received in middle school, high school, or both. In all 50 states, adolescents are permitted by law to consent for reproductive health services, including birth control, STI testing and treatment, and HIV testing. However, IRBs seem hesitant to allow researchers to ask adolescent MSM questions about their sexuality (Mustanski& Fisher, 2016).

According to Nieblas et al. (2015), the CDC reviewed 84 effective HIV prevention programs. Although two-thirds of all HIV infections are among MSM, only three of the 84 effective HIV prevention programs reviewed were developed for YMSM. A more holistic approach to sex education is necessary to include LGBTQ youth in sex education (Schalet et al., 2014). Existing HIV prevention efforts have failed to decrease HIV infections in YMSM.

For these reasons, qualitative research using a phenomenological method to explore the lived experiences of YMSM, 21-35 years of age, asking them for specific information about their shared experience of HIV prevention messages they received while they were in school and how it is affecting their current sexual risk behaviors is warranted. The knowledge they share about their lived experiences with school-based HIV prevention education will help in the designingfuture HIV prevention programs that will better address their needs.

Chapter 3 will contain a discussion of the research design and rationale. This discussion will be followed by a discussion on the role of the researcher. Next will be a presentation of the study's methodology, including instrumentation, procedures for recruitment, participation, and data collection, including data analysis plan. Then I will address issues of trustworthiness and identify ethical procedures for the study. This address will be concluded with a summary.

Chapter 3: Research Method

Introduction

I originally designed this study with the approval of the Walden University IRB to be conducted with YMSM 18-25 years of age who lived in Oakland, California, and received HIV prevention education in middle school, high school, or both in Oakland, California. I originally conducted advertising for participants for this study with YMSM at several clinics in Oakland, California. The original stipend for participating in this study was a $25.00 prepaid Visa card (see Grant &Sugarman, 2004). There were no responses from potential participants based on the original study design.

Through a number of adjustments to the original design and with the approval of the Walden University IRB (approval number 01 16 18 0126480), the final design of the study was to be conducted with YMSM 18-38 years of age who resided anywhere in Alameda County, Contra Costa County, or San Francisco County, and received HIV prevention education in middle school, high school, or both anywhere within the State of California. The stipend for participating in this study was increased from a $25.00 prepaid Visa card to a $50.00 prepaid Visa card. I conducted advertising for participants on Craig's List.

The purpose of this qualitative stud using a phenomenological approach was to fill a significant gap in the literature by exploring the lived experiences of YMSM 18-38 years of age who received HIV prevention education in either middle school, high school, or both, and how that education has affected their current sexual behaviors, specifically their risk for HIV infection. YMSM continue to be at high risk for HIV infection in the

United States despite educational efforts to prevent infection (CDC, 2016b; Pettifor et al., 2013; Phillips et al., 2015). According to Nieblas et al. (2015), the CDC reviewed 84 effective HIV prevention programs. Although two-thirds of all HIV infections are among MSM, only three of the 84 effective HIV prevention programs reviewed were developed for YMSM.

This chapter contains a description of this study and begins with the purpose of the study, followed by the research design and rationale for using a qualitative research method with a phenomenological approach. The next section includes the role of the researcher in qualitative research. The role of the researcher in a qualitative research is followed by the research methodology that Iused to answer the study's RQ. The last portion includes a discussion of the issues of trustworthiness and ethical procedures, followed with a summary of this section's main points.

Research Design and Rationale

The RQ for this qualitative study using a phenomenological approach was: What impact did the lived experience of receiving HIV prevention education, in middle school, high school, or both, have on YMSM in the past, and what affect has that education had on current sexual behaviors, specifically the risk of HIV infection? The primary phenomenon studied was the lived experiences of YMSM 18-38 years of age around HIV prevention education learned in middle school, high school, or both, and how that education has affected their current sexual behaviors, specifically the risk for infection with HIV disease. Although HIV disease has stabilized or decreased in all other affected populations, it remains high in YMSM, 18-25 years of age (CDC, 2016b).

Although roots of phenomenology can be traced to Kant, and Hegel, Husserl (1859-1938), a German philosopher, is considered the "father" of the philosophical movement known as phenomenology (Moustakas, 1994). Husserl believed that the personal world is reduced to personal experience. Phenomenological research provides a very rich and detailed description of the human experience (Creswell, 2014; Wilson et al., 2015). The results of phenomenological research come from the participants rather than being imposed by a structured statistical analysis (Lincoln & Guba, 1985). Although similar results might be achieved by a quantitative survey, those results would not be as rich and detailed as information provided by individual, in-depth phenomenological interviews. Getting rich and detailed information is the rationale for why I chose to conduct this study using a phenomenological approach.

Qualitative research methods consist of gathering data from a specific population by interacting with that specific population and developing results that apply to that particular population based upon themes identified and analyzed from participant interviews (Creswell, 2014; Moustakas, 1994; Trochim& Donnelly, 2008). I conducted individual, in-depth, 1-hour interviews with 13 YMSM 18-38 years of age, exploring their lived experiences receiving HIV prevention education in middle school, high school, or both, and how that education has affected their current sexual behaviors, specifically the risk of infection with HIV disease. Iaudio-recorded interviews and transcribed them verbatim. I analyzed transcripts for common themes.

Role of the Researcher

Husserl established the school of phenomenology. He referred to an unbiased approach to a phenomenon as epoche (Moustakas, 1994; van Manen, 1990). In qualitative research using a phenomenological approach, researchers must identify and then bracket all preconceived notions including bias they may have about the phenomenon to be studied so that the researcher can approach the research interview with an open, receptive presence (van Manen, 1990). To establish what impact the lived experience of receiving HIV prevention education in middle school, high school, or both had on YMSM in the past and what affect that education had on current sexual behaviors, specifically the risk of HIV infection, I had to experience the phenomenon as directly as possible myself. To accomplish this, I had to be a participant-observer when conducting in-depth interviews with participants (see Patton, 2015). As a participant-observer, I had to record observations of what I saw and heard. Having bracketed my preconceived notions, or biases, I analyzed and reported findings based solely on the information provided by participants.

Although I worked in the field of HIV disease for 24 years, most of my work was in the area of HIV education, prevention, testing, referral to care, and surveillance in Alameda County, California. I have not had a professional relationship of any kind with any of the participants in this study. I have no conflict of interest with any of the participants I recruited for this study. I have no power relationships with any of the participants I researched.

The HIV education portion of my work was done in community-based drug and alcohol programs in Alameda County. The only experience I have had in HIV prevention education in a formal classroom environment was briefly in 1992 when I was a volunteer, certified American Red Cross HIV educator who was invited to conduct HIV prevention presentations in alternative high schools in the Richmond Unified School District, now West Contra Costa Unified School District, in Contra Costa County, California.

In the Chapter 2 literature review, I acknowledgedthat I suspected schools were not doing an adequate job of equipping YMSM with the knowledge necessary to protect themselves from HIV infection. However, I bracketed that suspicion (researcher bias) and entered into the interview process and analysis with an unbiased, open mind.Only information provided by my participants about their shared experience with the phenomenon of the HIV prevention education they received in either middle school, high school, or both, and how that education affected their current sexual behaviors, specifically exposure to HIV disease, were included in this study.

Methodology

Participant Selection Logic

Criteria for participant selection was YMSM, 18-38 years of age, who had experienced HIV prevention education presented to them in middle school, high school, or both, and how their experience in receiving this education has affected their current sexual practices. I used the term young men who have sex with men rather than the terms homosexual, gay, or bisexual men because although all four terms can be used to describe a sexual behavior, homosexual, gay, and bisexual are frequently used to indicate a man's

sexual identity or orientation (CDC, 2016b). Because the terms homosexual, gay, or bisexual are frequently used as pejorative terms and may have consequences depending on where a person lives in the world, many men who do have sex with men will still identify as heterosexual or straight when asked for their sexual orientation (CDC, 2016g; UNAIDS, 2006).

If I am asking a young man if he has ever had sex with another man, I am asking about a behavior, I am not asking him to put a label on himself. Describing a behavior rather than a sexual identity is especially important when discussing sex with a young man who may be struggling with establishing his own sexual identity (CDC, 2016g). This struggle is why I used the term young men who have sex with men rather than homosexual, gay, or bisexual.

All qualitative research involves a purposeful sampling strategy. However, the purpose of the different types of qualitative research dictates what type of purposeful sampling strategy will be used. Since I was looking for participants who are YMSM who have a shared common experience, my sampling strategy was a criterion sampling.

Most researchers suggest the sample size should stop once data has reached saturation. Although this is something that is more easily done in retrospect, once the study has been completed and the data have reached saturation point, it is more difficult to suggest the number of participants going into a study. Guest, Bunce, and Johnson (2006) conducted a study analyzing the data provided through interviews of 60 participants in a West African study. This study is the only empirical study that has determined when data saturation occurs. The results of their study indicated that data

saturation occurred at the 12thinterview (p. 74). Using the results provided by Guest et al. (2006), I recruitedand interviewed 13 participants.

Eligibility criterion. Participants for this study were YMSM 18-38 years of age. Participants must have attended middle school, high school, or both, anywhere in the State of California and received HIVprevention education at least once while in middle school, high school, or both. Participants for this study must have acknowledged that they hadbeen sexually active with men within the last year. Participants must have been willing to participate in a 1houraudio-taped interview where they discussed their lived experiences around the HIV prevention education they received while in school and how that education has affected their current sexual behaviors.

