Between Knowledge & Practice:
Factors That Influence the Operationalization of Sexual Health Knowledge in
African American Female College Students

by

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A thesis submitted in partial fulfillment
of the requirements for the degree of
Master of Arts
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Date of Approval:
November 16, 2007

Keywords: barriers, sexually transmitted infections, behavior, implementation, culture, risk

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Dedication

This manuscript is dedicated to my daughter Amari, who gives drive and purpose to my life and my journey.
Acknowledgements

First, I would like to thank Dr. Elizabeth Bird, my committee chair; this manuscript is truly a reflection of her support and guidance. Second, I would like to thank the other members of my committee, Dr. Nancy Romero-Daza and Dr. Antoinette Jackson; their insight and direction have made me a better scholar. Next, I would like to thank Dr. Jonathan Gayles, who has unselfishly served as a source of encouragement and critique. And lastly, I would like to extend thanks to everyone else who has contributed to this document and my quest.
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ABSTRACT

This paper explores some of the factors that influence whether African American female college students implement safe sex knowledge. High rates of HIV/AIDS and other sexually-transmitted infections (STIs) in the black community and the overrepresentation of individuals under the age of 25 in sexually-transmitted infection (STI) reports indicate the need for research that investigates the physical, social, and cultural aspects of high-risk sexual behaviors and the factors that influence them for this group.

African American female college students present a unique challenge to sexual health educators; a challenge that has been relatively under acknowledged and under addressed in research and scholarly literature. This omission from research is likely the result of assumptions that suggest that the structural barriers that greatly impact the use of sexual health knowledge in low-income African American women do not exist for female college students from the same racial/ethnic background. However, focus group and survey data, collected during this study, suggest that this group may in-fact share some structural barriers with low-income African American women since financial and cultural barriers that may have existed in their communities do not necessarily become obsolete upon entering college.
Definition of Terms

STIs: This acronym is sometimes used to abbreviate sexually-transmitted infections, also called sexually-transmitted diseases (STDs). Throughout this work, I have chosen to use the term sexually-transmitted infection (STI) as it reflects the current preference of public health professionals.

African American: Agencies that offer the public reports on sexually-transmitted infections often use “African American” and “black” interchangeably. The CDC and other agencies that report national statistics consider African American and black as the same racial category (CDC 2007). However, both labels often have different meanings within the black community. Black is generally a more inclusive term; it refers to individuals who have African ancestry and generally live in the African Diaspora. African American generally refers to individuals who are descendants of African slaves brought to North America. Though both labels sometimes have different meanings within the black community, I will use the labels interchangeably as well, since the research and discussion are based on data from national agencies, which do not make these distinctions. When offering the results of the study, I will make distinctions if necessary.

Black: See previous explanation.
Structural barriers: Obstacles not necessarily related to individual behavior but rather to economic, logistic, and social realities that influence the lived experience of certain groups of people.

Sexual Health Knowledge: Knowledge of the level of risk within the respondent’s community and knowledge of the sexually-transmitted infections, their transmission, and their prevention.

Sexual Health: The capacity to enjoy and control sexual reproductive behavior in accordance with a social and personal ethic, while taking steps to avoid STD transmission.

Introduction

Each year within the United States 15 million people become infected with one or more sexually-transmitted infections (STIs). More than half those people contract STIs that cannot be cured (CDC 2000). STIs do not discriminate; biologically speaking every individual who engages in sex is at risk for contracting these types of infections. However, our society and our experiences within society are not solely dictated by biology, and this holds true for STIs. Social, cultural, and economic factors place certain individuals and groups at greater risk for contracting STIs. This is especially true for the African American community in general and African American women in particular.

African American women are disproportionately affected by sexually-transmitted infections. From chlamydia and gonorrhea to HIV and syphilis, black women are far more likely to contact these infections than their white counterparts (CDC 2005a).
Though some research suggests that a significant portion of this disparity can be linked to African American women’s limited access to proper sexual health education (CDC 2000), other scholars suggest that, although education can positively affect health choices, knowledge itself does not always lead to behavior change (CDC 1997; Carroll 1986; and Lawrence 1999).

This thesis seeks to identify and understand some of the factors that influence whether African American female college students use or implement safe sex knowledge. Considering the high rates of HIV/AIDS and other sexually-transmitted infections in the black community and the overrepresentation of individuals under the age of 25 in the populations most affected by STIs, it is imperative that researchers, policy makers, and educators look beyond approaches that limit the solution to sex education, and begin to analyze the physical, social, and cultural aspects of high-risk sexual behaviors and the factors that influence them.

Though this study does not consider history as an independent structural barrier, the subsequent data, results, and discussion offered need to be situated within the historical context of health within the black community, especially concerning the history of structural barriers like poverty and limited access to health care. Additionally, scholars have noted the intergenerational effect of historical events, like the Tuskegee Syphilis Study, on the health seeking behavior of African Americans (Gamble 1997; Bird & Bogart 2005). Gamble (1997), in her article “Under the Shadow of Tuskegee: African Americans and Health Care”, explores how the Tuskegee Syphilis Study and other events of medial exploitation and testing that occurred within the black community continue to
foster distrust in the black community toward the U.S. health system and health providers.

This study aimed to identify and understand the factors influencing the use of sexual health knowledge in African American female, as described and explored by the participants. History was not identified; however, its role in shaping the social and cultural context of the structural barriers is significant though it is beyond the scope and aim of this study.

**STIs and the United States**

The Centers for Disease Control (CDC) estimate that approximately 19 million sexually-transmitted infections are contracted annually within the United States (2005b). Although STIs are widespread within the United States, they continue to be one of the most under-recognized health problems (CDC 2000). While most people are aware of HIV (human immunodeficiency virus) and the consequences associated with contracting this virus, many remain relatively unaware of the risks and consequences associated with other STIs (CDC 2000). Additionally, though STIs are extremely common, they are often difficult to track. Many people remain asymptomatic after contracting certain infections and, thus, often go undiagnosed.

In *Tracking the Hidden Epidemics: Trends in STDs in the United States*, a report produced by the CDC (2000), the authors suggest that current sexually-transmitted infection rates within the United States are not the result of a single STI epidemic but rather of multiple epidemics and, therefore, discussions must consider the history and
prevalence of each significant STI. This is partially in response to the HIV/AIDS-dominated rhetoric. Though discussions about HIV/AIDS are extremely important, especially considering the fact that there is no cure for HIV/AIDS, these discussions have overshadowed the pervasive and prevalent realities of other STIs. However, as some sexually-transmitted infections can influence the transmission of others, discussions of STIs should not take place independent of one another but, like the issues themselves, must be layered and dynamic.

Identifying patterns in the transmission of STIs is one of the first steps in responding to these epidemics. Conversely, since some STIs are difficult to track, more is known about some STIs than others. Additionally, health providers are not required to report every sexually-transmitted infection they diagnose. Several highly prevalent viral infections, such as genital herpes and human papillomavirus, are not reported at all (CDC 2005b). However, in order to place this research and the subsequent discussion into national context, I will briefly discuss some notable STIs and estimates concerning their prevalence in the United States.

- *Chlamydia* is the most frequently reported infectious disease. It is estimated that each year there are 3 million new cases of chlamydia (CDC 2005b). Though the disease can be easily cured with antibiotics, 75% of women and 50% infected with chlamydia are asymptomatic and, therefore, many go undiagnosed (CDC 2000). Chlamydia is considered to be one of the most dangerous sexually-transmitted infections among women (CDC 2000). More than 40% of women with untreated chlamydia develop pelvic inflammatory disease (PID), and one in
five women with PID becomes infertile. Moreover, women with untreated chlamydia are three to five times more like to contract HIV, if exposed (CDC 2000).

- **Gonorrhea**, like chlamydia, is a bacterial infection that can be cured through the use of antibiotics. Additionally, like chlamydia, many women and men infected with gonorrhea are asymptomatic and, therefore, the disease often goes untreated and undiagnosed (CDC 2005b). Each year 650,000 Americans are affected with gonorrhea. Between 1975 and 1997 there was a 72% decline in the rate of infection; however, gonorrhea is on the rise for the first time in 20 years. Between 1997 and 1999 there was a 9% increase in the rate of infection (CDC 2000).

- **Syphilis**, a bacterial sexually-transmitted infection, is curable and the progression of the disease is preventable. However, if left untreated, it can lead to cardiovascular, neurological, and organ damage, and even to death (CDC 2005b). Untreated syphilis also increases the chances of sexual HIV transmission by up to five-fold. The reported rates of primary and secondary (P&S) syphilis, the most infectious stages of the disease, were at an all time low in 2000, but have since begun to increase. Between 2004 and 2005 the reported rate of P&S syphilis increased by 11.1% (CDC 2005b). In 2005 there were 8,724 reported cases of P&S syphilis in the US (2005b).

- **Human papillomavirus (HPV)**, unlike the three aforementioned STIs, is a viral infection and, thus, has no cure. Each year it is estimated that there are 5.5 million new cases of HPV. It is estimated that 75% of the reproductive-aged population
has been infected with HPV (CDC 2000). Researchers have identified 30 distinct
types of HVP that can infect the genital area; some types cause genital warts, and
other types cause subclinical infections. Genital warts are common and can be
treated; however, subclinical HPV infection is asymptomatic and can lead to
cervical, penile, and anal cancer. More than 80% of cervical cancer cases are
linked to this virus (2000).

- **Genital herpes**, an incurable STI, continues to infect more than 1 million people
  per year, spreading across all social, economic, racial, and ethnic lines, but
disproportionately impacting teens and young adults. Approximately 45 million
Americans, one out of every five people, are infected with this virus (CDC 2000).
The most prominent symptom associated with genital herpes is recurrent painful
ulcers. Not everyone with herpes has symptoms; in fact, many people are unaware
of their infection (Fleming 1997). However, visible or not, genital herpes can still
be transmitted between sexual partners.

- **HIV/AIDS**, like the viral infections noted above, has no cure. It is estimated that
  there are currently over 1 million persons in the US living with HIV/AIDS (CDC
  2007). Additionally, one out of every four persons living with this infection is
  unaware of it. The human immunodeficiency virus (HIV), which causes acquired
  immunodeficiency syndrome (AIDS), works by attacking the immune system. It
  finds and destroys the T cells needed by the immune system to fight disease. In
  2005, 37,331 new cases of HIV/AIDS were reported (CDC 2007). The most
  common mode of transmission for that year was male-to-male sexual contact,
representing approximately 50% of the newly diagnosed cases. The second most common mode of transmission was male-to-female sexual contact, which represented about 31% of the new diagnoses (2007).

**STIs and the Black Community**

A number of STIs disproportionately impact the black community. These disparities are partly due to more complete and accurate reporting by public clinics compared to private providers (CDC 2000). However, these reporting biases do not fully explain the disparities in sexually-transmitted infection rates. The reasons are not directly related to race or ethnicity but rather some of the barriers faced by many African Americans: limited access to quality health care, poverty, and a higher prevalence of disease in urban communities (CDC 2006).

African Americans also have a gonorrhea infection rate that is 18 times that of white Americans; it exceeds the rate of infection for all other racial/ethnic groups in the United States (CDC 2005b). When analyzing rates of syphilis infection, this trend continues. In 2005, the rate of primary and secondary syphilis infection was 5.4 times higher among African Americans than among whites (CDC 2005b). Moreover, of all racial/ethnic groups in the US, African Americans have been most heavily impacted by HIV/AIDS. In 2004, 50% of the reported AIDS cases within the U.S. were among African Americans, even though African Americans only represent approximately 13% of the population (CDC 2006). Even when analyzing HIV diagnoses rates by sex, African Americans represent approximately half of the new HIV/AIDS cases. African American
Women represent 64% of new HIV/AIDS cases, and Black men make up 41% of the new HIV/AIDS cases in 2005 (CDC 2007). HIV/AIDS is the leading cause of death among black males and black females aged 25 to 44 (FDH, 2006). The trend for African American children is similar; African American children were four times more likely to be infected with HIV than both white and Hispanic children (CDC 2006).

