

Project Management for Student Sexual Health Organization:

STI and HIV Knowledge, Prevention, and Care

A Project Report

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The Faculty of the Department of Anthropology

San Jose State University

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Master of Arts in Applied Anthropology

by Brett Witteck

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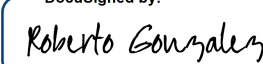
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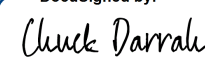
The Undersigned Graduate Committee Approves the Project Report Titled
Project Management for Student Sexual Health Organization:

STI and HIV Knowledge, Prevention, and Care

Brett Witteck

APPROVED FOR THE DEPARTMENT OF ANTHROPOLOGY
SAN JOSE STATE UNIVERSITY
May 2020

DocuSigned by:

Roberto Gonzalez
44796D06A06F464
Department of Anthropology

DocuSigned by:

Charles Darran
363C676DC96941C...
Department of Anthropology

DocuSigned by:

Matt Capriotti
B44A7001C9BD490...
Department of Psychology

Abstract

This project is in partnership with San Jose State University's *SJSU To Zero*, an HIV education and advocacy program. *SJSU To Zero* is funded by Santa Clara County's *Getting To Zero* HIV initiative, a program derived from a worldwide initiative to reduce HIV infections, deaths, and stigma down to zero. The study uncovers student needs and desires outcomes for ongoing campus sexual education and literacy initiatives. For this research project, I employed ethnographic methods to find out the student perspective on sexual wellness organizations, previous sexual education experience, and participants' general knowledge of sexual health. The study population is SJSU student participants that identify as gay, bisexual, and transgender. The research methods used throughout this project were participant observation, semi-structured interviews, and a resource scan of local and general sexual health information and resources. The findings from this study indicate that queer students would benefit from a reliable sexual wellness informational sexual education guidebook or module. The participants indicated there is 1) a lack of memorable or positive sexual education experiences in middle and high school, 2) students experienced scare tactic or abstinence-only training, 3) sexual disease stigma from those experiences established barriers to finding reliable information making it more difficult to navigate reliable answers. The deliverable is a live document for student sexual health resources to go on the SJSU Pride Center and *SJSU To Zero* website. The guidebook is free online to students and accompanied by additional presentation media. The final product came out during a global pandemic that allowed for the digitalization of *SJSU To Zero*.

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Chapter One

Project Background: Sexual Health Education

According to Santa Clara County's *Getting To Zero* campaign website, 1.2 million people currently live with HIV in the United States and 45,000 more are infected per year. HIV or Human Immunodeficiency Virus can be transmitted through blood, vaginal fluids, and semen. HIV can develop into AIDS which is an incurable virus with long term health consequences. HIV and AIDS prevention and patient care advocacy groups, like *SJSU to Zero* and SCC *Getting To Zero* continue work toward the goal of zero new infections, zero new deaths, and zero stigma related to HIV. As the number of individuals infected with HIV still rises, this study identifies areas of improvement for a campus sexual health literacy program. *SJSU To Zero*'s main objective is to educate as many San Jose State students as possible to break barriers of communication and provide current information to the LGBTQ+ community. My application objective is to assist *SJSU To Zero* to adapt its HIV education and advocacy project to their student populations through learning previous sexual health education experiences, what obstacles they continue to face, and how to best address student needs.

Project Partnership

I began a partnership with San Jose State University's *SJSU To Zero*, an HIV education and advocacy program on campus to assist students in learning more about HIV and overall sexual wellness practices. *SJSU To Zero* is a funded campaign by Santa Clara County's *Getting To Zero* HIV initiative, which is derived from a worldwide initiative, to reduce HIV infections, deaths, and stigma down to zero. It was through the lens of student perspective and acquired knowledge that my study reflected student needs and desired outcomes for on-campus sexual education programs. HIV education program members have experimented with the different ways to communicate with

students about sexual wellness whether that be one-on-one or in group settings. Unfortunately, there is limited feedback about how effective these methods were. For this project, I employed ethnographic methods to find out the student perspective on sexual wellness organizations, previous sexual education experience, and participants' general knowledge of STIs, specifically HIV. Students often experience generalized sexual education courses over the course of grade school, but often do not receive adequate medical and social follow-up or updates on the subject. The history of HIV and AIDS long proceeds that of the students and their sexual knowledge, thus updated information is used to combat past understandings, the formation of stigma due to misinformation, and to allow students to access and navigate resources in a time of need.

HIV.gov provides a timeline of HIV beginning in 1981 and continues through 2019. In 1997 three hundred thirty-seven individuals are diagnosed with the soon-to-be HIV epidemic. Organizations in Los Angeles, San Francisco, and New York began to publish findings and experiences of these patients, doctors, and nurses. In 1982, the first HIV prevention programs began and were mostly founded by gay men in San Francisco and New York. The second-ever organization, San Francisco AIDS Foundation was founded in 1982 and continues to be a primary resource to provide care to people living with HIV. HIV was known as the "gay disease" as a number of cases in Southern California were associated with gay men, but by 1983 females were testing positive due to relations with male partners who had contracted it.

In May 1988, the first large-scale attempt to educate the public about HIV and AIDS came out using an 8-page document entitled "*Understanding AIDS.*" This document was the first time the federal government sent out sexual wellness information to the public. HIV and AIDS informational material was not disseminated to the public until eight years into the epidemic. Throughout the late-1980s more information was produced for the public and other programs, such

as needle-exchange for drug users, began to halt infections. By the end of 1989, over 100,000 patients were diagnosed with AIDS and the “U.S. Health Resources and Services Administration (HRSA) granted \$20 million for HIV care and treatment through the Home-Based and Community-Based Care State grant program. For many states, this is their first involvement in HIV care and treatment” (HIV.gov 2020).

In 2016 the CDC began to examine a younger demographic as only one in five high school students had been tested for HIV. Additionally, in the same year, the White House Office of National AIDS Policy, the NIH Office of AIDS Research, and the National Institute of Mental Health co-hosted a meeting to address the issue of HIV stigma. In 2019, researchers worked to find a possible cure, develop new prevention tools, and President Trump announced his administration's goal to end the HIV epidemic over the next ten years. The AIDS-epidemic has been an ongoing feat for roughly forty-years, which illustrates the ongoing need for research to understand how people understand and perceive HIV and sexual wellness.

Literature Review

Sexual health education programs and opportunities are beneficial to teach effective communication skills for sexual partners, to educate students on sexual diseases and how to get tested and treated, and how to enact safer sex practices (Grundfest Schoepf 2008; Ahmed et al. 2013). The HIV epidemic persists despite over three decades of outreach and supporting prevention. There is a continuous need for further studies to uncover the limitations and barriers that prevent meaningful STI and HIV education and stigma reduction. The epidemic has led to inconsistent prevention methods, restrictive communication for HIV testing, discussion of status, and opening up to colleagues, peers, and medical physicians. The limitations on open

communication and restrictive practices have negative effects on narratives, community, and identity development (Bloom 2001; Bernays et al. 2017; Donham 1998).

Barriers function as obstacles to access all population members to discuss HIV or HIV prevention to prevent further spread. Chongyi Wei and colleagues (2016) assess barriers for HIV prevention by examining stigma, discrimination, and personal uptake of HIV testing for Chinese men who have sex with other men. The authors used a survey to learn how homophobia, stigma, discrimination, and HIV testing impact the subjective norms and impact their participants on getting HIV tested. The methods introduced to help break stigma is the transformation of social action, structural change, and the need for larger, cultural shifts. MSM, men who have sex with other men, have not been socially accepted in China and thus the survey brought up concerns for participant mental health. These individuals experienced family and societal rejection, and economic instability from job loss. Depression and community norms mediated how stigma and homophobia manifest for these Chinese MSM. The social implication of HIV has determined if participants would choose to disclose information or get tested. Therefore, as a researcher, one cannot assume the experiences or social understandings of their participant and how they perceive sexual wellness.

Studies have been done, like that of Annette Adams and colleagues (2003) which illustrate improved HIV treatment through comparative studies to identify changes in HIV perception, an individual's HIV risk behavior, and attitudes towards HIV testing. Adams et al. study used a cross-cultural survey for at-risk groups, specifically men who have sex with men (MSM), injecting drug users, and heterosexual individuals who have been exposed to sexually transmitted diseases. The interviews were done to determine individual perceptions and understandings of HIV prevention and treatment. They found no significant changes in risk reporting over the two years, but also

found no significant change in perceptions. The lack of change implies that people's minds are not changed about how they view sexual wellness. The authors propose a change in focus to tailor to individuals prior to at-risk exposure and early education to increase changed perception for HIV risk, behavior, and testing.

Another study examines the role of mobile counseling and testing services as a proper resource. Saidu Ahmed and colleagues (2013) examine the effectiveness of mobile HIV counseling and testing as a proper resource and the difficulty for mobile services to indicate who their most-at-risk population is. The study took place in Nigeria where nearly three million people live with HIV and are considered one most-at-risk group in need of HIV counseling and testing (HCT). The authors compare mobile HIV resources to those in a situated environment. Generally, multiple factors feed into the low response rate for testing, like lack of resources, remote location, not having accommodating hours of service, and even social stigma around HIV testing. The researchers conducted surveys to compare communities at-risk who have access to the mobile HCT and those who receive care from a facility-based location. The surveys asked about patient HIV knowledge, risk perception, awareness, and traditional beliefs to determine the effectiveness of mobile HIV counseling (Ahmed et al. 2013, 86). They found that subpopulations that do not have access to facility-based offices are more at-risk, thus the mobile services are important in education, testing, and promoting prevention methods. Studies like these illustrate the need for various forms of literacy, educational practices, and recognizing that people do not have the same access to resources or the same social understanding of sexual wellness.

Providing educational opportunities for students as an ongoing process and creating new forms of literacy to deliver resources to students is vital to promote sexual information. Chris Beyrer and colleagues (2011) discuss the most appropriate models, services, and hybrids for most-

at-risk populations (MARPs). These populations often face discrimination and stigma, which leads to limited care access and risk disclosure. Full integration service models implement the guidelines for those that are most-at-risk and levels of stigma with drug users, men who have sex with men, and sex workers. Another service is those that stand-alone to cater to a specific audience but runs the risk of increase stigma or discrimination. The service model best suited for HIV prevention and care is a hybrid model that builds a connection with the communities and provides other outreach and prevention services. Although the authors provide a steppingstone to approach MARP, it is also a functional tool to work with a population where not every person is accessible, accounted for, or identified.

Underrepresented Communities

Scholars have stated that underrepresented and invisible communities often receive inadequate health care services. The act disclosing sexual practice and behavior to a physician can be uncomfortable or problematic for communities often discriminated against for sexual orientation or gender representation. Kelly Baker and Brenda Beagan (2014, 579) examined those cultural competency moments for queer patient care through an anthropological critique. Baker and Beagan concluded that the importance of establishing meaningful interactions with queer people is important to produce inclusive relationships. Similarly, discussions of sexual wellness for students must keep in mind the various sexual identities that exist and how students may feel underrepresented or invisible in the sexual education discussion.

Jennifer Sarah Tiffany and colleagues (2013) discuss a need to promote sexual health information to the underrepresented adolescent population aged 13-29 years old. Sexual health promotion programs seek understanding at the single person level, rather than contextualized renditions of the complex lives of people considered. Sexual health in younger ages is important

to promote information, but how have those sexual health sessions gone for the younger generation. Participants discussed abstinence training as their first impression of sexual education and how that affects their efforts to learn more and comfort(stigma) experience in a discussion on sexual activity. It is important to recognize that every student has a different personal history that has led to them obtaining and retaining sexual health information.

Scholarly research has identified various ways to improve HIV outreach and educational opportunities, while focused on high or most at-risk populations. The number of studies conducted with college-level students is limited therefore their voices are not heard in larger conversations to address sexual wellness.

Project Agenda

Participants in this project consisted of San Jose State students who identify as part of the bisexual, gay, and trans-identifying community. All student participants are residents of Santa Clara County in range of SJSU and Santa Clara County's *Getting To Zero* mission. One demographic that emerged throughout the process was that each of my project participants had experience in a California educational background. Overall, 97.2% of first-time freshmen at San Jose State University students come from California public schools. As a large student population comes from around the state, only .9% come from out of state and 1.9% from out of the country, which means that most California students should have expected similar sexual health education¹. San Jose State students are not expected to take any courses on sexual wellness, do not have any form of educational module or forum to access general sexual wellness information, and come from a variety of educational backgrounds. The number of students that identify along the

¹ SJSU Student Quick Facts <http://www.iea.sjsu.edu/Students/QuickFacts/>

LGBTQ+ spectrum is relatively unknown for the campus environment and thus makes research on equipping these students with nonheteronormative resources that much more important.

This project is situated among the gay, bisexual, and trans-identifying communities in order to identify queer student sexual risk management and behaviors, knowledge of STIs and HIV, and identify areas of improvement for STI and HIV advocacy work done by *SJSU to Zero*. I used qualitative ethnographic methods of interview and participant observation at *SJSU To Zero* events, one-on-one interviews, and World AIDS Day on December 4th, 2019. Interviews and participant observation were sound ethnographic tools as *SJSU To Zero* has conducted surveys in the past, which those surveys did not give all answers to best address student needs and changes the program can make. The project was conducted to address queer student sexual education experiences as it affects how they engage with sexual health knowledge in the future. I look at the intersectionality of past sexual education experiences and how current sexual health programs work to address queer student needs.

I engaged in participant observation as an attendee at both school and county events around HIV education and advocacy. I did this to build relationships with the various stakeholders in *SJSU To Zero* from the students, to the program leads and coordinators, faculty directors, and the county that funds this SJSU's HIV education program. *SJSU To Zero* did not define a problem to solve, thus I used participant observation to engage with the community to discover which issues were most salient. The demographics that were included in the interview process were representative of age, ethnicity, sexual orientation, and academic year.

Significance of Project and Deliverable

Participant's sexual education histories and experiences are significant to this project in order to discover ways *SJSU To Zero* can address student needs. The collected experiences assist

the program to implement best practices for participants' desired form to receive sexual health information. Participants of this study discussed the lack of accessibility to locate answers to specific sexual health inquiries. The goal of my project is to use participant observation and semi-structured interviews to inform *SJSU To Zero* about ways to improve the relationship between programming efforts and student perspectives and desired participation in future programs. The project findings illustrate conflicts with sexual health education and misinformation, ongoing sexual disease stigma, and idealize how students want to receive or access sexual health information from a California State University. The project deliverable consists of an online guide PDF for student access regarding HIV information, testing resources, and resources to common concerns or questions generated during observations and interviews. In addition, the deliverable will also contain possible online forums to educate students remotely, this includes an online presentation with audio and single subject podcast episodes.

Project Objectives

My projects objectives are 1) to discuss if gay, bi, and trans students who utilize services at the Pride Center and *SJSU to Zero* have more knowledge of sexual health than those who do not use the service, 2) to uncover the experiences students had with sexual education prior to coming to San Jose State University, 3) find out what resources student need when looking for sexual health information, and 4) learn from students how to improve STD and HIV educational programs and ways they would prefer to receive sexual health knowledge.

California Sexual Education Policy

California sexual education policy has influenced comprehensive sexual education in grade schools and, although some students were not in grade school at the time of this initiative, some student participants were yet still discussed inadequate sexual education. When a student

experiences inadequate sexual health courses, it limits their knowledge and access to learn or broaden their understanding of sexual health literacy in the future. In 2003, California passed a progressive sex education law that took an all-or-nothing approach to a controversial subject². California schools are not required to teach sex education at all but if they do, they are mandated to adhere to an inclusive standard that embraces issues such as gender roles, HIV/AIDs prevention, emergency contraception, and sexual orientation and specifically prohibits abstinence-based approaches. (The Guardian 2015).

While California has blazed trails to incorporate more sufficient sexual health programs for secondary schools, students at the college level are not required to have follow-up sexual health courses (EdWeek 2015). This becomes an issue when the students that were not in secondary school at the time of these changes from 2016 onward did not receive follow-up education or resources for navigating sexual wellness. Therefore, this project seeks to understand gaps in student access and knowledge for their sexual health journeys and how *SJSU To Zero* can address the shortcomings of California's sexual health programs.

Participants, regardless of sexual orientation, age, or ethnicity were not getting adequate information pertaining to sexual health and literacy formats were not created to assist students in staying updated. For many of San Jose State University employees and students from California, or other areas with dismissive sexual education, they were not taught inclusive sexual health, but schools were given the choice to frame student knowledge.

