Governmentality, Biopower, and Sexual Citizenship: A Feminist Examination of Sexual and Reproductive Healthcare Experiences of 18-24 Year-Olds in the U.S. Southeast

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Governmentality, Biopower, and Sexual Citizenship: A Feminist Examination of Sexual and Reproductive Healthcare Experiences of 18-24 Year-Olds in the U.S. Southeast

by

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A dissertation submitted in partial fulfillment of the requirements for the degree of Doctor of Philosophy
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with a concentration in Medical Anthropology
College of Arts and Sciences

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DEDICATION

To all the students who shared the most intimate and vulnerable parts of their lives with me. This is for you.
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To all the students who participated in this project, thank you. I could not have accomplished this without your willingness to be open, vulnerable, and honest about your past and current sexual encounters. Thank you for allowing me the honor of learning from you and compiling your experiences into this project.

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ABSTRACT

Sexual and reproductive healthcare in the U.S. is a contentious and often stigmatized topic. Conservative politics and Christian religious ideology guide laws and policies that inform narratives of sexual citizenship that promote white, heterosexual, procreative, cis-gendered relationships as the ideal. For young people, exposure to sexuality education greatly influences their self-identity as sexual citizens and guides how they form intimate relationships. While sexual and reproductive healthcare has been included marginally in the discipline of anthropology, almost no research has focused on young people’s sexual and reproductive healthcare within the U.S.

This dissertation examines the viewpoints and experiences of 18-24 year-old undergraduate students at three state universities in the U.S. Southeast to assess how lived experiences with sexuality education and sexual encounters impact the choices students make when embarking on sexual activity. A theoretical framework of governmentality and biopower, sexual citizenship, and reproductive justice guided three research objectives: 1) To assess the sexual and reproductive healthcare knowledge of college age students; 2) To investigate how past lived experiences with sexual and reproductive healthcare education and partner interactions impact students’ views and self-conceptualizations of identity and needs in future sexual encounters and relationships; and 3) To explore how policies of national and state governments influence the production of sexual citizens, and identify the sexual narratives that guide identity formation and choices.
Feminist research methodology and the Social Ecological Model from public health guide this mixed methods project that incorporates qualitative, semi-structured interviews (n = 50) and a quantitative, online survey (n = 776). Results show that U.S. national and state government abstinence focused sexuality education is failing young people in providing them medically accurate information and social awareness of positive, healthy sexual relationships and that sexual citizenship in the U.S. is detrimental to women, transgender, and non-binary people, as well as homosexual, bisexual, pansexual, queer, and asexual people. Additionally, the strict definition of sexual citizenship negatively impacts the lived experiences of LGBTQIA+ individuals’ self-identity formation and impacts how they participate in sexual encounters. This sexual citizenship framework is promoting patriarchal control, toxic masculinity, and rape culture in sexual interactions of young people, which encourages sexual assault, rape, and pressured or coerced sexual activity.
CHAPTER 1:

INTRODUCTION

In the global capitalism world of Western culture, the advertisement motto of “sex sells” has infiltrated every aspect of consumerism. While commercials, magazines, webpages, and social media accounts are full of suggestive images of young, attractive, and sexually active individuals, the everyday conversations of sex, sexual attraction, and sexual activity are still largely held as taboo topics that are not encouraged for public or sometimes even private conversations. Today’s current generation of young people is consistently sent mixed messages on sexual encounters and relationships. With mainstream media and society constantly telling them that in order to be successful you must be skinny, attractive, and sexually available, the exact opposite is often true of real-life teachings on sexual behavior and establishing relationships that tend to focus on long-term, monogamous relationships where sexual activity is delayed until marriage. For college students specifically, the shift from high school to university life can be a time of growth, independence, and experimentation.

The typical college student (18-25 years old) is sexually active (Burnett et al 2013, Choi et al 2016, Lewis et al 2012); sexual experimentation, “hook-up” culture, aided by alcohol and drug consumption as well as social media/dating apps, can lead to risky sexual behaviors that increase chances of unintended pregnancy and sexually transmitted infections (Asare 2015, Bontempi et al 2009, Caldeira et al 2012, Fehr et al 2015, Letcher & Carmona 2015, Lindemann and Harbke 2012, McCave et al 2013, Wang 2013). Since 2000, abstinence-only sexual education programs or “sexual risk avoidance” programs have been promoted to teach students
how to say no to sex, with 37 states mandating that abstinence be either covered or stressed (Guttmacher 2018). This has occurred alongside the decline of programs that include information on birth control, as well as high school programs teaching any type of sex education (including abstinence) (Guttmacher 2017). The discussion of birth control methods in abstinence-only education is usually limited, casting birth control as an ineffective method to scare students away from sexual encounters (Kohler, Manhart, & Lafferty, 2008). Nationally, 332,560 women between 18-19 years old became pregnant in 2013 with 75% of those pregnancies being unintended (most recent year available; Guttmacher 2017). The recent political trend toward conservatism over the last ten years has sought to increase funding of sexual risk avoidance programs and crisis pregnancy centers, while restricting access and funding to comprehensive sexual education, contraceptives, and abortion (Guttmacher 2017). People affected the most by these policies are women of color and low socio-economic status women or those who have not received any formal reproductive healthcare education (Campbell 2017).

Chapter Overview

This introduction chapter gives an overview of the project background in relation to prior scholarship in anthropology, describes how the project was formed, and explains the research objectives. It then provides a literature review of the three theoretical frameworks that are used – governmentality and biopower, sexual citizenship, and reproductive justice – as well as a theoretical model to understand the relationship among them. The main arguments from my conclusions follow. I then give a brief overview of the three field sites where data was collected for the project. Finally, each chapter’s content is provided as a guide to the rest of the dissertation.
Project Background

This project was born out of several overlapping interests: how college aged students handle sexual encounters and relationship making; how different gender identities and sexual orientations affect these decision-making situations; and how current governmental policies impact the lives of college students. There are many public health studies that have examined different components of young peoples’ sexual and reproductive healthcare, such as focusing on contraceptive method choices, selecting one section of the population to examine (men who have sex with men), sexual assault, or age of first sexual initiation (see sources mentioned above). These studies are often quantitatively focused, and outcome based.

In anthropology, less has been written on the perspectives of young people and their decision making regarding sexual and reproductive healthcare; and in the U.S. context, this topic is still on the fringe of the discipline. Anthropological attention has covered pregnancy, birth, maternal mortality, assisted reproductive technologies, abortion, breast feeding, infant morality, state policies on birth and mothering, reproductive politics, menstruation, and female circumcision.¹ This body of work also includes foundational studies of cultural perceptions of gender norms in society (Mead 1973[1928], 1949; Rosaldo and Lamphere 1974; Rapp 1975), how women’s bodies are defined, objectified, and controlled often through metaphors of labor and production (Martin 2001[1987], how birth is experienced (Davis-Floyd 1992; Jordan 1993), decisions on abortion (Ginsburg 1998) and in vitro fertilization (Inhorn 2003).

In regards to sexual health, there are a few key areas that anthropology has focused on including HIV/AIDS research (Pfeiffer 2004; Pelto and Santiviago 2010; Halkitis et al 2013; ¹See Inhorn 2006 for a starting list of 150 ethnographic sources on women’s health.)
Pigg 2001; Heath 2016), STIs (Pliskin 1997; Goldade and Nichter 2010), human papillomavirus (Wentzell 2017; Wentzell 2015; Pop 2016), pap smear tests (Clarke and Casper 1996), cervical cancer (Gregg 2011) and other gynecological cancers (Markovic et al 2008), sex work (Butt 2008; Jung Yu 2013; Leonard 1990; Roche et al 2008), and sexual violence (Hirsch and Khan 2020; Mulla 2014). Family planning and contraception also have been covered (Hartmann 1987; Russell et al 2000; Sobo 1993; Tober et al 2006), including emergency contraception (Wynn and Trussell 2006), sterilization (Edu 2018, Kluchin 2009), vasectomies (Pomales 2013), and abstinence culture (Sobo and Bell 2001).

Studies specifically about young people have included rape experiences in South Africa (Wood et al 2008), vaginal discharge in Bangladesh (Rashid 2007), lesbian sexual and gender formation in Namibia (Lorway 2008), contraception service provision in New York City (Helmy 2015), engaging students in HIV/AIDS research (Copeland 2016), sexual health and decision making in Australia (Chenhall et al 2013), virginity and first sexual debut in Connecticut (Erickson et al 2013). To my knowledge, no studies have specifically looked at how sexuality education of young people in the U.S. southeast influences their sexual encounters and relationship formation.