In the state of Florida more African Americans are infected and have died as a result of contracting HIV than any other racial or ethnic group (FDH 2006). In Florida in 2005, 1 in 58 black males and 1 in 83 black females was living with a diagnosed case of HIV/AIDS. This compares with 1 in 310 white males and 1 in 1,625 white females. There are gaps between other racial and ethnic groups; however, the black-white gap is by far the largest. In 2005, there were 81,585 persons living with HIV/AIDS (PLWHAs) in Florida; 51% of these individuals were black (FDH 2006). These disparities become even more salient when analyzing sexually-transmitted infection rates among women in the United States.

*STIs and Black Women*  

The CDC reported that in 2004 HIV/AIDS cases among African American women were 23 times that of white women (CDC 2005b). African American women represent 13 % of the U.S. female population; however, they account for more than 64% of all HIV/AIDS cases (CDC 2006). In 2002, the Center for Disease Control (CDC) reported that HIV/AIDS was the leading cause of death for African American women between the ages of 25 and 34 years of age (2006). Heterosexually-acquired HIV
infection represents approximately 80\% of reported cases in African American women (2006). These disparities are not limited to HIV/AIDS; they are also evident when evaluating reports of other STIs.

In 2005, the reported rate of chlamydia for African American females was seven times higher than the rate among white females (CDC 2006). In 2004, African American females ages 15 to 24 had the highest gonorrhea rate of any age and race/ethnic group (CDC 2005b). Of those diagnosed with STIs each year, more than 50\% are between the ages of 15 and 24 (CDC 2005b).

**Sexual Health and Sexual Health Knowledge**

Since the concept of sexual health is central to this project, it must be defined. For this project this concept will consist of merging the more traditional definition of sexual health -- the absence and avoidance of sexually-transmitted diseases that could cause death and affect reproduction -- with the WHO (1986) definition -- the capacity to enjoy and control sexual reproductive behavior in accordance with a social and personal ethic. Sexual health will be defined as: the capacity to enjoy and control sexual reproductive behavior in accordance with a social and personal ethic, while taking steps to avoid STD transmission. Further, because part of this thesis is intended to gauge sexual health knowledge, it must also be defined. For the purposes of this study, sexual health knowledge will be defined as knowledge of the level of risk within the respondent’s community (based on CDC statistics) and knowledge of the sexual transmitted diseases, their transmission, and their prevention. Proper use of condoms can reduce the risk of
HIV transmission during vaginal intercourse by up to 90% (Pulerwitz 2002); however, their effectiveness in preventing other STIs is highly dependent on the pathology of the infection (CDC 2003). Because condoms are an important STI prevention strategy examining patterns of use will be important in determining sexual health and identifying high-risk behavior.

Importance of Study

African American female college students present a unique challenge to sexual health educators; a challenge that I believe has been relatively under acknowledged and under addressed in research and scholarly literature. An extensive amount of research evaluates the factors that affect whether low-income African American women utilize safer sex practices; however, these analyses have failed to include African American female college students. I believe this omission is the result of assumptions that suggest that the structural barriers that greatly impact the use of sexual health knowledge in low-income African American women (such as financial motivations, access to sexual health education and health care, cultural understandings of gender roles etc.), do not exist for college students of the same ethnic/racial background because of their ability to access higher education. Researchers thus conclude that the sexual practices of African American female college students are appropriately included in analyses that evaluate the sexual behavior of college students in general. These investigations tend to focus primarily on behavioral factors that influence STI transmission.
However, I assert that this group may in fact share some structural barriers with low-income African American women since financial and cultural barriers that may have existed in their communities do not necessarily become obsolete upon entering college. As different understandings of risk factors and access to sexual health knowledge exist for both of the aforementioned groups, part of the investigation will seek to explore which explanations are more applicable to the research group. Additionally, since African American female undergraduates are members of at least two high risk groups (i.e., African Americans and young adults), and since the primary mode of transmission for African American women is heterosexual contact (CDC 2005), an analysis of the factors influencing the implementation of sexual health knowledge could inform future health policy and health intervention strategies for this group.

The knowledge gained from this investigation will add to the scarce literature surrounding the sexual health of African American female college students. As the factors affecting this group may be uniquely different from those of the larger student body, this research will also serve to create a form and foundation to discuss the issues and barriers surrounding the sexual health and sexual health practices of African American female college students.
Chapter Two: Literature Review

Caught in Two Approaches to Education and Sexual Health

Relatively little research has been conducted concerning the operationalization of sexual health knowledge in African American female college students. This is in-spite of the fact that their age and racial/ethnic background make them members of two readily identifiable high risk groups: individuals under the age of twenty-five and African Americans. Information pertaining to the sexual health of college students in general and the sexual health of low-income African American women is more easily found.

African American female college students present a challenge to current ideas about the factors that increase STI risk among African Americans. Though some structural factors such as poverty and urban residence may still influence the transmission of STIs, other factors such as lack of access to knowledge and education may not. Though the university in which the research is being conducted (see Chapter 3) does not provide information about the socio-economic background of its students and, thus, poverty may be hard to determine, many students at the university come from highly urban areas around the state of Florida. Therefore, it is important to investigate whether or not these structural factors exist for the research group, though they are not identified for college students in general. In addition to exploring what noted risk factors (identified below) are identified by African American female college students, it is also important to look for trends in the data that may identify and explore other social
and cultural factors that influence sexual behavior and, thus, can influence perceptions of risk and prevention strategies used by the research group.

*Behavioral and Structural Barriers to Sexual Health*

Though college students, compared to other groups, are generally considered to be at a relatively low risk for contracting STIs; many students engage in high-risk behaviors that can increase their likelihood of contracting one of these infections (Gayle et al. 1990). Researchers have identified three high-risk behaviors that promote the transmission of HIV/AIDS and other STIs: having multiple sex partners, no or inconsistent condom use, and combining sexual behavior with drug/alcohol use (Rolison 2002; CDC 1997). Sexual health education and the promotion of condom use are generally considered the best ways to curb the spread of HIV and other STIs on college campuses (Healthy 1991). However, scholars note that although cognitive and attitudinal changes may result from sexual health education, these changes do not necessarily result in behavior change (Goertzel 1991; Carroll 1991). Research indicates that college students generally do not practice consistent condom use even though the majority of college students are sexually active (Strader 1991; Watkins et al. 1993; DiClemente et al. 1990). These high risk behaviors are also noted for African American women; however, researchers have identified additional structural factors that place black women at an even greater risk (CDC 2006).

Poverty, urban residence, limited access to health care, and sexual health knowledge influence the rates of STIs in the black community (St Lawrence 1998; CDC 2000). Scholars have acknowledged the connection between these macro level realities
and the incidence of disease in marginalized communities, yet few explain how they are linked (Singer 1994; Farmer et al 1996). This connection can be particularly elusive when attempting to conceptualize the relationship between poverty and sexually transmitted infections. Singer (1994), in his analysis of AIDS and health in urban communities, illustrates one way in which poverty is connected to the spread of STIs.

Poverty contributes to poor nutrition and susceptibility to infection. Poor nutrition, chronic stress, and prior disease produce a compromised immune system, increasing susceptibility to new infection. A range of socio-economic problems and stressors increase the likelihood of substance abuse and exposure to HIV. Substance abuse contributes to increased risk for exposure to an STD, which can, in turn, be a co-factor in HIV infection (Singer 1994: 936).

This reality is exacerbated by the concentration of STIs in poor communities. One out of every four African American families lives in poverty, which increases their chances of exposure to these types of infections (CDC 2006). Additionally, limited access to health care and health education serves to further compound the prevalence of STIs in the black community (CDC 2000). Almost one quarter of African Americans are uninsured, and over 33% of those who are uninsured lack a regular provider (Kaiser 2000). Understanding the connections between structural factors and the incidence of STIs is an important element to understanding sexually transmitted infections within their wider health context.
Safe Sex and Sex Education

Lack of access to sexual health education within the college community is not generally considered to be a barrier to sexual health. Research does not critique the availability of sexual health education on college campuses; however, it does challenge its effectiveness. Nevertheless, colleges and universities still use it as one of their primary approaches to responding to STIs on campuses. Students are reported to exhibit specific individual behaviors that place them at risk and, therefore, an intervention must primarily focus on increasing knowledge and promoting behavior modification.

Carroll’s (1988) study, which examined whether concern about AIDS influenced the sexual behavior of college students, also focused on individual high-risk behavior as the primary risk factor for HIV transmission. His findings suggest that students, though they may have knowledge of HIV, had not significantly changed their sexual practices. As this study is close to twenty years old, the results may not be reflective of students currently enrolled in post-secondary institutions. In addition to the age of the study, Carroll did not consider race or ethnicity in his analysis of the results or in his recruitment process, thereby ignoring possible social and cultural differences that could also impact behavior and the operationalization of sexual health knowledge.

Furthermore, the only method of data collection for this study was surveys, which is potentially problematic considering the research group and the topic of the survey (a more extensive critique of the use of surveys as the sole or primary mode of data collection is offered below). Though the study was based solely on data elicited through survey and was conducted relatively close to the beginning of the AIDS epidemic and,
therefore, may have been influenced by notions of risk, it raises important questions about the relationship between knowledge and behavior.

Sabia (2006), in a similar vein, suggests that sexual health education aimed at adolescents can be a double-edged sword. On one hand it provides necessary information about contraception, and on the other hand it can serve to de-stigmatize sex, thereby serving to encourage promiscuity. Though the age range in Sabia’s study is not exactly reflective of the average age of undergraduates on college campuses, the demystification of sex and its possible connection to sexual activity is very relevant to this investigation, especially considering the university’s emphasis on sexual health education. Sabia’s conclusions are further augmented by Marsigilio and Mott’s (1986) analysis of the impact of sex education on teenage sexuality.

They assert that although exposure to sex education courses among adolescents may increase the probability of subsequent sexual activity, it increases the likelihood of effective contraception use. As promising as their findings may be, the study is over 20 years old and may no longer be relevant. National statistics indicate that 3 million young adults contract a sexually transmitted infection each year (CDC 2000); additionally, research suggests that the majority of college students fail to use condoms during sexual intercourse (Strader 1991; Watkins et al., 1993; DiClemente et al., 1990), further emphasizing the importance of understanding the factors that influence the use of safe sex knowledge.

Since the operationalization of knowledge may be heavily impacted by social, economic, and cultural factors, it is important to explore how the research explains this disjuncture both in the African American and in the college student communities. As
most universities offer sex health courses and have student health education programs, lack of access to sex health knowledge is generally not considered a risk factor for college students. Additionally, though this study primarily focuses on the sexual health knowledge and behavior of college students, it is important to briefly explore the sociopolitical context of sexual health education for adolescents in the US, since prior sexual health knowledge and education may be a relevant factor impacting the sexual health behavior of the research group.