A bill was integrated into California Comprehensive Sexual Health and HIV/AIDS Prevention Education in January 2016. The California Healthy Youth Act (California Education

² The Guardian "California Judge Bans Abstinence Only Sex Education" (2015)
<https://www.theguardian.com/us-news/2015/may/14/california-judge-bans-abstinence-only-sex-education-clovis-unified>

Code (EC) sections 51930–51939), is a bill that requires school districts to ensure that all pupils in grades seven to twelve, inclusive, receive comprehensive sexual health education and HIV prevention education, has five primary purposes:

1. “To provide pupils with the knowledge and skills necessary to protect their sexual and reproductive health from HIV and other sexually transmitted infections and from unintended pregnancy;
2. To provide pupils with the knowledge and skills they need to develop healthy attitudes concerning adolescent growth and development, body image, gender, sexual orientation, relationships, marriage, and family;
3. To promote the understanding of sexuality as a normal part of human development;
4. To ensure pupils receive integrated, comprehensive, accurate, and unbiased sexual health and HIV prevention instruction and provide educators with clear tools and guidance to accomplish that end;
5. To provide pupils with the knowledge and skills necessary to have healthy, positive, and safe relationships and behaviors”

Abstinence or avoidance teaching style introduces students’ to concepts around pregnancy prevention and the main objective to teach students not to engage in sexual activity. Participants discussed that the abstinence training or education that was taught in grade school often had a dual focus on scare tactics. Teachers in classroom settings, and even parents of these participants, would use either picture of worst-case STDs, infections, and end results to scare students into not engaging in sexual activity. The participants noted how that has affected their ability to find information that clearly states the possible factors that can result from non-safe sexual practices or behaviors.

Anthropologists have joined the conversation to further reduce rates of HIV infection and to fight stigma through assessment, evaluation, development for educational outreach, medication accessibility, and social and personal relationships with medical officials, physicians, and antibiotics (Bernays et al. 2017). An anthropological perspective can identify barriers in STI and HIV education, connect that attendance in LGBTQ inclusive spaces, such as the Pride Center,

might affect sexual health knowledge and practice, and examine the role stigma plays in educational outreach and rates of infection.

Anthropological studies examine human behaviors and patterns and discovering these patterns can lead to improving strategies for health care programs and practices. Anthropological practices set up how our physical, social, and cultural backgrounds affect our understanding of personal and public health. Applied Anthropology uses the concepts and findings of anthropological data to accomplish the desired end. Applied Anthropology research can benefit layers of stakeholders that contribute to effective change.

An anthropological perspective assists to dismiss any objectivity in conversations for what sexual health programs should include and the most efficient ways to educate students in the future. The use of ethnographic methods is used to illustrate why people experience sexual health differently. Ethnographic methods to uncover student perspective and understanding are fundamental to medical anthropological studies of people's social and cultural lives around their sexual health. Anthropological trends and research challenge the assumptions of other disciplines, one specific to public health is that when one has increased knowledge about sexual health it impacts their behavior (Block 2017). Students are provided with conflicted messages and practices to practice safer sex throughout their educational journey. Similarly, my anthropological project of SJSU students illustrates a separation between what students were initially taught, what these people then learn growing up, what is retained and understood in their adult life, and how these students acquire accurate information on sexual health in the future.

Roadmap

In the following chapter, I discuss *SJSU To Zero* as an HIV education program and my experience as a volunteer. I explain what the program provided to students and what information

was chosen to educate students. Chapter three I discuss my research methods: resource scan, participant observation, and semi-structured and how such methods allowed me to engage with SJSU students and faculty to develop project themes and create a deliverable accessible to students and faculty. Finally, in chapter four I discuss the findings from my ethnographic study. I discuss participant experiences in previous sexual health courses or programs and how examining those experiences can improve *SJSU To Zero* ability to do student outreach. Last, I provide an MOU, my interview instrument, and the Sexual Health Guidebook deliverable in this report appendix.

Chapter 2

Focusing on a Program: *SJSU To Zero*

*SJSU to Zero*³ is an HIV education and advocacy program that was started on the San Jose campus in 2017 and is established within the Pride Center. The Pride Center is a location that aims to improve the campus climate for LGBTQ+ students and acts as a safe location for volunteer meetings and location of informational supplies. *SJSU to Zero* project volunteers “table throughout the semester and sponsor HIV educational programming for student organizations, classes, and for the campus community” (SJSU 2019). The HIV advocacy project distributes safer sex supplies, like condoms, dental dams, and lubricant; and educational materials and resource pamphlets to students on campus. The project team also provides in-person educational workshops on STI and HIV information and care, HIV reduction medication PrEP and PEP, and testing resources and facilities. The workshops are given to different disciplinary classrooms across campus based on professors’ contact with *SJSU to Zero*.

SJSU To Zero is a campus branch of the county *Getting To Zero* organization that aims to distribute information about HIV prevention and care to student communities. A collaborative partnership exists between *SJSU To Zero* and Santa Clara County’s *Getting To Zero* initiative that aims for a full reduction of stigma, infection, and deaths from HIV to zero. The organization has been around for three years and over that time they have engaged with students through individual connections during table events, and large groups in presentation styled conversations focused on PrEP, PEP, and U=U. The educators discuss HIV misconceptions, symptoms and long-term effects if gone untreated, and that HIV is now a manageable infection that does not have to lead to AIDS with current modern medicine. *SJSU To Zero*’s HIV educators link the students with information,

³ SJSU To Zero <http://www.sjsu.edu/pride/events.programs/programs/sjsutozero/>

campus resources to get tested, local venues that do low-cost testing or free testing, and baseline information about what HIV is.

HIV (Human Immunodeficiency Virus) is a virus that attacks the immune system and without treatment, HIV reduces the number of immune cells (T-cells) that can then turn into Acquired Immunodeficiency Syndrome (AIDS). AIDS is the late stage of HIV infection that occurs when the body's immune system is badly damaged because of the virus.

PrEP

PrEP is pre-exposure prophylaxis, a daily pill to combat HIV infection by up to 99%. The presence of this medication in the bloodstream assists in fighting infections but must be taken daily to have a high enough dosage to fight off any infectious virus. Individuals that are recommended to take PrEP are those with sexual partners living with HIV, if one often has condomless sex, have recently been diagnosed with another sexual disease as infection for HIV is greater, or if one is an injective drug user (CDC 2020). PrEP can only be prescribed by a medical physician and the patient must come in every three months for follow-up HIV and kidney testing before continuing with the medication.

PEP

PEP is post-exposure prophylaxis, an emergency use prevention pill where an individual takes antiretroviral therapy (ART) within forty-eight to seventy-two hours of possible HIV infection. The earlier one takes it, the more effective it is and PEP must be taken for a consecutive twenty-eight days once or twice a day (CDC 2020). PEP can only be prescribed with a medical provider or in an emergency clinic. More drugs and higher dosage are used to block prevention with PEP, so any exposed to HIV often may consider PrEP and condom use as alternatives.

$U=U$

$U=U$ stands for undetectable equals untransmittable and signifies those living with HIV, who take their ART medication regularly and suppress their viral load low enough that they cannot pass on the virus sexually (PreventionAccess 2019). The concept acknowledges progress in virus suppression, increasing self-esteem for those living with HIV, and breaks down stigma barriers around how one is capable of living with HIV. *SJSU To Zero* volunteers used the following figure

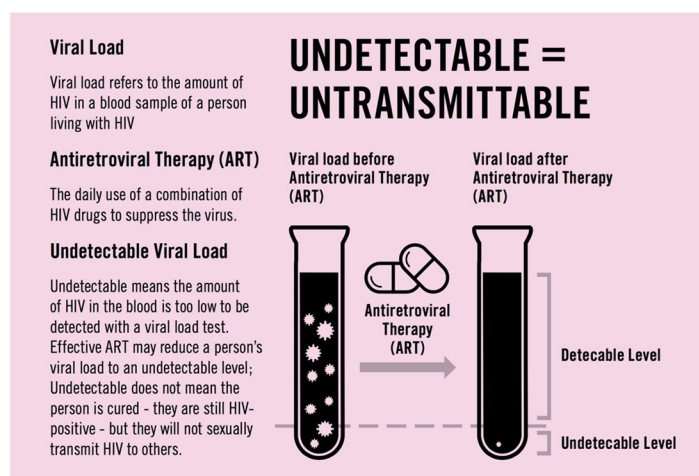


Figure A. Undetectable = Untransmittable informational flyer. *SJSU To Zero* has two letter size flyers with information on $U=U$ and its significance that were shown to students at tables and presentations.

to explain $U=U$ and what it means for both those living with HIV and how we can continue to reshape what it means to live a healthy life with the assistance of HIV medications.

SJSU to Zero project volunteers “table throughout the semester and sponsor HIV educational programming for student organizations, classes, and for the campus community” (SJSU 2019).

The HIV advocacy project distributes safer sex supplies, like condoms, dental dams, and lube; and educational materials and resource pamphlets to students on campus. The project team also produces educational workshops on STI and HIV information and care, HIV reduction medication PrEP and PEP, and testing resources and facilities. The workshop is a ten-minute informational presentation about HIV, PrEP, PEP, $U=U$, and ways to locate resources in the county and on campus. The presentations were created from pre-existing informational materials *SJSU To Zero* has had access to, additional information

from the CDC and SCC *Getting To Zero* websites, and were made to accommodate a limited amount of class time. Each presentation was conducted by an *SJSU To Zero* volunteer and was given to various academic disciplines across campus, such as courses in Human Sexualities, LGBTQ Studies, and Public Health, and was presented based on professors' responses and contact with *SJSU to Zero*. For additional information on sexual health topics [see Appendix C].

SJSU To Zero conducts weekly to biweekly tabling to present HIV and sexual wellness information to San Jose State students. The goal of these tabling events is to engage with students on the main street through the Cal state campus for a short period of time to deliver new ideas and information about HIV, HIV prevention tools, and local resources that provide testing and prevention medication. Ultimately, the issue that presents itself with tabling on a college campus is trying to engage students that are frequently on the go, navigating ways to communicate with students that have earbuds in, and those who state they have time limitations and therefore cannot stop to chat. The table event structure was a single table, staffed by one to three *SJSU To Zero* HIV educators, with a spread of informational materials and incentive items, such as snacks and giveaway items, like towels, bottles, pens, and more. Overall the tabling events lasted two to four hours and averaged ten to twenty students an hour depending on time, weather, and student engagement.

At the time I joined *SJSU To Zero* as a program coordinator, I began initiating a change to presenting ten-minute information slideshows in classrooms to students of various academic departments and colleges. The process began with coming together with *SJSU To Zero* volunteers and directors to establish what information is vital to the general mission statement and what we want students to take away. Information presented to students was narrowed to explaining what HIV is, the possible transmission methods and misconceptions, discussions about PrEP and PEP

as prevention tools, how to discuss HIV and destigmatize the illness, and ended with a list of campus and local resources for testing and access to prevention tools. Each presentation was editable to fit the class dynamic whether it was a Human Sexualities course, LGBTQ Studies, Women's Studies, or Biology. Finally, each presentation concluded with a question and answer portion that extended anywhere from five to forty-five minutes depending on student inquiry.

SJSU To Zero has a few virtual platforms for informing students. These platforms consist of a page on the SJSU Pride Center website, an Instagram page, Twitter, Facebook, and a direct email for student interest and inquiry. The media component of *SJSU To Zero* is limited with information and student feedback has not been obtained about their virtual platforms. Throughout my experience discussing sexual health and *SJSU To Zero* with students, I discovered that more accessible and digestible information was a concern or desire of students that were not sure where to find correct information on HIV and sexual wellness generally.

The first media link to *SJSU To Zero* is their website through the SJSU Pride Center. Once on the website, a user will find information about HIV, PrEP, PEP, U=U, a couple of sites linked to accessing PrEP or PEP, and contact information for the Pride Center and *SJSU To Zero*. The website does not have links regarding cost for testing or travel to these services but has two links to finding cost-reduction access to the medications. The student website also has a limited scope of information on each topic, therefore a guidebook for more in-depth information could benefit students looking to get on one of these medications or determining if it is right for them. *SJSU To Zero* also provides a section for news-related articles yet are outdated and only discuss the start of the organization rather than updated information on HIV or the prevention medications.

Santa Clara County *Getting To Zero* Initiative

Santa Clara County's *Getting To Zero* initiative has the goals of zero new HIV infections, zero deaths related to HIV, and to completely reduce the stigma associated with HIV. Their web link provides information about PrEP, a daily pill that prevents the infection of HIV and PEP, an antiretroviral medicine one can take within seventy-two hours, with an additional twenty-eight day of pills, to prevent HIV infection (GettingToZeroSCC; CDC 2020). Santa Clara County recommends that all individuals ages thirteen to sixty-four should be tested at least once and those individuals more sexually active, or with more sexual partners, get tested every six months. The site provides links, phone numbers, and text codes to find local HIV testing sites, as well as information on free and confidential testing resources.

Getting To Zero provides an online guideline-based strategy form to achieve these goals by July 30th, 2018 and indicates the national goals to reduce HIV infections and reduce HIV-related disparities and health inequities. The local plan is to increase the percentage of Californians that know their status to 95% and decrease the percentage of individuals with HIV to AIDS to 17%. The measures Santa Clara County *Getting To Zero* outline on this form are to 1) document baseline HIV data, 2) document number of provider training and those trained, 3) include opt-out testing messaging, 4) document number of contacts made through a pilot project, and 5) track number of needle exchange clients receiving an HIV test. Unfortunately, the work plan document has only one update on key action step status for meeting with community health partners in April of an undisclosed year. Otherwise, all key action steps are set on a two-year plan with a member or two responsible for each step, but the document itself has not been updated to follow the county progress.

Last, Santa Clara County's *Getting To Zero* team has a critical eye on stigma manifestation, which is shame and disgrace that results from prejudice associated with something deemed socially unacceptable. Stigma can manifest itself with words, beliefs, or actions that have a negative meaning for those at-risk or living with HIV. The website then provides a few examples of these negative stereotypes or words and actions that represent levels of stigma. They layout eight ways to combat stigma and it starts with breaking silence around HIV, sexual experiences, fears, and concerns and learning to communicate HIV infection and testing. Additional ways we can reduce stigma is challenging misinformation and negative attitudes, beliefs, and behaviors, and treating people living with HIV as anyone else and avoiding harmful and offensive language.

Overall, local prevention networks bridge educational gaps in people's sexual health knowledge. The *Getting To Zero* focuses on HIV prevention as they distribute information and resources online and at in-person events. Their website has links to both prevention tools and information for Pre-Exposure Prophylaxis (PrEP), from brands like Truvada and Descovy, which is taken to reduce the risk of HIV infection and is 99% effective when taken daily (CDC 2020). *Getting To Zero*'s website provides links to PrEP navigation sites for free or low-cost prescription needs. While these preventive prescriptions are available, not all are not equally accessible and navigating the online forums can be confusing or inconsistent. The local organization connects people with HIV navigation officers that link individuals to low-cost PrEP and testing resources.

The CDC website and Santa Clara County's *Getting To Zero* website both give information about PrEP and PEP, while the CDC has detailed boxes for how to start, how to ask for it, and how to afford it while being virtually separated from humans. The Santa Clara County website has a friendly font, photos of individuals from the community, yet does not have all the resources the CDC provides. *SJSU To Zero*'s website has sections on PrEP, PEP, U=U but seems to be missing

the student's voice or addressing the concerns of the SJSU student participants I was able to interview.

The United Nations Plan has an HIV reduction plan for 90% by 2030. A number of international programs work to reduce HIV stigma, infection rates, and deaths related to chronic illness and AIDS. The United Nations has a specialized department to reduce HIV infection rates and increase the use of antiretroviral therapies for those living with HIV. UNAIDS⁴ aims to end the AIDS epidemic by the year 2030. As of 2019, UNAIDS focuses on incorporating more political leadership and taking a human rights approach to accessible testing and recovery.

Lawrence Corey, a professor of Medicine and Laboratory Medicine at the University of Washington, and Glenda Gray (2017, 3798), physician and scientist specializing in the care of children and in HIV medicine, examine Medlock's 2017 HIV model concepts used in the United Nations Program on HIV and AIDS (UNAIDS). The model outlines a three-part program to diagnose 90 percent of individuals living with HIV, to deliver antiretroviral therapy (ART) to 90 percent of those diagnosed and achieve 90 percent viral suppression for those on treatment. The Medlock HIV model aims to reduce viral transmission with an increase in the number of people living with HIV that are on ART yet lose sight to reduce transmission pre-exposure and transmission from mother to child. The authors focus on the effects of ART, yet do not discuss preventive measures like PrEP and PEP, condom use, or methods to identify risk and prevention for those who may come into contact with HIV carriers. Corey and Gray state that the Medlock model places responsibility on those living with HIV rather than share responsibility with sexual partners and inform the general public on how to reduce HIV infections. Further research can benefit at-risk populations to identify additional tools necessary to limit STI and HIV exposure,

⁴ UNAIDS https://www.unaids.org/en/20190716_GR2019_communities

identify the resources needed to assist those living with HIV, and identify invisible populations or communities that do not identify with the currently recognized groups that receive HIV prevention resources and have access to testing sites.