For this dissertation project, I combined a quantitative public health approach to sexual and reproductive healthcare policy with qualitative methodologies from anthropology to gain a deep understanding of the background and lived experiences that influence how young people make future decisions. My approach builds upon scholarship in women and gender studies and sociology, by using a holistic approach to look at the intersections of gender identity and sexual orientation and how those are socially influenced through hegemonic narratives of governmentality and sexual citizenship.
The initial formation of this dissertation project was conducted as part of a pilot study for a Research Methods class I first took during my first semester at USF. The one-semester project expanded over two years, eventually leading to this dissertation project. Data for this project were collected from Fall 2015-2017 at USF. During this time, 356 online surveys and 9 semi-structured interviews were completed on undergraduate students’ contraceptive needs, decision making strategies, and social support networks. Respondents were representative of the overall racial/ethnic background of the student population for USF providing a solid foundation for generalizable observations and conclusions. Findings suggested that students lacked comprehensive sexual and reproductive healthcare (SRH) education, were unaware of student health resources, and that the university as a whole offered fragments of SRH education depending on student status (incoming freshman living on or off campus, international students, and transfer students are all exposed to different types of sexual education at different times of their academic careers). Additionally, pilot data suggested that SRH educational information was not standardized across the university, with students receiving different or inconsistent information from student health services, residential housing, orientation events, or no exposure at all.

From this pilot data, I expanded my scope of inquiry to adjust my research questions and refined my online survey, interview guide, and established a focus group guide. The project also expanded to include two additional field sites: The University of Kentucky and Louisiana State University. I had personal connections at both additional universities, and I wanted to incorporate a broader perspective on SRH in religiously and conservative states, but wanted to remain in the U.S. Southeast to provide geographical continuity.
This dissertation project was guided by three overarching research objectives:

1. To assess the sexual and reproductive healthcare knowledge of college age students 18 - 24 years old; including the key stakeholders and gatekeepers of information.

2. To investigate how past lived experiences with sexual and reproductive healthcare education and partner interactions impact their views and self-conceptualizations of identity and needs in future sexual encounters and relationships.

3. To explore how policies of national and state governments influence the production of sexual citizens (in this project, young people specifically), and identify the sexual narratives that guide identity formation and choices.

These objectives build on the other in order to provide a comprehensive view of the lived experiences of undergraduate college age students (18-24). The first objective starts with the foundation of sexual and reproductive healthcare knowledge to understand the types of information students were exposed to before they reached the university level. This includes the people and programs who provided or withheld SRH knowledge. This objective takes a micro- and macro-level approach by focusing on the individual’s experience, while examining large system factors that provided contributions. The second objective takes the first into account, examining early sexual interactions and lessons learned, to analyze how students consider prior knowledge during sexual encounters at college; largely focused on individual decision making and internal and external influences. Finally, the third objective is aimed at the macro-level of
governmental influences in controlling narratives on sexual citizenship and how those narratives impact individual comfort levels with SRH and personal identity formation.

Theoretical Perspectives

The above research objectives are framed and analyzed using three social science theories: governmentality, sexual citizenship, and reproductive justice. I have used a feminist methodological framework to guide every component of this dissertation project. Furthermore, the public health framework of the Social Ecological Model (SEM) is used to visually provide context on the interwoven layers for this topic.

Governmentality and Biopower

Governmentality is the will of a governmental body to control citizens through beliefs, aspirations, desires, and habits which condition people to act in their own self-interest, often not realizing where these ideals come from or how they influence behavior. Government acts in the interest of the population in wanting to achieve prosperity, economic viability, health, etc. Different from Foucault’s concept of discipline, which occurs in confined spaces, such as prisons or schools, governmentality operates on a population level. Through governmental rationality, i.e. governmentality, a variety of tactics, policies, and interventions, otherwise known as assemblages, are employed to reach better standards of living. These assemblages work together at different levels of government to form a power structure that asserts and reinforces itself. (Li 2007).

Foucault’s analysis of governmentality and biopower has become a foundational framework for studies on reproduction and the state. In *The History of Sexuality: Volume I,*
Foucault maps the emergence of state-controlled reproduction as aligned with population control at a time when political economy of governments conceptualized that instead of controlling individual people, it could control the overall population. This involved the government examining birth and death rates, marriage patterns, family lifestyles, and how these relationships were intermingled in producing labor and economies. This new-found observation system of government surveillance rested on a number of sexual observations and control mechanisms to produce active and productive citizens (Foucault 1990).

At the beginning of the eighteenth century, regulation of sexuality fell under three new categories that shifted it into the realm of secularization and state control: pedagogy (with regards to children’s sexuality), medicine (with specific emphasis on women’s bodies and their physiology), and demography (with the objective of regulating births) (Foucault 1990). These shifts would be the catalyst, according to Foucault, for discrimination and subjectification of specific groups of people during the nineteenth and twentieth centuries. Foucault’s concept of biopower coincides with the rise of governmentality in the nineteenth century and aligns with Marx and Engel’s (1848) theory on communism and economic workforce practices, and harkens back to Malthusian principles of the late eighteenth century (1798), in which capitalism is shaped by the ability of populations to produce large numbers of docile workers to advance the economy. This harnessing of biopower set the stage for increased social stratification and segregation of the working classes versus the bourgeoisie.

Through biopower, state governments can enact biopolitical control, to define an ideal family and an ideal woman along with her role in society. Biopower conceptualizes norms for social and reproductive behavior and diffuses those norms into the body of individuals that perpetuate them (Krause and De Zordo 2012). Most of the literature on this topic has been
written on the heterosexual woman experience of governmentality and biopolitical control. This type of governmentality can be enacted on both majority women’s bodies and marginalized women’s bodies, often both groups at the same time. This was seen in the eugenics and neo-eugenics movement in Europe and the U.S. in the twentieth century, mandating motherhood as being defined by the state government (Kluchin 2009). Kanaaneh (2002) asserts that biopower is now an effective tool used to liberate women or dominate them. State’s use of biopower to control individual and couples’ reproduction can weld the instrument through economic or political power, which can either cement an individual’s or couple’s loyalty to the nation (as with Israeli women) or can instigate resistance (as with Arab women). This system of governmentality and biopower methodology has been seen in Cuba, where the socialist state has attempted to define and mandate certain citizenship requirements onto women’s bodies. These policies espouse that unless they produce children at a rate to sustain population growth, then they are not doing their part to support the country (Andaya 2014). Biopower has also been ethnographically detailed in Mishtal’s (2015) study of post-socialist Poland, De Zordo’s (2012) work in Brazil on tubal ligations and Cardarello’s (2012) examination of the sanctioned forced removal of children for adoption, Marchesi’s (2013) research in Italy on morality, biopolitics, and fetal burial laws and Krause’s (2005) study on family-making and fertility rates, and Varley’s (2012) work on Islamic family planning in Pakistan.

Through biopower, government is able to take a specific characteristic of variation in its subjects, such as gender, race, ethnicity, fertility, and control how these differences are “shaped, managed, and selected in order to achieve political objectives” (Rabinow and Rose 2003: xi). Biopolitics are not static, but rather continuously change to fit the governmental narrative of the individual body versus the population body (Krause and De Zordo 2012). These political
objectives can control access to sexual and reproductive healthcare, either in opposition to reproducing, such as under the Fujimori administration’s sterilization campaign in Peru (Ewig 2010), or to increase reproduction of citizens, such as under the Ceausescu regime in Romania (Kligman 1992), or as seen in some current state laws in the U.S. requiring ultrasounds before obtaining an abortion in an attempt to shame women into keeping pregnancies (Rodrigues 2014). And, these policies can establish a racial hierarchy in the case of reproduction, in which specific groups of the population are targeted for health improvements (such as eliminating female genital cutting) in order to curb traditional reproductive practices (Thomas 2003).

Governmentality using biopolitical control can breach nation-state boundaries and can impact women in other populations or countries, such as the Mexico City Policy (“U.S. Global Gag Rule”), which removes US international funding from not only abortion providers, but any organization which counsels women on abortion or mentions abortion as an option to unplanned pregnancy. Bashford (2006) refers to this as global biopolitics, which began in the twentieth century and established a foundation for population control programs (Dalsgaard 2004, Greenhalgh 2008, Hartmann 2016, Krause 1994, Measham and Lopez-Escobar 2007, Mooney 2009, Rylko-Bauer 2014,). Global biopolitics has placed an emphasis on constricting third world women’s reproduction because they are classified as over-reproducing, which might lead to world over-population, and contributes to poverty (Wilson 2017). By removing this funding, other aspects of family planning and reproductive healthcare suffer, including cuts to cancer screenings and other contraception methods. This is a wider reach of governmentality and biopower that goes beyond national borders and infiltrates new boundaries based on a hegemonic international power structure that allows, in the U.S. context, religious ideology of one nation to
directly influence the lives of women in other countries who may or may not have the same religious beliefs (Barot and Cohen 2015).

Sexual Citizenship

The theory and classification of citizenship and a person’s relationship to the State as included or excluded has a long history in the social sciences, including in the discipline of anthropology. Citizenship study has included examinations and classifications of ideal and the legality of citizens (Arendt 2009; Fassin 2012), feminist theories of citizenship (Lister 2003), migration/immigration and refugees (Erel 2010; Holmes and Castaneda 2016; Green 2011), shifting boundaries of inclusion (Petryna and Follis 2015; Adams et al 2009), biological citizenship and healthcare citizenship (Biehl 2001), environmental citizenship (Kapoor 2017), and reproductive citizenship (Andaya 2014; Kligman 1992; Kanaaneh 2002; Thomas 2003; Pieper Mooney 2009 & 2010; Rousseau 2009; Ewig 2010; Bueno-Hansen 2015) to name a few.