The federal government has supported abstinence-only programs since 1981; however, since the mid-nineties federal support for these programs has increased (Santelli et al. 2006). Federal funding for abstinence-only programs was $60 million dollars in 1998 and has since increased to $168 million dollars in 2005 (Santelli et al. 2006). Since 1997, programs funded under the Adolescent and Family Life Act (AFLA) are required to emphasize the different benefits of abstinence, as outlined by section 510 of the 1996 Social Security Act, and are prohibited from disseminating information on contraceptive services, sexual orientation, and other aspects of human sexuality (Santelli et al. 2006). Programs funded through the maternal and child health grant for Special Projects of Regional and National Significance (SPRANS) are required to follow more stringent guidelines; these programs must teach all eight components of the federal definition for abstinence. Furthermore, information about contraception and safe sex practices can only be offered in extenuating circumstances (Santelli et al. 2006). These federal policies have a significant impact on the access to sexual health education for adolescents and, in turn, may impact the sexual knowledge and behaviors of some college students.
Perceptions of Risk

Like behavioral/structural barriers and sexual health knowledge, perception of risk significantly influences whether or not individuals choose to apply safe sex knowledge to their own behavior choices (O’Donnell, Doval, Duran, & O’Donnell 1995). In fact, perception of risk may play a more salient role in sexual health decision making than sexual health education (Kline, Kline, and Oken’s 1992; Prohaska et al., 1990). Moreover, sexual health knowledge may have only a limited impact on high risk behavior (Prohaska et al. 1990). Factors such as sexual practices, number of sexual partners, and the knowledge of one’s sexual partners’ histories may do more to shape individual perceptions of risks (Prohaska et al. 1990).

Carroll (1991) found that increased sexual health knowledge among females was not associated with risk. He concluded that this was likely because female students did not perceive themselves to be susceptible to HIV and, thus, were less motivated to use their safe sex knowledge. Understandings of risk also influence safe sex practices among African American women (Kline, Kline, and Oken, 1992; St Lawrence 1998; Sobo 1995). Similarly, Sobo (1995) asserts that perception of risk and, thus, condom use practices are shaped by African American women’s cultural understanding of heterosexual relationships.

Sobo suggests that “most women’s unsafe sexual strategies have to do with culturally recommended strategies for garnering favorable peer- and self- evaluation” (1995:78). The women in Sobo’s study indicated that they had condomless sex with their permanent partner because they desired to do so. Their feelings toward their sexual partner compelled them to engage in condomless sex. Use of condoms, according to the
participants, fosters a sense of emotional distance and distrust. Therefore, it was not the women’s understanding of risk that influenced them to use condoms; rather, it was their understanding of relationships and intimacy.

Kline, Kline, and Oken’s (1992) also explore black women’s perception of risk and its role in sexual decision making. They suggest that minority women often base condom use on the perceived level of risk associated with their partner. Additionally they note that some participants who were HIV negative and insisted on condom use with their primary male partners expressed uncertainty about those partners’ faithfulness, or concern about their use of drugs, irrespective of their understanding of the social expectations of heterosexual relationships, which Sobo (1995) identifies as a better indicator of condom use and risk perception.

Nichols (1990) explains why these perceptions of risk may be problematic and misleading. She suggests that multiple partnering may increase the risk for other STDs and, therefore, render a woman more vulnerable to the transfer of HIV into her bloodstream during or just after sex with her primary partner. Moreover, she asserts that there is no relationship between the number of sexual partners and seroconversion and that more women are infected by steady male partners than by one night stands.

Programmed by safer sex campaigns that vilify and denounce multiple partnering (promiscuity) and advise us to “know” our partners, most couples assume that monogamy confers protection from HIV and, therefore, do not maintain safer sex standards (Bolton, 1992). African American Women do not see themselves at high risk for HIV infection, even when high levels of objective risk are present (Hobfall et al,
Sobo (1995) posits that it is important to understand the elements and mechanisms of risk denial.

Denial has become a blanket term in the most liberal sense, tossed about freely, covering up or hiding away the broad range of complex factors that contribute to Acquired Immunodeficiency Syndrome risk misconceptions and unprotected sex. Until we examine these factors and arrive at an understanding of the mechanisms of AIDS-risk denial, we will be unable to suggest effective ways to lessen denial, and we will continue to be limited in our ability to decrease the high rates of unsafe sex it entails (Sobo 1995).

Though Sobo suggests understanding risk as it pertains to HIV, given the rates at which women, black women in particular, are becoming infected with a number of sexually transmitted infections, it is also important to understand risk and denial as it related to all prevalent STIs. Additionally, the research groups for the aforementioned studies included African American women of low-socioeconomic status, and though some of the women may have been college aged, these investigations did not considered how access to post-secondary educational institutions may alter or influence perception of risk or sexual health decision making.

**Communication and Sexual Health**

Some researchers have highlighted the role of discourse in promoting sexual health (Coleman & Ingram 1999; Pliskin 1997). Cultural understandings of gender roles, power, and taboo topics can act as barriers and prevent such discussions from occurring. Though her research was not conducted with African Americans or college students,
Pliskin’s (1997) analysis of the role of discourse in promoting sexual health is certainly relevant to the operationalization of sex health knowledge. Pliskin suggests that individuals fail to discuss sexual history and to ask questions that promote sexual health because American society does not have a discourse that supports such a discussion. Though Pliskin worked with adults who were already diagnosed with herpes, the social pressures that restrain discussions about sex between individuals may still apply to college-age African American women. Coleman and Ingram’s (1999) research on the strategies used by young people to ensure condom use reinforces Pliskin’s assertions.

Coleman and Ingram (1999) identified two different strategies used by young people to ensure the use of condoms during sexual intercourse: a verbal strategy involving explicit discussion and a non-verbal strategy where one person takes responsibility without discussing it with the other. The research recognized the role of verbal communication in ensuring condom use; however, they also suggest that non-verbal communication strategy has a role when verbal communication may be perceived as difficult. However, this strategy was primarily reported by males and, therefore, may imply the role of gendered power in dictating condom use.

Wenger et al. (1992) addresses the interplay between knowledge and communication between sexual partners, suggesting that an individuals’ awareness of their own sexual health status and their familiarity with sexual health knowledge increase the likelihood and degree of communication about HIV testing with their partners. No increase in communication with their partners was noted for students who only received the sexual health education offered through the research project. This is an interesting finding; however, the study gave little to no attention to the impact of
race/ethnicity or socio-economic status. Additionally, the data were primarily based on a questionnaire; this type of data collection strategy offers little insight into the underpinning factors that influence the researchers’ conclusions. Nonetheless, their finding, that an awareness of one’s own status may create a sense of empowerment and, therefore, evoke students to take a more active approach to their own sexual health, is relevant to this exploration.

The impact of discourse on sexual health is not limited to exchanges between sexual partners. Researchers have also sought to understand how parent-child communication and monitoring can impact the frequency of high risk sexual behavior and STI transmission rates in adolescents (Hutchinson 2003; Thompson and Spanier 1978). Hutchinson (2003) noted that there is a correlation between higher levels of mother-daughter sexual risk communication and fewer episodes of sexual or unprotected intercourse. According to Hutchinson, mothers who communicate with their daughters about sex can affect their daughter’s sexual behaviors in positive ways. Conversely, there is research that challenges these findings.

For example, Thompson and Spanier (1978) suggest that parents do not significantly influence whether adolescents and young adults practice safe sex, especially in college-aged women. Rather, the combination of partner and peer perspectives play a more important and influential role in sexual health decision making. Though this study was conducted in the late 70’s, it corresponds well with Lackey and Moberg’s (1998) finding that the parents in their study felt as if they had little impact on the sexual health practices of their children, who were more impacted by popular culture and their peers.
Self Image, Spirituality, and Sexual Decision Making

Pulerwitz and colleagues (2002) further explore the role of power in sexual decision making. Their research asserts that a woman’s ability to negotiate safer sexual practices, particularly condom use, is a vital component to STI prevention strategies, and that this ability is tied to their perception of power in the relationship. Women who reported higher levels of relationship power were five times more likely to report consistent condom use than women who reported lower levels of relationship power. The sample in this study consisted of primarily Latina women; however, the study by St. Lawrence (1999) also suggests that gender expectations and perceived roles may play a critical role in shaping the sexual behaviors of African American women.

St. Lawrence (1999) discusses how power and perceptions of power influence condom use in low-income African American women. She postulates that strategies to increase condom use aimed at African American women may be more effective if they consider the social, economic, and cultural realities of many African Americans women’s lives and the nature of relationships between African American males and females. She adds to this by asserting that living in inner city areas that have an increase incidence of HIV and poverty compounded by the reduction of potential African American male partners contributes to male dominance in interpersonal relationships. St. Lawrence also addresses the differences between knowledge and perception of risk in influencing condom use. She suggests that the perception of risk plays a more central role in promoting condom use than knowledge alone.

In St. Lawrence’s study, women who had less education, more fluid sexual relationships, were unemployed or only employed part time, had a low family income,
were receiving Medicaid benefits, and who also had children and daily responsibilities, were most at risk for contracting HIV. These circumstances, according to St Lawrence, likely reduce the power and control women may have in relationships, therefore, reducing their ability to insist on condom use with their partners. However, St. Lawrence failed to consider the impact of post-secondary education on women of low-socioeconomic status though black women in college may face financial barriers, engage in fluid relationships, and have unstable or limited employment.

Kline and colleagues (1992) challenge the issue of limited power concerning the sexual health of black women. In their study, low-income African American women displayed a remarkable sense of assertiveness in decisions surrounding all aspects of their sexuality, including the frequency of sexual encounters. They suggest that understandings or perceptions of risk rather than power inform the sexual decision making process of black women.

Ried and Smalls (2004) assert that improving the health status of African Americans must fundamentally address the intricate relationship between health and culture. They studied and analyzed the relationship between spirituality and health-promoting behavior. The results suggest that spiritually and religious salience are significant factors to consider in addressing health outcomes. Wallace and Foreman (1998) found that spirituality and religiosity had a salient impact on health behaviors among African American youth. As shown in their research, religious-oriented youth were less likely to participate in behaviors that compromised their health and more likely to engage in behaviors that improved their health compared to non-religious youth. Though the aim of this thesis is not to analyze the relationship between religious
salience and sexual health, in light of research that underscores the role of spirituality and the black church in the African American community (Randolph 1996; Billingsley and Caldwell 1991), it is important to consider the extent to which these orientations might impact the sexual health choices of the research group.

Conclusion

Although there is an extensive amount of research on sexual behavior, relatively little research has been conducted concerning the sexual health of African American female college students. Moreover, much of the existing research was and still is conducted in the form of surveys. While surveys have the ability to inform a study, using surveys as the primary or only mode of data collection has limitations. Surveys are generally best for collecting broad based, general information and often offer very little to understand the cultural, social, and economic realities that often influence behavior. “Surveys cannot provide much historical or contextual data to illuminate why people responded the way they did” (LeCompte and Schensul 1999). As Singer (1994) suggests, behavior occurs within a social context. It is important to understand and explore this social context and people’s understanding and experiences within the social context in order to best understand and respond to disease within a particular community (Joralemon 2006; Whiteford and Bennett 2005).