Instrumentation. In qualitative research using a phenomenological method, data is primarily collected through individual, in-depth interviews of participants who have shared a common lived experience (Creswell, 2013; Moustakas, 1994; Patton, 2015). Each participant engaged in a 1-hour, individual, in-depth interview in which he was asked to respond to the exploratory interview questions. Interviews were recorded with the participant's permission. Digital audio recordings were downloaded onto a computer where they weretranscribed verbatim.

Standardized open-ended interviews were conducted in this study. See Appendix A for the interview protocol. In standardized open-ended interview questions, each participant was asked the same open-ended questions in generally the same order but was allowed flexibility based on the progression of the interview. This method of interviewing is known as the hermeneutical approach to phenomenological research (Van

Manen, 2014). There are several reasons for conducting interviews in this way. First, each interview is only 1-hour in duration, and the intent is to collect as much rich and thick information from the participants as possible in that hour. Second, even though the interviews are structured, there will be opportunities to ask participants follow-up, open-ended questions. Third, by participants providing rich and thick information, this information will reduce the possibility of researcher biases (Moustakas, 1994; Turner III, 2010). In addition to reducing researcher biases, the use of rich, thick information allows the reader to decide if the information is transferrable to other settings. The interview questions are researcher produced.

For this study, using a phenomenological approach, content validity refers to how accurately the researcher presents the information collected from participants through interviews (Creswell, 2013). Content validity was established by participants. Once the audio recorded interview was completed, and the audio recording had been transcribed, the participant was invited to review the transcription to ascertain that what had been transcribed was not only what he said but also what he meant to say. Corrections will be made to ensure that what is transcribed is what the participant meant to say.

There is a gap in the literature investigating how YMSM, 18-38 years of age, received HIV prevention education while in middle school, high school, or both, as well as how the knowledge gained in HIV prevention education has helped them avoid becoming infected with HIV currently. Most of the data used to evaluate adolescent sexual behaviors come from the CDC YRBS. Although the YRBS has been used since 1991, it was not until 2015 that the CDC included questions about the respondents'

sexual identity as well as the sexual identity of their sexual partners. This lack of identity prevents the researcher from examining the responses from LGBT youth. According to Nieblas et al. (2015), the CDC reviewed 84 effective HIV prevention programs. Only three of the 84 effective HIV prevention programs reviewed were developed for YMSM.

Procedures for Recruitment, Participation, and Data Collection

Participants for this study were recruited from flyers advertising the study on Craig's List. These flyers described what the research study was about, the criteria for participating in the study, and what was expected of participants: a 1-hour interview that was recorded for transcription. The flyer indicated that participation was voluntary and that each participant would receive a $50.00 prepaid Visa card as a stipend for participating. Those who were interested in participating in the study were directed to call a phone number or email me at Walden University. Results of a subsequent telephone conversation were to confirm the person met study criteria and schedule an in-person interview.

Data was collected through individual, 1-hour, audio-recorded interviews. Interviews were conducted only by the researcher. Audio recorded interviews were transcribed only by the researcher. An individual follow-up interview wasoffered to each participant so that he would be able to review the transcript of their original interview, checking it for accuracy. Identified inaccuracies were corrected by the researcher until the participant was satisfied that the transcript accurately reflected not only what he said but also what he meant to say. Several participants accepted a second meeting where they could review the transcripts. Other participants opted for me, sending them the transcript

via email, and they returned it with any corrections. There was only one transcript I had to correct.

Data Analysis Plan

The RQ for this qualitative study, using a phenomenological approach, is What impact did the lived experience of receiving HIV prevention education in middle school, high school, or both, have on YMSM in the past, and what affect has that education had on current sexual behaviors, specifically risk of HIV infection. Data for this study was collected by audio-recorded and transcribed individual interviews. As the interview protocol indicates (Appendix A), specific, open-ended interview questions were asked to help each participant answer the RQ.

Seven exploratory interview questionswere used to collect data that was germane to the RQ. Each exploratory interview question directly asked the participant to relate their experiences receiving HIV prevention education in middle school, high school, or both. Exploratory question number 1 asked the participant to tell me about his experiences receiving HIV prevention education in school. Exploratory question number 2 asked the participant to tell me what he liked about the HIV prevention education he received in school. Exploratory question number 3 asked the participant to tell me what he did not like about the HIV prevention education he received while in school. Exploratory question number 4 asked the participant to tell me how he applies the HIV prevention education he received in school to his current life. Exploratory question 5 asked the participant to tell me what he would change about the HIV prevention education he received in school. Exploratory question 6 asked the participant to evaluate

how risky his sexual behaviors are today, based upon the HIV prevention education he received in school. The responses to these questions directly tied into the RQ this study was attempting to answer.

Once transcribed, the researcher studied the transcriptions using phenomenological analysis. Phenomenological analysis means I clustered pertinent data into themes. I then developed these themes into textual descriptions of the experience. These textual descriptions were integrated and developed into the meaning of the phenomenon as the participants experienced it. Transcriptions werehand-coded by the researcher (Creswell, 2014; Patton, 2015). Other than Microsoft Word, no other software was used for data analysis.

Issues of Trustworthiness

The purpose of this qualitative study was to answer the RQ that asks participants how they experienced HIV prevention education in middle school, high school, or both, and how that education has affected their current sexual behavior, specifically the risk for HIV infection. Credibility refers to how believable the results of the study are (Creswell, 2013; Lincoln & Guba, 1985; Moustakas, 1994; Patton, 2015). Two methods for confirming credibility are providing thick, rich descriptions of what participants tell me and having participants review transcripts for accuracy.

To establish credibility, I audio recorded all interviews. Recordings were transcribed, including not only what the participant said but also any pauses or hesitations in responses. Once a transcription was completed, the participant was invited to review the transcript for accuracy. Corrections were made regarding what the participant said

and what they intended to say. Another way to establish credibility for this study was to continue to interview participants until the study reaches the saturation point. Saturation is the point at which no new information is gathered through the interview process of participants (Creswell, 2013; Lincoln & Guba, 1985; Moustakas, 1994; Patton, 2015). Saturation point in this study was reached by interview 13.Finally, I reviewed my findings with the results of other studies that have interviewed MSM on their experiences with HIV prevention education in other parts of the United States.

Transferability in a qualitative study is the degree to which the results of a study in one location can be applied to participants experiencing the same phenomenon in a different location (Creswell, 2013; Lincoln & Guba, 1985; Moustakas, 1994; Patton, 2015). Transferability is accomplished by the reader of a study, based upon the information provided by the researcher. To help readers of this study decide on transferability, I provided detailed information on all processes of this study. I also provided a thick, rich description of what participants told me, as well as the ethnic and cultural differences of the participants.

Dependability is the ability to demonstrate that the results are consistent and can be repeated elsewhere (Creswell, 2013; Lincoln & Guba, 1985; Moustakas, 1994; Patton, 2015). To accomplish dependability, I tookthe results of my study and compared them with the results of similar studies conducted at other times and in other locations. Although similar results in other areas are desirable, contrasting results may also be acceptable if the study finds that YMSM students are receiving a better HIV prevention education locally than in other parts of the United States.

Confirmability is the extent to which the findings of the study reflect what the participants say is their lived experience of the phenomenon without the bias of the researcher (Creswell, 2013; Lincoln & Guba, 1985; Moustakas, 1994; Patton, 2015). I have worked in the field of HIV disease for 22 years. The only time I was involved in doing any HIV prevention education in a classroom was back in 1992 when I was a volunteer American Red Cross HIV educator. Although the literature review in chapter 2 indicates the educational system in this country is not doing a good job in protecting YMSM from HIV infection, reflexivity required that I bracket my own bias and allow the participants to present their experience their way.

I kept a journal of my thoughts during the data collection and data analysis process. In this journal, I identified anything a participant said that surprised me, as well as why what the participant said surprised me. I used my journal as a tool for avoiding any researcher bias, thereby allowing me to report only that information provided by the participants.

I was the only researcher in this study. I was solely responsible for interviewing participants, recording interviews, transcribing interviews, reviewing and correcting transcribed interviews, coding responses, and developing themes. All codes and developed themes are my responsibility.

Ethical Procedures

This study required Walden IRB approval before any part of this research could take place. A part of the Walden IRB approval process was documentation of the interview protocol (Appendix A). Another part of the Walden IRB approval process was

documentation that I had completed the NIH Web-based training course "Protecting Human Research Participants" (Appendix B).

Recruitment for this study was initiated by advertising the study on Craig's List. Craig's List is a web-based classified advertisements website found on the Internet. YMSM who were interested in participating in this study were asked to call me or contact me at my Walden University email address, providing me with a way to contact them. I contacted potential participants and screened them to ensure they met study requirements as enumerated in the ad on Craig's List. If the person met study requirements and was still interested in participating in the study, an appointment was made to meet for the interview.

Participants were allowed to choose the venue in which interviews would take place. The purpose for allowing participants to choose where they would be interviewed was to provide them with the most comfortable surroundings in which to share their experience of the phenomenon being studied. Six participants chose to be interviewed in public library study rooms. One participant chose to be interviewed in a college library study room. Two participants chose to be interviewed in their own homes. Two participants chose to be interviewed in outdoor public places that afforded an appropriate level of privacy. One participant chose to be interviewed in a hotel. One participant chose to be interviewed in a church surrounding.