The study of citizenship in the social sciences has a long history since the early 20th century, but women and other genders have been largely left out of the analysis, with most of the material emphasizing heterosexual men (Richardson 2012). The interpretation of sexuality and the intersection of one’s sexual orientation and citizenship has received even less attention (see below). Over the last 20 years, beginning with Evans’ (1993) seminal work, sexual citizenship has emerged as a growing subject in social science disciplines, specifically sociology and women and gender studies, but very little has been produced in anthropology. The reason for this gap in
the literature is unclear, which makes this project an important contribution to the intersection of sexual citizenship and anthropology.  

Sexual citizenship is defined as the adherence to formal and informal sexual norms that society prescribes and reinforces through cultural and social systems of behavior. Both individuals and groups of people are constrained by legal regulations, cultural acknowledgements of existence, political empowerments, and social equalities and dignities (Evans 1993). This structure guides cultural norms of acceptable behavior and provides a clear model for citizens to follow (Bell and Binnie 2000). Those who fall outside the model are labeled as deviant (Brandzel 2005). In the U.S., the model sexual citizen is a “phallic citizen,” putting white, heterosexual, cis-gendered men at the forefront of democracy and in control of all its institutions (Thomas 2017), with marriage and procreation being the ultimate result of full sexual citizenship manifestation (Mann 2013). Everyone else outside of the phallic citizen is demoted to second-class citizenship status. Some groups of people have had mainstream success in “masquerading” as phallic citizens (Phelan 2001). This “masquerading” is displayed most apparently in the advances of white, gay men’s legal rights acquisition over the last twenty years, specifically for marriage equality (Duggan 2002).

In the U.S. the advancement of gay marriage has been seen as a way to normalize sexual citizenship for gay and lesbian people (Bernstein and Naples 2010) and is deeply intertwined in the history of marriage and citizenship more broadly, including racialized notions of acceptability in addition to sexual orientation and gender identity (Brandzel 2005). Sexual

\[ A \text{ search of AnthroSource (1993 - present) for “sexual citizenship” returned 33 publications, of which only 13 were peer reviewed sources, and only 3 of which had a U.S. focus. A search of the JSTOR database of the same phrase in Anthropology journals only returned 41 publications, of which 29 were peer reviewed sources, and only 4 of which had a U.S. focus; neither search’s sources were mutually exclusive.}\]
citizenship narratives are also defined along racial lines, reinforcing the notion of second-class citizens. While white, heterosexual men are often congratulated for sexual activities, women are shamed for participating in or even expressing desire for sexual pleasure. White women are often portrayed as being virtuous, pious, passionless, and pure (Rury 1987), while Latina women are seen as at risk for early teenage pregnancy (Mann 2013), black women are seen as hypersexual and in need of control (Dickerson and Rousseau 2009), and Asian women are fetishized and dehumanized (Sirikul 2018).

This masquerading strategy is devoted to second class citizens modifying their behavior to socially and politically conform to heterosexual, cis-gendered ideals without disrupting the State. This acquiescence to the State, seeks to define everyone belonging to the same group, everyone is equal because we are all the same, as opposed to specific populations actively defining themselves as different; for instance, people who identify as queer (Thomas 2017). By allowing second class sexual citizens a few claims over phallic citizens’ rights, such as marriage, adoption, and beneficiary status, the State is able to “tame their diversity” and use access to these rights as a form of social control (Ammaturo 2015). The majority of sexual citizenship work has been in relation to heterosexual people and homosexual men, while very little attention has been given to lesbians and bisexual women. This focus shows the second-class citizenship nature of women in general, and women who do not need men for sexual pleasure specifically, and reflects the long-held notion that without the participation of men, sex is considered “not real” (Formby 2011).

However, as literature on queering institutions has shown (Meek 2012; Piontek 2006; Walks 2014), these strategies can provide a resistance model to heteronormative or phallic citizenship. The gay rights activism surrounding HIV/AIDS since the early 1990s to the present
is one example of sexual citizenship redefining political policies and cultural narratives, as well as queer communities rejecting binary classifications of sexuality and welcoming bisexual, pansexual, transgender, and even heterosexuals (not without controversy) into their spheres of communities (Bell 1995).

For young people, sexual citizenship formation is deeply influenced during their middle school and high school years (Tolman et al 2003). Their sexual citizenship is defined by teachers, administrators, coaches, and especially, peer interactions through sexual normative performances that reinforce ideal stereotypes of gender identity and sexual orientation. Sexuality education is taught through the assumption that sexual activity is dangerous and needs to be controlled, and that it is a biological process that is removed from socio-cultural factors and influences (Klein et al 2011). Sexual citizenship can also be classified as a way people conceptualize their right to sexual agency, such as how college students embark and participate in sexual activity (Hirsch and Khan 2020). Social and educational interactions that deny gender and sexuality diversity, either implicitly, through normative behavior, or explicitly, through sexuality educational, political, or religious teachings, reinforce heteronormative and cis-gendered lifestyles, actions, and viewpoints as the normal and acceptable behavior (Shipley 2013). Women as second-class sexual citizens are targeted more than men to behave and conform to sexual citizenship standards of model behavior. This targeted training begins early and is often delivered differently between racial groups. For instance, Latina girls have been targeted as high risk groups for sexual curiosity and teenage pregnancy in sexuality educational programs, and have been encouraged to abstain from sex and be “good girls” (Garcia 2009). These programs are largely guided by white, middle class ideals of life trajectory timelines and when specific goals of womanhood should be reached: high school, college, job, marriage, and
finally children. This idealized roadmap of life events ignores the structural and systemic
inequalities that people of color face, including economic and social disadvantages (Erickson
1998). This framework of life events demonstrates the intersectionality of racism, sexism, and
heteronormativity that defines sexual citizenship of various demographics in the U.S., all of
which do not meet the phallic citizen model.

Reproductive Justice

The term “reproductive justice” was coined in in the U.S. in 1994 by 12 black women at
a pro-choice conference in Chicago. The combination of the terms “reproductive rights,” of
which most mainstream, pro-choice groups now operate under, even if the main focus is abortion
rights, and “social justice” produced “reproductive justice,” in which there are four central tenets
to the theory, practice, and strategy:

1. The right not to have a child;
2. The right to have a child;
3. The right to parent children in safe and healthy environments;
4. Sexual autonomy and gender freedom are required for every person (Silliman et al 2016).

The divide between pro-life and pro-choice movements is focused on women’s
abortion/contraception access, with predominately white women (and men) controlling the
narrative. The second wave, mainstream feminism movement of the 1960s-1970s, largely
defined “women” as white, middle to upper class and heterosexual, and left out black, Latina,
Native American, Asian, trans, queer, and other sexual orientations that were not heterosexually
aligned as well as low socio-economic/working women (Davis 2016). The pro-life and pro-choice narratives both mask and support white supremacy and capitalism, of which both systems oppress communities of color, poor communities, and other marginalized individuals (Smith 2005). The pro-choice narrative is grounded in a neoliberal foundation that emphasizes the individual’s choice as the controlling factor in a woman’s ability to become pregnant or not. The mainstream pro-choice organizations currently use “reproductive rights” along with the pro-choice label to denote activism (NARAL, Planned Parenthood, etc.). While important for bodily autonomy, this framing of choice is limiting as it obfuscates larger societal factors that directly or indirectly influence a woman’s ability to make a choice, such as institutionalized racism, population control policies, sexual and gender orientations, economic opportunities, educational access, and exposure to physical or emotional partner violence or societal violence through policing and mass incarceration (Silliman and Bhattacharjee 2002).

Research has shown that women of color do not identify with the pro-choice model of advocating for reproductive rights and in some instances find it meaningless due to the aforementioned issues that impact their access to sexual and reproductive healthcare (Price 2010). In depth ethnographical analysis of these issues are found in Puerto Rican women’s sterilization choices (Lopez 2008), forced sterilization of Puerto Ricans, black, Latina, and Native American women in California, the southwestern border states, and North Carolina (Carpio 2004, Kluchin 2009), and coerced or misleading contraception guidelines and policies (Moskowitz and Jennings 1996). Reproductive justice advocates have been championing against population control policies, unsafe contraceptive methods, and the criminalization of certain pregnancy conditions (including drug use leading to incarceration). The reproductive justice strategy includes breaking down the systems of institutionalized racism that leads to structural
violence in healthcare settings, particularly for women of color (Farmer 2003; Silliman et al 2016; Smith 2005).