When combined with other forms of data collection, namely the more qualitative methods, “surveys can add great strength to a study…” (LeCompte and Schensul 1999: 72). The exploration of a topic as personal and as socially taboo as high-risk sexual behavior, is better served by utilizing a combination of different data collection
techniques, namely the qualitative methods central to anthropological inquiry (see Chapter 3).
Chapter Three: Methodology

Research Plan

The research was conducted on the University of South Florida (USF) campus between November 1, 2006, and June 30, 2007. Given the time frame in which the research was conducted and the limited financial and personnel resources of the researcher, participants were recruited based on a convenience sample. Data was collected in the form of surveys and focus groups. The original proposal for the research project included in-depth interviews as a data collection technique; however, students expressed little to no interest in participating in a one-on-one interview. As sex and sexual health are extremely personal and private topics, this was understandable. Participants preferred the comfort offered by filling out a survey or participating in a focus group. Twenty-four surveys were collected and three focus groups were conducted. Each focus group consisted of 4 to 5 participants. Surveys were used to gather preliminary information. They were later used to inform the construction of focus group questions. Additionally, I piloted the survey with African American females before administering it within the study. As sex can also be a very sensitive topic, I wanted to ensure that the survey was comfortable yet elicited important information. The research project was designed to be emergent and highly qualitative. This type of design offers rich information that can later be used to inform policy, intervention strategies, and future research projects; however, because of sample size and selection process, the insight gained from the research will not be generalizable.
No monetary compensation was offered to participants; however, considering the social, economic, and physical consequences of contracting HIV/AIDS and other STDs, I do believe that the information provided during the focus groups, which included statistics and prevention strategies, can be seen as incentives for participation.

Description of Research Site

The University of South Florida serves over 42,590 students; it is the second largest university in the state of Florida (USF 2005). The age group most at risk for contracting STIs is consistent with that of the undergraduate student body at USF. Moreover, of the 32,442 undergraduates at USF 59.2% are female and 12.5% are African American (USF 2005). The representation of both female and black students at the university supports an investigation of sexual health and sexual health practices of African American female college students.

Moreover, of the 42,590 students who attend USF, 40,255 are Florida residents; they represent 64 of the 67 counties within the state of Florida (USF 2005). Though the University of South Florida does not offer any information concerning the socioeconomic or health backgrounds of its students, within the USF Fact Book information is given concerning the number of students who attend USF from each of the 64 Florida counties represented. There were eight counties that had 1,000 or more residents attending USF: Hillsborough, Pinellas, Manatee, Broward, Sarasota, Polk, Pasco, and Orange County. The students from these counties make up more than 70% of the total USF student body. The Florida Department of Health’s report, “Silence is Death: The Crisis of HIV/AIDS in Florida’s Black Communities”, indicates that seven
of these eight counties (all except Pasco) are included in the top 20 counties in Florida that have an overrepresentation of African Americans living with HIV/AIDS (FDH 2006). Comparing the USF recruitment information to the information given by the Florida Department of Health further supports an investigation into the sexual health practices of the research group at this site.

There are three primary forms of sexual health education offered at USF: courses on sexual health and STIs, access to testing and information through Student Health Services (SHS), and outreach programs conducted through SHS (USF 2007). Though courses on sexual health and STIs are sometimes the result of collaborations with SHS, many are created and governed by the department within which the course is offered (information about two courses relevant to the study is offered in Chapter 4). Additionally, the education and outreach efforts of SHS focus primarily on behavior change, giving little consideration to the social and cultural context of these behaviors.

Research Questions

There was one primary and four secondary research questions that served to guide the construction and organization of the research study. I have listed them below along with an explanation of their place and use in this investigation.

1. What factors influence the operationalization of sexual health knowledge in African American female college students at the University of South Florida?
   a. What are the forms and sources of sexual health knowledge?
   b. What is the level of sexual health knowledge?
c. To what extent is sexual knowledge translated into individual sexual behavior choices?

d. What are some of the beliefs concerning risk and prevention?

The primary research question will allow me to explore the factors students identify as impeding or contributing to the implementation of sex health knowledge. Because there are likely to be different levels and sources of knowledge, the first sub-question becomes extremely relevant in determining if certain types of knowledge sources, e.g., media, university courses, health facilities, etc, correlate with healthier sexual behavior practices. Further, since some research suggests that knowledge will be related to positive behavioral change, the second question is intended to explore the connection between the level of knowledge and reported behaviors. This question is also important because one factor of high-risk behavior noted for low-income African American women is lack of sexual health knowledge, and college students are often assumed to have different levels of knowledge than the general public; thus, the question may inform ideas of risk for this group. The third sub-question is intended to examine the extent to which knowledge is translated into behavior. This question, like the latter, will inform notions of risk for the research group. Because perception of risk and prevention play a large role in constructing sexual behavior decisions, it is important to gauge beliefs about prevention and risk, and their impact of behavior; the goal of the last sub-question.
Participants and Recruiting Strategy

The initial plan was to recruit students through student organizations that catered to African American female students; however, this proved to be only minimally successful. Many organizations were initially very excited about the research project and the opportunity to participate, yet later were unable to fit the research project into their organization schedule. Some organizations were simply unavailable; they did not return emails and they did not adhere to their posted office hours. Other organizations had representatives who expressed an interest, but did not get approval from the organization executive board. Fortunately, two organizations were extremely interested in the research topic and were willing to allow me to ask some of their members to participate. These two organizations have a very strong presence on the USF campus. Additionally, as they focus on the experience of blacks and African Americans in the larger national and international context, they tend attract students interested in various issues related to the black experience in the U.S. and abroad.

After recruiting participants from the two organizations, there was still a need for more participants. Between January and March I contacted several professors who taught classes that were known to attract African American female students, and petitioned the professors to allow me to administer my surveys and invite students to participate in the focus group and in-depth interview portions of the research project. Two professors approved my request. However, most students from their classes reluctantly chose to fill out the surveys and not participate further. As the end of the semester approached, I continued to try to recruit participants through word of mouth, attending as many organization meetings as possible. Though by this time I had
collected a sufficient number of surveys, I was still in need of participants for the focus groups and in-depth interviews.

Unfortunately, at the end of the spring semester, I still needed more participants. Since the attendance levels during the summer semesters are light compared to the fall and spring, this meant that recruiting participants would be even more difficult. At this point I decided again to petition professors who taught classes known to attract African American female college students. This strategy had the most potential as there would be a concentration of black females in one place, at least relative to the rest of the campus. I also decided to hand out flyers at the most frequented campus venues and resources. This proved to be successful.

**Data Collection Techniques**

Qualitative data collection methods can be used to explore substantive areas about which little is known, obtain intricate details about a phenomena, and offer insight into the meaning or nature of an experience, or this case behavior (Strauss and Corbin 1998). Thus, they lend themselves well to this type of investigation. Additionally, qualitative data enables the researcher to better explore the context of a particular occurrence. Biology and behavior occur within a particular social, cultural, historical, and economic context (Joralemon 2006; Whiteford and Bennett 2005). For this investigation, I chose to utilize focus groups and a survey in order to gather data.

Focus groups were chosen because they generate a breadth of new information rapidly, as they provide a forum that allows multiple individuals to discuss their norms, beliefs, and experiences related to a given topic (Bryant 2007). Additionally, this
method was utilized “because focus group participants talk with peers in an informal setting, they use everyday vocabulary, jokes, and culturally appropriate ways of disagreeing” (Bryant 2007:117). As sex, sexual behavior, and sexual health are personal and intimate topics, it was important for the structure of the chosen method of data collection to support and foster a sense of comfort and support.

Though focus groups are an extremely effective means of data collection, the quality of data generated is contingent on the moderator’s skills and ability to regulate and interact with the discussants (Bryant 2007: 117). Moreover, if the moderator is unable to allow all participants to contribute to a relatively equal extent, results can be misleading. Also, as focus groups generally rely on a non-random sample, results cannot be generalized to the larger population; however, the goal of this research project is to produce rich qualitative data, which does not have to be statistically significant. Lastly, since researcher cannot prevent participants from sharing what has been discussed during the interview, anonymity can be compromised, which raises ethical questions about confidentiality and the topics that can be covered. Though, surveys are generally better for protecting anonymity than focus groups, they amount and depth of data they elicit is limited (LeCompte and Schensul 1999).

“Surveys are the most widely used form of systematic data collection” (L and S 1999). They are extremely effective for obtaining limited information from a large group. In this investigation surveys were used to gather information later used to guide the themes presented in the focus groups as well as to gather limited demographic information. However, as LeCompte and Schensul (1999:69) note, “[a]lthough surveys can be quite efficient and economical, there are limitations to their utility…” Surveys as
the sole or primary method of data collection renders limited information about the context of an event. Additionally, it is difficult to avoid reflectivity and corroborate the accuracy of survey respondents’ answers when no other data are collected. Conversely, when surveys are combined with other forms of data collection, they can add strength and validity to the data the resulting conclusions and/or recommendations.

The surveys were collected toward the beginning of the research project. On the back of the surveys was a sex quiz, designed to gather insight into the level of students’ sexual health knowledge. It was also intended to balance the tone of the survey. Many of the questions included in the survey elicited very personal and potentially uncomfortable information, so it was important to integrate a lighter and more impersonal element. The survey included questions about: the sources of sexual health knowledge, sexual orientation, number of sexual partners over the past 12 months, patterns of condom use, and understanding of risk and “at risk” groups (for complete survey refer to Appendix A).

Even with the addition of the sex survey most students were uncomfortable filling out the survey, though they were very interested in learning the answers to the sex quiz. This observation further problematizes the use of surveys as the primary or sole research collection technique when addressing the topic of sexual health.

Focus groups proved to be very difficult to set up; however, they also proved to be an extremely rich source of data. There were a number of logistic issues that came with setting up the focus groups. Finding a recognizable, cheap, and available location was challenging, though in the end it was accomplished. The focus groups were constructed to gather very general information about the factors the women believed
impact sexual health and the use of sexual health knowledge. They were very successful. I believe that this was because they offered the students the security of speaking about a personal topic in very general terms. Surprisingly, some students chose to speak about their own behavior and experiences during the session even though they declined participation in the in-depth interview. Focus groups were conducted on campus and were comprised of 4 to 5 students. The questions asked during the focus groups were similar to the questions included in the survey; however, focus groups were constructed to allow the students the opportunity to critically analyze through active discussion and exchange (focus group questions are listed in Appendix B).

Data Analysis

As previously indicated, student interest in the survey element of the research project was limited. There are limitations to the data that could be extracted from the surveys as some students answered selectively. This is likely an indication of their discomfort with the topic and the survey questions; thus, information elicited from the surveys will be considered within and in conjunction with the data elicited from the focus groups. Twenty-four surveys were filled out by African American females; however, four surveys did not contain sufficient data to allow for categorization and analysis; thus, they were not considered in the data analysis process.

Surveys were divided based on the level of sexual activity and the number of sexual partners reported by the participants. Additionally, participants who were categorized as sexually active were separated based on how frequently they reported
using their sexual health knowledge to make decisions about their own behavior.

Furthermore, the sex quiz, found on the back of the survey, was used to gain insight on the survey participants’ level of sexual health knowledge. It also served as a point of comparison for respondents who indicated that they had taken a college course on sexual health and those who had not.

Analysis of the surveys elicited themes that were used to aid in shaping the focus group questions. The focus groups elicited a considerable amount of data. A total of 100 pages of data, in the form of transcriptions, were gained from the focus groups. Data were analyzed and coded. The dominant themes from the data were extracted and will be presented and used to guide the subsequent discussion.

**Ethical Issues and Considerations**

A number of ethical issues are relevant to this type of study. Sex and sexual behavior are often socially taboo and/or private topics on the individual level but are more easily discussed when spoken about in more general terms. Anonymity becomes extremely important. Prior to the beginning of each focus group, I spoke with all the participants about the sensitivity of the topic and asked that the experiences and information shared during the focus group be kept confidential. Additionally, talking about STIs may be psychologically harmful to individuals who may know someone who has contracted an STI or who may have contracted an STI himself or herself. Thus, I did my best to control judgmental and derogatory comments, about both people and behaviors, from being made. In the focus groups, I asked questions that were more general in order to facilitate more participation and a more open discussion. This also
helped to avoid conflict based on personal behaviors. Further, as sex is a private topic and as some students offered information about their personal behavior, pseudonyms are used when reporting the findings to protect the identity of the participants.
Chapter Four: Results

Basic Demographic Information

All women included in the study self-identified as black or African American. Additionally, all students were undergraduates. Though some information about age and city of residence was collected during the surveys, to protect participant anonymity, it was not collected during the focus group. However the average of survey respondents was 20.9, 85% of which attended high school within the state of Florida. Most of the women who participated in the survey were upper classman; only two were freshman.