When the participant arrived for the interview, I provided him with a copy of the consent form. I asked him to read along silently as I read the consent form to him. The consent form included information on the purpose of the study, and how the information

would be collected through a 1-hour, audio-recorded interview. The participant was informed that his participation was voluntary, and that should he begin to feel uncomfortable at any time during the interview process; he could stop it without negative consequences. I also explained that, even after the participant began the interview, should he decide he no longer wanted to be included in the interview, he was free to withdraw from participation with no negative repercussions. I explained that the interview would be recorded and transcribed into a computer where the information would be analyzed.

I explained the following to each participant about the informed consent form:Their name would not be attached to the interview. A unique, anonymous code would identify each interview. Each participant would receive a $50.00 prepaid Visa card as a stipend for his participation upon completion of the interview. Participants who withdrewfrom the study before the interview process was completedwould still receive the $50.00 prepaid Visa card as a stipend. The participant was given the name of the person to contact at Walden University if he needed additional information about the study.

I then asked the participant if he understood what had been read to him, and if he had any further questions. I answered any questions the participant had and then askedhim to sign both his copy and my copy of the informed consent form. I signed both copies of the form. One copy was for the participant. The other copy was for my files.

Signed informed consent forms were secured in a locked, metal file cabinet, inside a locked room, removed from the interview site. Files containing each participant's name and unique, anonymous, identification code were also kept in a locked, metal file

cabinet, inside a locked room, removed from the interview site. Hard copy transcripts were compared to audio recordings for accuracy. Once accuracy was confirmed, audio recordings and hard copies of transcripts were kept in a secure location for the required five years.

Although most YMSM are accustomed to talking about themselves, if I observed that a participant was exhibiting physical, emotional, or mental distress, I was prepared to stop the interview and ascertain whether the interview should continue. During the 13 interviews, I observed no occasions when a participant appeared to be in any distress. All interviews were conducted without any problems.

Summary

This chapter contained a discussion of the research's design and methodology, which was qualitative, using a phenomenology approach, and the rationale, which was to obtain the lived experiences of the participants, YMSM, 18-38 years of age, around HIV prevention education learned in middle school, high school, or both, and how that education has affected their current sexual behaviors. Also included was a discussion of the criterion sampling, the collection of data via computer recorded interviews and the validity and reliability of the research components, including the trustworthiness of the participants, and the ethics of how participants were chosen for the study.

In chapter 4, I will describe the setting the study took place in and the demographics of the participants. This description will be followed by a discussion about the data collection method and analysis. Next, will be an evaluation of the evidence of trustworthiness and how it was achieved. Finally, I will report on the results of the study.

Chapter 4: Results

Introduction

The RQ for this phenomenological qualitative study was: What impact did the lived experience of receiving HIV prevention education, in middle school, high school, or both, have on YMSM in the past, and what affect has that education had on current sexual behaviors, specifically the risk of HIV infection?The purpose of this qualitative study using a phenomenological approach was to fill a significant gap in the literature by exploring the lived experiences of YMSM 18-38 years of age who received HIV prevention education in either middle school, high school, or both, and how that education has affected their current sexual behaviors, specifically their risk for HV infection. YMSM continue to be at high risk for HIV infection in the United States despite educational efforts aimed atprevention (CDC, 2016b; Pettifor et al., 2013; Phillips et al., 2015). According to Nieblas et al. (2015), the CDC reviewed 84 effective HIV prevention programs. Although two-thirds of all HIV infections are among MSM, only three of the 84 effective HIV prevention programs reviewed were developed for YMSM.

This chapter contains a description of this study and begins with the purpose, followed by the setting and demographics. The next section includes data collection, followed by data analysis. Then I discuss the evidence of trustworthiness. The last sections present results, followed by a summary of the section's main points.

Demographics

Thirteen men participated in this study. They ranged in age from 21 to 35 years. All 13 participants identified as an MSM. Eleven identified as gay and two identified as

bisexual. Ten had received their HIV prevention education in Northern California, and three had received their HIV prevention education in Southern California.

Table 1

Participant Demographics

Name	Age	Race	County	Sex orient.	HIV education
Adam	23	Arabian	Alameda	Gay	Northern California
Charles	30	Black	Alameda	Gay	Northern California
David	34	Asian	Alameda	Gay	Northern California
Edward	25	White	Alameda	Gay	Northern California
Fred	32	Black	Alameda	Gay	Northern California
George	21	White	Contra Costa	Gay	Northern California
Harry	31	White	San Francisco	Bisexual	Northern California
John	35	White	San Francisco	Gay	Southern California
Kevin	35	White	San Francisco	Gay	Southern California
Larry	35	White	San Francisco	Gay	Southern California
Michael	34	Latino	Contra Costa	Bisexual	Northern California
Norman	25	White	Alameda	Gay	Northern California
Robert	35	Black	Alameda	Bisexual	Northern California

Note: All names are fictitious. County is county of residence.

Data Collection

In qualitative research using a phenomenological method, data is primarily collected through individual, in-depth interviews of participants who have shared a common lived experience (Creswell, 2013; Moustakas, 1994; Patton, 2015). Information advertising the study was posted on Craig's List. Thirteen YMSM responded to the

advertisement and qualified to participate in the study. Each YMSM participated in a 1-hour, individual, in-depth interview in which he was asked to respond to seven exploratory interview questions about his experiences receiving HIV prevention education in middle school, high school, or both anywhere in the state of California and how he has applied that education to his current life (see Appendix A: Interview Protocol).

Participants were allowed to choose the venue in which interviews would take place. The reason for allowing participants to choose where they would be interviewed was to provide them with the most comfortable surroundings in which to share their experience of the phenomenon being studied. Six participants chose to be interviewed in public library study rooms. One participant chose to be interviewed in a college library study room. Two participants chose to be interviewed in their own homes. Two participants chose to be interviewed in outdoor public places that afforded an appropriate level of privacy. One participant chose to be interviewed in a hotel. One participant chose to be interviewed in a church surrounding.

These were individual, one-time interviews for data collection purposes. Although 1hour was allotted for each interview, the actual amount of time the interviews took ranged from eight to 25 minutes. Each participant was asked the same questions. Audio of interviews was digitally recorded. Two interviews only lasted eight minutes. Although short, participants provided information appropriate to this study. Limitations of these two brief interviews are further explored in Chapter 5.

I downloaded digital recordings onto a computer where I transcribed them verbatim. I invited participants to review their transcript to confirm that what was typed was what they had said, or meant to say. Six of the participants elected to meet with me in person to review the transcripts. Seven of the participants elected to have me e-mail them transcripts, which they reviewed for accuracy and e-mailed back to me with any corrections.

There were no variations or unusual circumstances during the data collection process from what was described in Chapter 3. I conducted and recorded all the interviews with the permission of each participant. I transcribed all the interviews and reviewed them with participants. I conducted some transcription reviews with participants in person. Other transcripts were e-mailed to participants, and they responded with corrections by e-mail. There was only one occasion where I had to correct. David asked me to change the word “production” to “protection” in his interview.

Data Analysis

The RQ for this qualitative study using a phenomenological approach was: What impact did the lived experience of receiving HIV prevention education in middle school, high school, or both, have on YMSM in the past, and what affect has that education had on current sexual behaviors, specifically risk of HIV infection? Data sources used for this study were transcripts of individual interviews. As the interview protocol indicates (Appendix A), I asked specific, open-ended interview questions to help each participant answer the RQ.

I used seven exploratory interview questions to collect data that was germane to the RQ. Each exploratory interview question directly asked the participant to relate their experiences receiving HIV prevention education in middle school, high school, or both. Once transcribed, the analytical process involved reading the transcripts several times, highlighting the salient points, and grouping these into themes. Themes were developed into textual descriptions of the experience. Textual descriptions of the experience were integrated and developed into the meaning of the phenomenon as the participants experienced it.

Four themes emerged from the seven exploratory questions asked of participants in this study. The first theme that became evident through these interviews was a lack of curriculum consistency. The second theme that appeared through these interviews was the lack of LGBT content in the curriculum. The third theme that became evident through these interviews was the impact of stigma and homophobia on participants. The fourth theme that came out of these interviews was the lack of classroom management. In answer to the primary RQ of how HIV prevention education they received in school has affected their current sexual behaviors, specifically their risk for HIV infection,participants said they do not incorporate any of the HIV prevention education they received in schoolto their current lives other than learning how to use a condom to protect from STIs, including HIV disease.

Although there were two interviews that were only eight minutes each in duration, they were included in this study because the datathey providedwere congruent with the

information provided bythe other participants. All the participants said essentially the same thing. There were no discrepant cases.

Evidence of Trustworthiness

Credibility

In Chapter 3, credibility was described as how believable the results of astudy are (Creswell, 2013; Lincoln & Guba, 1985; Moustakas, 1994; Patton, 2015). To achievethis, I implemented credibility strategies as outlined in Chapter 3. I chose to confirm credibility by providing thick, rich descriptions of what participants told me, as well as having participants review transcripts for accuracy.I audio-recorded all interviews digitally to establish credibility. I transcribed the recordings, including not only what the participants said but also any pauses or hesitations in responses. Once the transcriptions were completed, participants were invited to review the transcripts for accuracy. Corrections to transcripts were made as directed by participants.

Three participants agreed to a second meeting to review transcripts for accuracy. Ten participants elected to have copies of their transcripts sent to them via e-mail. They reviewed the transcripts and then e-mailed responses back to me that the transcripts were correct as typed, or they sent me corrections.

Another way to establish credibility for this study was to continue to interview participants until the study reachedthe saturation point. Saturation is the point at which no new information is gathered through the interview process of participants (Creswell, 2013; Lincoln & Guba, 1985; Moustakas, 1994; Patton, 2015). After 13 interviews, I saw significant replication of the key information.

