Not all my identities were accepted growing up in a religious, politically and socially conservative family. I was disowned for a period of time identifying as a gay man, scorned for not identifying as a Christian, mocked for appreciating "liberal" or "progressive" views, and teased for wanting to continue my education past baccalaureate. Despite my identifying as a minority in my social networks as a child, I recognize that I am the majority to American society-at-large. Although I am a sexual minority, a first-generation student, and a non-traditional student during my master's degree, I must recognize my other identities. I acknowledge the intersecting axes of privilege I have as a white, cisgender, able-bodied, man who was born in the U.S., whose English was my first language, and whose family is lower-middle class, a religious majority and had multiple generations living in the U.S. I incorporate diversity, equity, and inclusion in my research, teaching, and service.

I incorporate diversity, equity, and inclusion in my research. Most HIV research samples populations from metropolitan cities located on the coast, such as New York City, Miami, or San Francisco. There is a lack of representation of other geographic regions and rural voices in my field. I view geographic location and urban-ness as privilege and social determinant of health, as non-coastal regions and rural areas are less likely to have access to HIV prevention and care services. My research focuses on how the rural and healthcare environment influences HIV prevention, HIV care, and HIV healthcare outcomes. I have created and will continue to create community-academic partnerships which ensure that research projects are community-driven, encompass interdisciplinary and interprofessional perspectives, and have translational benefits to the community. I have worked with a variety of organizations from a nonprofit AIDS service organization to a large regional emergency department, and from LGBTQ+ social media groups to LGBTQ+ health-providing clinics. My community partners are co-researchers, collaborating with me on the conceptualization, implementation, and dissemination of research. My research bridges the discordance between community, theory, practice, and policy so communities can create and sustain sexual health equity.

I mentor undergraduate and graduate students who are minorities by assisting them in their research development. I have mentored four students in my projects: two were first-year undergraduate students, and two were first-year doctoral students. I mentored a first-generation female undergraduate research assistant who came from a rural area in Indiana and wanted to learn more about sexual health research. I asked her what knowledge and skills she wanted to acquire, and she was interested in the "behind the scenes" work such as recruitment, transcription, and public dissemination. She gained recruitment, transcription, and qualitative research knowledge and skills that some doctoral students first get exposed to when they do their dissertation. I also mentored a first-year woman of color doctoral student who wanted to learn more about interview question development and analysis. She co-coded the data with me, and the experience of reading and coding the transcripts helped her develop her semi-structured interview study. Undergraduate and graduate students are co-authors on articles submitted to peer-review journals. They are CITI-certified (Collaborative Institutional Training Initiative) so they can be engaged in my future projects or other researchers' projects, or they can pursue their own research projects.

I incorporate diversity, equity, and inclusion in my teaching. I use the Fink's Taxonomy as my pedagogical approach–which states significant learning occurs when learners remember information, think critically and creatively, connect information to other academic disciplines and realms of life, learn about others and oneself, and develop new feelings and interests regarding a topic. I construct a classroom environment where students feel motivated, comfortable, and able to learn, critique, and grow. I will provide three examples of this below. The first example is students co-design the course during the first week of class, such as developing the course schedule, classroom conduct guidelines, and instructional strategies. This shares the decision-making process, as well as ensures topics and instructional materials are significant to them. Another example is my students read articles from multiple and intersectional perspectives, such as reading articles where we compare transgender women of color healthcare experiences with rural LGBTQ+ healthcare experiences. Students are exposed to how different

communities experience health, as well as discuss ways to address social determinants of health that contribute to disparities. The last example is students will work in small groups to apply course concepts to contemporary public health topics, ask and reflect how their peers' and their subjectivity contributes to their perspective on the topic, and be comfortable with non-consensus. Students learn that consensus is often the majority-rule, and they acquire knowledge and skills on how to ensure all voices are represented in the deliverable.

Lastly, I incorporate diversity, equity, and inclusion in my service. I was the evaluator for the LGBTQ+ Culture Center's programs at Indiana University. Staff wanted to change their name (formerly the GLBT Student Services) because they received feedback their name was not inclusive of the student community they serve. I collaborated with staff to create a survey where students, faculty, staff, and community members chose four names and had the option to elaborate on their choice in an open-ended text box. Because of this work, the GLBT Student Services was renamed as the LGBTQ+ Culture Center. I was also the exit focus group coordinator for Office of Undergraduate Academic Affairs (OUAA) in the College of Arts and Sciences. OUAA wanted to explore graduating seniors' academic and academic advising experiences, and they wanted to obtain experiences from a variety of student groups (e.g., female students, minority students). I managed the conceptualization, implementation and the dissemination of the project. We used quota sampling to ensure each focus group represented the graduating student body in terms of sex, race, and academic discipline (arts and humanities, social and historical sciences, natural and mathematical sciences). Since it appeared the first cycle of focus groups recruited students who had high GPAs and were attending medical school, we expanded our quota variables in the second year to also include first-generation status, international status (domestic or international), post-graduate plan (e.g., graduate school, industry), and GPA (4 categories). These new variables helped create a more diverse and representative focus groups. Since quota sampling is representative of the population, only one or two racial minorities and international students were in each focus group. Yet, research shows these populations have a different perspective than their counterparts. In the second year, we added an exclusive racial minority student focus group and an exclusive international student focus group where these students chose which focus group they wanted to attend (standard, exclusively racial minority/international student group, doesn't matter to them). These exclusive focus groups provided a different perspective on how minority students and international students experience the curriculum and academic advising. For my service experiences, I work with a diverse set of stakeholders to help reach outcomes that are equitable and inclusive of multiple voices.