SJSU To Zero Volunteer Experience

My interest in student sexual health began when I attended an event for *SJSU To Zero*, called “Lunch and Learn,” in the Student Wellness Center. They conducted a panel of San Jose faculty and professors and community organizers as they discussed HIV, sexual wellness, testing, and the overall *Getting To Zero* initiative. After this first interaction with the HIV education organization, I reached out to their Program Coordinator and began tabling with them once to twice a week, every to every other week. Over the next few months, I began meeting with Santa Clara County’s *Getting To Zero* Community-Based Participatory Research project (CBPR) in which they are looking at healthcare provider experiences and patient stigma. Unfortunately, the timeline for the CBPR project extended the length of my graduate study by two years, therefore I shifted gears. The various shifts in initiating my project, I began to work with *SJSU To Zero* as a Program Coordinator and to conduct qualitative research over the duration of my graduate studies.

In the following section, I discuss my process of engagement for this project and communication with program stakeholders. I refer to my participant observation at various *SJSU To Zero* tabling and presentation events. I discuss what it meant to be a program volunteer, the different programs and activities the program conducted and how in-person presentations were introduced as an education tool.

2018: World AIDS Day

December 1st is recognized as World AIDS Day, the Pride Center, *SJSU To Zero*, Public Health and the County’s *Getting To Zero* programs participate in a campus wide sexual wellness

event. December 4th, 2018 began my first day volunteering with *SJSU To Zero* and Santa Clara County's Public Health department. I signed up for a shift that lasted from roughly 9 AM until 2:30 PM. I was stationed at the "Condom and Lube Bar" which was fantastically Candyland themed with giveaways of flavored lube and colorfully packaged condoms. We, me, another *SJSU To Zero* volunteer and about five Public Health department workers, set up jars of condoms, lube, candy, and mock candy marbles to set the color theme. We hung a banner behind us in the tent with the Candyland walkway pattern. I spent the morning explaining the proper way to use a condom, giving away safer sex supplies along the assembly line set up, and discussed sexual health and sexual wellness with students, faculty, and campus observers. As an anthropologist, I was actively engaged in participant observations throughout the experience and in my upcoming volunteer opportunities. I was able to observe the reactions of those students who did attend tabling events and the body language and reaction of those who did not participate.

The *SJSU To Zero* WORLD AIDS DAY crew was me and another undergraduate student volunteer, who ran the table as the Public Health workers focused on the HIV testing vehicle behind us. While the experience was frantic and students were coming from various directions down 7th street to claim some free supplies, it was also engaging and exciting to hear and answer questions students had about sexual health products and prevention tools. Students asked questions that ranged from the ways to use a condom, difference in water or silicon-based lubricants, what are dental dams and how to use them, and where they could access low-cost or free sexual health testing.

2019: Active Volunteering

Fast forward to the Spring 2019 semester, Jamie took off post-graduation and I stepped into the position of project coordinator and management. *SJSU To Zero* continued to conduct

tabling events on a weekly basis, usually twice a week. The tabling event brought in roughly thirty to fifty students over three to five-hour periods to average ten students an hour. Over the course of the semester, we would get students that returned to the tables to either pick up snacks, a handful of the campaign pens with revolving messages, and a pamphlet or two. At the time we had eight different informational pamphlets that ranged from PrEP, PEP, U=U, general guide to living with HIV, a local resource guide, and more. Within the first few weeks of the Spring semester, I recommended condensing the informational material into a trifold brochure with the basic information we want students to take away from the short two or three minute stop at the *SJSU To Zero* table.

Students were generally unaware of specific resources, like PrEP and PEP are and where to obtain them, and some students even hinted that they were unaware of HIV as an ongoing illness and not just a part of the 1980s and 1990s. The observation method was beneficial to understand and identify ongoing thoughts, behaviors, and interactions between students and *SJSU To Zero* volunteers. The ability to participate gave me access to both how the volunteers distributed information pertaining to HIV and sexual health, while also seeing how students engaged and reacted to receiving such information in a formal, less academic format. During my time in the field, observing table events, class presentations, and sitting in on



Figure B. Researcher and Volunteer, Brett Witteck, pictured here with previous *SJSU To Zero* program coordinator and volunteer, Jules in Spring 2019.

organization meetings, I was able to sharpen my note taking and listening skills. I wanted to understand how students engaged with sexual health information and how these learning engagements could be better structured. I took an active role in *SJSU To Zero* which gave me access to HIV and Peer Health educators, Santa Clara County *Getting To Zero* members, and established a trusting relationship with students on SJSU campus.

Over the course of the Fall 2019 academic semester, participant observation consisted of directly working with *SJSU To Zero* to table HIV and sexual health information in the middle San Jose State University's campus. With one or two HIV educators, we would set up a table with pamphlets, stickers, giveaway items, and safe sex supply kits on the middle campus pathway to discuss sexual health with students who would stop to engage. On a good day, over about a three-

hour period, we would talk up to thirty students and give away a number of safe sex kits, informational brochures, and giveaway items, like pens, gym towels, and water bottles. The incentives were used in order to draw students over to the table and engage in short informational sessions.

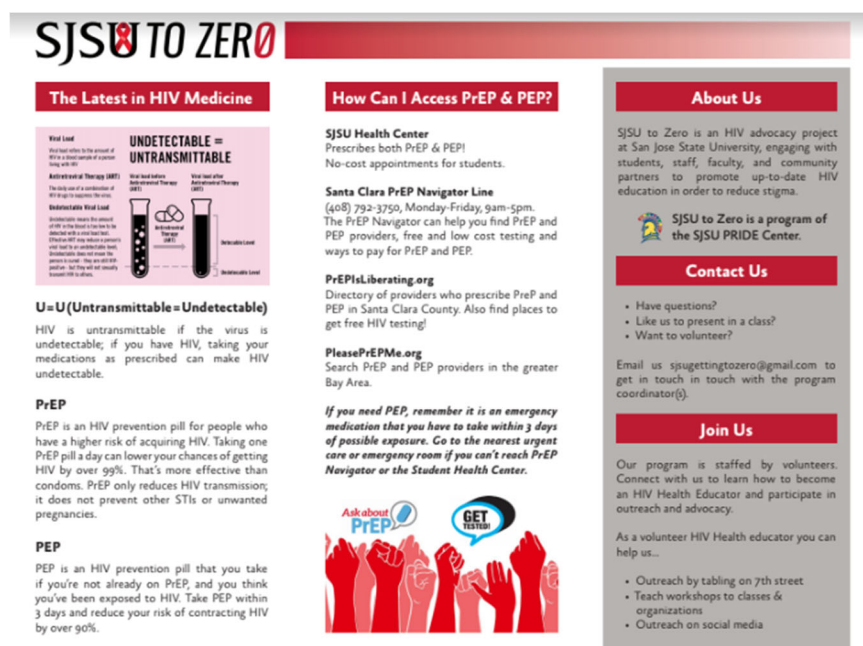


Figure C. Side one of *SJSU To Zero*'s informational pamphlet picturing excerpts on U=U, PrEP and PEP. This pamphlet was a collaborative project initiated through early observations and to condense information for pamphlet distribution.

The conversation with the passers-by would start by introducing the initiative *SJSU To Zero*, an HIV education project, and then ask if they knew about PrEP, PEP, or U=U. Many individuals who stopped stated that they were not aware of PEP and U=U. A number of them knew PrEP by the “I’m on the pill” commercial and by the color of the pill, blue, yet were not aware of what the prescription did, how effective it was, or the process to acquire it.

One student even stated that “people on this campus [SJSU] don’t have sex” and that the program was out of place. Students often had earbuds in or avoided eye contact as they either did not have the time to stop, were on their way to another destination or class, and others were using phones and electronic devices which pulled their attention down. Another individual that had stopped by the table on a sunny Tuesday around noon said she passed our table because she thought the table and volunteers were out for some type of zero-tolerance drug program. She then indicated that she made this observation and came to this conclusion because the tablecloth *SJSU To Zero* used was blood red and they did not have a banner that clearly stated their cause.

SJSU To Zero is a student-led and hosted HIV education and advocacy program that started on the San Jose campus in 2017 when it was funded by Santa Clara County’s *Getting To Zero* initiative. The program is hosted within the Pride Center to improve the campus climate for LGBTQ+ students and acts as a location for volunteer meetings, informational supplies, and provides a safe and respectful environment.

Students that came to *SJSU To Zero* tabling events were handed a trifold brochure, constructed by me, a previous *SJSU To Zero* coordinator, and the *SJSU To Zero* directors throughout the Spring 2018 semester. The objective of these short, personal engagements about HIV education and local resources was to get information out into the community and allow people the chance to accurate information to discuss HIV and sexual health. *SJSU To Zero* HIV educators

were expected to ask attendees to join their email listing, but otherwise, there is no follow-up on if the information present was retained and helpful.

The participant observations were used to inform the questions I would ask in my semi-structured interviews. After a few weeks of observations and assisting with *SJSU To Zero* tabling events and preparing slideshow presentations to bring the initiative into classroom settings, I was able to set up the direction for my interview questions and probes.

SJSU To Zero was also conducting “Lunch & Learn” activities within the Student Wellness Center. These lunch activities often did not pull in a full room of students, but rather staff, faculty, and students who were close to the group or already members would attend. The panel was five faculty members and the MC. The crowd ranged from fifteen to twenty-five people. The student population we want to educate was not in the room at the time. Following this panel, we began thinking of other platforms to disseminate information to SJSU students. This process began with constructing a PowerPoint presentation with the information we want to disseminate. I made a



rough draft of the presentation that was shared with the two directors of the program. After receiving recommendations and changes, I presented it to two student volunteers involved in *SJSU To Zero* to formulate different versions. I made one with a Social Science focus, another student volunteer created a Public Health presentation, and the third volunteer focused

on BME or Sciences which had slightly different HIV pictures and diagrams.

These presentations were constructed and test-run among *SJSU To Zero* members before presented to students in academic classrooms. First, I reached out to the Anthropology department to find classes willing to let me experiment with this new media representation. During this time, I boosted the Instagram page and used it as a moment to actively recruit program volunteers. These attempts were not successful as no student reached out personally, but I was able to approach others that do similar sexual health work for feedback. A total of thirteen presentations took place over October and November of the Fall 2019 semester, each class had no less than twenty-five students, some reached up to 60 and even a 200-student lecture hall. While these presentations were great to engage students in current HIV information and representation, we were not able to seek longitudinal attitudes and changes that may have been made due to students receiving the information.

Anthropological Contribution

Sex education involves stakeholders from policymakers, health professionals, teachers, families, and teenage learners. Anthropology contributes to the contradictory and the unexpected. While students have had moments of sexual health enlightenment, they are yet to be experts or feel comfortable having larger discussions around sexual wellness and behavior. The use of anthropological methods within sexual health illustrates the impact on student's past experiences that affect the success to acquire new sexual literacy. The goal of this project is to express how students' sexual health knowledge is affected by how they were taught, what they were told, and how they access information going forward.

In the next chapter, I discuss how I choose and implement my ethnographic methods. I conducted participant observation at *SJSU To Zero* volunteer events throughout the 2019 fiscal year. I then conducted twelve semi-structured interviews with students and faculty to discover past

sexual health literacy experiences and how to best improve a campus sexual health program. Last, I discuss the use of a resource scan to determine how much sexual health knowledge is accessible and available.

Chapter 3

Finding and Refining the Problem

I began my project in order to identify how much sexual wellness knowledge and opportunity students at San Jose State University have had. *SJSU To Zero* had pre-existing surveys from tabling and presentation events but did not tell how students desired to learn or what information was sought out or perceived as most beneficial. Students who attended *SJSU To Zero* events were asked to take these surveys either after talking to students at tabling events or at one of the lunch & learn events. The survey was focused on students' general knowledge about HIV transmission and prevention tools. Although access to these surveys was beneficial to understand what questions *SJSU To Zero* was asking and what students' responses were to HIV knowledge, I crafted a qualitative method approach. I wanted to know more about what students had previously learned about sex education and how they experience these follow-up opportunities to learn about advances in sexual health. The project was focused on the student perspective about learning sexual health knowledge, what their experiences were and how their individual experiences can help *SJSU To Zero* improve their HIV literacy program.

My ethnographic methods were chosen prior to starting my project in an IRB application. I participated in participant observation with *SJSU To Zero* through lunch and learn events, volunteering at table and classroom presentation events, and eventually integrating myself into a program management role. Ethnographic studies, such as this, allowed me time to uncover the issues and perspectives of the students, as well as *SJSU To Zero* stakeholders. Participant observation allowed me to see how *SJSU To Zero* was previously collecting data through their surveys, what communication was like for program members and students, and allowed me to craft interview questions that focused on those student interactions.

SJSU To Zero distributes HIV prevention information to their student audience in physical paper format, therefore it gave me the opportunity, as a researcher, to uncover the perspectives of students on the receiving end. If students were willing to stay at the table, I was able to have a few five-minute conversations about what it meant to receive sexual health information and how people traditionally expected to find this information. Although SJSU students may not generally be on the search for sexual wellness information, there was a clear disconnect from student's previous sexual education histories and the knowledge *SJSU To Zero* wanted to distribute. In the following section, I discuss my research methods and how I used them to identify how San Jose State student participants understand, navigate, and seek sexual health informational materials.

Participant Observation

Participant observation allowed me to identify how students engage in small talk about experiences around sexual diseases, sexual wellness, and HIV testing and the associated stigma. The observations were done in order to uncover areas where sexual health education or knowledge gaps exist and assist in formulating my interview questions (Schensul et al. 2013, 151). Participant observation warrant insight into the commonplace sexual health conversations and concerns for students on the San Jose State campus. During the participant observation process, I discussed sexual health literacy via *SJSU To Zero* informational guides and discussed sexual risk, behaviors and practices with students to identify ways students seek to manage risk, utilize testing resources, and how much they recall or are knowledgeable about sexual health education programs and materials.

Participant observation act as one form of exploratory ethnographic data collection to investigate the social and public spaces and experiences of SJSU students (LeCompte and Schensul 2013). The observations were conducted through existing forums of sexual health information that

SJSU To Zero had conducted. At tabling events and classroom presentations, I was able to ask students what their prior knowledge was around HIV and STIs. Often students would come up to the table, hear what we were discussing sexual wellness and HIV and were taken back. Students expected a catch from the tabling event, as they often were taken back and asked, “what do I need to do or sign?” and our response was simply that we want to deliver important information on how HIV and prevention tools have progressed.

The participant observations acted as a bridge to receive student perspectives on sexual health organizations and how students react to receiving sexual wellness information in a public forum. I was able to observe the students who kept walking with earbuds in, those students who were interested in the free materials, those who stopped and actively engaged in the conversation, and even those who were confused or opposed to sharing sexual information in a public place.

Semi-Structured Interviews

I recruited interview participants by reaching out to the Pride Center, who then sent out an email to their student newsletter listing and purposive sampling. Sexual education is often directed towards heterosexual students and preventing teenage pregnancy, therefore I wanted to hear from queer students experiencing sexual education in a different light. I was endorsed by the Pride Center, as the central location for *SJSU To Zero*, via an email and an approved letter submitted to the IRB prior to conducting research. The number of queer students on San Jose State’s campus is unknown, therefore there was no base sample population to recruit from. I was endorsed by the Pride Center via email they sent to an overall contact listing which was helpful in gaining access to the queer student population. I anticipated the use of a snowball sample where other participants share information about other potential participants interested in the study, yet all participants I asked were not able to identify other gay, bisexual, or trans-identifying San Jose State University

students. The use of purposive sampling is to identify and recruit participants with the desired qualities, for this study that was reliant on sexual orientation and student status or enrollment (Bernard 2006, 190). I used purposive sampling because I knew my population would consist of students or individuals who are associated with San Jose State University and identify within the LGBTQ+ spectrum.

I was not able to acquire a list of students from the Pride Center or student services, as the total number of LGBTQ+ students is unknown, and I did not want to out any participant by approaching them for the study. I focused on three LGBTQ+ sub-populations: gay, bisexual, and transgender identifying individuals. I ended up conducting twelve interviews over a three-and-a-half-week span, in which I reached saturation for questions regarding sexual education backgrounds and various ways to improve student sexual health access and literacy. I interviewed seven gay identifying participants, four bisexual identifying participants, and one trans-identifying participant.

Through the semi-structured interviews, I was able to learn about SJSU student's experiences with sex education in the past, current knowledge of resources for sex educational material, and uncover existing stigma, confusion, or discomfort with sexual health education and knowledge-based programming. The instrument I used for interviews guided conversations from general educational history, current knowledge around sexual health and sexual diseases, and how students could envision future outreach programming for STI and HIV education. My interview instrument (Appendix) consisted of 5 core questions focused on participant STI or STD knowledge, HIV knowledge and related sexual disease prevention tools or medications, the individuals or communities at-risk and how they would define risk, and what, if any, campus and county sexual health resources or programs up until the interview had taken place.