Finally, I reviewed my findings with the results of other studies that have interviewed YMSM on their experiences with HIV prevention education in other parts of the United States. For example, when my participants told me their teachers were restricted to certain information regarding sex in general and HIV specifically, I was reminded of similar findings in the results of the Project GRACE study conducted by Lloyd et al. (2012). According to Schalet et al. (2014), AOUM was the sex education/HIV prevention education program funded by the Federal Government.

Transferability

In Chapter 3, I defined transferability in a qualitative study as the degree to which the results of a study in one location can be applied to participants experiencing the same phenomenon in a different location (Creswell, 2013; Lincoln & Guba, 1985; Moustakas, 1994; Patton, 2015). Transferability is accomplished by the reader of a study based upon the information provided by the researcher. To help readers of this study decide on transferability, I have provided detailed information on all processes of this study and thick, rich description of what participants told me, as well as the ethnic and cultural differences of the participants. Finally, I made reference to the findings of other studies conducted with YMSM in other areas of the country. When participants mentioned that the education they received on HIV prevention was focused on AOUM, it reminded me of similar responses recorded in the Project GRACE study conducted by Lloyd et al. (2012) in North Carolina. From 1981 through 2010, the only programs the Federal Government would fund were AOUM programs (Andrasik&Lostutter, 2012). When participants explained that the sex education and HIV prevention they received was

directed at and focused on heterosexual students, I was reminded of the results of a study conducted by LaSala et al. (2015) that school authorities were ignoring the needs of YMSM and their families.

Dependability

In Chapter 3, dependability was defined as the ability to demonstrate that the results are consistent and can be repeated elsewhere (Creswell, 2013; Lincoln & Guba, 1985; Moustakas, 1994; Patton, 2015). I said that to accomplish dependability. I would compare and contrast the results of my study with the results of similar studies conducted at other times and in other locations. There were no adjustments made to the dependability strategies stated in chapter 3.

Confirmability

In Chapter 3, confirmability was defined as the extent to which the findings of the study reflect what the participants say is their lived experience of the phenomenon without the bias of the researcher (Creswell, 2013; Lincoln & Guba, 1985; Moustakas, 1994; Patton, 2015). Although the literature review in chapter 2 indicates that the educational system in this country is not doing a good job in protecting YMSM from HIV infections, reflexivity requires that I will bracket my own bias and allow all the participants to present their experience their way.

To ensure that the information presented in the study is solely the information provided to me by participants, interviews were recorded, transcribed, and reviewed by participants for accuracy of the content. There is no data in this study that is not backed

up by audio recording, transcription, and confirmation by the participant that what I typed is what they said.

Results

To answer the RQ in this study, individual interviews were conducted with 13 participants. In those interviews, participants were asked seven exploratory questions (see Appendix A: Interview Protocol). Based on participant responses to those exploratory questions, four themes emerged. Those four themes were: lack of curriculum consistency; lack of LGBT content in the curriculum; the impact of stigma and homophobia on participants; and lack of classroom management.

Theme 1: Lack of Curriculum Consistency.

The first theme to emerge from these interviews was that there was no uniformity to the way HIV prevention education was taught in California. There did not appear to be a specific course on HIV prevention education. HIV prevention education was incorporated into other classes.

In middle school, George remembers HIV prevention education was presented to students "voluntarily." It was a one-time presentation "in the auditorium during a lunch break." He says it was "very detailed and scientific about describing the different consequences that HIV and other STDs could have." He recalls that the lady who was presenting the information, "Referred to it (HIV) as a death sentence." He said it was very frightening to him. It caused him to be "very, very shy about expressing the fact he might have feelings for a guy." He continued, "Frightening the hell out of some of us"

exasperated feelings of anxiety and depression he was already experiencing in middle school. He "didn't think it was the right approach."

In middle school, Michael remembers HIV prevention education in eighth grade. It was a one-time presentation in the auditorium by a guest speaker. The emphasis was on safe sex: "If you were to have sex, use a condom and stuff like that."

In middle school, Harry remembers HIV prevention education was presented over one week in health class. He says the education he received was "really cut and dry." It was negative. "Don't have sex. Wait until you are married. If you get it (HIV) you're going to die." He said, "In high school, it got a little bit more specific, but it was the same attitude, and I stopped paying attention."

In middle school, John remembers HIV prevention education as part of the sex education curriculum. The science teacher taught it. He recalls wondering if the teacher "had any training in sex ed, or how to present it." He went on to say, "A lot of the people were uncomfortable… because she was so much older (than the students). She used scientific words. She didn't have an answer to a lot of the questions that others asked." He said he "was too 'skittish' and shy at the time to raise my hand."

In middle school, Norman remembers HIV prevention education as a part of sex education in science class. He recalls, "There wasn't a specific focus on HIV." The class "was mostly about (the) reproductive system and using condoms." He summed it up by saying, "Basically just condom use (for) preventing the infection of any kind, including HIV."

In high school, Larry remembers getting HIV prevention education in a "special" sex education class taught to male students only, by a male teacher. As Larry described it, "It was justfearmongering, not a scientific base, and more to do with interactions between a man and a woman. It was very fearmongering, abstinence based. They said they weren't allowed to talk about protection and stuff."

In high school, Fred remembers HIV prevention education as being part of a mandatory health education class in his freshman year. Part of the curriculum "was sexual education class, and we went over several things, from every disease that affects people and HIV." As he recalls, HIV prevention education was included in one 90-minute block.

In high school, David remembers a similar experience with HIV prevention education. It was taught in the sex education portion of his health education class. As he recalled, "There was nothing specific about HIV itself. It was all sexually transmitted diseases." He said, "The sex-ed section was like a week of information."

In high school, John remembers HIV prevention education "was part of the sex education curriculum." A man taught it. John recalls, "He talked about abstinence from a nonspiritual approach." By that, John meant that the teacher left out God and the Bible as the reason to abstain. John says Baptist parents raised him. John summed up his HIV prevention education in high school this way, "So sometimes I look back and think that maybe it was just scare tactics to keep us from making a mistake. Well-meaning as though it may have been, I don't think fear was the way to go about it."

In high school, Kevin remembers HIV prevention education was a part of health education. It was also covered in biology class. As Kevin recalls, “The biology teacher would keep up on the news and talk about developments in HIV and AIDS.”

In high school, Norman remembers HIV prevention education was “sexual education in biology class.” He recalls, “We learned about the way it could be transmitted, which is something that I already knew.” In high school, Adam remembers he had HIV prevention education in biology class. He recalls wishing there was more education “that promotes safe sex.”

There was an apparent difference in where participants received their HIV prevention education. John and Larry received HIV prevention education in Southern California. They said that the curriculum was based on fearmongering and scare tactics. John said, “So sometimes I look back and think that maybe it was just scare tactics to keep us, you know, from making a mistake.” Larry received HIV prevention education in Southern California. He said, “It was really… fearmongering not scientific.” He went on to say, “They mentioned the STDs, but it was more just to scare you.” Kevin said that, although the information he received in the classroom was “okay,” he lived in an area where, “There was a lot of military, like military retirees… and not maybe so supportive of the gay community.”

In summary, according to the responses of the participants of this study, there was no uniformity to the HIV prevention education they received in school. The information they received varied from AOUM, always to wear a condom. Scare tactics regarding the consequences of becoming infected with not only HIV but also other sexually transmitted

diseases were used. HIV prevention education was not taught as its curriculum. It was squeezed into other subjects.

Except learning how to use a condom to protect from STIs, including HIV disease, participants do not incorporate any of the HIV prevention education they received in school to their current lives. The reasons for this range from Kevin's statement that the teachers only spoke about AOUM, to David's statement, there was no in-depth information on HIV. George and Larry's statement that the HIV prevention education was fearmongering, to Larry's statement that he does not apply anything he learned about HIV prevention education he learned in school to his current life because it was "just so controlled and bare bones."

Theme 2: Lack of LGBT Content in Curriculum

The second theme to emerge from these interviews was that the focus of HIV prevention education was toward heterosexual students. Specifically, the focus was on vaginal intercourse. There was no mention of anal or oral sex, or masturbation, behaviors that are as familiar in heterosexual sex as they are in homosexual sex.

When asked about HIV prevention education he received in high school, Adam remembered, "They mostly talked about birth control." He recalled, "They always talked about the pill." When asked why he was interested in birth control, his response was, "I was trying to push myself as like being straight, I guess, and the way to prevent, like, not having a baby, is having the birth control."

When asked about the HIV prevention education he received in school, David remembered that "In middle school, they never talked about anal sex… or oral sex." He

summed it up by saying, “It was just purely vaginal sex. They barely even talked about masturbation.” Even though how HIV is transmitted and how you can protect yourself from HIV was taught in high school, David agreed to the summation that in his experience “HIV education was a part of sex ed; there was no separate thing on HIV, and that sex education was geared to heterosexual students."

When asked about the HIV prevention education he received in school, Kevin remembered that in middle school (Catholic school), the primary message was “abstinence no sex before marriage.” In high school, HIV prevention education was “geared toward heterosexuals.”

When asked about the HIV prevention education he received in high school, Larry remembered, “(It was) more and more to do with interactions between a man and a woman.” He recalled further into the interview that he did not like the fact, “It was (taught) more through the paradigm of like a man and a woman having sex and like their relationship with HIV.”