Using the term reproductive justice paired with a universal human rights framework is one avenue women of color in U.S. based organizations are trying to control the narrative. This term not only captures the mandates set down in the U.N. Declaration of Human Rights, but also incorporates issues of gender, race, and class dynamics that limit personal freedom, liberty, and the right to make choices (Silliman et al 2016). The key component of the reproductive justice methodology is to question, resist, and reconfigure structures of power (Jesudason and Kimport 2013). It is a framework designed to move beyond the pro-choice rhetoric of access to abortion (Price 2010) and examine the layers of inequalities and limited opportunities that women of color have to control their own reproductive destinies (Ross 2006). This shifts the focus beyond reproductive rights to reproductive oppression and how to advocate for the dismantling of that oppression (Ross 2006). Theoretically, the concepts of intersectionality, scholarship on fertility and population control, and feminist critiques of pro-choice narratives guide the reproductive justice movement (Crenshaw 1998; Davis 1983; Roberts 1997; Solinger 2005).

Numerous issues that fall under the umbrella of reproductive justice, but some of the most prominent are combating HIV/AIDS, addressing the maternal and infant mortality of women of color, specifically black women, advocating for high quality sexuality education that is both comprehensive and medically accurate, obtainable access to contraception and abortion, redistributing wealth, and providing communities of color to make and regulate their own decisions (Mays 2006). Additionally, reproductive justice allows for the connection to environmental justice, mass incarceration justice (including the criminalization of pregnant women and mothers), economic justice, and LGBTQIA+ rights (Price 2008).
Reproductive health, reproductive rights, and reproductive justice all work together to help improve the overall status of sexual and reproductive health and rights issues. Reproductive justice is the organizational framework and methodology that advocates for movement building across groups that are disproportionately impacted by government policies and predominant sexual citizenship narratives that oppress and limit reproductive freedoms. Even though reproductive justice is centered on women of color, poor women, Indigenous women, queer women, women with disabilities, women who are in prison, and who are immigrants, the framework can be extended to transgender and nonbinary individuals, bisexual and pansexual individuals, and homosexual men. This expansion, by focusing on the core tenets of the methodology and building upon it, can help advance the three areas that comprise reproductive oppression: sexual and reproductive healthcare (obtainable, accurate, and non-coercive), reproductive rights (laws and enforcement), and reproductive justice (transformation of political, economic, and socio-cultural institutions and contesting power hierarchies). Reproductive justice organizing combines academic and public health interests to form coalitions that help advance education and democracy to address the foundational tenants of the methodology (Mason 2013).

Incorporating a theoretical and methodological framework of reproductive justice in research projects can help advocate for resisting current structures and breaking them down into more inclusive categories (Silliman et al 2016; Ross et al 2017; Bakhru et al 2019). This intersectional approach can facilitate centering transgender, non-binary, gender fluid, bisexual, pansexual, and asexual people within overlapping structures of race/ethnicity, class, ability, and nativity. Reproductive justice further moves beyond homonormativity (white, upper class, out, gay men) and advocates for all LGBTQIA+ spectrum peoples to achieve reproductive justice and advance definitions of sexual citizenship to be more encompassing, including recognizing past
oppressions and trauma, while advocating for reparations. This framework includes those groups, through deviant sexual citizenship categories, who have been sterilized against their will at various points in history (Black, Puerto Rican, Native American and Latina women in the U.S.) and groups that have been deemed unworthy of parental rights (disabled people, gay couples trying to adopt, poor women on welfare).

**Theory Connections**

![Diagram showing connections between governmentality and biopower, sexual citizenship, and reproductive oppression, with arrows indicating relationships towards a feminist methodology and reproductive rights and justice.]

**Figure 1.** Theoretical model showing the relationships of governmentality and biopower, sexual citizenship, and reproductive oppression, which is resisted, contested, and dismantled by sexual and reproductive healthcare access, reproductive rights, and reproductive justice. This dissertation is focused on two of the three main elements under reproductive oppression: sexual and reproductive healthcare and reproductive justice (denoted by stars). These elements are all surrounded by a feminist methodology that acts as an overarching framework to analyze and understand these relationships.

The above figure is a model that I propose as a way to advance the theoretical study of governmentality and biopower, sexual citizenship, and sexual and reproductive healthcare and reproductive justice, and as a way to understand the applied framework for education curriculum,
programs, and interventions. I want to bring these theories into conversation with each other and provide a roadmap through which to understand how narratives and information are passed down from national governmental hegemonic institutions to individuals who make sexual and reproductive healthcare decisions based on learned knowledge and personal experiences with institutions, their communities, peer groups, partners, and their families. Anthropology provides a holistic lens through which to analyze the interplay of theories, methods, and public health models. A feminist perspective and methodology guide all components of the project, including the theoretical framing, design and data collection, analysis, and dissemination of results. Using this view, the model illustrates how forms of governmentality and hegemonic narratives of sexuality directly influence ideal perceptions of sexual citizenship, both broadly on the population level and locally on the individual level. Additional sub-themes and narratives are included to show the interconnectedness of the two theories and how specific socio-cultural constructions, such as the patriarchy, toxic masculinity, and rape culture influence people to social conformity. Incorporating the reproductive justice model of advocacy provides a path to contest, resist, and dismantle institutional power that works to reinforce reproductive oppression.

Main Arguments

Within this dissertation, I outline the following main arguments:

1. Abstinence focused sexuality education is failing to provide young people with medically accurate information and social awareness of positive, healthy sexual relationships;
2. Sexual citizenship in the U.S. is overtly aligned with heterosexual, cis-gendered, white, middle to upper class, and abled bodied maleness, which is to the detriment of women, transgender, and non-binary people, as well as homosexual, bisexual, pansexual, queer, and asexual people. This alignment contributes to a reductionist version of sexuality education, creating risky, coercive, or dangerous sexual encounters. Additionally, it stigmatizes those groups as less than worthy of healthy and enjoyable sexual encounters and lifestyles.

3. The strict definition of heteronormative, cis-gendered sexual citizenship negatively impacts the lived experiences of LGBTQIA+ individuals self-identify formation and impacts how they participate in sexual encounters;

4. The U.S. sexual citizenship definition is promoting patriarchal control, toxic masculinity, and rape culture in sexual interactions of young people, which encourages sexual assault, rape, and pressured or coerced sexual activity.

The Settings

This dissertation project was conducted in three field sites that are large, state funded, public universities in the U.S. Southeast: The University of South Florida (USF), in Tampa, The University of Kentucky (UK), in Lexington, and Louisiana State University (LSU), in Baton Rouge. These three field sites were picked because they are all geographically located in the U.S. Southeast. The region is politically and religiously conservative, including how states approach sexual and reproductive healthcare education and access. However, there are subtle differences in each field site location and state policies and viewpoints that provide a rich pool of
information and deeper analysis than one field site could do. The three sites also held personal
connections for me as a researcher, which made the process of IRB approval, obtaining
university and faculty institutional support, and learning the landscape of each school a smoother
transition while rotating field sites throughout data collection.

University of South Florida

Founded in 1956, The University of South Florida (USF) is located in an urban
environment, across three campuses in the greater Tampa Bay Area: USF Tampa, USF St.
Petersburg, and USF Sarasota-Manatee. Only data from the Tampa campus of USF was
collected. This campus is the largest of the three, with 37,350 undergraduate students of which
54.9% are female. Of the total student body population of undergraduates and grad students
(39,629 students) 44% are non-white, with 4% not reporting their race/ethnicity (USF Annual
Report 2019/2020). The university currently does not collect information on students who
identity outside the gender binary, except for an “other” category and does not provide
race/ethnic identity information for undergraduates only. It is not the flagship state school for
the state of Florida, but it is in the top five Florida schools based on enrollment, and is now the
only Preeminent Research University in a metropolitan area in the state. Tuition for a full time,
undergraduate Florida resident in 2019-2020 is $6,410 per year and for non-Florida residents it is
$17,324 per year. See Table 1 in Appendix A for the racial and ethnic breakdown in diversity for
overall Tampa campus enrollment as well as population statistics for the city of Tampa. The
university provides a variety of resources related to student health and wellness, including sexual
and reproductive healthcare. Separate offices on campus include the Student Health Services
Center, The Wellness Center, The Center for Student Well Being, the Counseling Center,
Victims’ Advocacy office, the Recreational Center, and the LGBTQ Multicultural Office. The USF Student Health Services Center (SHS) for fiscal year 2017 saw 61% female patients and conducted 5,634 sexual health and gynecology appointments (SHS Annual Report 2017). Within SHS is a clinic specifically devoted to LGBTQ healthcare needs, including providing consultation and hormonal therapy for transgender students who are transitioning. The number of students who submit claims or file cases with Victims’ Advocacy is currently not publicly available data.

*University of Kentucky*

Founded in 1865, the University of Kentucky in Lexington is the flagship school for the state and is also in an urban environment with over 22,000 undergraduate students; 54% female, but only 24% non-white students (UK Interactive Fact Book 2019-2020). Tuition and fees for a full time Kentucky resident in 2019 – 2020 is $12,360 per year and for non-residents it is $30,680 per year. See Table 1 in Appendix A for the racial and ethnic breakdown in diversity for undergraduate students as well as population statistics for the city of Lexington. The university provides a Student Health Services Center, including care for LGBTQ individuals, and a Mental Health/Counseling Center, as well as a Recreational Center, the Dinkle-Mas Suite for LGBTQ People, and a Victim’s Advocacy office. Data on UK’s student health center is currently unavailable.