I asked the participant if they had the desired location on campus to meet. Depending on participant response, I would either contact the Pride Center to use their conference room between the Gender Equity Center or, more often, I would reserve a meeting space in one of the study rooms in the Martin Luther King Jr. library. These rooms had a one-hour reservation period, which was enough time for all but two interviews. The spaces were comfortable, spacious, and were fairly soundproof to not disturb other library users. I arrived a few minutes early to each interview and waited on a coordinated side of the library, often discussed in an email thread to set up the interview.

At the beginning of each interview, I made my intentions clear for the project to the participant and relay a brief description of the project and have them sign a consent form. I explained to each participant that any shared information would be anonymous, personal information would remain confidential, and that I would record the interview. I then disclosed that each recording was done in order to make sure I am representing the participant accurately and that the recording would be deleted from the device and transcription software at the end of the project in May 2020. I found that once I told them I wouldn't take notes, we were both able to situate ourselves to have face-to-face conversations. This tactic was useful as participants seemed to get better situated or relaxed in their seat, which was seen through open body language and produced a more relaxed environment. I discussed with students about my objectives and intentions with a description of my study and had each participant sign a consent form. I explained that information would remain confidential, that all recorded audio of the interviews would be deleted at the end of the project and that any information shared would remain anonymous via a pseudonym.

Each participant interview ranged twenty minutes to an hour and was often reliant on the participant's involvement in other sexual health organizations or previous sexual health background. I used a basic audio recorder for each interview and set it in the middle of the table, with the microphone facing the space between the student and myself. After I introduced the project interview objectives, I asked a handful of demographic questions, age, sexual orientation, academic year, and then dive into questions about sexual health. Participants were asked if they had been to either an *SJSU To Zero* event or the Pride Center and what activities attracted them to these locations to get a sense of how students traditionally engage with these resources and spaces. I was curious to the extent that they had heard of *SJSU To Zero* prior to attending the interview, if they had heard of Santa Clara County's *Getting To Zero* HIV initiative, and if they had attended the Pride Center at any point during their academic career.

After each interview, I went through each question on the interview protocol and made notes about what the participant shared. I tried my best to make sure each participant was heard and comfortable and did not take extensive notes during the interview so I did not come across as distracted or to divert their attention to my notes. I found that not taking immediate notes during the conversation allowed for open conversation and allowed me to engage in the conversation to ask additional probe questions. I took general notes on themes that occurred throughout the discussion and worked to make sure each participant had my full attention during the interview by recording and not taking notes during the process. I asked students at the end of each interview to let any queer friends or colleagues about the research participant opportunity but only received one additional interview through this method.

I took notes on how the interview went, how the student's body language came across during the interview process, any questions I was left with, and general themes I found throughout

the conversation. I took each of the recording files from the audio recorder I used and then uploaded the audio clips to my computer. Each interview audio file was uploaded to Otter.ai, an online transcription site, and was then edited for spelling or grammatical errors. I then took the finished transcription and put them in separate word documents that would allow me to code for common themes and ideas. Then I created a codebook that encompasses all themes that emerged throughout the interviews. I made several drafts of the coding lists, as common themes would emerge, yet ideas and examples were difficult to fit into single, streamlined areas.

Semi-structured interviews worked well to produce qualitative data from my participants as it allowed me to have a guide for the questions I wanted to be answered while they also left room for other discussions. The interviews allowed me to ask participants about their general experiences with sexual education throughout their academic careers and those answers were later coded for common themes. My initial goal was 15 interviews, divided evenly between gay, bisexual, and transgender participants. I ended up with 12 interviews, mostly consisting of gay identifying students and only a handful of bisexual and trans-identifying. Therefore, if future research were to be conducted on the SJSU campus, I suggest finding interviewees that identify along the LGBTQ+ spectrum to get a well-rounded student perspective.

Semi-structured interviews proved to be an effective method to gather information from willing participants. The interview template I constructed prior to the start of each interview with guiding questions and probing questions allowed me to dive a bit deeper into the student participants' experience. The semi-structured interviews were used as my main method to gather data on questions related to participants' past experiences. I also include more commonplace informal interviews and interactions in my report analysis as I was able to ask students if they had

prior knowledge about HIV, had heard or known of the current HIV prevention tools, and make general connections with San Jose State students in a less structured setting.

Resource Scan

I began my search for student-centered sexual wellness information by googling San Jose State's sexual health, sexual wellness, etc. These searches guide one back to either the Pride Center website, the Public Health Department website and to an SJSU Student Wellness tab. Each of these links takes you to a generalized information segment. The Pride Center website links to two articles on making dental dams out of condoms, with no other links to additional information. The Sexual Wellness link takes one to information about the Condom Co-Op hours of operation, a guide on how to put on a condom, and information on making a dental dam out of a glove.

I conducted an additional resource scan of Santa Clara County's *Getting To Zero* website to find out what information they provided for patrons of the county. My goal for the additional resource scan is to identify which resources are being offered and accessible to our student population and discover what information is of importance to transfer to *SJSU To Zero* to relay to students. Then I conducted a scan of San Jose State's Public Health Department website to find parallels and disconnections between SJSU's Pride Center and *SJSU To Zero* sites.

Last, I did a baseline search for sexual wellness and health information for California college campuses and any national efforts to improve sexual health programs. The baseline resource scan included the CDC website on sexual health, California sexual education policy and guidelines, and identifying other websites that link in sexual wellness information to one's specific area or zip code. The CDC website has supportive links for those living with HIV to mental health, talking to medical physicians and providers, and steps towards family planning. Unfortunately, the

CDC and none of the other sources I scanned for information provide similar conversation topics or guides to those who want to get on PrEP or obtain PEP or how to talk to sexual partners.

Qualitative Data Analysis

Once each interview was finished, I took notes on how the participant answered the interview questions, how the student's body language came across during the interview process, any questions that were asked or that I was left with, and general themes I found throughout the conversation. I took each recording file from the audio recorder, uploaded the audio clips to my computer and into my transcription software. Each interview audio file was uploaded to Otter.ai, an online transcription site, and was then edited for spelling or grammatical errors. I then took the finished transcription and put each one in separate word documents that would allow me to code for common themes and ideas. Then I created a working codebook that encompasses all themes that emerged throughout the interviews. I made several drafts of the coding lists, as common themes would emerge, yet ideas and examples would cross over one another and were difficult to fit into single, streamlined themes.

The combined methodological approaches of observations and semi-structured interviews allowed me the chance to capture a portion of student interest in having access to sexual health literacy materials and that students would benefit from better sexual education in middle and high school. Participant observation allowed me to engage with students, and San Jose State's general public, on 7th Street and in classroom settings, to understand any disconnect or areas of conflict with HIV education and sexual health literacy. The observations gave me the opportunity to connect with students on ways to take in information, what information and products were most influential, and see how students generally reacted and behaved when having a discussion about sexual health and testing.

Overall, from this process, I found that students collectively stated they did not receive adequate sexual health education courses during their first and secondary school terms. Often students could not recall what they learned in sexual education or identify how it affected their sexual behaviors and practice. Although the state of California implements guidelines and educational material for sexual health, students do not often receive such information in useful ways or without long-lasting negative associations. Sexual education material reached students in forms of scare tactics, video scenarios, abstinence-only approaches, pregnancy and birth information, and a lack of follow-up on current trends around sexual health information. Participants of this study indicated accessible follow-up information is important to their ongoing knowledge, alternative forms of media should be used to provide wider outreach to students and accessible whenever a student requires access, and sexual wellness education should not solely focus on sexual transmitted diseases, but prevention tools, how to communicate, and personal experiences to illustrate various perspectives of living with HIV or overcoming other sexual diseases.

Chapter 4

Developing a Solution

The combined methodological approaches of observations and semi-structured interviews allowed me to capture the scope of student interest in accessing sexual health literacy materials. Participant observation allowed me to engage with students and San Jose State's general public on 7th Street and in classroom settings. The observations lead me to identify areas of disconnect or conflict with HIV education and sexual health literacy. Through observation, I had the opportunity to connect with students to find out preferred methods to receive information, what information and products were most influential, and see how students reacted and behaved during discussions about sexual health and testing. Next, semi-structured interviews allowed me to dig deeper into student knowledge and the concerns students have gathered since their last sexual health experience. Participants shared their experiences with inadequate sexual health programs, current and previous tactics used to educate them whether it was scare tactics, safer sex prevention tools, or abstinence-only training that focused on no sexual interaction and implications of pregnancy. I conclude the interview section with the ways student participants state they can benefit from more inclusive and engaging sexual education in primary and secondary school years.

SJSU To Zero table events often drew in roughly ten students or passers-by over an hour period. Students were often not inclined to come to a table about sexual health as they passed with earbuds in or stated they were not able to stop for long periods of time. Students were asked if they would take a few moments to learn about HIV. We found most students who met at table events were not aware of HIV as an ongoing epidemic, did not know about new prevention tools and medications, and thanked us for the update upon leaving. The information was disclosed to those students over two to three minutes depending on their previous knowledge. *SJSU To Zero*

volunteers were encouraged to ask if the student had heard of PrEP, PEP, or U=U. Regardless of their answer, the student was handed a pamphlet with definitions and visuals (see Figure C), while discussing what each meant. Then the volunteer indicated that any materials on the table were free to have, such as towels with PrEP and *SJSU To Zero* imprinted, water bottles with the same logo, and additional information materials and magazines. One student reaction after being asked if they knew about these materials was “I am gay, it is expected that I know this.” This single interaction does not speak for everyone but is not uncommon as HIV and AIDS have historically been linked to queer folk. There is an expectation that queer people should know more about HIV and sexual health than their hetero counterparts, even though sex education courses are often heteronormatively focused.

The table events would last two to three hours and students were reluctant to come up to our table, especially without promotion of giveaway items which was later introduced. One afternoon as another volunteer and I called out to students passing by if they wanted free pens or snacks, one faculty member indicated they thought the *SJSU To Zero* table was a “Zero-Tolerance Drug” table because of the red tablecloth and visible PrEP as a medication. This statement from the faculty member was enough for us to rethink how we layout our table and what words or phrases are best to engage with a passerby. Minor changes began to take place at table events based on student and faculty responses to us on the street. I made it a point to ask students that stopped if they wanted information material, regardless of the ability to have an elongated conversation. If I had the opportunity, I asked the student if they felt the pamphlet seemed helpful and digestible based on the first appearance as follow-ups are not common.

Last, students that attended the tabling events often expected there to be “a catch” that they would have to sign up or do something in exchange for the materials *SJSU To Zero* was distributed.

Volunteers assured these students that there was no catch and we simply want to distribute useful and necessary information to every person. This mentality is not uncommon as the 7th Street pathway where *SJSU To Zero* tabled was often occupied by campus clubs looking to recruit students, sorority and frat recruitment, and tents or vans that sold or distributed products, student artwork, and more in return for money or contact information. *SJSU To Zero* did have an email list and a survey that students could take, but none was necessary for them to receive this information.

The observations allowed me to learn how to have specific conversations around HIV without making the passerby uncomfortable. Even though *SJSU To Zero* had a table of materials and sometimes displayed a large banner, I had to find ways to disclose our intentions about providing information with no expectation for anything in return. I had the opportunity to discuss with students how and if they hear about sexual health information currently, gather bits of what information students did know about HIV, and even had some students disclose their initial experiences learning sexual health.

Participant observation and my experience volunteering with *SJSU To Zero* allowed me to craft an interview instrument [see Appendix B]. I began the interview process by asking participants about their experience in sexual health programs or sexual education courses. I found asking students to explain their background or childhood experiences with learning about sexual health was a valid spot to see how they envision sexual health generally. Participants disclosed their experience navigating sexual wellness on their own or through communities. Some individuals discussed the discomfort and scare tactics their schoolteachers or parents would use to teach them about sexual diseases and infections. Throughout these interviews I discovered that all the participants had experience in California schools and each participant had experienced slightly

different forms of sexual education. There was a distinction between two types of educational practice that focused on sexual activity, the two were abstinence-only based learning and scare tactics to discourage students from partaking in sexual activity. Participants made no connection to a lower desire for sexual engagement, but rather that they were uncomfortable discussing sex and sexual health with providers, parents, and educators. Other student participants indicated that they were more comfortable learning information on their own or through the communities they were part of.

Interview Coding

Due to the exploratory nature of this project, coding was essential to exploring and defining student experiences. Constructing the codes came from my desire to understand how students have interacted with sex education in their past. My codes were broadly defined by abstinence-only based educational training, experiencing scare tactics from elders and educators to prevent them from engaging in unsafe sexual activity, the limitations from the school or public policy of what is allowed to be taught, and what the participants envision for improved, future sexual education.

I began the coding process by transcribing each of the interviews in an online software, Otter.ai, and highlighted depending on the themes (Schensul and LeCompte 2010, 200). I highlighted sections of text and specific words that related to participant experience. I then broke down each of those themes into age or academic level participants experienced sexual education courses, who they received the information from, and which aspects of sexual education either assisted or stunted their ability to learn.

Findings

Participants disclosed a number of ways that sexual education courses affected their thinking and how to improve those experiences for future learners. Participants across my

interviews stated their schools or parents approach the discussion of sex and safer sex practice from an abstinence-only approach. Scare tactics were also used as an attempt to get students to not engage in sexual activity or as to warn them of the dangers of sex. Students are then persuaded to not ask questions, struggle to view sexual knowledge in a positive way, and these tactics only provide the worst situations. Participants then discussed the alternative approaches that were made to learn about sexual wellness through community members or on the internet.

Abstinence Based Learning

Participants often acknowledge the limitations for what can be taught in a school setting and information was dependent on the student's academic level. Abstinence-only sexual education across the United States is widely recognized through school systems but is not proven as an effective practice to reduce sexual interaction or reduce contraction of sexual diseases. An abstinence-only approach displayed a brief halt in 2010 but with increased funding was re-introduced in 2015 through 2017 (Planned Parenthood 2020). Abstinence education is proven to not be effective, but many of my participants indicated the approach was popular in their younger academic years.

Freddie is a twenty-eight-year-old, trans-identifying individual with a background in private catholic school. Freddie has lived in the Santa Clara County region for nearly twenty-five years, thus experiencing California's sexual education policy. Their first experience was in high school through an extra circular program rather than the school itself. Freddie stated that by the time he had a sexual education course that it was run with the specific instruction that students did not receive a cohesive or inclusive knowledge about LGBTQ+ sexual wellness information. The catholic school they attended focused on an abstinence-only approach and without that outside course, Freddie may not have received any sexual education courses.

Jacqueline, age 33 from Alameda County, was either age fourteen or fifteen when she first began learning sexual education. She was taught about “what happens during sex” from her parents who are both in the medical field. Jacqueline felt she got a real in-depth conversation about where babies come from but did not recall receiving information on safe sex practices. Her parents focused on an abstinence-only approach and in high school she said it was a conservative, scare tactic approach that also promoted condom use. Experiences like this illustrate the contradictions young students learn when taught one thing by parents, another by the school, and finding out information on their own over time.

Students may request more open discussion that speaks to experience and connection to people in order to learn from them. Erika is a twenty-three-year-old, bisexual, female student. Erika explained that her first encounter with sexual education was not in an open space for communication and inclusivity. The environment was rather hushed, and students were either told not to discuss it, not to worry about it or not think about sex.

“I wish... when I first learned about [sexual education] in elementary school and junior high, that it wasn't just like, always yunno, ‘shhh, like, no one talks about this.’ I wish that it would have been like, “Hey, you know, like, this is what this is like, let's let's talk about it, like more open.” - Erika

Participants expressed the desire to learn about sexual wellness at a young age and to be reminded that it is something to discuss and think about. Experiences in middle school or high school education affects students' mentality around their sexual identities and knowledge. differently and receive similar information on the subject, collectively they experience less than ideal educational opportunities with different backgrounds in sexual health knowledge. Abstinence-only sexual education may be taught in academic settings, it can also be set by an individual's parents or family members. Additional barriers exist that limit what is allowed to be

said, what information students are allowed to receive from the school or teachers and are often left to fend for themselves without the tools.

Medical Provider Connection

Participants stated concerns that healthcare providers either did not present sexual wellness options or simply did not discuss patients' sexual activity, prevention tools, or general information unless asked by the individual. While communication between patient and doctor is vital to these conversations, sometimes that can mean coming out in uncomfortable environments or not receiving equal treatment or information based on sexual orientation.

Jayce is a twenty-three-year-old, Filipino senior student who was born and raised in the San Jose area. Jayce has been going to the same family doctor for twenty-three years. Conversations on sexual wellness were often overlooked. He said that his medical physician "just kind of breezes over stuff" and did not take him "seriously as a sexual person." That results in minimal conversations about sexual activity unless Jayce brought it up himself. He said that he goes to Planned Parenthood to seek out other testing alternatives because his medical doctor is "too comfortable" with him.