Sources of Sexual Health Education

Before exploring the specific factors that influenced whether or not the women in the study used sexual health knowledge, it was important to explore their sources of information about sex and their perception of these sources. The women who participated in the survey aspect of the investigation were asked to identify their sources of information about sex and to indicate which they considered to be their primary sources of information, the most useful, and the most relatable (this term refers to whether or not the participants felt as if they could connect or relate to the information offered to them). As this was structured as an open ended question, students, if they desired, were able to report multiple sources of information. Students’ responses varied; sources of sex knowledge ranged from information obtained through the internet to high
school and college classrooms. Sources reported by the students two or more times are presented in the table below.

Table 1: Reported Sources of Sex Information (Survey Data)

<table>
<thead>
<tr>
<th>Source</th>
<th># of Times Reported</th>
<th>Class</th>
<th>Books</th>
<th>Internet</th>
<th>Friends</th>
<th>Parents</th>
<th>Doctor</th>
</tr>
</thead>
<tbody>
<tr>
<td>TV</td>
<td>5</td>
<td>13</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>Primary</td>
<td>4</td>
<td>6</td>
<td>5</td>
<td>5</td>
<td>2</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>Useful</td>
<td>3</td>
<td>6</td>
<td>3</td>
<td>0</td>
<td>1</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Relatable</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

The most frequently reported source of sexual health information was the classroom (both secondary and post-secondary). It was reported more than twice as frequently as any other source, followed by parents, doctors, and television. Though the implications that can be gained from analysis of the survey data are limited, it is interesting to note that although television as a source of knowledge was reported less frequently than sexual health courses and parents, it is more frequently reported as a source a knowledge the participants could relate to best. This sentiment was shared by some of the women in the focus group.

Sherrie: I think media. I think two big influences I have had were seeing “Rent” and during AIDS week a lot of information is given to you through the TV. So if you are just flipping through the channels BET/ MTV/ VH1 there is always something on teaching you something you probably didn’t know.

Mass media, particularly television, acted as an informal tool though which the women could learn information about sex. Not only did it offer information used to inform their
own sexual behavior, it provided a social context within which the women could situate social representations of sex and the sexual behavior of African Americans.

Jena: We are misrepresented in the media. I mean I watch some of these movies and I get so pissed off because why this black girl got to be so sexed up she got to be all on somebody’s jock and stuff. Why every time? And these images… a lot of the time they are consistent.

Rachel: No one says anything about the Real World crew like, “Oh these white women are having sex with strangers”, but the minute you see somebody black on TV having sex it is like, “Oh they are so promiscuous”.

Television was both a source of information and a source of misinformation. Though it had the potential to offer needed information about sex, the ubiquitous images of hyper-sexualized black women served to reinforce negative stereotypes about African Americans, black women in particular. Television was the source of knowledge survey participants related to best; medical providers were the source of information they related to least.

Although five participants reported that their doctor(s) was their primary source of sexual health knowledge, only one participant indicated that the information obtained from the doctor was useful, and no one indicated that it was relatable. This disparity was also apparent upon analysis of the focus group data. When participants were asked their primary sources of sexual health knowledge, no one identified medical professionals as a source of knowledge.
As mentioned previously, participants noted a number of different sources of sexual health knowledge; however, the two primary types of sex knowledge noted in were informal social networks, comprised of family and friends, and educational institutions, secondary and post-secondary.

*Educational Institutions.* Several students indicated that they had taken college courses about sex. However, their sentiments about the courses varied. Some courses, those primarily based on the pathology of STIs and other diseases, were said to be informative yet unpopular. Courses that focused on behavior, and offered less information about types of STIs and their modes of transmission, were more popular. Two of the courses that the students identified taking were Human Sexual Behavior (HSB) and Survey of Human Diseases (SHD). According to the USF undergraduate catalog, Survey of Human Diseases, course number HSC 4554, provided “[a]n overview of the nature, types, and mechanisms of diseases of the major body systems”, and Human Sexual Behavior, course number WST 2600, explored “[t]he dynamics of human sexuality: biological, constitutional, cultural, and psychological aspects. The range of sexual behavior across groups. [sic] Sources of beliefs and attitudes about sex, including sex roles and especially human sexuality.” (USF 2006). Rachel and Jena described their experiences in one of the most popular sexual health classes offered at the university, Human Sexual Behavior:

Rachel: I learned a lot from that class. I took it my freshman year and I was still kind of new to the sex thing back then. Thank the Lord. I think classes like that do bring
awareness but I think unfortunately they talked more about behaviors then protection and prevention of these STIs.

Jena: When I took that class it was like she was trying to get me to question my sexuality. I guess because she was a lesbian. I didn’t feel like I got too much out of that because she was like everyone thinks that they are this or that but they could be something else. I was like, “lady teach me about behaviors, sex, or whatever else”.

Those who had taken a course that focused less on behavior and more on diseases had a different response. Samantha, a public health student, detailed her experience in a more scientifically based course.

Samantha: I took AIDS & HIV in perspective like my sophomore year and survey of human diseases. Those classes were scary but you learn a lot of stuff but it is not required for everyone to take only if you are like a premed major or public health. So it still really doesn’t help us because a lot of people won’t want to take those classes but I usually take those classes because I find that to be really interesting and I learn a lot about human disease and all that stuff.

Some students indicated that they intentionally avoid such courses because, as Jena remarks, “a fact based/ fact heavy class like that would be…a lot of memorization that is probably why I wouldn’t take the class. I don’t want to study like that”.

Despite the unpopularity of some sexual health courses, sexual education classes in general were identified as a primary source of knowledge. As with the survey respondents, most of the women who participated in the focus group reported sexual health classes as a primary source of sexual health knowledge. Some in the focus
groups indicated that they began to receive sexual health information as early as middle school; although, the information received was, at times, reported to be far from thorough. Rachel, a senior, commented, “I just learned straight up AIDS; it went from having your period to AIDS”.

A number of the women shared this same sentiment about the inadequacy of sexual health information offered in secondary school.

Liz: I am thinking back to when I was in high school, and I went to private school so it was like, “Don’t teach my child anything that is not math or English”, but we had physical ed. class, sex class, and it was like put a condom on and things like that, but it was basically don’t have sex. There was no… what is it going to do to me if I have sex.

Though participants identified the limited nature of the sex education that they received during high school, they did not believe that the schools were solely responsible for the less-than-adequate information they received.

Mikayla: The hard thing is that the school system has to deal with parents who are living lies because parents want to act like they did not have sex before they got married. Parents want to act like they didn’t do pot or didn’t do anything before they got married. And a lot of time they were exposed to all those kinds of things.

Eryka: I was taught in school about AIDS. They had the human sex class. I am not sure if they still offer it now. But I think that parents need to take an active step and make up where the school doesn’t.
Participants suggested that it is the responsibility of the parents to reinforce and expand on the information offered through the school system. This was interesting considering the experiences many women reported when their parents addressed the topic of sex and sexual behavior.

*Informal Social networks*

*Friends.* Before high school; before they experienced their first menstrual cycle; even before many of the participants learned how to write their names, some of the participants were learning about sex. Informal sex education, for the participants, began as early as six years old. From young girls having conversations about where babies came from to older cousins telling young female cousins about the process of “popping the cherry,” information was shared and understandings, or misunderstandings, about sex began to be shaped.

Mikayla: I was exposed to sex by a five year old kid whose dad had porn magazines. He was five; I was five too, but he was five and had access to porn magazines. We were playing house- and I guess his dad had porn videos too- so he is trying to do what he saw on those videos. A five year old kid!

Christy: I actually first found out or learned about sex from my friend. I was like in elementary, and my best friend she was like a little older than me. She actually told me about…well she was the first one to tell me where babies come from. I remember that and she told me that sex was what needed to take place in order for it to happen, and I was like “ewe”.
These informal interactions served as an introduction to sex. These types of experiences were not unique. Many women reported learning about sex from close friends and/or family, and, as can be seen from the two statements listed above, the educators were just children themselves.

Rachel: Everyone has that fast friend maturing way before… she was doing things you would have never thought about doing. As so everything you learned- the good and the bad- you got from her. I always had that friend even in elementary school. She was kissing and having sex before you, and you were just intrigued by it, even though you had little knowledge about it.

Rachel’s experience reemphasizes the role of some youth as sexual health educators. Learning about sex on the playground or at a friends or family member’s house was commonplace. Additionally, per the statement above, these lessons were not only based on hearsay; they were sometimes based on actual experience.

Parents. Sex education from parents, though this was not common among participants, often took the form of warnings about the consequences of sex, primarily pregnancy.

Jena: My mom told me about the social aspects of sex. If you sleep around, you might get pregnant. That was my big fear. She didn’t say anything about STDs and AIDS. She was just like there are consequences for sex; you could catch something, or you could have a baby. So I didn’t mess with that for a long time. She scared me.
Christy: I mean my mom never told me about STDs and all this stuff. I mean I don’t know if she was educated or not. It is like they focused on don’t bring a baby home. They only focus on the pregnancy aspect like, “Oh! It’s going to be such a financial burden to the family”, but what about our actual health when it comes to engaging in unprotected sex?

Iman, a sophomore, indicated that in her household sex education, at least for the teenage females, was less about education and more about creating fear, very different from the education that her brothers and her male cousins received. She shared an anecdote about when her parents found a condom in her brother’s wallet.

Iman: It was clearly different in my household, very different… For girls it is like the fear factor, but for my brother… I remember I kind of jumped into a conversation because my mother found a condom in his wallet. And I am thinking, “Yes! He is going to get into trouble… get him mom”, but as soon as she saw it she said, “Okay… now it is time for me to talk about sex with him”. I am like okay maybe I will be in the conversation, but my mom closed the door. Later, after the conversation, she walked by and told me to come into her room, and she was like, “You see this? You don’t know what this is and you will never know what this is!” and I am just like, “It is a condom; I already know what it is”. It is like she tried her best to say don’t even think about sex until later in life.

For many of the women parents were more a source of fear and potential reprimand than a source of information about sex and safe sex practices. Though, as Iman’s story exemplifies, this may not be the case for young males. Males are expected to have sex, and, therefore, counseling and sex education are appropriate and anticipated. However,
females are to remain pure and sex free until later in life, preferably until marriage. Even when some of the participants did begin to engage in sexual activity, they still avoided talking to their parents about sex. Jena said, “It is like that fear. If I was having sex, I would not tell [her mother] because I was scared of her”. For others, their sexual activity will remain a secret until marriage.

Rachel: My mother still to this day does not know, and she will never know until I take my vows… It is not only because you are scared. It is also because you are embarrassed. You don’t want to disappoint…

Though many respondents spoke of their own inability to speak to their parents about sex, they often emphasized the role parents need to take in sexual health education. The discussants believed that parents need to be more realistic about the potential for their daughters to have premarital sex. They need to equip their children, especially their daughters, with the information and the tools necessary to make positive sexual health choices.