*Louisiana State University*

The addition of Louisiana State University (LSU) as the third field site provided a larger, representative sample size. Founded in 1860 in Baton Rouge Louisiana, LSU is the flagship
school for the state and has an undergraduate student body population of 25,920, with 53% being female, and 32% being non-white (LSU Factbook 2019). Tuition and fees for a full time Louisiana resident in 2019 – 2020 is $11,962 per year and for non-residents it is $28,639 per year. See Table 1 in Appendix A for the racial and ethnic breakdown in diversity for undergraduate LSU enrollment as well as population statistics for the city of Baton Rouge. The university provides a Student Health Services and Counseling Center, a Women’s Center, Victim’s Advocacy Office, a Recreational Center, Wellness Promotion Services, and an LGBTQ Office. Data on LSU’s student health center is currently unavailable.

**Overview of Chapters**

This introduction chapter discussed the project formation, study justification, and theoretical frameworks on which this dissertation is based. Chapter 2 provides a breakdown of the methodology of the dissertation including an overview of how I used a feminist methodology to guide the formation and execution of the project, and the incorporated the Public Health Social Ecological Model to frame recommendations from the results. Additionally, Chapter 2 explains the data collection methods, limitations, and an overview of the analysis.

Chapters 3 – 5 give detailed explanations of the main results from this project. Chapter 3 provides a discussion on sexuality education in the U.S., including the different types that are most commonly taught and the stances of the current federal government. It provides an analysis of governmentality and sexual citizenship narratives and how those are perpetuated through sexuality education programs in middle and high school. It also discusses the common themes that students identified during their sexuality education experiences and how those teachings impacted their lives later.
Chapter 4 examines sexual violence that students in this project experienced, including assault and rape. The sub-themes of patriarchy, rape culture, and toxic masculinity are discussed to show the impact sexual citizenship narratives have on young people who experience sexual violence. Some quotes are graphic and may be triggering for some readers.

Chapter 5 focuses on the experiences of LGBTQIA+ students who were interviewed for this project. They provided detailed descriptions of their “coming out” narratives, interactions with healthcare providers, and how they negotiate sexual encounters. The chapter is framed by looking at current federal policies that affect LGBTQIA+ populations in the U.S. and how these tie into ideal sexual citizenship narratives.

Chapter 6 concludes the dissertation with a summary of main findings for each research objective and how they connect to the theoretical and methodological frameworks. I discuss the applications of the research and the contributions to anthropology and public health, as well as directions for future research.
CHAPTER 2:
METHODOLOGY

Feminist Anthropology as a Methodology

Being a feminist is a practice that is embodied in everyday life and through activities both at the individual and community level. Feminist practice embodies social and societal transformation by working with networks or movements that promote feminist ideals; whether that is at the local level with specific groups that provide direct services to individuals or national movements that seek to challenge and restructure neoliberalism, capitalism, and colonialism. For academics, feminist practice includes redefining the production of knowledge and shifting theories and pedagogies towards feminist visions instead of replicating and duplicating the patriarchal, neoliberal model of the academy (Mohanty 2003). Positionality for feminist scholars has always presented a debate. By openly exploring research from a feminist perspective, anthropologists and others have been dismissed as being biased since they are assumed to only focus on one predominant viewpoint in their work: women (Abu-Lughod 2006 [1991]). This seems hypocritical and ironic considering most foundational research in the discipline of anthropology was only focused on male perspectives that went unchallenged and unquestioned, including on issues dealing with positionality, reflexivity, and voice (for example: Malinowski 1922, Evans-Pritchard 1940, Turner 1957). Leacock (1987) and Haraway (1988) both argue that one can never become truly objective in their research, and that the closer one is to their research subjects, the better the product will be, because this produces a level of caring that is not found in more “objective” studies. Mandating that research must be “objective” for Haraway reinforces an
asserts that her alignment with feminist movements makes it impossible for her to be “objective”
as science defines it.

In the U.S., anthropology as a discipline didn’t focus on feminist issues until the second
wave of feminism began in the 1970s, with two foundational published works, *Women, Culture,
and Society* (Rosaldo and Lamphere 1974) and *Toward an Anthropology of Women* (Rapp 1975).
This decade included the founding of the first journal devoted to women’s studies (Feminist
Studies), *Signs: The Journal of Women in Culture and Society*, *Toward an Anthropology of
Women*, the Association of Black Anthropologists, the National Women’s Studies Association,
Women Against Violence Against Women, and the National Center for Lesbian Rights. These
associations and publications, along with the landmark ruling of Roe v. Wade, and the first U.N.
World Conference on Women (1975) helped establish feminist studies as a part of the
anthropological discipline. Feminist anthropologists established themselves by challenging and
advancing the experiences of women.

However, this new section of anthropology suffered from tensions, including the lack of
representation of women of color, and women of differing sexual orientations (Craven and Davis
2014). These tensions provided new theories and methodologies to analyze different forms of
oppression and intersectionality, including lesbian and queer theories of existence, differences in
white women versus women of color’s lived experiences, indigenous women, and the
intersections of women who self-identify on multiple levels of feminism (such as queer women
of color). Feminist ethnography specifically, and the methodology to conduct such research, did
not become prevalent in the discipline until the late 1980s – 1990s, in which feminist
anthropology entered its “heyday” (Behar 2002). Authors such as Martin (1987), Stacey (1988),

Feminist ethnography is itself a counter-storytelling of established ethnographic works, that seeks to contest patriarchal and neoliberal frameworks that impact public policies and personal lived realities through examining issues of gender, race, class, and sexuality. It is a primed method to complete Nader’s call for “studying up” (1972). At its very core, feminist anthropology is simultaneously philosophical and political (Harrison 2013). “Critical analysis that is informed by an explicit politics has to grapple with those politics overtly rather than cede to the tendency to downplay their role” (Speed 2008:231). Feminist methodology examines hegemonic structures that have real world impacts and seeks to dismantle those narratives and oppressions. It places advocacy for the most vulnerable and oppressed at the center of research.

Feminist methodology utilizes an intersectionality approach, in which gender, race, class, and sexuality are all examined in order to provide a holistic viewpoint of the patriarchal forces that marginalize and oppress women (Ahmed 2017; Crenshaw 1998; Schulz and Mullings 2006). This perspective uses “interlocking axes” that are combined to examine all aspects that influence the situation of women, and not just one sliver of the problem (Speed 2008). This element of methodology allows for varieties of viewpoints in order to understand oppression or marginalization and not just the dominate political structure, as these axes operate simultaneously. On the surface, the claim of intersectionality is an easy one, however in practice, as Ewig (2010) notes, “although theories of intersectionality abound, empirical intersectional analyses are still rare” (p. 211).
Davis and Craven (2016) argue that feminist ethnography cannot be defined by a single
definition nor can the practice of conducting a feminist ethnography be on a linear path. The
authors’ definition encompasses five key areas:

1. It involves a commitment to intersectionality (race, gender and sexuality, class, ability, and the
   nation) that focuses on power differentials
2. It incorporates feminist scholarship
3. It contests injustice and issues of marginality
4. It identifies and examines power dynamics
5. It produces scholarship to contribute to advancing justice causes, campaigns, organizations,
   and communities using a feminist lens.

This means that political commitments inform the research and are expressly
communicated to research participants (Bueno-Hansen 2015). Part of conducting a feminist
ethnography is to contest institutions that seek to silence feminist voices, and this includes
academic institutions. Neoliberal institutions have disproportionally restricted feminist research
on topics that challenge or seek to transform narratives surrounding sex work, reproductive
rights, inequalities, marginalization, violence and abuse, and drug use by classifying them as
“risky” projects that require advanced documentation and oversight in order to be approved.
Chin (2013) asserts that part of the job as feminist ethnographers is to challenge IRBs and
academic institutions that seek to silence research that does not conform to the neoliberal
standard of “easy” research. Using a feminist methodology seeks to incorporate social and
political activism into the approach.
Anthropology and feminist activism have had a difficult and sometimes contentious relationship in the world of academia, and in turn, how this translates to ethnographic research or activism in organizing and implementing policies. “The engaged fields of feminist scholarship and activism do not sit easily with anthropology because of the different social locations from which women’s lives are being assessed and gender politics analyzed” (Abu-Lughod 2016:602). This relationship has been referred to as an “awkward” encounter or dialogue by Strathern (1987). The two disciplines have different foundational approaches to analyzing women’s issues.