Jayce had to break a barrier with his doctor in order to get on PrEP. The relationship he built with his doctor was ongoing over twenty years and PrEP would not have been mentioned if Jayce had not asked how to start the process. The doctor asked him if he was sexually active and using condoms, Jayce responded positively, and his doctor was confused why he would want to get on PrEP. Jayce then came out as gay to his doctor. "I told him I am gay and he [the doctor] was like 'Oh!' and there was a big 'AHA' moment." While heterosexual couples are at risk for HIV, his doctor made the connection through Jayce needing to come out and disclose his sexual

identity with his doctor. Once he came out, his doctor was then willing and quick to discuss HIV prevention tools.

“There was some time where my doctor was very conservative were she talked about it but [also be] hetero about it... which kind of affected me just thinking about [sex] in a heterosexual way... even though I am part of the LGBTQ+ community where I wish I knew some things earlier in life than later” - Ryan

Ryan, on the other hand, did not have the same experience with a healthcare provider. He acknowledges that his doctor was a nice person, she just did not provide him with adequate information that suited his needs. Conversations about what gender is and is not with a provider was one important factor for Ryan to discuss with a medical provider. He does not want the conservation of sexual wellness to come with preconceived notions about gender and his identity as a person and a patient.

Scare tactics

Six of the eleven student participants and one faculty participant disclosed that they experienced scare tactics as a form of sexual health education. The sexual education experience was not limited to a classroom, but included conversations with their parents, school educators, friends, and even the required media or videos used to assist in teaching sexual health courses. Scare tactic methods to teach students about sexual wellness have inevitably stunted the ability to engage with sexual wellness material freely, makes it difficult for students to navigate sites for credible information, and has made conversations with friends, parents, and providers uncomfortable and can produce feelings of judgment. It became evident that participants of this project were exposed to scare tactics within more than their school settings.

Bryce is a twenty-two-year-old, gay, Asian graduate student. He discussed how the sexual educational opportunities he experienced growing up were often in the form of STD scare tactics.

“Oh, middle school, our bio teacher had an STI or STD section for a little bit of a class and she showed us the visuals of what chlamydia, trichomoniasis, and all that stuff was and that kind of scared me.”

Bryce discussed the negative impact he experienced due to seeing the worst-case pictures from an STD. Scare-oriented sexual education with young learners can be harmful to their ideas around STD contraction. Students are then not properly taught how to prevent such diseases but are scared to discuss them. Scare tactics altered what Bryce remembers learning from that class time and limited the accurate sexual information he learned. He states an increase in awareness in how to effectively teach sexual health due to experience in human sexualities courses. These courses discuss condom use, general safer sex practices, and includes personal experiences that can open eyes to experiences and combat misinformation. Last, Bryce indicated that most of his learning about sexual education did not come from an educational school environment, but rather that learned through people and his personal experiences in the gay community.

Jayce disclosed to me that he did not receive adequate sexual wellness information from his school and his dad used a horror story to teach him the effects of sexual activity. He discussed his experience in fifth and sixth grade where his sex education journey started. When asked about how he has learned about sexual health, he responded: “haven’t really, I don’t know.” His memory of the elementary school health courses was slim, and he did not recall a follow-up on the information in high school. Scare tactics were not limited to the school experience but could be brought home.

One of the stories Jayce was told as a child came from his father. His dad told Jayce to use condoms, because when they test for STIs and the way “they [doctors] test for gonorrhea is to shove a Q-TIP up his [penis].” Scare tactics and misinformation like what Jayce’s father presented to him can have long-lasting effects on how he views sexual health and wellness practices. Jayce

used to hesitate to discuss sexual, medical matters with his doctor due to a mix of scare tactics and varying levels of comfort. Although the scare tactic did not educate Jayce on transmission or prevention methods, beyond the use of condoms, he said that it was effective in altering his behavior and that sexual education in middle school was not effective.

“I don't like that motto of abstinence or I'm going to scare you out of sex or, you know, ... sex is fun and like, you know, sex can be all these great things, right? And here's how you can do that responsibly. Have a good time. Take care of yourself and your partner, right? Like, and this is how you do that. And if you do engage in it, this is that ... you know the risk that comes [with] being sexually active.” - Freddie

Freddie works at a local LGBTQ+ center and disclosed that he has seen scare tactics often used. He states that the dialogue focused on “you don't have sex or you get pregnant or die type thing [is outdated]...I just don't think that that's a good model.” He emphasized that he would rather see a model that destigmatizes HIV. Educational experiences need to put the person in a more positive light and that is for those seeking testing and treatment or those living with any chronic illness. Freddie references the recent advertising around PrEP in the San Jose region and the work that Santa Clara County has done to get PrEP into the public. He would rather see positive conversations about communication with partners, conversations about consent and boundaries that get to key issues around sexual wellness. Freddie and Bryce both emphasize the effectiveness to teach students at young ages as those lessons can alter their sexual worldview.

“I went to public schools in Florida, which have policies of abstinence only sex education... minimal sex ed overall, it was all abstinence focused. There was no discussion of safe sex... There was discussion of STIs but really as medical conditions and the really devastating effects” - Marcus

Marcus, a thirty-two-year-old, white, gay male disclosed his experience in Florida's public schools as a teenager. Marcus was taught abstinence-only sex education. He remembers that there was no real discussions of safe sex practices and no discussion of STIs, but rather the students were presented with the devastating effects of untreated sexually transmitted infections. As a queer

person, Marcus disclosed that it was through other queer people where he learned most about sexual wellness. While he did the research for himself to learn how to protect himself sexually with condoms, it was a mix of the queer community and his own while to learn that lead to his knowledge. The experience of scare tactics in an academic setting stressed the need of proper education through the communities he was a part of. These collective experiences of scare tactic use illustrate the widespread use and how it does not connect with students as they continue their education journeys.

The sexual education experience happens in the late primary school and mid secondary years and participants stated they are often short lived. Each participant in this study has had experience in the California school system. California students experience the short duration of sexual health literacy and were often left to either fear sex, avoiding the subject or withheld outdated or misinformation.

Studies on queer student experience with sexual education (Currin 2017) indicate a lack of connection and representation to queer information which stunts student ability to identify and engage with the material. A number of participants stated there was an extended conversation about pregnancy prevention for heterosexual couples.

Alternatives

“I remember actually like my instructor was, he was a gay man, but even he had his regulations that he needed to [meet] the curriculum ... and so there wasn't any talk about like ... gay sex stuff.” - Michael

While not every participant's education experience was taught in an abstinence style, ideas about heteronormative sex and not provided inclusive materials affected how these participants learned. Schools that provided sexual education courses still were not always inclusive to

LGBTQ+ members and identified with either catholic ideals, heterosexual understanding of sexual relationships and penetrative sex, or simply ignored the topic.

Participants stated that they gained information from communities they identified with and gained knowledge through socialization.

“I have a friend that lives with HIV. And besides having to make sure that his diet is healthier, he exercises regularly, and he takes his pills and protects his partner... I know she [her friend's significant other] gets tested like every three to six months just to make sure it has not been passed to her too... but like I said they have the pills that help suppress the infection rate and it's just not, it's not an end to living, it's just a life problem now that you have to deal with a little bit and it's going to take work to make sure you keep it under control. It's definitely not a death sentence that it used to be at all... I think that's encouraging because it encourages people to be more honest with their partners and use protection more often... [to] take the necessary steps to make sure it doesn't spread further.”

“[My friend has] the pills that help suppress the infection rate... [HIV] is not an end to living, it's just a life problem now that you have to deal with a little bit and it's going to take work to make sure you keep it under control, but it's definitely not a death sentence that it used to be at all... it encourages people to be more honest with their partners and use protection more often because they feel like, ‘Oh, I can tell people that I have this and take the necessary steps to make sure it doesn't spread further.’” - Jacqueline

In the interview, Jacqueline referenced her polyamorous community as a source of knowledge. She said being involved in the community made her more aware of best practice for getting tested every three to six months. Her social network informed her on best methods to sexual care and wellness rather than a school program or required sexual education course. Jacqueline has a community that can provide her with best practice and wellness knowledge, but not all students have these same connections.

“I learned [sexual education] through experience and like through like the gay community and... not much of like, you know, the [school] education background of it.” - Bryce

Bryce noted that he learned about STDs generally in a middle school Biology course. He said that what he learned in school was more from a scare tactic approach and did not resonate

with him. He sought out members of the gay community that new more about sexual wellness, testing, and was able to provide experience and stories to help Bryce understand the severity of practicing safer sex. Members of the community who have firsthand experience navigating questions and concerns around sexual health are vital resources to learning how modern, everyday people cope. A *Human Sexualities* course Bryce took at San Jose State had a guest lecture from a woman exposed to AIDS at a young age. He said that having a member of the community to come in and discuss real life implications of HIV and AIDS helped him understand a new level of importance.

Michael and Bryce noted that the gay community is a place to learn about not only one's sexual health, but one's sexual self as well. Connections to people who have gone through STD screenings, those people who were able to obtain PrEP, the experiences of those navigating their sexual identities, and those who live with HIV can tell us about their experiences and in what ways does sexual health influence our everyday lives.

How To Improve Sexual Wellness

“Talking about gender identities, different sexual orientation, having an LGBT component around other legit sexual identities and then I think I would also like to see destigmatization of sexual health... like you know this is a normal sexual thing and seeing it in up like sex-positive way” - Freddie

Participants were asked about how *SJSU To Zero* could improve their outreach and services. A number of the interviewees said they want reliable access to sexual health information on their own time. Participants have disclosed that they struggle to indicate which sources are reliable and have relatable, engaging content. Additionally, some participants said they are not likely to engage in this content in classroom settings or with strangers at a tabling event. Rather, they indicated that they would like access to this information to go over on their own time and

have a place they can ask follow-up questions or get assistance with the proper resources. Interviewees from this project imagined a sexual health literacy guide or incorporated sexual wellness into the freshman student modules. These modules currently include alcohol and substance abuse and sexual assault and domestic abuse, but do not have sections to cover how to be sexually well and access sexual wellness resources.

Participants were asked to discuss what discourses would benefit them most to stay informed and learn more about their sexual health. I then asked participants how they envision a future sexual health program to inform students of a younger demographic, followed by how they envision sexual health programs for students like them at a college level. A number of participants stated that they would like to have more detailed conversations about gender, gender identities, sexual orientation, and sexual identities. For example, Freddie discusses what he would like to see.

Jacqueline said she has interest in learning about prevention care and proper use of safer sex supplies. This was exciting because *SJSU To Zero* has made a goal to teach students about HIV preventive care.

“... I'd be interested in learning more about preventative stuff like PrEP and PEP. I'd be interested in learning about the people going into an understanding like hey, condoms kind of suck and what can you look for when finding a better condom to encourage safer sex... [inform us of] different tools that can reduce risk with safer sex like hey... ‘this is lube... and learning more about communicating with your partner is definitely a big one. I think that's the biggest one.’” - Jacqueline

We had a discussion about what PrEP and PEP are throughout the interview. She connected our discussion of undetectable equals untransmittable (U=U) to her friend living with HIV. At the end of the interview, Jacqueline was emailed a digital copy of the *SJSU To Zero* program pamphlet with condensed information about PrEP, PEP, U=U, and local resources. Jacqueline stated that she would like to see schools and educational programs include students in the conversation and not scare them away from learning about their sexual selves.

“approach [sexual education] with the understanding that you know, high schoolers are going to have sex and that you're not to provide scare tactics against them but to try and like really be like, you know, this these are real dangers that you can face...” - Jacqueline

Samantha, a twenty-three-year-old bisexual student said that not knowing about sexual health status and passing something on to someone else can be scary. She said because she is in a classroom most of the day while on campus, that she would not engage with the material the same if it was presented at an event or through a readily accessible platform.

“I wanted to be taught in a way that will actually resonate with me and actually, I guess like, help me remember all of these things. Because in the way that I learned it, mostly it was just like in a classroom setting. Maybe even just having like an open discussion about it, like, Hey, you know, these are the different things and like maybe showing pictures or even like, videos or like people's stories of like, this is how I got it or like, this is how I got it and they got treated and now I'm good. Make it more kind of, like personalized” - Samantha

Alternative approaches to classroom settings begin with accessible information regardless of person interaction. Digital information networks are important to get current and accurate information and share stories within the community. A final suggestion that multiple participants brought forward was they could imagine incoming students benefiting from a sexual wellness and sexual health literacy module. Similar to the Title IX and Sexual Assault modules that first year and transfer students are required to complete. Participants in this study indicated that a module around the ways to communicate and practice safer sex was important.

Based on the research I was able to identify the nature of the problem faced by students and how they can best be addressed. Students discussed growing up confronted with scare tactics or being told not to engage in sexual activity which limited their ability to reach out when they wanted to know more. Many of the participants discussed not having a trustworthy location to find the information that they need. Therefore, I gathered information about sexual wellness, sexually

transmitted diseases, and links to stories and advice to discuss sexual health with partners, family, friends, and doctors. The point of a sexual health guidebook is to centralize information for students to access that continues to be updated and add additional resources depending on student questions or concerns.

Final Thoughts & Deliverables

Overall, the results from this project allowed me to produce a sexual health guide-pdf that outlines what STDs are, what HIV is, links to articles on communication, links to blogs and podcast on LGBTQ+ topics and sexual health, it includes local campus and county resources, and provides definitions, symptoms, and next steps for sexual health care. The guide [Appendix C] addresses the *SJSU To Zero* mission and gives students access to learn more about sexual health with confidence that this information is accurate and current.

The findings from the participant observations, sexual wellness materials resource scan, and semi-structured interviews informed me that 1) the participants past experiences with sexual health have long term impact on what they retain and learn, 2) students want to be presented with and would benefit from accurate and accessible sexual education information, 3) these participants use various methods to educate themselves in addition the school sexual education that experience, and 4) we may suspect these participants experience a level of internal stigma in discussion of sexual health. The themes that these students discussed with me over the course of this project have allowed me to develop two deliverables:

The first deliverable is for *SJSU To Zero* and is a sexual health guidebook accessible to students via the Pride Center's *Sexual Wellness* and *SJSU To Zero* website. The guidebook serves as a living document to educate students about sexual health practice, give information on sexual infections and diseases, have accessible links to online and in-person resources, and STD and HIV

testing facilities. Participants were asked which information materials, tools, or information they would like to receive from a campus program. The answers I received included accessible information for commuters or students who do not live on campus, a place to learn how to communicate sexual health with partners and incorporate personal stories and experiences. The guidebook includes links to alternative media platforms like blogs, podcasts, and presentations for additional sexual health information.

The second deliverable is an audio-visual presentation with an additional podcast segment on *SJSU To Zero* to allow students new media forms to learn this information. The podcast segment is an introduction to *SJSU To Zero* and HIV education, testing resources, and how to get involved. An additional suggestion is to continue the podcast series with new students and faculty to talk about how to talk to partners or medical physicians about sexual wellness and keep students updated on-campus activities. The addition of these two resources to the SJSU Pride Center site will begin to address student access to the informational materials and resources on campus and in Santa Clara County. Last, despite the Spring 2020 COVID-19 Pandemic which resulted in a campus closure only six weeks into the semester, I added an additional deliverable of a voice-over *SJSU To Zero* presentation to be sent to classrooms where presentations took place in recent semesters.

An anthropological take on sexual health literacy programs illustrates involvement of multiple stakeholders from policymakers, health professionals, teachers, families, and teenage learners. Anthropology contributes to the contradictory and the unexpected. Participants of this study had moments of sexual health enlightenment through their educational experience, but they were yet to feel like experts. College level students are at an age they may feel comfortable having larger discussions around sexual wellness and behavior than they did as children. Anthropological

methods help to illustrate the impact on student's past experiences that affect their future success to confidently acquire new sexual health literacy.

Students' sexual health knowledge is affected by how they were taught, what they were told, and how they access information going forward. Participants of this study identified different ways they would prefer to be educated about sexual health information and that they are still interested in learning more. The purpose of this study was to listen to gay, bi, and trans-identifying students in order to improve an HIV education program. The deliverables in this project report are only the beginning, the sexual health pdf-guide [Appendix C] is only a starting point for *SJSU To Zero* as they continue to digitize information, reach out to students in new and creative ways, and keep information updated.

Limitations and Future Research

This project had a limited scope of student participants and future studies can address the larger LGBTQ+ student population. The number of LGBTQ+ identifying students at San Jose State is unknown and therefore, there may be countless students who have felt they did not receive adequate sexual wellness information and do not know of the resources available to them.

One main limitation to my project was my sample size and diversity of sample population. My sampling population was produced by email thread and word of mouth, which worked well for an unknown population, but an extended study or a broader outreach approach would benefit finding a larger sample size. The sample was limited to twelve participants, which is quite small and does not fully represent the views of LGBTQ+ students. Despite the small sample size, the idea is *SJSU To Zero* and other sexual health education programs can learn from students about their needs and modify both deliverables in the future. The goal of this project was not to give a concrete answer to how students can learn sexual health or to define one specific way to teach

students, but rather, to open ideas for *SJSU To Zero* to broaden their network and approach for San Jose State students.