In summary, according to the responses of the participants of this study, some participants were completely “turned off” by the fact that the HIV prevention education was focused not only on heterosexual sex but only on penis-vagina penetration. There appeared to be little if any, instruction on other sexual behaviors that are common to both heterosexual couples and homosexual couples. There was no mention of anal or oral sex or masturbation.

Participants do not incorporate any of the HIV prevention education they learned in school to their current lives, except using a condom in safer-sex situations. Except

using a condom was because the education was focused on heterosexual students, specifically penis-vagina sex. Adam stated they mostly talked about birth control. David said the teachers never mentioned anal or oral sex, behaviors engaged in by both heterosexual and same-sex couples.

Theme 3: Impact of Stigma and Homophobia on Participants

The third theme to emerge from these interviews was the need for a venue students could use to ask questions in other than the classroom environment where students with questions were afraid they would be made fun of or bullied, for being identified by heterosexual students as being homosexual or bisexual. Participants said that not only is there a stigma around HIV and homosexuality, but there is also teasing and bullying of students who are perceived as LGBTQ.

At the time Adam received HIV prevention education in high school, he was not "out" about being "gay." He found the discussions about birth control interesting because at that time, he "was trying to push myself as like being straight." When asked if there was any negativity about gay men, Adam responded, "There's a lot of bullying about being gay because they're (the straight students) not totally cool with it." Because of his perception of other student's attitudes toward "gays," and not being "out," he refrained from asking questions in the classroom environment.

At the time Fred received HIV prevention education in high school, he said, "Co-ed is the best route to go because if it's just men… you may have to separate the gay guys from the heterosexual guys. The girls were always the ones who protected us." When asked if he ran "into a lot of prejudice from heterosexual men in high school," Fred

responded, “I’ve never been physically assaulted ever. I’ve been called names from time to time.” In response to the hypothetical question of how would he protect “a male student that was not out, that hadn’t declared their sexual identity,” Fred responded, “Maybe just have the availability for people to speak with teachers after class.” Talking with the teachers might “take away the stigma.”

At the time George received HIV prevention education, he mentioned that in middle school, there were “a couple of kids who used to harass me a bit.” He felt that others would identify those who participated in the HIV prevention education class as being LGBTQ kids. When he took the class in middle school, it was voluntary. He believes the class should be mandatory because “It would create less of a stigma (of being LGBTQ).” He said he was bullied because he was singled out as being in the sexual minority. He believes the classes should be co-ed because it would “reduce the stigma of irresponsible homosexuality.”

At the time Kevin received HIV prevention education he said, “There was a lot of boys being immature and making jokes about seeing the reproductive system and then discussing sex openly in a classroom with your adult teacher.” Girls, being present in the class, were good because, “Girls at that age were, seemed a little more, mature and able to handle it then we (boys) were. When asked if there was any gay-bashing, Kevin responded, “Yeah, there was.”

At the time Larry received HIV prevention education, he said, “He wasn’t fully aware of my orientation. Given the political climate at the time, you know, you weren’t really wanting to raise your hand and ask certain questions.” At another point in the

interview, Larry said, “If you’re in a group… you don’t want to be the one, you know, asking the gay question.” When asked, “If you had asked a gay question, would you have been the target of bullying.” Larry responded, “that (there) would be a good chance I would be bullied and ostracized by my peers.” When asked how he would change things, he said, “I would like to see a way to anonymously ask questions.”

At the time Norman received HIV prevention education, he said, “It wasn’t very extensive or in-depth.” The HIV prevention education he received in biology class was augmented by “some discussions in high school GSA (Gay-Straight Alliance).” In response to the question, “Was there stigma when you were in high school and middle school,” Norman responded, “Yes, and to this day as well.”

At the time Robert received HIV prevention education, he said, “In high school, you don’t want your friends to talk about you, point their finger like ‘Oh you queer’ or ‘you faggot.’” Robert’s first gay experience was in high school. He appears to be still struggling with identifying as bisexual. In regards to this first gay experience, Robert says, “To this day, they don’t even know (I am bisexual).”

In summary, according to the responses of the participants of this study, at the time participants received HIV prevention education, some were not sure of their sexual identity, others were wrestling with their sexual identity, and still others knew they were gay. Regardless of where participants were on the sexual spectrum, all of them wanted to fit in with the heterosexual majority. Therefore, they refrained from asking questions in class that might give them the stigma of being gay.

A common theme throughout this research was the inability of participants to ask questions concerning same-sex sexual behaviors. For some, it was the fear of gay stigma. For others, it was the fear of verbal ridicule by heterosexual male classmates. For still others, it was the fear of physical attack by heterosexual male classmates. Regardless of the reason for their fears, or wanting to fit in with other students, participants did not get answers to questions pertinent to their same-sex sexual behaviors. For this reason, participants were unable to apply anything they learned in school to their current lives, other than using condoms for safer-sex practices.

Theme 4: Lack of Classroom Management

A fourth theme that came out of these interviews was that teachers appeared to be incapable of controlling student behavior in HIV prevention education classes. Some participants alluded to this. Other participants were very specific that teachers were incapable of controlling student behavior in HIV prevention education classes.

Adam remembered in high school that, “They (the students) don’t want to listen. They’re always on their phones.” Harry recalled that the HIV prevention education teacher in middle school was, “Like a substitute, like it was always just random people filling in, and we thought it was a joke.”

Kevin remembered that in his HIV prevention education class, “Our teacher in high school wasn’t really as interested in the subject.” About his HIV prevention education class, John recalled, “We no more wanted to listen to her explaining to us than she wanted to.” When asked, “Did you feel that your teachers couldn’t relate to kids when they were talking about sex?” Larry responded, “It just kind of felt that way.”

When the students asked questions, the teacher said, “They had to go completely through the prism of abstinence-only.”

Robert said that if he could design an HIV prevention education program, it would not be like the one he received. He said, “They (the teachers) just talk and talk while the kids just throw books and all this type of stuff.” Michael remembered, “A lot of people just took it as a joke, and a lot of them were just like playing around while I was trying to listen. They weren’t taking it seriously.” When asked how the teacher responded to this, Michael said, “She just kept on going with her lecture. She didn’t say, ‘Hey, you guys, stop playing around.’”

In summary, according to the responses of the participants of this study, participants mentioned that teachers appeared incapable of maintaining student discipline in the classroom during HIV prevention education. Misbehaving student behavior ranged from making sexual jokes regarding the LGBTQ community to labeling students who asked questions about homosexual behaviors as gay, to verbally and physically assaulting students suspected of being gay. For this reason, participants elected to keep their mouths shut and not ask questions about gay sex.

Theme four and theme three appear to be related. The fear of gay stigma, or the fear of either verbal or physical attack by heterosexual male students, would not be so extreme if teachers had better control over the classroom environment. Because respondents did not feel safe asking about same-sex sexual behaviors, the HIV prevention education they received in school, except for condom use, is not applied in their current lives.

Summary

Four themes emerged from the seven exploratory questions asked of participants in this study. The first theme that became evident through these interviews was a lack of curriculum consistency. There was no uniformity to the way HIV prevention education was taught in California. There did not appear to be a specific course on HIV prevention education. HIV prevention education was incorporated into other classes. In answer to the primary RQ of how the HIV prevention they received in school has affected their current sexual behaviors, specifically their risk for HIV infection,information gained from participants in theme number one indicated that, other than using condoms for safer-sex practices, nothing else learned in school has been incorporated into their current life.

The second theme that appeared through these interviews was the lack of LGBT content in the curriculum. The focus of HIV prevention education was toward heterosexual students. Specifically, the focus was on vaginal intercourse. There was little, if any, mention of anal or oral sex, or masturbation, behaviors that are as familiar in heterosexual sex as they are in homosexual sex. In response to the primary RQ of how the HIV prevention they received in school has affected their current sexual behaviors, specifically therisk for HIV infection,information gained from participants in theme number two indicates thatnothing learned in this area was brought forward by participants to their current sexual behaviors. Nothing learned in this area was brought forward because heterosexual sex, particularly penis-vagina sex, is not applicable in most of their lives,

The third theme that became evident through these interviews was the impact of stigma and homophobia on participants. The need for a venue that students could use to ask questions other than the classroom environment where students with questions were afraid they would be made fun of or bullied, for being identified by heterosexual students as being homosexual or bisexual. Participants said that not only is there a stigma around HIV and homosexuality, but there is also teasing and bullying of students who are perceived as LGBTQ. In answer to the primary RQ of how the HIV prevention education they received in school has affected their current sexual behaviors, specifically their risk for HIV infection, information gained from participants in theme number three indicate that, due to a classroom environment that appeared hostile to LGBTQ students, they refrained from asking questions. They got their questions answered from different sources and brought nothing forward from the HIV prevention education classroom experience to their current sexual behaviors.

The fourth theme that came out of these interviews was the lack of classroom management. Teachers appeared incapable of controlling student behavior in HIV prevention education classes. When students were acting up in class, teachers would ignore them and keep going on with the lecture. This acting up by other students tended to make participants of this study feel uncomfortable about asking same-sex sexual questions. In answer to the primary RQ of how HIV prevention education they received in school has affected their current sexual behaviors, specifically their risk for HIV infection,participants said they brought nothing forward from the classroom to their current sexual behaviors regarding this theme.