Rachel: We need to be realistic in our approach when teaching the youth. People are going to have sex. We need to target parents. There are parents who are afraid to talk about it because they are scared their daughter will be this loose hooker, and it is not that serious. I know when my mother was sixteen she had those urges. She is not going to say that to me, but I know she did. Look at the numbers; something is not being said and it is not us. We can’t blame the schools we can’t blame USF “well they don’t have the resources.” The only people who can save us are the people who can help raise us. If they are not teaching us the truth and what is really happening then that problem is going to be much larger.
According to the women, parents were afraid that, if they shared sexual health information with their daughter, they would become promiscuous. Moreover, at times, they also try to view their children’s motivations and behaviors regarding sex as distinct from their own. Participants asserted that the “tendency of the parent was often the trait of the child”; therefore, parents need to be more realistic about their children’s sexual health and take a more proactive stance.

**Overall Safe Sex Knowledge**

As stated previously, students’ overall safe sex knowledge would be measured by the student’s knowledge of the level of risk within their community and their knowledge of sexual transmitted infections, their transmission and their prevention. Though unstructured assessment of the students’ sexual health knowledge occurred throughout data collection, a more structured assessment was incorporated through the use of the sex quiz (sex quiz and its answers are offered in Appendix C). The sex quiz was located on the back of the survey.

Out of the 20 surveys that were included in analysis, 18 included data used in the sex quiz analysis. There were nine possible answers on the sex quiz, so scores were tallied as the number correct out of 9. The overall sex quiz average was 6.16, which suggests that most of the students have some knowledge of sexually-transmitted diseases and their impact on the black community. The 18 sex quizzes were then divided into two categories: students who had taken a sexual health course in college and students who had not. Nine students who filled out the sex quiz had taken a course, and nine had not. The
two groups were then compared to determine if there was a substantial difference in the scores received. Interestingly, there was not.

The average score of students who had taken a sexual health course in college was 5.8; the average score of students who had not taken a sexual health course was 6.4. This suggested that the sexual health courses taken by the students had very little impact on their overall sexual health knowledge, as measured in this report. Additionally, most of the students who reported taking a sexual health course in college reported taking a course that primarily focuses on behavior, which could explain this finding. These findings parallel well with the opinions of students, presented above, concerning students avoiding fact-based heavy memorization sexual health courses. As with the surveys, because of the number of respondents, analysis of the sex quiz and its resulting implications are limited when viewed in isolation; however, when considered with the data elicited from the focus groups, the findings are insightful and telling.

The Operationalization of Knowledge

The women noted several factors that influenced whether they utilized positive sexual health information. These factors were separated into two larger domains: individual-based factors and socially/culturally-based factors. Individually-based factors were those that remained relatively based on the individual and/or her understandings and behavior at any point in time. These factors were not presented as universal barriers or institutions; rather they varied from person to person. On the contrary, socially/culturally- based factors were related to structural barriers and cultural understandings or institutions that groups, African Americans in particular, often
experienced or were involved in on a regular basis. The factors are presented in the table below.

Table 2: Factors That Influence the Use of Sexual Health Knowledge

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<thead>
<tr>
<th>Individually-based Factors</th>
<th>Socially/Culturally-based Factors</th>
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<tbody>
<tr>
<td>Self-Esteem/ Self-Value</td>
<td>Financial Motivations</td>
</tr>
<tr>
<td>Perception of Risk</td>
<td>Environment</td>
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<tr>
<td>Heat of the Moment</td>
<td>Male-Female Relationships</td>
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<td></td>
<td>Religion</td>
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*Individual-based Factors*

*Self-Esteem and Self-Value.* According to the women, self-esteem and self-value impact the use of sexual health knowledge. They suggest that the more a woman values herself the more she will practice safe sex. If she values herself, she will be less likely to acquiesce if pressured by her partner. Her power to demand or regulate safe sex and the use of protection is directly related to her perception of herself. Samantha contends that, “[i]f your self esteem is low and the guy is hot, you may be like “okay.’’ Many of the women voiced their love for themselves and their unwillingness to compromise on safe sex.

Liz: I love myself so I don’t feel like gender has anything to do with it. If you like sex and you know you are going to have sex, the man should not have to bring a condom. If you know you are going to have sex with this man you carry yourself a condom just in case he doesn’t have one.
Mikayla: I may love this brother or I may want him but if he doesn’t come correct he is not going to get this.

Though some of the women, like those noted above, never seemed to challenge their self-worth, others did. Some participants clearly recalled the point in their lives when their perception of themselves, and thus their behavior, changed.

Kary: It wasn’t until I began to value my self-worth and started to believe that I could be someone… “Why are you allowing men to abuse you not necessarily physically but mentally, going around having this person and that person”. When I was actually able to see that, “hey you are going to be a lawyer one day; you have all this stuff going for you why are you settling for less? That is when I was able to step back and say I don’t need this trash.

Additionally, many of the women suggested that issues with self-esteem may stem from lack of parental attention and care, especially from fathers or strong male figures. Father-daughter relationships, according to the participants, set the tone for future male-female relationships, and what values or attentions a female lacks from her father she may look for in a partner. This is critical considering the number of single-parent, female-headed households in the black community.

Liz: So many young girls, especially ladies who didn’t grow up with fathers, go to sex or a guy for that confidence because their self-esteem is low. I feel like females just need to start appreciating themselves… I had a friend, she didn’t contract HIV, but she always kept condoms around everywhere; she got one guy who was feeding her the right thing; she didn’t use a condom and she ended up getting pregnant. I was like,
“You are the one who is always telling me make sure you have a condom if you have sex. What is it that he said that made you feel so less of yourself that you don’t have to listen? What this man told you that you don’t have to value what you felt?” It is like people are looking for love in all the wrong places because maybe they didn’t get it. I don’t know it is just…. it is like people with low self esteem they are just looking for it elsewhere.

Self-esteem and self-value are marked as important elements in negotiating safe sex and practicing positive sexual health behavior.

Perception of Risk. Like self-esteem and self-value, many women noted how someone’s understanding of their own risk affects their use of safe sex knowledge. Perception of risk, more than the availability or acquisition of knowledge, is important to promoting positive sexual health behavior. Moreover, even taking advantage of available resources requires some acceptance and understanding of one’s own risk. According to the participants, one’s acceptance of her own vulnerability and risk, often remains unrecognized until something impactful happens to her or to someone close to her.

Mikayla: Even with being educated, because when I think of education I think of theory, it doesn’t become real until you apply it. So we get all this theory flying around, because sometimes things aren’t real until they happen to us or until it happens to someone that we know, so we have all this theory but it requires application in order to make it effective. And sometimes we feel like, because we hit and miss and hit and miss and it did not happen to us, that we are okay.
Rachel: Yeah, they have free everything so there is no reason why people shouldn’t know but as far as practicing it... it is easier said than done. Because I would say that the majority of people that I know, I can’t speak for the campus or black females here, I don’t think that we are always effective at practicing what we have heard, and that is just normal. Usually something traumatic has to happen for us to be like, “Oh, okay; now I know.” I mean it happens; it has happened to me before to where you have to put on the brakes and say, “Okay; now I get it.” I don’t think we, I mean there are people who do, but most of us don’t. We are humans and we make mistakes and sometimes you have to get hit before you get up.

These findings offer insight into the two trends concerning risk that were found in data from the surveys: self-centered perception of risk and a society-centered perception of risk. When asked whether they considered themselves at risk for contracting an STI, some survey respondents noted that because they did not use protection every time they had sex, they were in-fact at risk for contracting an STI. For the purposes of this paper this is considered a self-centered perception of risk. These students were aware of and acknowledged their high-risk behavior. When asked the same question other students responded by indicating that “everyone is at risk”. This is considered a society-centered perception of risk. The students understanding of risk is generalized, which may serve to distance the student from their own behavior. This will be explored further in the discussion section of this paper. However, in both the surveys and the focus groups, the personalization of risk provoked action and insistence of safe sex.
Iman: I know in my situation, like all the boyfriends I have had, I do not see why I would not have that conversation with you. It is like just kissing alone scares me. Remember we used to be like kissing is a scary thing, because it is so scary; it leads to other things.

Rachel: I mean I am sexually active, and I have a whole shoe box of condoms. I am not ashamed of it because pregnancies and STDs and stuff they affect both partners. Unfortunately STDs hurt females more because our bodies react to them more quickly. Most men can walk around with chlamydia forever and never know. For women we are more in tune with our bodies, because we have periods and stuff, so we notice stuff that is wrong, and it affects us quickly. But I think that most women are considered promiscuous, if they do wear condoms, but I don’t care.

For the women, accepting their own vulnerability compelled them to be adamant about the practice of safe sex. They also stated that for some the acceptance of their own vulnerability could lead to avoidance and denial, especially as it related to testing. One participant spoke about her experience taking an HIV test, and how it reinforced her acceptance of her own risk.

Liz: Fear I think is number one. We are all here and talking. I have had two, and I couldn’t eat, I couldn’t sleep, I was crying. I think it is fear. I would honestly like to take a survey and see why people won’t get tested… I think it is “I have had unprotected sex before … oh Jesus”.

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Though most of the women acknowledged their risk concerning sex that involves penile/vaginal contact, very few acknowledged their risk when participating in other forms of sex, most notably oral sex. A number of survey respondents and focus group participants failed to acknowledge the risk associated with oral sex. Some of those surveyed, who indicated that they were not at risk, reported the non-use of condoms or other barrier methods during oral sex. In-fact, on the surveys, condoms was the only form of protection that the participants reported using, implying that there may be an underlying misconception about the limitations of condoms as a form of protection.

Liz: Honestly, I hate to admit this, but I just realized maybe a couple of years ago that a condom does not protect against everything. It took me to get to the age of twenty-three to realize what a condom may not save me from.

Knowledge, understanding of risk, value of self, and access to resources are not mutually exclusive. The participants noted that all of these elements combined increase the use of positive sexual health knowledge before and during intercourse.

Heat of the Moment. As effective as knowledge, access, understanding or risk, and self-value are, they are sometimes compromised in the heat of the moment. If sex is unplanned, the likelihood that an individual engages in safe sex decreases, according to the participants.

Liz: How many people honestly think of contracting a disease in the heat of the moment? That is why I believe that is has nothing to do with education. If you are hot and bothered and you want to have something right now, if you have three master’s
degrees on your wall… people don’t wonder if this guy has HIV in the heat of the moment. It is afterwards that you think maybe. It is afterwards that you run to the clinic like I want to get a HIV test.

Rachel: I think we have all gotten to the point where the test is that last thing on your mind especially in the heat of the moment. I think the majority of people are not talking to their partners like they need to. I know my first we did not talk about that. I mean you kind of think about it in the back of your head – I mean I wondered if…. never mind now we are here- what can you do you now! What can you do in the moment!

Even the most educated female, like the respondents noted, could be vulnerable in the heat of the moment. Women become so consumed by the right now that there is little to no thought directed towards the possible consequences. Though these situations were not seen as ideal, they were not critiqued. Rather, they were seen as a larger social reality that affects all kinds of people for all kinds of backgrounds. No solutions for being caught in the heat of the moment were directly offered by the women; however, they did allude to the need and benefit of partner communication and preparation in preventing rash decisions in the heat of the moment.

Social and Cultural Factors

Economic Motivations and Environment. During the focus groups the factors of environment and economic motivations were often addressed simultaneously. Because a family’s economic situation often impacts or helps to shape an individual’s environment, the two factors were thought of as indivisible. The women noted how an individual’s economic situation can cause them to compromise safe sex; moreover, they
indicated that parental, specifically maternal, survival strategies linked to sex can influence the sexual practices and survival strategies use by young women, both in and out of college.