Anthropology views an “other,” in this case cis-gendered, heterosexual men, and tries to understand the power relationships between men and women and how those relationships affect larger cultural constructions such as the economy, politics, and kinship structures, etc. Traditionally, anthropology’s focus is not to combat misconceptions or voice an opinion on the structure of society as being either good or bad, liberating or oppressive. Feminist studies on the other hand start at a place of analyzing a misrepresentation, and seek to destroy the deeply held stereotypes of women’s experiences that are perpetuated through a system of patriarchal oppression (Strathern 1987). According to Visweswaran (1997) anthropologists have tried to redefine what ethnography is rather than what feminism contributes to the work specifically in an attempt to address the awkwardness of the research. Ethnographies have redefined what gender is and how it is viewed and interpreted, instead of using feminist methods to influence the construction of the ethnography itself, and challenge patriarchal power hierarchies and stereotypes. Gruenbaum (2001) argues that as feminist anthropologists, researchers should be focused on tackling ethical dilemmas and solving conflicts that provide support for individual autonomy and address problems at the social group level.
Das reminds anthropologists working in the public policy realm that the discipline has often “been accused of making the social so complex as to make it useless for any policy purposes that demand some reduction of complexity,” (Das 2003:301). Scheper-Hughes would argue the same, that academics who write overly complicated works filled with jargon are useless and “they are far too willing to serve any master” (Scheper-Hughes 1995:418). This is important for feminist anthropologists who are doing applied work, as part of the focus of the research and recommendations is to make those suggestions clear and concise, and this Das says, is one way that anthropologists can be the most effective. It is also one way that feminist practice comes into play, because serving any master goes against the foundational tenets of what practicing a feminist anthropology entails.

Incorporating a Feminist Methodology Approach

Given the importance of using a feminist methodology in my own life and to understand the broad and nuanced issues surrounding the topic of sexual and reproductive healthcare in the U.S., I have tried to include an intersectional feminist lens throughout every step of the project from formulation to results dissemination. As a privileged, middle class, cis-gendered, heterosexual, white woman, I continually make efforts to confront biases of being white and in a position of power that may skew my feminism into realms that work against an intersectional approach. The white feminist positionality is one that must constantly be questioned by white women and brought to the front of analysis in order to not reinforce patriarchal narratives and the hegemonic structures they support.

The commitment to intersectionality was essential to the design of the project and participant recruitment. All students who met the age and enrollment criteria (see below for more
information) were included in the online survey. This diversity provided a voice for numerous race/ethnicities, gender identities, and sexual orientations in order to provide a broad perspective on which to base analysis. Additionally, my undergraduate research assistants also met the intersectionality criteria by being diverse in how they self-identified in race/ethnicity, gender, and sexual orientation, and provided expertise on their own university experience and asked compelling follow up questions after transcriptions were complete that helped propel my own analysis forward. These voices are coupled with the inclusion of feminist scholarship, of which I have tried to incorporate throughout the project. My hope is that this project advances Foucauldian theories of governmentality and biopower into a new realm that encompasses an intersectional approach in order to shift sexual citizenship narratives into the sphere of reproductive justice.

The dissertation is centered on contesting the patriarchal structures that currently define governmentality and sexual citizenship through sexual and reproductive healthcare in the U.S. As such, the three results chapters are focused on identifying and analyzing issues of power imbalances that young people experience regarding sexual and reproductive healthcare, through interpersonal relationships and interacting with authority figures (doctors and educators). The examination culminates in a reproductive justice-oriented section that uses an applied anthropological and public health framing to make recommendations on future interventions, policies, and avenues for further activism.

**Positionality of the Researcher and Funding**

Over the last several decades, the discipline of anthropology has seen a shift from the standard model of spending one-to-two years in the field to complete a dissertation to a more
localized and easily accessible model of “at home” anthropological research. While the latter type of dissertation project is seen as less prestigious by some in the discipline, it affords numerous benefits to the researcher, including financial feasibility, entree to research participants, and lesser degrees of culture shock and assimilation. I greatly benefited from these three factors while conducting this dissertation project. Most of my adult life thus far has been spent on university campuses in Tennessee, California, and Florida. As a student who has participated in the undergraduate and graduate experiences, my perceptions and understandings of how university systems are structured provided a solid foundation to undertake this research project. The additional layer of teaching multiple undergraduate classes, mentoring, and interacting with students daily, and being an age not too far removed from my research subjects, allowed easier access to students and diminished the power structure of researcher versus participant. This helped establish a relationship of trust between myself and the students who participated in this project, as evidenced by their openness and vulnerability discussing sensitive topics such as past sexual history and sexual violence.

Making sure the students who spoke with me felt comfortable and in a protective space was given the highest priority. This was done not only by reinforcing the informed consent wording and emphasizing their ability to stop at any time, but also using non-biased and non-judgmental language and reactions in my questions and body language. This created a safe and friendly atmosphere, which additionally decreased the power hierarchy between us.

For myself, hearing emotionally charged and graphic accounts of sexual violence added a layer of intimacy with the narratives that deeply impacted my mental health. The vicarious, or secondary trauma, was an ever-present weight throughout the duration of this project. I utilized friends, who also conduct ethnographic research, as a social support system to share experiences
and coping strategies. Shifting the narrative in my mind from “horrific traumatic events” towards a framework of “telling stories of traumatic events to bring awareness and impact change” dramatically helped me as I analyzed and wrote about the experiences that students survived. Using a positive internal dialogue as opposed to a negative one, was one of the best coping strategies I used to complete this project.

I was fortunate enough to apply and receive an Emerging Scholars award from the Society of Family Planning, a national non-profit organization focused on increasing contraception and abortion research, training, and access across the U.S. This grant funded all of the incentives for participants, equipment and transcription service fees, a stipend for my first research assistant, and several field site trips from Kentucky to USF and LSU over the course of eight months. An additional Research Scholarship Award from the College of Public Health provided the funding needed to finish the project.

Data Collection

I utilized multiple anthropological methods to collect qualitative and quantitative data from September 2018-2019 at USF in Tampa, UK in Lexington, and LSU in Baton Rouge to complete the aforementioned research objectives/aims in Chapter 1. This project consisted of a quantitative online survey and qualitative semi-structured interviews with students. Online, anonymous surveys and questionnaires allowed me to reach a large target population and are a beneficial tool when conducting research on sensitive topics (Schensul and LeCompte 2013). Semi-structured interviews were conducted to provide in-depth information on students’ education, viewpoints, and perceptions of sexual and reproductive healthcare (Bernard 2011).
Data collection consisted of two phases: Phase 1 was online survey recruitment and administration to undergraduate students and Phase 2 consisted of semi-structured interviews with students who left their contact information after they filled out the online survey. Data collection began in the Fall of 2018 and ended in the Fall of 2019. For those who participated in an interview, I referred to them by number and school location. The same naming convention is used throughout the dissertation, except in Chapter 5 to highlight the sexual orientation or gender identity of individuals. Due to the large number of students who completed the survey and for those who were interviewed, I decided against giving participants an alternative name, as I did not want others reading it potentially thinking they could identify someone in the data. Additionally, it felt disingenuous to provide names to those students who had undergone a major self-identification change, such as those participants who were transgender and fully out, or those who were transgender and afraid to come out, as well as non-binary individuals. Being able to choose one’s own name that represents who they are as a person is a pivotal and life affirming step for individuals who switch their gender assigned at birth. Assigning them names that they did not pick, and which could potentially be misconstrued as one gender or another, felt like a personal violation of their trust and one that I was not willing to break. All data was collected at the three universities identified in Chapter 1 (USF, UK, and LSU), and nowhere else.

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3 Institutional Review Board approval was provided through USF with supporting letters from two professors at UK and two professors at LSU. Because of the ways I recruited survey and interview participants, I did not need IRB approval through UK or LSU’s IRB system.

4 Everyone who was interviewed signed an IRB approved informed consent form, and everyone who filled out the survey was given consent information at the beginning before agreeing to participate. This study included only minimal risks to participants as per IRB regulations and definitions.

5 Files were named according to school and number of interview (for example: USF 1, USF Employee 1, etc.)
Participant Recruitment

Online survey participants were recruited via email through personal university connections. This included professors, graduate students who were teaching undergraduate classes, department listservs, club and organizations, offices on campus, and others passing the survey along in a snowball sampling method (Bernard 2011).

Quantitative Online Survey

The online survey, distributed through email and housed via Qualtrics, collected demographic data, contraceptive choices and methods, sexuality education, social support networks for decision making, STI and HIV testing and awareness information, frequency of using the student health services center, and awareness of services provided at each university. I created my own survey instrument that had been previously validated from a pilot project I previously conducted, focused on female undergraduate contraceptive method usage. For this project, the survey was expanded to be more inclusive of the spectrum of gender identities and sexual orientations. The survey totaled 85 questions, with most questions being multiple choice. Any currently enrolled undergraduate student who was between the ages of 18 - 24 was eligible for participation in the project. At the end of the survey, students were asked if they would like to participate in an interview or focus group, and if they said yes, contact information was collected for follow-up recruitment. All students who filled out the survey were entered into a drawing for a $50 Amazon gift card through an external form to keep their survey information anonymous. Three gift cards were given out.

6 Emails contained IRB approved wording introducing the project and a flyer that I made specific to each school that advertised the topic and incentives for participants.
Across the three universities, the survey was sent to 497 professors, 366 clubs and organizations, 54 different departments to capture a range of majors, 19 campus offices, and 6 to miscellaneous categories to a total of 942 emails sent. For USF specifically emails were sent to 173 professors, 45 clubs and organizations, 20 departments, zero campus offices, and four miscellaneous people. For UK emails were sent to 160 professors, 158 clubs and organizations, 13 departments, 15 campus offices, and 2 miscellaneous people. And, for LSU, emails were sent to 164 professors, 163 clubs and organizations, 21 departments, four campus offices, and zero miscellaneous people.