In Chapter 5, I will present my interpretation of the findings, followed by a discussion about the limitations of the study. Next will be recommendations for further research that are grounded in the strengths and limitations of the current study. Then I will discuss the implication for social change this study makes. Chapter 5 will wrap up with a conclusion.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this qualitative, phenomenological study was to fill a significant gap in the literature by exploring the lived experiences of YMSM who received HIV prevention education in either middle school, high school, or both, and how that education has affected their current sexual behaviors, specifically their risk for HIV infection. Through individual, in-depth interviews of YMSM 18-38 years of age, I hoped to identify any unmet needs of YMSM so that future HIV educational efforts in middle school, high school, or both may more completely meet the needs of YMSM. By better meeting the HIV prevention education needs of YMSM, the HBM would predict greater adherence to safer-sex practices resulting in lower HIV infection rates.

Four key findings emerged from the interviews conducted with participants of this study. The first key finding was that there was no uniformity in the way HIV prevention education was taught in California. The second key finding was that HIV prevention education was focused on heterosexual practices, specifically vaginal intercourse. The third and fourth key findings were both rooted in the participant's fears of stigma and homophobia caused by being teased or bullied by heterosexual students. The third key finding was that YMSM did not feel comfortable asking questions specific to same-sex practices within the classroom, and they desired an outside, anonymous space to ask their questions. The fourth key finding was that teachers were unable to maintain control of student behavior in the classroom environment during HIV prevention education curriculum. These four key findings supported the overall trend among the participants

that the HIV prevention education they received was severely limited in applicability to their practices and resulted in very sporadic condom use in their current sexual practice.

Interpretation of the Findings

First Key Finding: Lack of Curriculum Consistency

The first key finding that became evident was that there was no reported uniformity to the way HIV prevention education was taught in California. There did not appear to be a dedicated course on HIV prevention education. Rather, HIV prevention education was incorporated into other class curricula such as biology or health education classes or was presented as a one-time presentation, for example, in a school assembly. According to participants in this study, the curriculum presented ranged from AOUM to CSE, also referred to as SBSE.

The results from this study regarding inconsistency in HIV prevention curriculum are consistent with prior research (Bigelow, 2012; Borawski et al., 2015; Luker, 2007; May, 2010; NCSL, 2016). This inconsistency in the way HIV prevention education is taught is apparently due to lack of agreement about which curriculum is more appropriate for teaching sex education to students in school: AOUM, CSE, or SBSE. Although this lack of agreement has been around for many years, with the introduction of HIV disease in 1981, the argument intensified (Lord, 2010; National Library of Medicine, n.d., Paragraph 4).

In summary, according to the responses of the participants of this study, there was no uniformity to the HIV prevention education they received in school. The information they received varied from AOUM to “always wear a condom.” Scare tactics regarding the

consequences of becoming infected with not only HIV but also other sexually transmitted diseases were used. HIV prevention education was not taught as a curriculum. It was squeezed into other subjects. Except for learning how to use a condom to protect from STIs including HIV disease, participants did not incorporate any of the HIV prevention education they received in school to their current lives.Although all participants said they learned about wearing a condom to protect from STIs and HIV disease, their use of condoms today is reserved for sex with strangers and then only applied sporadically (see Milano, 2015).

Second Key Finding: Lack of LGBT Content in Curriculum

The second key finding was that the focus of the HIV prevention education was geared toward heterosexual practices, specifically vaginal intercourse. There was little, if any, mention of anal or oral sex or masturbation, behaviors that are practiced among persons of all sexual orientations (Bay-Cheng, 2003; Donovan 1998; LaSalaet al., 2015; Lloyd et al., 2012). Because most participants were only interested in having sexual relations with other men and not with women, it was understandable that they felt they did not benefit from the HIV prevention education other than learning to wear a condom to have safer sex. This second key finding was consistent with findings in other studies researched (Arrington-Sanders et al., 2013; Bay-Cheng, 2003; Brooks & Bridges, 2015; LaSala et al., 2015).

Even though all participants said the only thing they learned in HIV prevention education class was how to wear a condom to prevent STIs and HIV disease, they admitted that they only use a condom today when they meet a new partnerthey know

nothing about. Once they get to know the new partner, they no longer use a condom unless the partner acknowledges that he is HIV positive. Even though they acknowledged learning in school about always using condoms to prevent STIs and HIV infection, participants only partially apply it to their lives today (see Milano, 215).

The lack of reported inclusivity in the curriculum was consistent with prior research. In a critique of sex education taught in schools, Schalet et al. (2014) claimed that AOUM was ineffective and scientifically inaccurate and that although EBI were a step in the right direction, they did not address issues important to LGBTQ students. In an article published in the *Sex Education Journal* critiquing SBSE programs, Bay-Cheng (2003) pointed out that most sex education is taught from a fear perspective when it comes to talking about the dangers and risks of teen sex.Bay-Cheng goes on to say that sex education focuses on heterosexual sex as normal sexual behavior to the exclusion of all other sexual behaviors. Bay-Cheng recommended that SBSE should address not only the heterosexual students but also LGBTQ students. SBSE should not teach sex education from a fear basis of just presenting the negative consequences of teenage sexuality. It should also teach developing relationships and respect for each other.

Other studies that found that HIV prevention education curricula were focused on heterosexual students to the detriment of LGBTQ students include Arrington-Sanders et al. (2013), who evaluated and found SBSE programs to be so poor at fulfilling the needs of LGBTQ students that African American YMSM sought out relationships with older African-American MSM to educate them about their sexuality. According to Nieblas et al. (2015), the CDC reviewed 84 effective HIV prevention programs. Although two-

thirds of all HIV infections are among MSM, only three of the 84 effective HIV prevention programs reviewed were developed for YMSM. Schalet et al. (2014) concluded that a more holistic approach to sex education is necessary to include LGBTQ youth. Existing HIV prevention efforts have failed to decrease HIV infections in YMSM. LaSala et al. (2015) found in their research that the needs of YMSM and their families for a more inclusive CSE and HIV prevention curriculum were ignored by school authorities.

It was difficult to find studies that identify HIV prevention education programs that had a positive impact on LGBTQ students. This difficulty in finding programs that have a positive impact on LGBTQ students is because much of the data used to evaluate these programs comes from secondary data provided by the CDC. Until 2015, the CDC did not identify the sexual identity of the respondent or the respondent's partner (CDC, 2016g). Because of this, it is impossible to separate the responses of LGBTQ students from the general student population. For example, Ma et al. (2014) used data from the 2009 YRBS to assess the association between HIV education, risky sexual behaviors, and academic grades. Their results found sex and HIV education was effective in delaying sexual debut increased condom use and that other forms of contraceptive use reduced STIs and pregnancies. However, there was no way of determining the effects of this study on YMSM.

In another example, Kohler et al. (2008) took the responses of 1,719 never-married heterosexual adolescents 15-19 years of age from the National Survey of Family Growth and concluded that teaching sex education did not increase risk of teen sexual activity or STIs. It also caused a lower risk of pregnancy. All respondents identified as

heterosexual. Adewuyi (2015) used the 2012 District of Columbia Middle School YRBS to assess the knowledge of HIV of 1,933 African American eighth graders. Adewuyi'sresults indicated that even after HIV education, students, especially male students, were still engaging in risky behaviors that could put them at risk for exposure to HIV disease. Again, there was no way of identifying LGBTQ survey respondents.

In summary, some participants were completely "turned off" by the fact that the HIV prevention education was focused not only on heterosexual sex but only vaginal intercourse. There appeared to be little if any instruction on other sexual behaviors that are common to both heterosexual couples and homosexual couples. There was no mention of anal or oral sex or masturbation. As a result, participants of this study did not incorporate any of the HIV prevention education they learned in school to their current lives, except for using a condom in safer-sex situations, and even then their current use of condoms is sporadic and limited to new partners they know nothing about (see Milano, 2015).

Third Key Finding: Impact of Stigma and Homophobia on Participation

The third and fourth key findings that became evident through participant interviews in this study were both rooted in the participant's fears of stigma and homophobia. The third key finding through these interviews was the need for a venue that students could use to ask same-sex sexual questions outside of the classroom environment anonymously. The reason for this was because sexual minority students were afraid of being teased or bullied by heterosexual students as gay or perceived as gay if they ask same-sex sexual questions openly in the classroom environment.

The CDC appears to support the fears voiced in this study. According to the CDC (2016b), 84% of youth 15-24 years of age said there is a stigma around HIV in the United States. Stigma and homophobia around HIV disease were given as reasons why only 22% of sexually active high school students have been tested for HIV. Stigma and homophobia were also given by the CDC as to why high school students engage in unprotected sexual behaviors.

According to the CDC (2016b), for YMSM who are just beginning to explore their sexuality, homophobia can pose obstacles to HIV testing and treatment. These YMSM do not want to test for HIV disease because they are afraid that if they are seen at an HIV test site, they will be identified as being homosexual (Bauermeister, Pingel et al., 2015; CDC, 2016b; Phillips et al., 2015; Wilson et al., 2015). Internalized homophobia can also lead to mental health disorders, such as depression and anxiety (Millar et al., 2016; Nieblas et al, 2015; Puckett et al., 2015). Internalized homophobia can lead to barriers to HIV prevention education (Andrasik&Lostutter, 2012; Fields et al., 2015). For YMSM stigma and homophobia are given as a reason why they do not ask for HIV prevention education that meets their specific needs.