Semi-structured interviews with open questions was beneficial to allow participants to jump back and forth throughout their sex education experiences. In the future, I would suggest finding locations for interviews that did have time limitations, like the library spaces I used that could only be reserved one hour at a time, per day. The use of a short survey or form with more concrete information would also be helpful for future research to identify the various ways people identify themselves and their experiences. Participants answering their sexual education knowledge on a survey did not seem to answer questions of their experiences or how they retain information but are a helpful tool to assist in qualitative findings. Additionally, future research that can be done on California State University campus can consider recruitment from LGBTQ+ living situations, like the Rainbow housing communities at San Jose State University housing. Further continuation of sexual wellness studies with college-level students contribute to how a younger demographic seeks out sexual wellness information.

Global pandemics and epidemics, like that of HIV, restructure both global and Western understandings of social, cultural, and health worlds. Anthropological studies also indicate inequalities or insufficient care towards specific aspects of healthcare or areas where current trends and health practices do not meet the intended audience. Singer (2012, 20) indicates that the direct impact and association with applied anthropology in the medical field, as science is not something that exists in a social vacuum, can be used to solve human issues and promote healthier life practices. Medical anthropologists study cultural maintenance and change people's and communities' experiences and the patterns those people exhibit as a result.

Closing Remarks

Overall, this project in partnership with San Jose State University's *SJSU To Zero*, uncovers student needs and desired outcomes for ongoing campus sexual education and literacy initiatives. I employed a set of ethnographic methods, resource scans, participant observation, and semi-structured interviews to identify student perspectives on sexual wellness organizations, previous sexual education experience, and participants' general knowledge of STIs. Further research is needed to get a more rounded scope of gay, bisexual, and transgender SJSU student experiences and their recommendations for improvement. The findings from this study indicate that SJSU students would benefit from sufficient follow-up on sexual wellness via a sexual education guidebook or freshman module to access sexual health information when they need it. The participants indicated there is 1) a lack of memorable or positive sexual education experiences in middle and high school, 2) sexual disease stigma from such educational experiences established barriers to knowledge/access, often as a scare tactic or abstinence training, and 4) insufficient navigation to reliable answers regarding sexual health. The deliverable is a live Sexual Health Guidebook to link students with educational information and resources on sexual wellness, sexual diseases, communication practices with parents, partners, friends, and medical physicians. The guidebook is free online to students and accompanied by additional media materials. Digitalizing *SJSU To Zero* will allow students to have easier access to reliable information and allow for wider distribution across campus.

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Appendices

Appendix A MOU

Applied Anthropology M.A. Program San Jose State University

Graduate Committee Memorandum of Understanding

The purpose of this MOU is to formalize membership of the undersigned student's graduate committee. Any changes in committee membership, plan (A or B), or significant changes in topic should be documented in a brief written addendum to this MOU. It is the responsibility of the student and committee chair to inform other committee members of the changes.

Student Brett Witteck
(Please Print Name) (Please sign & date)

Plan: Plan A Thesis or **Plan B Project** (circle one)

Committee Chair/
Advisor: Roberto Gonzalez
(Please Print Name) (Please sign & date)

Committee Members: Chuck Darrah
(Please Print Name) (Please sign & date)

Matthew Capriotti

Brief Abstract/Proposal:

The goal of this study is to examine, identify, and assess gay, bi, and trans student perceptions of STI and HIV risk-taking behaviors and management in connection to an LGBTQ community hub on the SJSU campus.

The audience for this research are SJSU gay, bisexual, and trans identifying students. This study will bring awareness of current student perceptions and practice in regards to ongoing STI and HIV education programs and outreach. My research questions are 1) do gay, bi, and trans men students who utilize services at the Pride Center /SJSU to Zero have more knowledge of sexual health risks, behaviors, and management than those who do not use the service? 2) How do students who do and do not attend the Pride Center/SJSU to Zero translate STI and HIV education and knowledge into risk-taking and management behaviors? 3) How does stigma affect (a) student knowledge and consumption of sexual health services and (b) experiences of risk management and risk-taking (i.e., behaviors)?

Appendix B

Interview Instrument

Introduction

Thank you for joining me today and know that your presence is important to the research being done to benefit *SJSU to Zero*. My name is Brett Witteck and I am a graduate student at San Jose State University. As you may be aware, I am conducting this research with *SJSU to Zero*, an on-campus HIV education and advocacy project, in order to learn more about student sexual health knowledge, risk management skills, and overall perception around sexual health.

I am here to learn from you by asking you some questions about your experiences (or lack of) with sexual health programs. I anticipate that the information gathered here will assist leaders at the SJSU to Zero and in Santa Clara County “Getting to Zero” HIV advocacy program, to better serve the community.

Before we get started, I want to make sure you had a chance to read the consent notice we provided for you.

Did you have a chance to read it? (Yes/No).

Do you have any questions about it or our project?

OK, let's get started

-

Demographics

- Sexual orientation
- Age
- Ethnicity
- How long have you lived in Santa Clara County? Or San Jose, CA?
 - How long have you lived in ____ (outside of SSC/SJ)?
- What is your academic year standing at San Jose State University?
 - I.e. first, second, third, fourth, graduate, etc.

Starter question

Could you tell me some of the reasons you came up to -

SJSU to Zero table?

the Pride Center?

Other, _____?

(How you came into contact with this interview)

Did you come to these events

because you want to be here/it is a nice place to hang out?

have someone you support here/meet up with other people?

or you have to be here for any reason/work/group work/etc.?

Motivation Question(s) Awesome, thank you so much. I would like to start off by asking you what do you know about safer sex-sexual health practices:

At what age did you learn about sex education? How did you learn about sexual health? Was it effective in producing safer sexual health practices?

Questions Can you tell me a bit about what you know about STIs?

What comes to mind when you think of STI or STD? Do you know what services are available in regards to STIs?

I.e. Health center, testing resources,
etc. Now, what do you know about HIV?

What comes to mind when you hear the word HIV? Do you know what services are available in regards to STIs?

I.e. Health center, testing resources,
etc.

What do you know about sexual health prevention tools - condoms, PrEP, PEP, or U=U?

Would you define yourself at “risk” in sexual settings?

For you, who is “at-risk” for HIV/STIs?

Could you define “risk behavior”?

Trimpop 1994: any consciously, or non-consciously controlled **behavior** with a perceived uncertainty about its outcome, and/or about its possible benefits, or costs for the physical, economic or psycho-social well-being of oneself or others.

How about “risk management”?

How might you manage your encounters with risk?

Do you implement safer practices because of what you have learned in class or at these events?

What do you think is an effective practice to teach/learn about sexual education and safe sexual health practices? Prior to this interview, were you aware that SJSU has *SJSU to Zero*: an HIV education and advocacy project?

Concluding Remarks Again, thank you so much. Those are all the questions I have at this time. In the few minutes we have left, is there anything you want to mention about your experiences here that we did not ask about? *(This question can be skipped if conflicting with*

time constants)

Thank you once again for your help. Results from this project will be provided to *SJSU to Zero* and Santa Clara County's *Getting to Zero*, in case you are interested.

Enjoy the rest of your
day.

Appendix C

[Student Sexual Health Guidebook](#) - April 2020

Below is a 28 page guidebook to Sexual Health presented by Brett Witteck to *SJSU To Zero*.



#endHIVstigma #UequalsU #PrEP #PEP @SJSUTOZERO

SJSU To Zero is an HIV advocacy project based at San Jose State University, engaging with students, staff, faculty, and community partners to promote HIV education and stigma reduction on campus.

SJSU To Zero is an HIV education and advocacy group at San Jose State University. We are the campus branch of Santa Clara County's "Getting To Zero" HIV initiative.

Our project goals are to assist in educating the student population and reduce new cases of HIV and deaths related to HIV down to zero AND to eliminate stigma around HIV.

How can you get involved in working with SJSU To Zero?

Email us at SJSUGettingToZero@gmail.com

Or direct message us at one of the following social media platforms

- @SJSUtoZero on Facebook, Instagram, and Twitter.

Check us out online!
<http://bit.ly/sjsutozero>
sjsugettingtozero@gmail.com

@SJSUtoZero



SEXUAL HEALTH RESOURCE GUIDE
PRESENTED BY SJSU TO ZERO

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Let's Communicate!

We struggle to talk about our sexual orientation or gender identity because we do not know how to define ourselves or our situations. Check out a glossary of definitions that were created to make conversations a bit easier.

[The Safe Zone Project](#)

LGBTQ+ Vocabulary: Glossary of Terms

[Human Rights Campaign](#)

Glossary of Terms

[National LGBT Health Education Center](#) (2016)

Glossary of LGBT Terms for Health Care Teams

[Planned Parenthood](#)

Definitions vary depending on the website.

Here we provide some different definitions from the sites listed above to demonstrate how the language to communicate continues to transform.

Gender Identity

- ❑ **Gender identity** – *noun*: the internal perception of one's gender, and how they label themselves, based on how much they align or don't align with what they understand their options for gender to be. Often conflated with biological sex, or sex assigned at birth. (SZP)
- ❑ **Gender identity** | One's innermost concept of self as male, female, a blend of both or neither – how individuals perceive themselves and what they call themselves. One's gender identity can be the same or different from their sex assigned at birth. (HRC)
- ❑ **Gender Identity** "isn't about who you're attracted to, but about who you ARE – male, female, genderqueer, etc." (Planned Parenthood)
- ❑ **Gender identity** (noun) – A person's internal sense of being a man/male, woman/female, both, neither, or another gender (HEC)
- ❑ Gender Identity aims to answer questions like "Who am I?", "What does it mean to *feel* like a man or woman or neither or both?", and "To which gender (class) might I belong to?"

Sexual Orientation

- ❑ **Sexual orientation** | An inherent or immutable enduring emotional, romantic or sexual attraction to other people (HRC)
- ❑ "Sexual orientation is about who you're attracted to and want to have relationships with... Sexual orientation is about who you're attracted to and who you feel drawn to romantically, emotionally, and sexually." (Planned Parenthood)
- ❑ Sexual orientation (noun) – How a person characterizes their emotional and sexual attraction to others (HEC)
- ❑ sexual orientation – noun: the type of sexual, romantic, emotional/spiritual attraction one has the capacity to feel for some others, generally labeled based on the gender relationship between the person and the people they are attracted to. Often confused with sexual preference. (SZP)

Gender // Sex

- ❑ **Gender** is generally considered culture
- ❑ **Sex** considered biological
- *We are assigned to a gender and are expected to identify as such through socialization and societal norms. Gender is historical and changes over time, vary from place to place.

Non-binary /

- ❑ An adjective describing a person who does not identify exclusively as a man or a woman. Non-binary people may identify as being both a man and a woman, somewhere in between, or as falling completely outside these categories. While many also identify as transgender, not all non-binary people do. (HRC)

[The National LGBT Health Education Center \(HEC\) "Outdated Terms to Avoid."](#)

*Note that definitions and terms may become outdated or not accurately depict someone.

Transgender History: The Roots of Today's Revolution by Susan Stryker (2017: Second Edition)

[ACADEMIA.edu](#) - Downloadable version

[Amazon](#) - Purchasable

*Pages 10 - 41 provides LGBTQ+ terms, concepts, and historical context

I Wanna Know: How to Communicate

"Talking openly makes relationships more fun and satisfying; especially when you both talk about each other's needs for physical, emotional, mental, and sexual health."

Communication With Parents

"Teens who talk with their parents about sex are less likely to become pregnant because they're more likely to use contraception or protection when they become sexually active."

Sex Education (Netflix Series 2019-)

A teenage boy with a sex therapist mother teams up with a high school classmate to set up an underground sex therapy clinic at school.

SiemPrE Por Ti Webseries



SiemPrE Por Ti

The toolkit integrates "SiemPrE Por Ti", a four-episode web series that seeks to inform about PrEP and the importance of STD/HIV testing, to guide a discussion about HIV related stigma

How To Talk About Sex

Healthline

"Every healthy sexual relationship requires constant communication. It is important to focus on both your needs and the needs of your partner. It's a good idea to be open about what your needs are and to always keep the communication open."

LGBT Foundation: Sexual Health

LGBT Foundation provides a range of sexual health services focused on sex positivity and sexual wellbeing, should you need us. We offer rapid HIV testing across Greater Manchester, one-to-one advice 'Let's talk about sex', group workshops and spaces, free condoms and lube, outreach stalls with a range of resources, and group play packs.

What is Good Sexual Health: Youtube

Watts the Safeword. Sexual health and how we talk about sex is an important topic! From stats about STI's to being more open to talking about sexual health in schools, all this and more with our special guest EricPaulLeue!

Partner(s)

Ashley Fowler from Sex, Etc.

["How Do Teen Couples Talk About STDs?"](#)

Parents

Emma Ogando from Sex, Etc.

["How My Mom Made It O.K. to Talk About Sex"](#)

Medical Physician

Ashley Fowler from Sex, Etc.

["How to Talk to Your Health Care Provider"](#)

GLMA: Health Professional Advancing LGBTQ Equality

LGBTQ people have some unique health needs and concerns. Unfortunately, many health care providers don't fully understand these issues, so it's important to take charge of your health by asking your healthcare provider about the health matters that may apply to you. The health issues listed in the factsheets are identified as most commonly of concern for LGBTQ people.

[Top Ten Issues to Discuss with Your Healthcare Provider](#)

UC Davis: Student Sexual Health Guide

[Let's Talk about It: A Guide to Consent and Sexcessful Communication](#)

(UC Davis Health Education and Promotion, CARE). This was developed by students and professionals to assist you in enjoying physically and emotionally safe, pleasurable and fulfilling sexual experiences. It covers a variety of topics such as:

- ☐ Consent
- ☐ Healthy Relationships
- ☐ Texting, Sexting and Dating Apps
- ☐ Exploring your desires and boundaries

❑ Step-by-step communication

Sexuality can be a fun and fulfilling part of life. It is your choice whether or not you are sexually active, what kind of sexual activities you partake in, when, and with whom. In order to have fulfilling sexual experiences, it is important to communicate these wants and needs to your partner(s) and, additionally, take into account theirs. This communication might seem awkward or difficult, but there are simple steps you can take to communicate effectively in order to have fun and safer sex life.

Let's Talk STI/STDs

STI - Sexually Transmitted Infection // STD - Sexually Transmitted Disease

In this section, we cover the most common STI/STDs.

This includes definitions, symptoms, current cures or management tips, and next steps.

How do I know?

Most STDs have no signs or symptoms, so you or your partner(s) could be infected and not know it.

The only way to know your STD status is to get tested. You can search for a clinic [here](#).

--

Also, it is known that having an STD makes it easier to get HIV. It's important to get tested to protect your health and the health of your partner.

How are STDs spread?

STDs are spread through sexual contact with someone who has an STD. Sexual contact includes oral, anal, and vaginal sex, as well as genital skin-to-skin contact.

Some STDs—like HIV, chlamydia, and gonorrhea—are spread through sexual fluids, like semen. Other STDs, including HIV and hepatitis B, are also spread through blood. Genital herpes, syphilis, and human papillomavirus (HPV) are most often spread through genital skin-to-skin contact.

Which STDs are treated or managed?

Some STDs, like gonorrhea, chlamydia, and syphilis, *can be cured with medication*. If you are ever treated for an STD, be sure to finish all of your medicine, even if you feel better. Your partner(s) should be tested and treated, too. It is important to remember that you are at risk for the same or a new STD every time you have sex without using a condom and/or have sex with someone who has an STD.

STDs like herpes and HIV *cannot be cured*, but medicines can be prescribed to manage symptoms.