Completed surveys totaled 778. The confidence intervals for each survey compared to university population size are: USF with 425 surveys in the 95% confidence level; UK with 183 surveys for an 80% confidence level; and LSU with 170 surveys for a confidence level of 80%. Confidence interval for the aggregate data are: 99% confidence level. Due to the nature of survey distribution (listservs, clubs and organizations, individual classes) it is impossible to determine the survey response rate due to information barriers. Not all professors responded they distributed the survey, even though survey responses would spike when professors were contacted. Additionally, I did not have members lists or numbers of participants for clubs and organizations at UK and LSU, and I did not have access to membership information from listservs at any of the three universities. See Table 2 in Appendix A for emails sent for survey distribution and confidence intervals.

**Semi-structured Interviews with Students**

I conducted semi-structured interviews using a thematic interview guide I created based on themes from the survey, my pilot project’s interview data, and literature relating to sexual and
reproductive healthcare and knowledge (see Appendix C for interview guide). This guided allowed interviews to have structure for specific groups of questions (such as contraceptive decision making) but allowed for in-depth discussion and branching off into tangential topics that students felt were important information for me to have. The questions also aligned with the three research objectives for the overall project as discussion in Chapter 1.

Semi-structured interviews with men, women, and transgender/non-binary students who spanned a wide ranges of sexual orientations were conducted from December 2018 to July 2019 to provide information on sexual education exposure, contraceptive decision making strategies, past sexual history, social support networks, approaches to healthy sexual relationships, where students access/search for reproductive health information, and use of campus resources, including the student health centers. Students who expressed interest in being interviewed at the end of their completed survey were contacted to participate. I purposely oversampled students who self-identified as LGBTQIA+, as their voices are often left out in large projects that are not specifically focused on LGBTQIA+ issues.

In total, 50 student interviews were conducted with interviews ranging from 20 minutes to 90 minutes. All interviews took place in private offices at each university. All interviews were recorded and then transcribed by either me, one of four undergraduate research assistants, or the Rev Transcription company. All interview recordings were de-identified if not transcribed by me. Student interview participants received a $15 gift card (Starbucks or Amazon) for completing an interview.

Before beginning discussions of sexual assault and harassment, students were again reminded that they could stop the interview at any time and that they could determine what information they were comfortable with providing. All students who answered that they had
experienced sexual assault, harassment, forced, or unwanted sexual encounters were specifically asked if they felt comfortable discussing the details of those experiences. In both the online survey and the semi-structured interviews, students were prompted with language asking about “forced” or “unwanted” sexual encounters. This wording was to let the interviewee use their own language to describe their experiences, and several used the words assault, harassment, and rape to describe their previous situations. The adoption of this linguistic feminist interviewing strategy has been used elsewhere as well (Raymond and Corse 2018).

Data Collection Limitations

There are a few limitations to using a feminist methodological approach. One of them is that it is still not completely recognized as a legitimate research methodology in the discipline or the academy more broadly. Claims that the research cannot be objective because the researcher is too involved or too close with the participants has been used to discount research findings. Many power structures, including academic institutions, also do not agree that advocating for particular political issues or actions to result in change is an appropriate way to conduct research. These ideas go against the foundation of applied anthropology, feminism, and my own ethical guidelines, and so are discredited as “limitations” to this project.

I also encountered a few IRB restrictions for recruitment that limited the ways I could reach students. Due to IRB recruitment restrictions at UK and LSU when using another institution’s IRB (in this case USF), I was only able to email my survey and recruitment flyer to professors and clubs and organizations. There were strict rules regarding in-person recruitment on campus. Although I had established connections at both UK and LSU, it became apparent that my affiliation with USF and not as a student at UK and LSU was a hinderance to people being
willing to distribute my survey to their students. As such, the survey completion rates for UK and LSU are lower than at USF.

There were also limitations at all three schools on individual peoples’ perceptions of sexual and reproductive healthcare as an inappropriate topic for the audience (undergraduate students) or thought the timing was insensitive (this was not elaborated on). These professors, specifically, were uncomfortable or unwilling to send out a survey on a topic that was “taboo,” other professors had strict policies on not posting or distributing any outside class material to their students.

Overview of Analysis

Survey Data

Survey data provided descriptive demographic data from participants on gender identity, sexual orientation, race/ethnicity, age, religion, sexual education, sexual history (including age of first sexual encounter and number of sexual partners to date), current birth control method, social support networks (including partners, parents, and friends), sexual assault experiences, and campus resources used or awareness of resources available. This demographic data provided additional information to support the qualitative information collected in student interviews (see Appendix A for tables on demographics of participants).

Interviews

All interviews (50 students) were recorded and transcribed by either me, one of four undergraduate research assistants, or through the company Rev Transcription. I listened to and edited all transcriptions not done by me (when needed). All student transcripts were imported
into MAXQDA analytical software for coding analysis. I established a codebook consisting of a priori codes based on the survey and interview guides as well as the theoretical frameworks of governmentality, sexual citizenship, and reproductive justice. I then added in additional codes during initial coding of the first 10 interviews to complete the codebook with a set of emerging themes. After the first round of coding, I conducted a second round of coding to check consistency of the initial coding, since I was the only person coding the material. The topic areas and themes that were identified as the most prominent are included in the results chapters.

Social Ecological Model

Methodologically, the Public Health Social Ecological Model was applied to guide recommendations from the project in order to understand parameters and the status of students’ self-efficacy toward their own sexual and reproductive healthcare (see Figure 2 below). There are several variations of this model, but the one used in this dissertation follows the levels of Policy - Community - Organization - Interpersonal - and Interpersonal. The model categories multiple levels to contextualize influencers of sexual and reproductive healthcare, including students’ perceptions and their social support networks that influence decision-making, accessibility of resources, and the political narratives that control university policies (Coreil 2009). This model helps identify key communication and action points for targeted interventions for students.
Conclusion

This chapter provided an overview on feminist anthropology as a methodology and how I incorporated that framework into this dissertation project as well as applying the public health Social Ecological Model. It also gave an overview of the data collection methods I used: an online survey and semi-structured interviews to inform the research objectives listed in Chapter 1. It concludes with information from the online survey and student interviews on demographics, sexual history, sexual practices, sexuality education, and instances of forced, unwanted, and uncomfortable sexual encounters.
CHAPTER 3:
SEXUALITY EDUCATION

Sexuality education in the U.S. has been and is a culturally charged topic undergoing a variety of iterations since the early 1900s: sexuality education, family planning education, and pregnancy prevention to name a few. Presently, 95 percent of people in the U.S. by the time they reach the age of 18 have been exposed to some type of sexuality education curriculum through either public or private schools, community organizations and nonprofits, or religious affiliated programs (Martinez et al 2010). Sexual activity in young people is driven by a variety of influential factors including family structure, economic class, educational access, and religious ideology, but often the only time sexuality education is addressed is through public health programs and initiatives, including sexuality education during school (Perrin and DeJoy 2003).

There are a variety of sexuality education models that are taught in the U.S.: abstinence only (sexual risk avoidance), abstinence plus (often called “comprehensive”), and the emerging rights-based sexuality education are the three most popular. Since the early 1980s, the federal government trend has been to promote abstinence only or abstinence plus sexuality education. Abstinence only education teaches that sexual activity should be avoided until marriage, while abstinence plus takes a harm reduction approach to disease and encourages safe sex practices through condom usage, but still promotes an abstinence until marriage message. Abstinence plus is often referred to as comprehensive sexuality education, although true comprehensive models include much more information (Berglas 2014). The use of the word “comprehensive” to describe sexuality education has been used in a variety of ways, and there is no standard
definition of what comprehensive sexuality education entails (Haberland 2015). Schools teaching sexuality education has been occurring since the early 1900s, and while a full recounting of the history of such programs is beyond the purview of this dissertation, Moran (2000) provides a thorough historical account of the movement beginning with the 20th century’s hygiene movement and the association of white, middle class concerns with unhygienic immigrant populations and high birth rates up to the present focus on heteronormative, monogamous relationships resulting in delayed sexual activity until marriage.

The first attempt by the U.S. federal government to officially regulate sexuality education was in 1983 under President Reagan through a Title XX program called the Adolescent Family Life Act (AFLA), otherwise commonly referred to as “The Chastity Act.” This act established an abstinence only education framework that promoted abstinence as the only way to prevent pregnancy and STIs, while barring any educator from mentioning abortion in any way. While the AFLA encountered resistance and a battle through the federal court system, including The Supreme Court, it was eventually upheld, provided that information be medically accurate and not delivered in any religious setting during school hours (Perrin and DeJoy 2003).