In some U.S. school districts questions regarding same-sex sexual behaviors are met with negative responses (Barrett & Bound, 2015; Kellinger, 2015; Lloyd et al., 2012). No promo homolaws are in effect in nine states and several school districts. No promo homo laws “restrict or prohibit any school-based instruction, counseling, discussion, or activity that could be construed as being positive about or promoting homosexuality” (Barrett & Bound, 2015, p.267). However, it can also be interpreted as

banning teachers from saying anything about homosexuality unless it is negative (Kellinger, 2015). Although proponents of no promo homo laws claim they keep sex education neutral (Barrett & Bound, 2015; Kellinger, 2015), what this law does is continue to maintain the stigma and homophobia that alienates LGBTQ students (Shelton, 2015). No promo homo laws were frequently found in the southern United States where HIV infections are particularly high.

A review of the literature showed several HIV prevention programs had been developed for LGBTQ youth as alternatives to school-based sex education programs (SBSE) because SBSE programs are not meeting the sex education needs of YMSM, including stigma and homophobia (Arrington-Sanders et al., 2015; Mustanski et al., 2015; Mustanski et al., 2013). Arrington-Sanders et al. (2015) did 90-minute, qualitative interviews with 47 black YMSM, 15-19 years old, on the impact of using sexually explicit material (SEM). Respondents said they used SEM to develop their self-image. SEM provided a safe, anonymous space in which to learn about gay sex. There is a negative stigma around same-sex relations at home and school, and schools are not providing them with information about same-sex relationships.

Mustanski, Ryan, and Garofalo (2014) surveyed 202 YMSM, 16-20 years of age, on the feasibility, acceptability, and initial efficacy of Queer Sex Ed (QSE), an online sexual health promotion program. All participants completed pre- and post-test surveys online and an online sexual health curriculum of five modules. This study was a mixed-methods design. The strengths of this study were that participants indicated they learned more than in a school-based sex education program, and they appreciated the

comprehensive LGBT specific approach. Limitations included using a pre-post change design rather than a randomized control trial so results may have come from factors unrelated to the intervention. Future post-intervention outcomes should be longer than two weeks.

Mustanski, Garofalo, Monahan, Gratzer, and Andrews (2013) studied the feasibility, acceptability, and preliminary efficacy of "Keep It UP!" (KIU), an online HIV prevention program for YMSM. The method was a randomized clinical trial with 102 sexually active YMSM, 18-24 years of age. The KIU intervention included seven modules, completed across three sessions. Strengths of the study were a positive response from participants on both quantitative and qualitative responses. Limitations included the design of the study did not allow authors to conclude what elements of the intervention led to the lower rate of unprotected anal intercourse.

Lightfoot, Taboada, Taggart, Tran, and Burtaine (2015) reviewed the pilot study of AMP! (Arts-based, multiple interventions, Peer education), an interactive theatre production for HIV prevention. AMP! wasdeveloped in Los Angeles, California and adapted for testing in North Carolina. HIV and STD rates are higher among youth in the Southern United States, basically due to their abstinence-based approach to sex education (Lloyd et al., 2012). The program utilized interactive theatre to educate students about sexual health. The goal of the AMP! Program was to supplement school sex education around HIV transmission and reduce stigma around people living with HIV. Participants were 317 ninth graders in two public high schools. The researchers used mixed methods with pre-test, post-test surveys, and focus groups. The strengths of this study were that

there was a significant increase in HIV knowledge and a decrease in HIV stigma. Limitations included it was a convenience sampling and may not be generalizable.

The studies mentioned above were developed as an alternative to school-based HIV prevention education programs because school-based programs were not meeting the needs of same-sex students. Either no attempt was made to change the school-based programs, or their requests for inclusion of same-sex students in school-based programs were ignored. This study identifies those same shortcomings of school-based programs in California and is making recommendations for resolving these shortcomings.

In summary, the anticipatory fear of stigma and homophobia led participants to be afraid to ask questions concerning same-sex sexual behaviors during classroom-based sex education. As a result, participants did not get answers to questions pertinent to their same-sex sexual behaviors. For this reason, participants said that they were unable to apply anything they learned in school to their current lives.

Fourth Key Finding: Lack of Classroom Management

The fourth key finding that became evident through the interviews in this study was that teachers were unable to maintain control of student behavior in the classroom environment during HIV prevention education class. When heterosexual students were acting up in class, teachers would ignore them and keep going on with the lecture. Heterosexual students acting up in the classroommade participants of this study feel unsafe about asking same-sex sexual behavior questions in the classroom environment. By asking same-sex sexual behavior questions when teachers seemed incapable of controlling the classroom environment, participants felt they would be self-identifying as

a YMSM which would cause them to be singled-out by heterosexual students and subject them to homophobic remarks or physical attacks. Participants said they did not learn anything in HIV prevention education class that they could apply to their current sexual behaviors.

In summary, participants mentioned that teachers appeared incapable of maintaining student discipline in the classroom during HIV prevention education. Misbehaving student behavior ranged from making disparaging sexual jokes regarding the LGBTQ community to labeling students who asked questions about same-sex sexual behaviors as gay, to verbally and physically assaulting students suspected of being gay. Because all participants in this study said they did not feel safe asking about same-sex sexual behaviors, all participants said the HIV prevention education they received in middle school, high school, or both, is not applied in their current lives.

The theoretical framework for this qualitative study was the HBM (Champion & Skinner, 2008). The HBM is based on the theoretical propositions that people make decisions about behaviors that affect their health by weighing the severity of the disease, their risk of becoming infected by their current behaviors, the benefit of modifying their current behaviors to protect them from infection, and obstacles to modifying their current behavior to avoid chance of infection. The HBM was chosen as the theoretical foundation for this study because of its successful application in lowering high-risk behavior in individuals at risk for infection with HIV disease through education (Rosenstock et al., 1994).

Students in California are required to receive HIV prevention education: once in middle school and once in high school. Because the HIV infection rate in this population remains high, YMSM may not be receiving sufficient information in middle school, high school, or both, about the severity of HIV disease and the behaviors that put one at higher risk for infection to effectively utilize the theoretical propositions of the HBM. The majority of the studies in my literature review identified HIV prevention education for YMSM as a failure (Adewuyi, 2015; Arrington-Sanders et al., 2015; Bay-Cheng, 2003; LaSala et al., 2015).

I chose California to conduct my study because of its progressive attitude toward education, as well as its aggressive stance on the prevention and treatment of HIV disease. If YMSM were receiving HIV prevention education that was applicable to their lifestyles, then the HBMshould work at decreasing HIV prevention infection rates in this population. Like previous studies, my study concludes HIV prevention education in California is a failure.

Limitations of the Study

There were several limitations to this study. The first limitation is that the information gained from this study is specific to the participants interviewed. It is not meant to be generalizable to YMSM anywhere else. Participants of this study live in Alameda County, Contra Costa County, or San Francisco County. Participants of this study received their HIV prevention education in middle school, high school, or both, in a school district within the State of California. The HIV prevention education they received was relevant to the culture and communities in which they lived in California. Their

experiences may be different from the HIV education received by YMSM who live in other parts of the country based upon the culture and communities in which they reside.

The second limitation of this study is that it was limited to English-speaking participants. Although non-English speaking participants might provide different information than English-speaking participants, since the State of California, Department of Education only requires that HIV prevention education be taught in English, this study was restricted to English-speaking participants. Future studies may want to focus on YMSM who received non-English HIV prevention education strategies.

The third limitation in this study was that participants received different HIV prevention education curriculums in either middle school, high school, or both, depending upon where in the State of California they received their HIV prevention education. This limitation impacted the lived experiences they brought to the individual interview and how they applied what they learned in school about HIV prevention to their current sexual behaviors. Future studies may want to focus on participants in a more centralized location.

The fourth limitation in this study was the variation in the age of participants and the length of time since they had received HIV prevention education in middle school, high school, or both. The older the participant and the longer they had been out of school, the more difficult it was to differentiate the HIV prevention education they received in school, to the HIV prevention education they might have received since leaving school. The way to minimize this limitation was to focus participant on knowledge gained through the educational process while in middle school, high school, or both. Minimizing

this limitation was achieved by asking participants to respond to the interview questions based solely on what was presented to them in the HIV prevention education they received in middle school, high school, or both.

Finally, as noted previously, two of the thirteen interviews conducted in this study were each approximately eight minutes in duration. Although exploratory questions were asked in an attempt to elicit more information, neither was forthcoming. Although brief, the participants made responses pertinent to this study, so information from their interviews was included. However, the brevity of their responses may have a limiting impact on the overall findings and implications. Future research in this area may wish to pilot test questions to determine how well they encourage participants to respond.

Recommendations

Based on the response of participants in this study, the following recommendations are made regarding HIV prevention education taught in California:

Recommendation 1

In response to participant claims of no uniformity in HIV prevention education they received in school, it is recommended that the federal government develop a standardized, comprehensive, evidence-based HIV prevention education curriculum and implement it in all 50 states. This curriculum should be taught at least once in middle school and once in high school. This curriculum should be age-appropriate and be more than a one-time presentation in the school auditorium.

Recommendation 2

In response to participant claims that HIV prevention education was taught to heterosexual sexual behaviors with a focus on penis-vagina sex, to the exclusion of same-sex sexual behaviors, it is recommended that any federal government developed HIV prevention education curriculum shall address the needs of all students, regardless of sexual identity or orientation. This curriculum should address all sexual behaviors in addition to penis-vagina sex and be taught to all students in a non-judgmental way. This all-inclusive HIV prevention education should be age appropriate.