<https://medical-dictionary.thefreedictionary.com/sexually+transmitted+diseases>

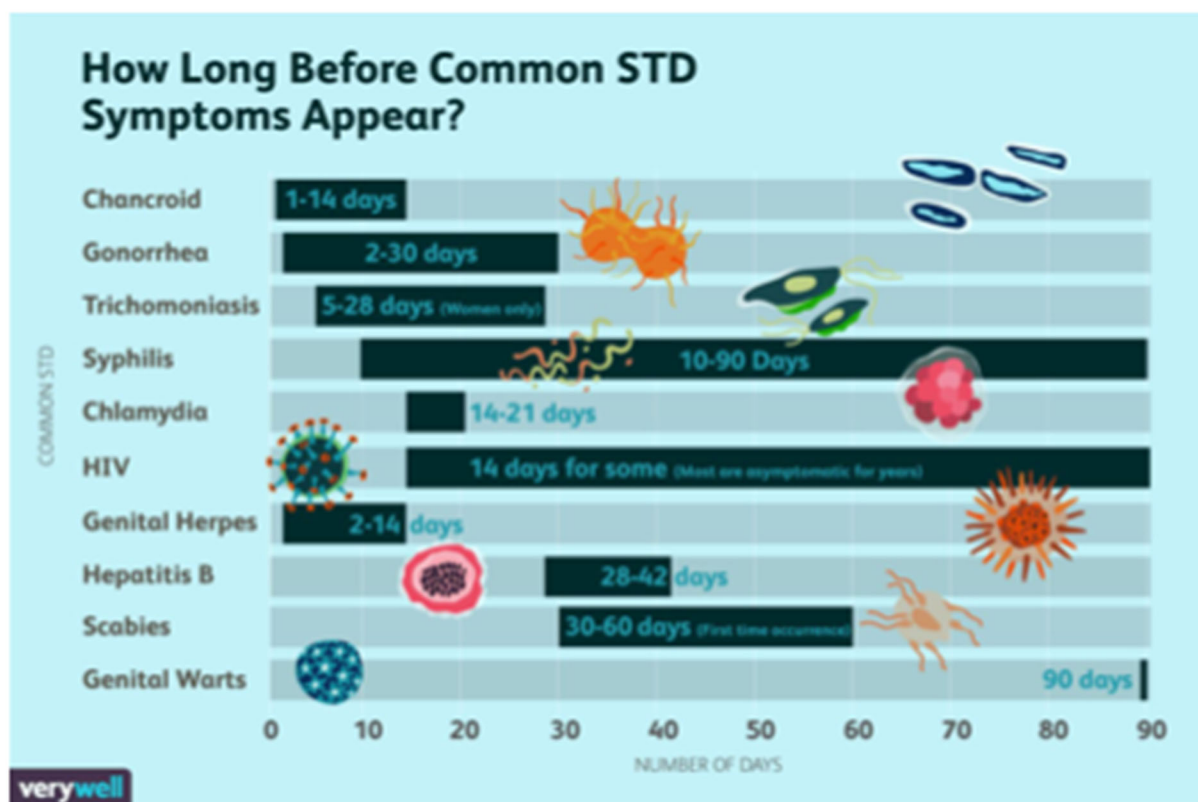
CDC recommends sexually active gay and bisexual men get tested for:

- ☐ HIV at least once a year
- ☐ Syphilis
- ☐ Hepatitis B

- ☐ Hepatitis C based on risk factors
- ☐ Chlamydia and gonorrhea of the rectum if you've had receptive anal sex (been a "bottom") in the past year
- ☐ Chlamydia and gonorrhea of the penis if you have had insertive anal sex (been a "top") or received oral sex in the past year
- ☐ Gonorrhea of the throat if you've performed oral sex (i.e., your mouth on your partner's penis, vagina, or anus) in the past year
- ☐ Sometimes, your healthcare provider may suggest a herpes test.

I was just diagnosed with... What do I do now?

Your healthcare provider can offer you the best care if you discuss your sexual history openly. You should have a provider you are comfortable with. You can also visit [GetTested](http://GetTested.org) to find a confidential, free or low-cost STD testing location near you.



Verywellhealth.com - STD Incubation Period Chart

What are the most common STDs?

Chlamydia

One of the most common and often causes no symptoms. According to WebMD

Chlamydia symptoms in women

- ☐ Abnormal vaginal discharge that may have an odor
- ☐ Bleeding between periods
- ☐ Painful periods
- ☐ Abdominal pain with fever
- ☐ Pain when having sex
- ☐ Itching or burning in or around the vagina
- ☐ Pain when urinating

Chlamydia symptoms in men

- ☐ Small amounts of clear or cloudy discharge from the tip of the penis
- ☐ Painful urination
- ☐ Burning and itching around the opening of the penis
- ☐ Pain and swelling around the testicles

*with treatment, the infection can clear up within one to two weeks. After taking antibiotics, people should be re-tested after three months to ensure the infection has been cured.

Human papillomavirus (HPV)

HPV is the most common sexually transmitted infection. It can be transmitted by having vaginal, anal or oral sex with someone carrying the virus. Anyone that is sexually active is at risk for HPV.

Lower your chances:

- ☐ Vaccination
- ☐ Get screened for cervical cancer
- ☐ It is important to use condoms during safer sex practice

HPV vaccination is recommended at age 11 or 12 and for everyone through age 26.

According to the CDC

There is no test to find out a person's "HPV status." Also, there is no approved HPV test to find HPV in the mouth or throat.

There are HPV tests that can be used to screen for cervical cancer. These tests are only recommended for screening in women aged 30 years and older. HPV tests are not recommended to screen men, adolescents, or women under the age of 30 years.

Most people with HPV do not know they are infected and never develop symptoms or health problems from it. Some people find out they have HPV when they get genital warts. Women may find out they have HPV when they get an abnormal Pap test result (during cervical cancer screening). Others may only find out once they've developed more serious problems from HPV, such as cancers.

<https://www.cdc.gov/std/hpv/stdfact-hpv.htm>

Genital herpes

Genital herpes is an STD caused by two types of viruses. The viruses are called herpes simplex virus type 1 (HSV-1) and herpes simplex virus type 2 (HSV-2).

How does genital herpes get transmitted?

It can be transmitted by having vaginal, anal, or oral sex with someone who has the disease.

If you do not have herpes, you can get infected if you come into contact with the herpes virus in:

- ☐ A herpes sore
- ☐ Saliva (if your partner has an oral herpes infection) or genital secretions (if your partner has a genital herpes infection)
- ☐ Skin in the oral area if your partner has an oral herpes infection, or skin in the genital area if your partner has a genital herpes infection.

You can get herpes from a sex partner who does not have a visible sore or who may not know he or she is infected. It is also possible to get genital herpes if you receive oral sex from a sex partner who has oral herpes.

You will not get herpes from toilet seats, bedding, or swimming pools, or from touching objects around you such as silverware, soap, or towels. If you have additional questions about how herpes is spread, consider discussing your concerns with a healthcare provider.

How do I know if I have genital herpes?

Most people who have genital herpes have no symptoms or have very mild symptoms. You may not notice mild symptoms or you may mistake them for another skin condition, such as a

pimple or ingrown hair. Because of this, most people who have herpes do not know it. Herpes sores usually appear as one or more blisters on or around the genitals, rectum or mouth. The blisters break and leave painful sores that may take a week or more to heal.

Your healthcare provider may diagnose genital herpes by simply looking at your symptoms. Providers can also take a sample from the sore(s) and test it. In certain situations, a blood test may be used to look for herpes antibodies. Have an honest and open talk with your health care provider and ask whether you should be tested for herpes or other STDs.

There is no cure for herpes, but medicines are available to prevent or shorten outbreaks.

Gonorrhea

Gonorrhea can cause infections in the genitals, rectum, and throat. It is a very common infection, especially among young people ages 15-24 years. It is spread by having vaginal, anal, or oral sex with someone carrying gonorrhea.

Any sexually active person is at risk for gonorrhea and should use condoms with sexual partners. Have an honest and open discussion with your health care provider to see if you should get tested for gonorrhea or any STDs.

What are the symptoms? According to the CDC

Some men with gonorrhea may have no symptoms at all. However, men who do have symptoms may have:

- ☐ A burning sensation when urinating
- ☐ A white, yellow, or green discharge from the penis
- ☐ Painful or swollen testicles (although this is less common)

Most women with gonorrhea do not have any symptoms. Even when a woman has symptoms, they are often mild and can be mistaken for a bladder or vaginal infection.

Women with gonorrhea are at risk of developing serious complications from the infection, even if they don't have any symptoms.

Symptoms in women can include:

- ☐ Painful or burning sensation when urinating
- ☐ Increased vaginal discharge
- ☐ Vaginal bleeding between periods

Rectal infections may either cause no symptoms or cause symptoms in both men and women that may include:

- ☐ Discharge
- ☐ Anal itching
- ☐ Soreness
- ☐ Bleeding
- ☐ Painful bowel movements

Can gonorrhea be cured?

Yes, with the right treatment. Medications should not be shared with anyone. Medications can stop the infection, but will not undo any permanent damage caused by the disease. You should wait seven days after the medication before having sex again. This will avoid the chances of getting infected again or spreading gonorrhea to someone else.

Syphilis

The following information provided by CDC.gov

[Syphilis](#) is a sexually transmitted infection that can cause serious health problems if it is not treated. Syphilis is divided into stages (primary, secondary, latent, and tertiary). There are different signs and symptoms associated with each stage.

You can get syphilis by direct contact with a syphilis sore during vaginal, anal, or oral sex. You can find sores on or around the penis, vagina, or anus, or in the rectum, on the lips, or in the mouth.

Syphilis is divided into stages (primary, secondary, latent, and tertiary), with different signs and symptoms associated with each stage. A person with primary syphilis generally has a sore or sores at the original site of infection. These sores usually occur on or around the genitals, around the anus or in the rectum, or in or around the mouth. These sores are usually (but not always) firm, round, and painless. Symptoms of secondary syphilis include skin rash, swollen lymph nodes, and fever. The signs and symptoms of primary and secondary syphilis can be mild, and they might not be noticed. During the latent stage, there are no signs or symptoms. Tertiary syphilis is associated with severe medical problems. A doctor can usually diagnose tertiary syphilis with the help of multiple tests. It can affect the heart, brain, and other organs of the body.

Symptoms of syphilis in adults vary by stage:

Primary Stage

During the first (primary) stage of syphilis, you may notice a single sore or multiple sores. The sore is the location where syphilis entered your body. Sores are usually (but not always) firm, round, and painless. Because the sore is painless, it can easily go unnoticed. The sore usually lasts 3 to 6 weeks and heals regardless of whether or not you receive treatment. Even after the sore goes away, you must still receive treatment. This will stop your infection from moving to the secondary stage.

Secondary Stage

During the secondary stage, you may have skin rashes and/or mucous membrane lesions. Mucous membrane lesions are sores in your mouth, vagina, or anus. This stage usually starts with a rash on one or more areas of your body. The rash can show up when your primary sore is healing or several weeks after the sore has healed. The rash can look like rough, red, or reddish-brown spots on the palms of your hands and/or the bottoms of your feet. The rash usually won't itch and it is sometimes so faint that you won't notice it. Other symptoms you may have can include fever, swollen lymph glands, sore throat, patchy hair loss, headaches, weight loss, muscle aches, and fatigue (feeling very tired). The symptoms from this stage will go away whether or not you receive treatment. Without the right treatment, your infection will move to the latent and possibly tertiary stages of syphilis.

Latent Stage

The latent stage of syphilis is a period of time when there are no visible signs or symptoms of syphilis. If you do not receive treatment, you can continue to have syphilis in your body for years without any signs or symptoms.

Tertiary Stage

Most people with untreated syphilis do not develop tertiary syphilis. However, when it does happen it can affect many different organ systems. These include the heart and blood vessels, and the brain and nervous system. Tertiary syphilis is very serious and would occur 10–30 years after your infection began. In tertiary syphilis, the disease damages your internal organs and can result in death.

Neurosyphilis and Ocular Syphilis

Without treatment, syphilis can spread to the brain and nervous system (neurosyphilis) or to the eye (ocular syphilis). This can happen during any of the stages described above.

Symptoms of neurosyphilis include:

- ☐ severe headache
- ☐ difficulty coordinating muscle movements

- ☐ paralysis (not able to move certain parts of your body)
- ☐ numbness

- ☐ dementia (mental disorder)



HIV = HUMAN IMMUNODEFICIENCY VIRUS

HIV is a virus that attacks the immune system, resulting in a chronic, progressive illness that leaves people vulnerable to opportunistic infections and cancers.

In order to be infected, the virus must enter a person's bloodstream. HIV cannot survive outside the body.



Symptoms of ocular syphilis include changes in your vision and even blindness

Syphilis can be cured with the right antibiotics from your healthcare provider. However, treatment might not undo any damage that the infection has already done.

What is HIV?

HIV (Human Immunodeficiency Virus)

A virus that attacks the immune system and without treatment, HIV reduces the number of immune cells (T-cells) that can then turn into Acquired Immunodeficiency Syndrome (AIDS).

What does Immunodeficiency mean?

Immunodeficiency means that the immune system cannot fight infections

What is an Opportunistic infection?

An opportunistic infection is one that is caused by pathogens/take advantage

HIV can be controlled with treatment, ART (antiretroviral therapy) and that is proven to have little risk of developing into AIDS. HIV takes over the T-Cell and uses it to multiply itself and without T-cells, the body can't fight infection as well. Therefore, people who are living with HIV are more likely to get infections, like the common cold or the

flu. BUT with Antiretroviral treatment, medications can help block various stages of the HIV virus lifecycle. HIV is a virus spread through certain body fluids that attacks the body's immune system, specifically the CD4 cells, often called T cells. Over time, HIV can destroy so many of these cells that the body can't fight off infections and disease. These special cells help the immune system fight off infections (CDC 2019)

Symptoms of new HIV-1 infection include:

- ☐ Tiredness
- ☐ Fever
- ☐ joint or muscle aches
- ☐ Headache
- ☐ sore throat

HIVSURE™

HIV IS NOT TRANSMITTED BY...



Insect bites



Toilet seats



Kissing



Sharing cutlery



Touching

YOU CAN GET HIV VIA...



Sex without a condom



Passed from mother to baby



Sharing injecting equipment



Contaminated blood transfusions & organ transplants

Take steps to prevent getting or transmitting HIV



Protect yourself and your partners



Treatment with HIV medicines can prevent HIV from developing (U=U)

- ☐ Vomiting
- ☐ diarrhea
- ☐ rash
- ☐ night sweats
- ☐ enlarged

lymph nodes in the neck or groin.

Who is at risk of infection and how?

Unprotected sex, unprotected sex with a partner that is either living HIV + or with someone who does not know their HIV status. HIV is not necessarily transmitted every time you have sex. Therefore, taking an HIV test is not a way to find out if your partner is infected. Anybody is at risk of HIV if infected fluids from an HIV-positive person enters their body.

HIV Transmission

CDC.gov

"You can get or transmit HIV only through specific activities. Most commonly, people get or transmit HIV through sexual behaviors and needle or syringe use.

Only certain body fluids—blood, semen (cum), pre-seminal fluid (pre-cum), rectal fluids, vaginal fluids, and breast milk—from a person who has HIV can transmit HIV. These fluids must come in contact with a mucous membrane or damaged tissue or be directly injected into the bloodstream (from a needle or syringe) for transmission to occur. Mucous membranes are found inside the rectum, vagina, penis, and mouth."

Aids.org

"HIV can be transmitted from an infected person to another through:

- ☐ Blood (including menstrual blood)
- ☐ Semen
- ☐ Vaginal secretions
- ☐ Breast milk
- ☐ Blood contains the highest concentration of the virus, followed by semen, followed by vaginal fluids, followed by breast milk.

* Activities That Allow HIV Transmission

- ☐ Unprotected sexual contact
- ☐ Direct blood contact, including injection drug needles, blood transfusions, accidents in health care settings or certain blood products
- ☐ Mother to baby (before or during birth, or through breast milk)
- ☐ Sexual intercourse (vaginal and anal): In the genitals and the rectum, HIV may infect the mucous membranes directly or enter through cuts and sores caused during intercourse (many of which would be unnoticed). Vaginal and anal intercourse is a high-risk practice.
- ☐ Oral sex (mouth-penis, mouth-vagina): The mouth is an inhospitable environment for HIV (in semen, vaginal fluid or blood), meaning the risk of HIV transmission through the throat, gums and oral membranes are lower than through vaginal or anal membranes. There are, however, documented cases where HIV was transmitted orally, so we can't say that getting HIV-infected semen, vaginal fluid or blood in the mouth is without risk. However, oral sex is considered a low-risk practice.

- ❑ **Sharing injection needles:** An injection needle can pass blood directly from one person's bloodstream to another. It is a very efficient way to transmit a blood-borne virus. Sharing needles is considered a high-risk practice.
- ❑ **Mother to Child:** It is possible for an HIV-infected mother to pass the virus directly before or during birth, or through breast milk. Breast milk contains HIV, and while small amounts of breast milk do not pose a significant threat of infection to adults, it is a viable means of transmission to infants."

Myths persist about how HIV is transmitted. This section provides the facts about HIV risk from different types of sex, injection drug use, and other activities.



When should I get tested for HIV?

Most HIV tests, including most rapid tests and home tests, are antibody tests. Antibodies are produced by your immune system when you're exposed to viruses like HIV or bacteria. HIV antibody tests look for these antibodies to HIV in your blood or oral fluid.

The soonest an antibody test will detect infection is 3 weeks. Most (approximately 97%), but not all, people will develop detectable antibodies within 3 to 12 weeks (21 to 84 days) of infection. If you have any type of antibody test and have a positive result, you will need to take a follow-up test to confirm your result.

A combination, or fourth-generation, test looks for both HIV antibodies and antigens. Antigens are foreign substances that cause your immune system to activate. The antigen is part of the virus itself and is present during acute HIV infection (the phase of infection right after people are infected but before they develop antibodies to HIV). Combination tests are now recommended for HIV testing that's done in labs and are becoming more common in the U.S.