Liz: I know a lot of women who are with guys because of what they are doing for them financially. He don’t want to use a condom so, if he is paying my rent, my car note, my insurance and everything if he don’t want to use a condom, we are not using a condom. We are where we come from. There are plenty of girls in college who are still doing the same thing. They are still sleeping with guys for money. I think it just depends on which way you look at it. I think for the most part it is about even but I think if you look at those people who are not in college and you look at their circumstances. I think the problem is that you have to look more into where they come from, what is their background, how they think- which is really a big part and that is more of what is going to give you. To me it is better to group them by their circumstances then necessarily grouping them by being in college or not in college.

Mikayla: However you were raised culturally or socially, it seems normal to us. If your normal environment is to see your sister go out with Mark, John, Jack, and Jerry Monday, Tuesday, Wednesday, Thursday, and Friday night. Or it was normal to see your mother dating four, five, or six guys just to make ends meet and to get her hair and her nails done. If that is your normal environment, I don’t care where you go, that is still going to be normal to you.

Economic and environmental factors were not presented as deterministic; however, the women emphasized the importance of considering these factors when educating women. Because of this, the women suggested that education strategies, especially in
the college setting, need to take more of a holistic approach to sexual health education, considering both environmental and cultural influences that could affect sexual practices.

Liz: Don’t stereotype me because I go to school. You do not know what my background is. Look at the statistics of black women and why; look at the statistics of white women and why. Look at all of it and teach us that, and take that into consideration. Teach us everything because you don’t know what we go to when we leave this place.

The women also noted how assumptions about accessing higher education could influence sexual health strategies. Liz, above, suggests that sexual health educators take a broad approach to sexual health education by addressing all or most of the factors that may influence sexual health outcomes and decision making.

**Male-Female relationships.** Understandings of male-female relationships, often based on larger cultural understandings and societal trends, also impacted the use of safe sex knowledge. According to the participants, despite suspicions of infidelity some women continue to engage in unsafe sex. For some, unsafe sex becomes equal to or serves as an indication of trust, and for others, it serves to reinforce their primary rights to the men in their life.

Iman: I think that a lot them [women] would still chose to sleep with their man, husbands, boyfriends for a long time because it is like the men in their life are like “what you don’t trust me” even though you don’t trust him, but it is still that, “Well, I
don’t want him to feel a certain way, or I don’t want our relationship to change because I don’t trust him”.

Eva: Well, I have a friend who is in a relationship and she knows the guy is cheating on her, and she says that her mom told her that she has to keep what is rightfully hers, so he can go out to play just as long as he comes home. And a lot of people now are in to the whole open relationships like people who are in the military who say when I am gone you can do whatever but when I am here you are mine.

These statements highlight the belief that a man or at least a decent man is a commodity, and therefore, compromising safe sex and, in-fact, one’s own health is a small price to pay for the potential benefits of maintaining a relationship. This corresponds well with Sobo’s findings (1995). Within this type of relationship, power is given to the male. It becomes his decision whether or not to practice safe sex. This becomes even more problematic in light of the women’s insistence that men are often less aware or less willing to acknowledge their risk for contracting STIs, and their use of safe sex is generally primarily concerned with the prevention of pregnancy, which they believe can be remedied by the effective use of the withdrawal method.

Religion. The women noted the effectiveness of religion or a belief system in regulating or impacting sexual behavior. Religion, at times, served as a tool for self-reflection and can in turn cause a woman to abandon any high-risk behavior or sexual behavior altogether. In other instances, religion was said to delay the beginning of sexual activity either because of fear of going to hell, because of rhetoric that
encourages waiting until marriage, or because increased religious involvement serves to
distract an individual from thinking about sex.

Rachel: Another group who may be less susceptible to getting this maybe the religious
groups. Not to say that… because my pastor’s fifteen year old son had a baby… those
who believe in some kind of god as super holy. However, I do believe that when you
are grounded in something… I didn’t lose my virginity until I got to college- because I
feared that I was going to hell. My parents didn’t tell me that, but because of Sunday
school and vacation bible school, I felt like this was something that was immoral. I was
always at church, and there I did not think that much about sex, and every time I did
think about sex I thought about the consequences and what would God say. So I believe
that a good amount of people who go to church and are strictly group in church are less
prone to have sex before marriage.

Mikayla: When we come to ourselves, or when we decide we want to lead a different
life or a better life or not make ourselves vulnerable to those types of situations then we
make changes within ourselves and say no I am not going to do that. Whether it is for
God… or whether it is because you want to save yourself for your husband then you
start making those conscious choices about why you don’t do a certain thing.

Although the women note the effectiveness of religion in discouraging and controlling
sexual behavior, they critique the inability or unwillingness of religious institutions to
educate or allow for questions about sex or sexual activity outside of marriage.
Rachel: And when you are religious you don’t really ask questions. When you ask
questions someone will give you a bible verse. There is always a bible verse for
everything fun you want to do. Now I might ask God why, but back then you would not
dare.

Rachel notes that in some religious setting discussions about sex, if they are
allowed at all, are limited and/or regulated. This was seen as a barrier to sexual
health, though the women suggested that they understand the potential conflict.
Additionally, although they thought that it would be beneficial, they did not
believe that it was the responsibility of the institution to offer sexual health
education. And though discussions about sex were a rarity, religious
institutions, by regulating behavior, were seen as promoters of sexual health.
Chapter Five: Discussion & Recommendations

Discussion

A number of individual and social/cultural factors were found to impact the use of sexual health knowledge in this research group. Data collected from surveys and focus groups suggest that African American female college students may share some of the same structural and cultural barriers with low-income African American women that are believed to affect sexual health and the implementation of sexual health knowledge. Participants indicated that financial motivations, which may compel women to rely on sex to secure financial and other material resources, and cultural understanding of heterosexual relationships, which may encourage women to overlook their male partner’s infidelity and continue to engage in unprotected sex, can impact the operationalization of sexual health knowledge. Interventions directed at such women, which focus primarily or solely on behavior, may not be effective or appropriate. Though the participants noted the impact of social and cultural factors on the operationalization of sexual health knowledge, what is most interesting is that it is often a combination of individual and social/cultural factors that influence knowledge use, which suggests that education and outreach efforts need to be as layered as the factors themselves.

Education efforts offered in academic environments often fail to incorporate strategies that target the social/cultural factors that influence knowledge use, likely because of an assumption which suggests that African American female college students, because of their ability to access higher education, do not share the same
structural and cultural barriers identified for low-income women of the same racial/ethnic background. Additionally, incorporation without proper effort and consideration may result in the inclusion of stereotypes of race and socio-economic status. However, an in-depth analysis of the specific needs of the population, small or large, will help to mitigate these potential missteps. What the participants stressed most, when it came to sexual health knowledge, was the need for a grounded approach that took social, economic, and environmental factors into consideration. Just as sex is an event that takes place between individuals, sex education should be personalized, at least as much as possible. Additionally, since sexual health education does not always result in positive sexual health behavior, intervention efforts need to extend beyond sex and sexual behavior.

Issues of gender and gendered power were also found to impact the sexual decision-making process of some women. Thus, sexual education efforts must also include strategies that target the women’s emotional and social health, particularly relating to their abilities to negotiate their own sexual health, which includes but is not limited to, their comfort and/or willingness to carry and use condoms as a form of protection. Moreover, women reported the potential influence that males may have on female’s use of sexual health knowledge. This, in light of reports from the women that, in their experience, males are less aware or concerned with their sexual health status, suggests that these efforts need to extend beyond women. Males must be encouraged to know their status and women need to be encouraged to take control of their own sexual health.
An important element in controlling one’s sexual health is understanding and acknowledging one’s own risk. Within the study, two themes emerged concerning understanding risk. Some respondents personalized risk; thus, they exhibited what I call a “self-centered perception of risk”. They were aware of and acknowledged their high-risk behavior. Focus group data suggest that accepting or embracing one’s risk may be the result of an event that impacted the person or someone close to them and, thus, makes them aware of their own vulnerability. Though some data suggests that a self-centered perception of risk may promote positive sexual health choices, more research is required to confirm this finding.

Some students, basing their perception of risk on the overall risk of anyone who engages in sex, exhibited a “society-centered perception of risk”. Their understanding of their own risk was generalized, which may in some instances serve to disassociate the student from her own high-risk behavior and the resulting individual and specific consequences. It may also be the case that students were simply acknowledging the impact of STIs in the larger U.S. context, and therefore, relating it to their own vulnerability. However, as the question was phrased, “Do you believe that you are risk for contracting a sexually transmitted infection?” I do believe that the former explanation is the most plausible. Data did not suggest that a society-centered perception of risk resulted in an increase in high-risk behavior; however, focus group data did suggest that acknowledgement of one’s own risk is an important factor connected to more positive sexual health choices.

Additionally, many respondents were unaware of the limitations of condoms. Though condoms can be very effective in preventing pregnancy and preventing certain
infections, if used correctly, they are not effective against everything. Condoms only cover the shaft of the male’s penis, leaving the area around the shaft exposed; thus, condoms are only minimally effective for protecting against infections that are transmitted through skin-to-skin contact. Moreover, many women did not acknowledge the need to use condoms during oral sex, possibly because they are unaware of the risk involved in oral sex. Both of these issues, in addition to one’s acknowledgement of their own risk, can act as barriers to practicing safe sex.

Making “heat of the moment” decisions concerning sex was also presented as a barrier to the use of sexual health knowledge. I propose that this factor is best managed by the promotion of sexual health preparation in conjunction with the model of health education suggested above. Women should be empowered and encouraged to control their own sexual health; one way this is accomplished is through carrying and using condoms, an element of sexual health preparation.

Unlike the previous factors, social and cultural factors have to be addressed and incorporated with caution and sensitivity. Not all African American female college students face economic, environmental, social, and cultural barriers to sexual health, and to suggest such would be problematic. However, what is also problematic is the suggestion that because these women are in college, their circumstances and approaches to sexual health are comparable to the larger dominant college population. Thus, as suggested previously, steps much be taken to gauge the needs of a population and efforts need to be implemented that are purposed to meet these needs. Based on the data collected for this study, African American female college students at this research site may experience some social/cultural barriers to sexual health. The factors indentified in
this study are: economics and environment, cultural understandings of male-female relationships, and religion. Recommendations for addressing these factors will be offered below. In addition to the factors influencing the implementation of sexual health knowledge, it is also important to discuss some sources of sexual health knowledge identified by the women and their implications.

Informal sexual health knowledge for the women began as early as six years old, years before parents or educational institutions generally begin to consider the need for education. These interactions intended to educate about sex and sexual behavior create a foundation of understandings and misunderstandings about sex. It is in a child’s nature to absorb and share information, and outside of separating one’s child from any kind of social interactions these situations cannot be avoided. However, it is important to consider this form of sexual health education and its impact when creating and implementing health interventions, especially concerning freshman students. In light of the “abstinence-only education” approach of the current national administration, we, as health educators and researchers, must acknowledge that, whether or not the school system is teaching about sex and sexual behavior, children are learning and acquiring information about sex. Information about abstinence is an important element of sexual health campaigns for adolescents; however, information about abstinence must be placed within the larger discussion of sexual health and safe-sex practices (Santelli et al. 2006; Fortenberry 2005).

Moreover, the participants in the study indicated their parents often avoided discussions surrounding sex and sexual health. Though some women noted that their parents did share some information with them, for most of the women the information
offered was intended to evoke fear. However, despite their own experiences, the women recognized the power and potential of parents as a source of sexual health knowledge. It is parents’ responsibility to educate their children concerning sex. According to the participants, if parents foster supportive and communicative relationships with their children, teenagers and young adults may make more healthful decisions concerning sex and sexual behavior. Like the informal sex education participants received from their friends, educational institutions cannot directly affect this factor outside of encouraging parents to discuss sex and sexual health with their children. In relation to this factor, academic institutions need to focus on augmenting and validating the information students acquire from these sources.