Recommendation 3

In response to participant claims that they were afraid to ask same-sex sexual questions during HIV prevention education for fear of verbal or physical attacks by heterosexual students, it is recommended that congress be encouraged to pass legislation that will protect LGBTQ students from discrimination based on sexual orientation and gender identity. According to the Human Rights Foundation (2018), H. R. 5374/S. 2584, the Student Non-Discrimination Act of 2018, is stalled in Congress. Passage of this legislation would help ensure that the HIV prevention education curriculum is taught in a non-judgmental way. However, the positive impact would also require enhanced teacher education and training. It would also help teachers maintain a safe classroom environment for LGBTQ students.

Recommendation 4

In response to participant claims that they did not get answers to their same-sex questions because they were afraid to ask them, it is recommended that written

information be distributed to all students on where they can go for more information on HIV prevention, including where they can test for HIV disease. Written information distributed to the students could include the development of a health center on school grounds, as well as agencies in the community that may be of student benefit. This information should be printed in English as well as languages familiar to other students in the school.

Implications

The theoretical foundation for this study is the HBM. With regard to HIV prevention education, the HBM predicts that in order to change high-risk behaviors, a person must believe that they are engaged in behaviors that put them at high–risk for infection with HIV disease and that HIV is a disease they do not want to become infected with (Champion & Skinner, 2008; Rosenstock et al., 1994). All of the participants in this study self-identified as low risk for infection with HIV disease, despite their continued sporadic condom use with new partners when the HIV status of the partner is unknown. None of the participants in this study are currently on Pre-Exposure Prophylaxis (PrEP), which might mitigate some of the risks of contracting HIV through sporadic condom use. None of the participants appeared to be ready to change any of their sexual behaviors. Thus, it appears that the findings support the HBM in that participants, due to non-inclusive HIV education, did not perceive themselves at risk and thus have not modified their sexual behaviors.

Positive Social Change

The results of this study show that current HIV prevention education taught in middle school, high school, or both, is not meeting the needs of non-heterosexual students. This lack of inclusion is negatively impacting their sexual practices and putting them at risk for HIV infection. The findings of this study are consistent with the findings of other studies conducted in different areas of the United States in that there is inconsistency in the way HIV prevention education is taught in middle school, high school, or both (Bigelow, 2012; Borawski et al., 2015; Luker, 2007; May, 2010; NCSL, 2016).

The CDC (2019b) reported that between 2010 and 2016, HIV cases among youth decreased 6% overall. Among young women, the HIV infection rate was down 32%. However, the rate of HIV infection among YMSM remained the same. For white YMSM, HIV infection rates were down 6%. For black or African American YMSM, the HIV infection rates were down 5%. Among Hispanics/Latino YMSM, the HIV infection rates were up 17%.

According to the CDC (2019b), there were 38,739 cases of HIV disease diagnosed in the United States in 2017. Of those 38,739 cases of HIV disease, 8,164 cases were among youth, 13 to 24 years of age. Of those 8,164 cases among youth, 7,125 cases were among YMSM. Youth accounted for 21% of all the HIV cases diagnosed in 2017, and 93% of that 21% were YMSM.

Several factors were listed for why the rate of HIV infection remained the same among YMSM (CDC, 2019b). The factors cited by the CDC coincide with the results of

this study. At the top of that list was a lack of sexual education that YMSM needed to remain HIV frees (Bigelow, 2012; Borawski et al., 2015; Luker, 2007; May, 2010; NCSL, 2016). The CDC found that schools requiring students to receive HIV prevention education, "decreased from 64% in 2000 to 41% in 2014" (CDC, 2019b). The CDC also recommended that sex education should start earlier than in middle school.

Other reasons are cited by the CDC (2019b) for why the HIV infection rate remains so high. These reasons included low HIV testing rates (Bauermeister, Pingel et al., 2015; CDC, 2016b; Phillips et al., 2015; Wilson et al., 2015), substance abuse (Bauermeister, Pingel et al., 2015; Newcomb et al., 2014a; Newcomb et al., 2014b; Phillips et al., 2015; Wilson et al., 2015), low condom use (Amola & Grimmett, 2015; Bauermeister, Eaton et al., 2015; Hergenrather, Emmanuel, Durant, & Rhodes, 2016; Milano, 2015; Mustanski, Ryan, & Garofalo, 2014; Wilson et al., 2015; Zou et al., 2014), and multiple sex partners. Among YMSM students, only 15% have ever tested for HIV disease. Twenty percent of YMSM students used alcohol or drugs the last time they had sexual intercourse. Forty-eight percent of YMSM students did not use a condom the last time they had sexual intercourse. Twenty-four percent of YMSM students reported having sexual intercourse with four or more persons during their life.

Results of this study suggest that positive social change can be accomplished at the policy level by having the federal government design a comprehensive HIV prevention education program that meets the needs of all students, not just the sexual majority, and implementing that required program throughout the United States. In this way, all students would be presented with the same education on how to prevent HIV

infection in their lives, regardless of sexual orientation or where they live. Through inclusivity of all students in HIV prevention education, positive social change might have a beneficial effect on the societal, family, and individual levels.

Stigma and homophobia also came up around teachers being unable to provide a safe environment in which to conduct HIV prevention education. Although California has laws prohibiting harassment based on sexual orientation, the findings from this study suggest that such laws are not adhered to in the classroom. California has an opportunity to publicize these laws to school districts better. California should also require that school districts provide targeted teacher training regarding how to provide a safe learning environment. School districts should provide students and their parents with information on where they can file grievances about harassment or bullying due to sexual orientation. Providing this information could bring about positive social change to the family and individual student.

The purpose of this qualitative phenomenological study was to explore the lived experiences of YMSM who received HIV prevention education in either middle school, high school, or both, and how that education has affected their current sexual behaviors, specifically their risk for HIV infection. The participants of this study ranged in age from 21 to 35 years. Future studies may want to look at finding ways of collecting participant data closer to the time that the participant received HIV prevention education, in middle school, high school, or both.

Because the State of California only requires HIV prevention education in English, this study was limited to collecting data from English speaking participants.

According to the CDC (2019b), there has been a 17% increase in HIV infection rates among Hispanic/Latinos. Future studies may want to collect participant data about HIV prevention education from Spanish speaking students in California.

Based on the results of this study, positive social change can be achieved in three ways. First, by the federal government developing and implementing a comprehensive HIV prevention education curriculum nationwide that covers the needs of all students, regardless of sexual orientation. Second, by the federal government enacting and enforcing federal legislation that prohibits discrimination against students based on sexual orientation. Third, by educating students and their parents about their rights and protections under anti-discrimination laws due to sexual orientation currently in force in their state

Conclusion

The purpose of this qualitative phenomenological study was to explore the lived experiences of YMSM who received HIV prevention education in either middle school, high school, or both, and how that education has affected their current sexual behaviors, specifically their risk for HIV infection. Through individual, in-depth interviews, this researcher hoped to identify any unmet needs so that future HIV educational efforts in middle school, high school, or both, may more completely meet the needs of YMSM. By better meeting the HIV prevention education needs of YMSM, the HIV infection rate in this population should decrease.

Four key findings were apparent through the interviews. First, there was no uniformity in what was taught, or how it was taught, regarding HIV prevention education.

Second, the focus of HIV prevention education was on heterosexual students, specifically penis-vagina sex, to the exclusion of LGBTQ students. The third and fourth findings revolved around participant's fears of stigma and homophobia caused by being teased, or bullied, by heterosexual students. LGBTQ students were afraid to ask same-sex sexual questions.

The overall result of these four key findings was that the majority of participants were unable to utilize most of the curriculum taught, which negatively impacted their safer-sex practices (e.g., sporadic condom use).

Recommendations for resolving these key findings include the development of a standardized, comprehensive, HIV prevention education program that would be utilized in all 50 states. The HIV prevention education program It should be taught in a nonjudgmental way in middle school and high school. It should be age-appropriate and be more than a one-time presentation. The curriculum should address the needs of all students, regardless of sexual identity. Congress should be encouraged to pass the Student Non-Discrimination Act (SNDA) to protect LGBTQ students and alleviate their fears of being teased or bullied by heterosexual students.

HIV infections in YMSM continue to rise despite educational efforts to promote safer sex practices. Providing a standardized, all-inclusive, non-judgmental HIV prevention education, in a classroom environment where it is safe to ask and get answers to same-sex sexual questions should increase safer-sex practices and therefore decrease the number of HIV positive results in among YMSM.

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Appendix A: Interview Protocol

Time of interview:

Date:

Place:

Interviewer:

Interviewee:

Project: The research question for this qualitative study, using a phenomenological approach, is *What impact did the lived experience of receiving HIV prevention education in middle school, high school, or both, have on YMSM in the past, and what affect has that education had on current sexual behaviors, specifically risk of HIV infection*?

Questions:

1. Tell me about your experiences receiving HIV prevention education while in school?

2. What did you like about the HIV prevention education you received while in school, and why?

3. What did you not like about the HIV prevention education you received while in school, and why?

4. How do you apply the HIV prevention education you learned in school to your life currently, and why?

5. If you could change the HIV prevention education you received in school, what would you change and why would you change it?

6. How risky do you believe your sexual behaviors today are, particularly unprotected anal receptive intercourse, based upon the HIV prevention education you received in school?

7. Now that men who have sex with men may legally marry, have you given any thought about marrying another man?

8. (Thank the individual for participating in this interview. Assure him of confidentiality of responses and potential future interviews.)

Appendix B: National Institutes of Health Certificate of Completion

Certificate of Completion

The National Institutes of Health (NIH) Office of Extramural Research certifies that **Michael Tachet** successfully completed the NIH Web-based training course "Protecting Human Research Participants".

Date of completion: 06/11/2013.

Certification Number: 1195606.