Most, but not all people, will have enough HIV in their blood for a nucleic acid test to detect infection 1 to 4 weeks (7 to 28 days) after infection.

-- Hiv.gov --

Youth & HIV


Individuals ages 13 to 24 make up 21% of current HIV diagnosis or over 8,000 people a year. The college demographic has a heavy set of 17 to 24-year-olds on campus. Youth with HIV are the least likely of any age group to be linked to care in a timely manner and have a suppressed viral load. Addressing HIV in youth requires that young people have access to information and tools they need to reduce their risk, make healthy decisions, and get treatment and care if they have HIV.



Check out the video for the [CDC's "What is PrEP?"](#)

What is PrEP?

- Pre Exposure Prophylaxis
- Truvada (tenofovir, emtricitabine)
- Once daily pill that **prevents HIV**
 - CDC: reduces the risk of HIV infection by up to 92%
 - Effectiveness differs based on *usage*
- PrEP
 - Post Exposure Prophylaxis



Prevention Tools:

PrEP

PrEP (Pre-exposure prophylaxis) is a pill taken daily that prevents HIV infection by up to 99%. A person must be HIV negative in order to take it and are required to meet with medical physicians every three months for follow-up HIV tests and a kidney test to ensure there are no health problems or implications that are affecting you. PrEP does not protect against other STIs or sexually transmitted diseases, therefore safer sex practices such as condom use are highly recommended.

Student discussion about being on PrEP:

<https://www.youtube.com/watch?v=IUvx8zWPk5g&feature=youtu.be>

Currently, there are only two FDA-approved medications for PrEP.

Both are combinations of two anti-HIV drugs in a single pill:

emtricitabine and tenofovir disoproxil fumarate, sold under the brand name Truvada®

emtricitabine and tenofovir alafenamide, sold under the brand name Descovy®

Truvada® is approved for PrEP for all adults and adolescents at risk of HIV. Descovy® is approved for PrEP for some adults and adolescents, but it is not approved for those who are at risk of getting HIV through receptive vaginal sex because effectiveness in this population has not been evaluated.

Serious side effects of TRUVADA may also include:

Kidney problems, including kidney failure. Your healthcare provider should do blood and urine tests to check your kidneys before and during treatment with TRUVADA. If you develop kidney problems, your healthcare provider may tell you to stop taking TRUVADA. Too much lactic acid in your blood (lactic acidosis), which is a serious but rare medical emergency that can lead to death. Tell your healthcare provider right away if you get these symptoms: weakness or being more tired than usual, unusual muscle pain, being short of breath or fast breathing, stomach pain with nausea and vomiting, cold or blue hands and feet, feel dizzy or lightheaded, or a fast or abnormal heartbeat. Severe liver problems, which in rare cases can lead to death. Tell your healthcare provider right away if you get these symptoms: skin or the white part of your eyes turns yellow, dark "tea-colored" urine, light-colored stools, loss of appetite for several days or longer, nausea, or stomach-area pain. Bone problems, including

bone pain, softening or thinning, which may lead to fractures. Your healthcare provider may do tests to check your bones.

Common side effects in people taking TRUVADA for PrEP are:
headache, stomach-area (abdomen) pain, and decreased weight.

Tell your healthcare provider if you have any side effects that bother you or do not go away.

PEP (Post-Exposure Prophylaxis)

Post-exposure prophylaxis is a set of pills that must be taken for 28 consecutive days in order to rid of possible HIV infection within your system.

As you go further into the 72 hours, the effectiveness drops off, so it's important to seek PEP ASAP. It's an antiretroviral taken for 28 days. It can be obtained from a doctor's office or emergency room.

PEP (post-exposure prophylaxis) means taking antiretroviral medicines (ART) after being potentially exposed to HIV to prevent becoming infected.

PEP should be used only in emergency situations and must be started within 72 hours after recent possible exposure to HIV. If you think you've recently been exposed to HIV during sex or through sharing needles and works to prepare drugs or if you've been sexually assaulted, talk to your health care provider or an emergency room doctor about PEP right away.

U=U (Undetectable = Untransmittable)

U = U means that people living with HIV who achieve and maintain an undetectable viral load—the amount of HIV in the blood—by taking and adhering to antiretroviral therapy (ART) as prescribed cannot sexually transmit the virus to others. U=U can help control the HIV pandemic by preventing HIV transmission, and it can reduce the stigma that many people with HIV face.

If we accomplish U=U if you think for a moment, what does that mean? That means we don't have anybody transmitting infection. U=U is the foundation of being able to end the epidemic.

[Undetectable = Untransmittable: PreventionAccess.org](http://PreventionAccess.org)

"The science is clear. People living with HIV can feel confident that if they have an undetectable viral load and take their medications as prescribed, they cannot pass on HIV to sexual partners (Undetectable = Untransmittable U=U).

U=U offers freedom and hope. For many people living with HIV and their partners, U=U opens up social, sexual, and reproductive choices they never thought would be possible. It is an unprecedented opportunity to transform the lives of people with HIV and the field:

The well-being of people with HIV: Transforms the social, sexual, and reproductive lives of people with HIV by freeing them from the shame and fear of sexual transmission to their partners.

HIV stigma: Dismantles the HIV stigma that has been destroying lives and impeding progress in the field since the beginning of the epidemic.

Treatment goals: Reduces the anxiety associated with testing, and encourages people living with HIV to start and stay on treatment to stay healthy and prevent transmission.

Universal access: It offers a public health argument to increase access and remove barriers to treatment, care, and diagnostics to save lives and prevent new transmissions.

However, the majority of millions of people living with HIV do not know U=U, and many do not have access to the diagnostics, treatment, and care they need to achieve and maintain an undetectable viral load. There are still confusing messages, outdated websites, and uninformed policymakers and healthcare workers who are not comfortable sharing this information, don't yet know about it, or don't yet realize the significance of it."

AIDS

Hiv.gov

AIDS is the late stage of HIV infection that occurs when the body's immune system is badly damaged because of the virus.

In the U.S., most people with HIV do not develop AIDS because taking HIV medicine every day as prescribed stops the progression of the disease.

A person with HIV is considered to have progressed to AIDS when:

the number of their CD4 cells falls below 200 cells per cubic millimeter of blood (200 cells/mm³). (In someone with a healthy immune system, CD4 counts are between 500 and 1,600 cells/mm³.) OR
they develop one or more opportunistic infections regardless of their CD4 count.

Without HIV medicine, people with AIDS typically survive for about 3 years. Once someone has a dangerous opportunistic illness, life expectancy without treatment falls to about 1 year. HIV medicine can still help people at this stage of HIV infection, and it can even be lifesaving. But people who start ART soon after they get HIV to experience more benefits—that's why HIV testing is so important.

[A Timeline of HIV and AIDS](#)

The HIV.gov Timeline reflects the history of the domestic HIV/AIDS epidemic from the first reported cases in 1981 to the present—where advances in HIV prevention, care, and treatment offer hope for a long, healthy life to people who are living with, or at risk for, HIV and AIDS

[HISTORY Channel: History of AIDS](#)

In the 1980s and early 1990s, the outbreak of HIV and AIDS swept across the United States and rest of the world, though the disease originated decades earlier. Today, more than 70 million people have been infected with HIV and about 35 million have died from AIDS since the start of the pandemic, according to the World Health Organization (WHO).

Blogs

[Feedspot](#) incredible list of their Top 100 LGBT Blogs and Websites last updated April 7th, 2020. These blogs range from News, Arts and Culture, Politics, Entertainment, Pop Culture, Music, TV, Sports, Feminism, Law, Sex Positivity, and more.

https://www.thetrevorproject.org/trvr_support_center/sexual-health/

The Trevor Project has support links to

- [Planned Parenthood](#)
- [Sexual Health blogs \(Scarleteen and Sex, Etc.\)](#)
- [Center for Young Women's Health](#)
- [Young Men's Health](#)
- [Trans Youth Sexual Health Booklet](#)

FOR BLOGGERS

Submit Your Blog

FOR MARKETERS

How to engage an audience of influencers marketing and word of mouth with new influencers in niche markets? Increase your outreach by connecting with authors

Top 100 LGBT Blogs And Websites For the LGBT Community in 2020
Last Updated April 7, 2020

Contribute (show) About this list & ranking

Submit Blog
We will add the most relevant and interesting blogs to our top 100 list. You can also help us by submitting your own blog to our list.

FOR YOUR BLOG

LGBT Blogs

View Latest Posts Get Bloggers Contacts

1. LGBTQ Nation

LGBTQ NATION

A United Community
About Blog News, Opinions, Arts and Culture - The Most Followed LGBTQ News Source
Frequency: Weekly - Tue
Blog: lgbqnation.com +138,000
Facebook: [lgbqnation](https://www.facebook.com/lgbqnation) Twitter: [lgbqnation](https://twitter.com/lgbqnation) Instagram: [lgbqnation](https://www.instagram.com/lgbqnation)

Healthline labels there "Best

Sexual Health Blogs of 2018

<https://www.healthline.com/health/best-sexual-health-blogs#1>

Podcasts

"[Top 12 Podcasts Hosted by Queer Women, For Your Queer Ears](#)"

Samara (2015) - Autostraddle.com

[Best LGBT Podcasts \(2020\)](#)

Player.fm

The list of podcasts genres spans comedy, politics, history, identity, and more.

[Queer Sex Ed Podcast](#)

PodBean Podcast - this link only provides 5 preview episodes

Themes: identity, expression, BDSM, etc.

They provide links to their Spotify and www.queersexed.org

[Stripper Writer](#) (Instagram and Podcast)

Strange Bed Fellows: Sex Health and Politics

About the Hosts:

Elle is your season 1 and 2 co-hosts and producer of Strange Bedfellows. Elle's photos and writing have been published online for over thirteen years, and she has spent the last ten years as a stripper, webcam worker, paid companion, writer and lobbyist in Oregon. Elle co-parents a child and loves poodles

Jon is your Season 2 host. He enjoys writing, following current affairs, has worked in webcam, as a paid cuddler, writing for various online outlets and his college newspaper, and enjoys video games and hanging out with his boyfriend in Northern California.

[STD & HIV Testing Services](#)

Santa Clara County Public Health

The Crane Center offers HIV and STD Testing

Crane Center

976 Lenzen Avenue

San Jose, CA 95126

Phone: (408) 792-3720

Fax: (408) 792-3721

Email: cranecenter@phd.sccgov.org

NOTICE: To prevent spread of COVID-19, HIV testing, Hepatitis C testing and STD screening will not be available in Suite 1800 until further notice. If you meet any of the criteria listed at the top of this page, call 408-792-3720 to schedule an appointment.

Free HIV & Hepatitis C Testing

Location: Suite 1800

Cost: Free for adults & youth age 12+

Hours:

- Monday, Wednesday, Friday: 9:00 AM - 4:30 PM
- Tuesday: 9:00 AM - 6:30 PM
- Thursday 9:00 AM - 1:00 PM

Here Are Some Things to Know Before Your HIV Test (in English & Spanish or English & Vietnamese).

Clinical evaluation and treatment for STDs, including PrEP (Pre-Exposure Prophylaxis) and PEP (Post-Exposure Prophylaxis)

Location: Suite 1500A; walk-ins accepted - symptomatic patients only*

Cost: \$40 for adults & \$5 for youth age 12-17

Hours:

- Monday: 12:30 PM - 6:30 PM
- Wednesday: 5:30 PM - 8:30 PM
- Thursday: 5:30 PM - 8:30 PM

*Clinic will open for registration 30 minutes prior to posted times and will close to walk-in patients once maximum clinic volume has been reached each day. *Therefore, we may close before posted times.* To increase the likelihood that you will be seen, please arrive early. Please be aware that wait times may vary.

STD Screening

Location: Suite 1800; for people with no symptoms, by appointment only

Cost: \$40 for adults and \$5 for youth age 12-17

Hours:

- Tuesday: 9:00 AM - 4:30 PM

Closed: Saturday, Sunday, Holiday

Alternate Test Sites

[Asian Americans for Community Involvement \(AACI\)](#)

Free HIV Rapid Testing, Counseling, and Referrals in Santa Clara County

[Watergarden](#)

1010 The Alameda, San Jose, CA 95126

Free HIV Rapid Testing

(408) 975-2730

[Billy DeFrank Lesbian/Gay/Bisexual/Transgender Community Center](#)

938 The Alameda, San Jose, CA 95126

Free HIV Rapid Testing; anonymous and confidential results available.

(408) 293-3040

[Get Tested: National HIV and STD Testing](#)

Find free, fast, and confidential testing near you

[LGBTQ Youth Space](#)

452 S 1st St, San Jose, CA 95133 (Weekdays after 3pm).

Medi-Cal, Covered California, & Family PACT
(1877-96-BENEFITS)

Planned Parenthood
(408) 287-7526
1691 The Alameda, San Jose, CA 95126

Gilead Advancing Access Program
<https://www.gileadadvancingaccess.com/>
<http://prepisliberating.org/>
<https://www.pleaseprepme.org>

SJSU Student Health Center

HIV/AIDS information:

Individual counseling and group presentations are provided by Health Educators and peer health educators. Confidential HIV Testing is \$12.

Family PACT:

Are you interested in reproductive health care services at no cost to you? Many SJSU students are eligible for Family PACT.

To schedule an eligibility appointment, call the Student Health Center at (408)924-6122.

Gender Affirming Care Services: NOTE: Gender Affirming Care Clinic at SJSU's Student Health Center (SHC) is full at this time and unable to accept new patients. Please check back later for updates.

Local Resource for care includes: Gender Care Clinic, 777 E. Santa Clara St. San Jose, CA (408) 977-4411. Accepts any age range.

The Student Health Center offers hormonal treatment for transgender and non-binary students interested in hormonal therapy. Students interested in starting gender-affirming therapy need to provide a letter of support following WPATH guidelines from a mental health professional following a minimum of two counseling sessions. Medical appointments for gender-affirming care will not be booked until the patient has obtained the support letter from a mental health professional. Please note for those students obtaining letters from the SJSU Counseling Center (CAPS), the counselor will coordinate referrals

directly with the health care provider prescribing the treatment prior to medical appointment booking.

Students who have started the transition process elsewhere (and have already had prior medical and mental health consultations) may request to transfer their gender-affirming treatment to the SHC. Transferred records should include medical and mental health documentation of initial evaluations related to hormonal therapy, as well as their most recent visits, labs related to treatment, and if applicable, their hormone/medication doses. Once received, the records will be reviewed and a decision made regarding the transfer of care. Health center staff will contact the student for a clinical appointment if the transfer of care is accepted. Students needing greater expertise than can be provided by the health center will be referred for care at a local trans clinic.

[SJSU Sexual Wellness](#)

Condom Co-op in the Wellness Lounge -- 4 free safer sex supplies per day!
Free 30-minute confidential appointment at Wellness Center --
Call (408) 924-6122 to schedule an appointment.

[Peer Health Educators](#)

(@sjsu_phe)

Follow SJSU To Zero on Instagram, Twitter, and Facebook

@SJSUtoZero -- come volunteer with us!

Email: SJSUgettingToZero@gmail.com

Appendix D

[SJSU To Zero: HIV Education Presentation](#)



Appendix E

Partner Organization Note



Matthew Capriotti, PhD
Assistant Professor
Department of Psychology

San José State University
One Washington Square
San José, CA 95192-0120

Phone: 408-924-5641
Email: matthew.capriotti@sjsu.edu

April 27, 2020

Dr. Roberto Gonzalez
Department Chair of Anthropology
San Jose State University
One Washington Square
San Jose, CA, 95192

Dear Dr. Gonzalez,

I write to recognize Brett Witteck's contributions to *SJSU to Zero*. *SJSU to Zero* is a campus-based HIV prevention, education, and stigma reduction project active since 2017. Over the past 2 years, Mr. Witteck has partnered with us to provide valuable education to students and other members of the SJSU community. Most recently, he has compiled a sexual health resource guide and a voiced-over powerpoint presentation. Each of these products communicates accurate, up-to-date information about the nature and prevention of HIV and other sexually transmitted infections (STIs). These products are appropriately voiced to reach the diverse population that is our SJSU community, and they will be useful in our future efforts to bring to scale education, resources, and stigma-reduction surrounding HIV and other STIs in our SJSU community. Mr. Witteck produced these products within the timeline we discussed, and he participated in this collaboration with a stellar degree of professionalism and consistency. I am grateful for his efforts, which have undoubtedly contributed to *SJSU to Zero's* mission. Please contact me if any further discussion would be helpful.

Sincerely,

A handwritten signature in black ink, appearing to read "Matthew Capriotti".

Matthew Capriotti, PhD
Assistant Professor
Department of Psychology
San Jose State University

Co-Founding Director
SJSU to Zero