Post-secondary institutions, like USF, do have a responsibility to acknowledge and respond to the health needs of the student body. Sexual health courses are an important element in meeting this responsibility. Students had mixed reviews of the courses. Courses largely based on behavior were more popular; however, according to the women, little attention is given to STIs, their transmission, their treatment, and their consequences. Information about the impact of STIs on the U.S. population and specific segments of the population is also given little attention. Those classes that do focus on diseases and their pathology are not as popular, and, in fact, they are often avoided. Sexual behavior is a very important topic; however, discussions of sexual behavior need to be coupled with discussions of the consequences of sexual behavior, namely STIs, while grounding the context of sex and sexual behavior in the larger U.S. society as well as the surrounding community.
Throughout this discussion, I have spoken of the need to investigate the specific sexual health needs of the student population. Much of the literature that currently exists employs the use of surveys to gauge the research population. Though this study focused on African American female college students, I assert that this finding can be applied to the larger student body. Some students who filled out the surveys answered the questions selectively; this may indicate some discomfort with this method of data collection. Sex and sexual behavior, especially when explored at the individual level, are very taboo and uncomfortable topics. Additionally, in light of findings concerning student’s perception of risk, surveys may serve as an uncomfortable and undesired form of personal behavior analysis and reflection. When students were offered the opportunity, through the use of focus groups, to discuss sexual behavior and to explain their opinions and experiences of behavior in a safe environment, they were more inclined to share and be self-reflective, whether speaking in general or specifically about their own behavior.

The findings from this study parallel the findings from other studies that aim to identify understand the factors that influence the implementation of sexual health knowledge among low-income African American women. Like the women in Sobo’s (1995) study, the participants in this study emphasize the role of cultural understandings of male-female relationships in influencing the use of sexual health knowledge. Additionally, women discussed how understanding of risk can serve to lessen or increase high-risk behavior, as did the women in Kline and colleagues’ 1992 study.

Though this research explores factors that influence the operationalization of sexual health knowledge in African American female college students, I contend that
the factors that influence sexual health overall in a college environment are as varied and as diverse as the student body itself. There are many issues that affect whether or not people practice safe sex, and outreach efforts need to take this into consideration.

**Recommendations**

As stated previously, incorporating an understanding of social and cultural barriers into sexual health education interventions needs to be approached with caution and sensitivity. USF is limited in its ability to directly address these factors, since exposure to these structural barriers, cultural institutions, and cultural understanding happen long before students set foot on campus. For example, little can be done in the academic setting that changes the sexual health education and support efforts of religious institutions; however, understanding their impact on sexual practices and sexual health knowledge is critical to providing effective support services to these students. The aim should not be to discredit or critique the religious system, rather outreach and efforts should provide the education, support, and resources that students may or may not find in other environments. The same is true for the economic and environmental factors that may negatively influence the use of sexual health knowledge. Structural changes, beyond the capacity of the educational institutions, need to be implemented to properly alleviate the economic strain that perpetuates and encourages survival sex strategies and the resulting environment. Consequently, the university needs to understand the context from which some students may come, and make resources available that adequately meet the students’ needs.
At the end of each focus group, I allowed students the opportunity to offer solutions to the current epidemic(s) facing the black community, both in and out of college settings. Over and over again the students expressed the need to go back into their communities and educate other people. I believe that specifically targeting African American women to be involved in education efforts, either through involvement with student organizations that have a large representation of African American women or in cooperation with professors who teach courses shown to attract this population of students, would provide an excellent opportunity to teach students about STIs, their causes, and their consequences, while allowing them to explore and create solutions for other barriers that impact sexual health in the black community overall. Below I offer a general strategy that can be used to include various students and involve them in responding to various health topics; however, this strategy was designed to foster and facilitate community outreach and participation from the research group in order to offer a forum for exploring and responding to the topic of sexual health in the black community.

The entity of Student Health Services that offers health education could create a large student organization campaign or a meta-organization that explores and responds to health in various communities, both on and off campus. Incorporating off campus outreach will: 1) offer an incentive for participation in the form of community-based volunteer hours, 2) offer students the opportunity to take roles as leaders in promoting health in their own community, which is not limited to the student’s racial/ethnic background, 3) establish a cycle of knowledge between the students and the surrounding community, and 4) potentially impact future USF students.
Once the meta-organization or organization campaign is constructed, it can be divided into various communities reflecting current social divisions (i.e. race/ethnicity, socio-economic status, age, etc.). Student organizations can choose one or two of the outreach populations, and those who chose the same population can work collectively (under the guidance of a SHS staff member) to make community connections and develop an outreach campaign or strategy. I believe that if students have the opportunity to be involved in every step of the process it will promote ownership, accountability, and responsibility on the part of the students.

An important element of this education-through-education strategy is allowing the students to be creative. They should be primarily responsible for deciding the type of outreach and the content of outreach they believe to be most appropriate for the outreach population (e.g., creating films, flyers, or participating in direct education efforts). Allowing the students to be creative also enables them to create strategies that incorporate their own individual strengths. Participation in an outreach campaign not only promotes familiarity with a given health topic, it also allows the opportunity to identify and explore social and cultural factors that affect health, in turn, allowing the chance to collaborate to design an outreach strategy that reflects these factors while allowing the students and the chosen community to engage in dialogues surrounding the health topic.

Specific campaigns can be semester-long or continue for longer periods if they are found to be very effective and elicit sufficient amounts of student support. Awards can be given out to student organizations at the end of the fall and spring semesters, which could also serve as an incentive for participation. Additionally, funding should be
secured to allow the students to have more flexibility when creating or implementing a specific health campaign. As sex, sexual behavior, and sexual health are nationally recognized issues and because they directly impact the students in the organizations, initially campaigns can be based around these themes and issues. However, this strategy can serve the education and outreach efforts of a number of topics influencing student health.

Applied Anthropology, as a discipline, is uniquely equipped to explore and respond to the social and cultural factors that impact and influence health. Biology and disease happen within cultural settings, and in order to effectively respond to issues of health and illness, the cultural context needs to be taken into consideration. This research project aimed to explore the social and cultural barriers that influenced whether or not African American female college students used safe sex knowledge. Data suggest that women were impacted by individually-based and socially/culturally-based factors. Education efforts that focus solely on individual behavior may only be minimally effective. Interventions and education strategies need to be informed from and reflect the social and cultural realities from which the students come.

Considering the rates at which individuals under twenty-five are contracting STIs in addition to the rates at which certain communities are disproportionately affected by these infections, it is important for post-secondary institutions, like USF, to develop and implement strategies that encourage knowledge dissemination, knowledge ownership, and knowledge operationalization for their students. This research project identifies various factors that influence the use of sexual health knowledge for African American female college students: self esteem, perception of risk, heat of the moment
decisions, financial and environmental instability, cultural understanding of relationships, and religious institutions. Developing an education strategy that considers the impact of these factors and involving the students in education and outreach activities, I believe, is the best way to respond to the issues and the resulting high-risk behaviors that they may serve to augment.

I believe that the research and discussion offered above can serve as a foundation for discussions and interventions that aim to improve sexual health knowledge and the sexual health behaviors for African American female college students. The factors influencing their use of sexual health knowledge are varied; moreover, they may share some of the structural and cultural barriers identified for low-income African American women. Future research should explore the interplay between the factors identified that impact the use of sexual health knowledge and the resulting web of factors within with sexual health discussions are made. Also, as indicated in the definition of terms, “black” and “African American” often have different meaning within the black community, future research should explore these intricacies and their impact on the dissemination of sexual health knowledge and the effectiveness of intervention strategies.
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Appendix A: Research Survey

1. Gender: Male or Female

2. Age _____

3. What is your ethnic background? ___________________________

4. What high school did you attend? (Please give the State, County, and name of school)

5. Classification: Circle the most accurate answer.
   Freshman Sophomore Junior Senior

6. What are your primary sources of information about sex and healthy sex practices? (Example: Parents, TV)

7. Have you ever taken a college course about sex and sexual practices? Yes or No

8. If so, what was the name of the course and what year did you take it in?

9. What sources of information about sex are the most useful?

10. What sources of information about sex do you relate to best?

11. Do you use the information you learn about sex to make decisions about your own behavior?
    Always Sometimes Never

12. What are some things that may influence whether or not you use this information?

13. Are you sexually active? Yes or No

14. Indicate your sexual orientation:
    Heterosexual Bisexual Homosexual

15. How many partners have you had over the past 12 months?
    Circle the most accurate answer.
    0 1-2 3 or more

16. What types of sex do you engage in? Circle all that apply.
17. If you are sexually active, how often do you use a condom during vaginal sex? Circle the most accurate answer.
   Always       Sometimes       Never       N/A

   How often do you use a condom when you engage in anal sex?
   Always       Sometimes       Never       N/A

   How often do you use a condom when you engage in oral sex?
   Always       Sometimes       Never       N/A

18. What other methods of protection do you use to prevent sexually transmitted infections?

19. Do you believe that you are at risk of contracting a sexually transmitted infection? Yes or No

   Why or Why not?

20. If you are sexually active, how easy is it for you and your partner to talk about sex? Circle the most accurate answer.
   Very Easy   Somewhat Easy   Difficult   Very Difficult

21. Is there a group of people that you believe are more at risk for contracting sexually transmitted diseases? If so, why are they more at risk?
Appendix B: Focus Group Questions

1. What are some primary sources of information about sex and healthy sex practices? (Example: Parents, TV) Does this differ from other groups?

2. How effective are college courses that promote safer sex?

3. What sources of information are the most useful?

4. What sources of information for you relate to best?

5. Do you think that many African American women use the information they hear to make decisions about their own behavior?

6. What types of things could influence whether or not they use this information? Could someone give an example?

7. Do you think that gender influences safer sex practices?

8. Are the different responsibilities for men and women?

9. Why do you think the HIV and other STI’s have impacted the African American community so greatly?

10. Are their particular groups of people that are more at risk?

11. What increases their risk?

12. What could be done to decrease their risk?

13. What could be done to address the STI epidemic in the African American Community?

14. Are their differences in STI risk between black women in college and black women who do not go to college? Why do you believe this is so?
Appendix C: Sex Quiz

Sex Quiz
How Much Do You Really Know?
(Answers are bolded)

1. More than _____ percent of all people will have a sexually transmitted infection (STI) at some point in their lifetime?
   a. 25
   b. 70
   c. 32
   d. 50

2. Close to 50% of the individuals in the US with HIV are under the age of 25.
   a. True
   b. False

3. African Americans represent 13% of the US population. What percentage of the US AIDS cases do they represent?
   a. 50%
   b. 29%
   c. 65%
   d. 13%

4. Contracting the Human Papilloma Virus (HPV) increases a woman’s risk of developing _______________?
   a. Breast Cancer
   b. Cervical Cancer
   c. Migraines
   d. Diabetes

5. Circle the two most common STI’s.
   a. Chlamydia
   b. Trichomoniasis
   c. HIV
   d. Syphilis
   e. Gonorrhea

6. 75% of women and 50% of men infected with chlamydia do not develop any symptoms.
   a. True
   b. False
7. Circle the STIs that can be cured by the use of antibiotics. (There could be one or more answers)
   a. HIV/AIDS
   b. Chlamydia
   c. Gonorrhea
   d. HPV- Human Papilloma Virus
   e. Herpes
   f. Hepatitis B