The second major federal piece of legislation to support abstinence only education was tacked on last minute to the 1996 Personal Responsibility and Work Opportunity Reconciliation Act, also known as “welfare reform.” This Act was largely sponsored due to the high numbers of babies being born out of wedlock and low marriage rates. Within the Act was language mandating abstinence only education funding through the Title V program, which included for the first time at the federal level, language stating that abstinence until marriage would be the expectation for any school age person and that monogamous relationships through marriage are the expected standard for all human sexual activity (Perrin and DeJoy 2003). This legislation
also upheld the same racist and classist notions of the early hygiene movement, by targeting low income, largely minority populations for further governmental oversight and control of access to resources, and allowing school-based sexuality education (SBSE) to provide guidance to these populations as well (Bey-Cheng 2003).

In the last few years under the Trump Administration, the U.S. government has shifted the language of abstinence only education to be called “sexual risk avoidance” programs in order to hold younger people more accountable for their actions; moving from risk reduction of sexual behavior to risk avoidance of such behaviors in the first place. The new branding of these programs also employs the “success sequencing for poverty prevention” strategy that promotes finishing high school, working full time, and being married before sexual activity occurs as a way for students to break the cycle of poverty (Boyer 2018).

Abstinence only and abstinence plus (comprehensive) education strategies both promote a dichotomy of good versus bad behavior. This dichotomy reinforces moral codes of conduct that are directly tied to Christian values and teachings of appropriate human sexual behavior (Bey-Cheng 2003). A landmark ethnographic study by Fine (1988) in New York City, classified SBSE as promoting three narratives: sexuality as violence, sexuality as victimization, and sexuality as morality. These three narratives influenced the ways students interpreted their own sexual behavior. All three narratives promote the dichotomy of good versus bad sexual behavior, leaving no room for grey areas of sexual encounters and viewpoints. Studies have also demonstrated how ineffective the promotion of abstinence-only education is when it is used as the singular tool for prevention, often times proving to do more harm than good (Bruckner and Bearman, 2005; Kohler et al, 2008; Trenholm et al, 2008; Underhill et al, 2007; Walcott et al,
No study to date has been able to prove that abstinence only education works (Perrin and DeJoy 2003, Berglas 2014).

Since 1996, the U.S. federal government has spent over $2 billion dollars on abstinence only sexuality education programs, policies, and promotion of the topic (Boyer 2018). Both the abstinence only policy and abstinence plus policy promote an ideal version of cis-gendered, heterosexual, monogamous relationships that lead to marriage, while excluding those students who may identify outside the gender binary, have different sexual orientations, and/or who cannot legally marry.

The shift towards rights-based sexuality education has been a slow one as the majority of sexuality education in the U.S. teaches abstinence and abstinence plus curriculum (Constantine et al 2015). The rights-based approach takes a broader view of sexuality and incorporates non-binary gender identities, full spectrum sexual orientations, and individual human rights as a way to promote healthy sexual activities and relationships (Berglas et al 2014). Topics included in this approach are sex positivity, personal autonomy and decision making, relationship power dynamics, emotional wellbeing, access to health information and services, as well as the other tenants found in abstinence plus education (Hardee et al 2014). This rights-based approach is in line with reproductive rights discourse and moves closer to a reproductive justice model.

Other developed countries take a more sex-positive approach than the U.S. does when it comes to sexuality education for students and have adapted rights-based curriculum. The Netherlands is one country that is often touted as one of the best models for incorporating comprehensive sexuality education. Students learn about contraception, abortion, STIs/HIV, pregnancy, and sexual responsibility in a supportive environment that recognizes teenage sexuality and wants/needs. Compared to the U.S., the Netherlands has better sexual health
outcomes for young people, including higher rates of contraception use and lower rates of teenage pregnancies and abortions (Ferguson et al 2008). France and Australia also use positive comprehensive sexuality education to teach young people about sexuality and how to have safe sexual encounters (Weaver et al 2005). Sweden also utilizes a comprehensive and inclusive sexuality education approach, which centers gender and sexual orientation diversity, as well as teaching anti-discrimination in those areas, but is still struggling to be inclusive of different races, ethnicities, and religions (Bengtsson and Bolander 2020).

State Laws for Sexuality Education

This dissertation project was focused on the U.S. Southeast, where states are more conservative and religiously affiliated than other geographical areas of the country. This political and religious influence dictates how states approach sexuality education for young people. The three states in this study – Florida, Kentucky, and Louisiana – all mandate some type of sexuality education that focuses on abstinence. See Table 9 on breakdown of sexuality education mandates and related facts by state.

Florida State Laws

Florida’s teen pregnancy rate is above the national average at 46 per 1,000 women as compared to 43 per 1,000 women (Guttmacher 2017). The state requires that public schools teach comprehensive health education, including promoting abstinence as the expected norm for students as well as including pregnancy consequences. In addition, the state policy has a specific clause that allows local determinations of values or cultural customs to supersede state policy, in essence allowing schools to opt out of certain aspects of health education they object to. If
schools decide to incorporate additional curriculum in HIV, they must also include the following: teach the benefits of heterosexual marriage and abstinence until then; abstinence as the best way to avoid HIV/STIs and pregnancy; students have ability to control their own behavior; and that all information must be age and grade appropriate. The state does allow parents to opt out of sexuality education components specifically (SIECUS FL State Profile FY2018). Florida public education states to “teach abstinence from sexual activity outside of marriage as the expected standard for all school-aged students while teaching the benefits of monogamous heterosexual marriage” (Florida Dept. of Education 2018).

Kentucky State Laws

Kentucky has a higher rate of teenage pregnancy than the national average of 52 per 1,000 women. Kentucky does not have a specific sexuality education curriculum in place, but students are required to take .5 credit hours of general health education, in which sexuality education is broadly addressed by discussing reproductive anatomy, decision-making regarding abstinence, HIV/STIs, and pregnancy, as well as physical and mental implications. In 2018, the state legislature added language stating that abstinence is the expected action for students and that permanent, monogamous relationships would be promoted (SIECUS KY State Profile FY2018).

Louisiana State Laws

Louisiana has the highest rate of teenage pregnancy of the three states in this dissertation, with an average of 54 per 1,000 women. The state of Louisiana defines sexual health as, “The area of health education encompassing a broad scope of concepts and skills, including acquiring information about sexual development, reproductive health, interpersonal relationships, body
image, and gender roles, recognizing habits that protect female and male reproductive health; and learning about pregnancy, childbirth, and the development of infants and children. It also includes skill development in areas such as communication, decision-making refusal techniques, and goal-setting. Sexual health topics are grounded in the premise that sexuality is natural, ongoing process that begins in infancy and continues through life.” (Louisiana Health Education Grade-level Expectations Handbook; p. 57 - link through SIECUS LA State Profile doc)

The state of Louisiana currently does not have a mandated state policy for sexuality education, leaving it up to specific counties, parishes, or schools to decide if they want to include sexuality education curriculum, with an additional mandate that students in K-6 grades will not be given any information on sexuality education (except in New Orleans). However, if schools choose to teach sexuality education, there are requirements for the instruction. Schools cannot include material that is homosexually explicit, nor can they provide advice or promote abortion as a reproductive healthcare option. Schools are also prohibited from handing out any type of contraceptive or abortifacient. Additionally, the instruction must include that abstinence is the expected norm for all students until they are married and is the best way to avoid pregnancy, HIV/STIs, and other tangential health issues, as well as promoting adoption and including the benefits of adoption to people wanting children (SIECUS State Profile FY2018). Other requirements are that the material covered must be age appropriate, it cannot promote religion, and parents have to be notified ahead of time and given a choice to opt-out their children from the material (Guttmacher 2018).
Theory: Governmentality and Biopower

Foucault’s concepts of governmentality and biopower provide a framework to understand the U.S. positionality on sexuality education (1990). Sexuality education is one of the mechanisms applied through the state’s various assemblages to enact biopolitical control over citizens’ bodies. The control for most people starts early, with topics of sexuality still being considered a cultural taboo that is only discussed in private settings, if at all. The suppression of the topic is continued throughout a child’s life as the hegemonic narrative for sexuality education is founded on abstinence, resistance, delayed actions, and the withholding of knowledge.

The U.S. has strong links to Christianity and that is used by the government to set a code of morals and standards for sexual activity. As a majority Christian nation, both within the population and among governmental elected officials, the concepts of purity and virginity are linked to appropriate behaviors for young people, especially women, as seen through the sexuality education tenants of waiting until marriage and the emphasis on diseases. Men are often given “passes” on these societal expectations and operate according to double standards. The hegemonic structure of patriarchy, discussed more in Chapter 4, emphasizes control over women’s bodies and choices, while men are not bound by the same oppressive constructs. By promoting a narrative of delayed sexual activity until marriage, the government is leaving out those people who identify anywhere on the LGBTQIA+ spectrum. This reinforces the notion, as discussed later in Chapter 5, that those people are deviant from society, and in some cases, have their very existence questioned.

Feminist researchers have spoken on the intersection of heteronormativity and sexuality education, and the ways it reinforces hegemonic narratives of patriarchal control and ideals, especially in relation to women’s bodies (Fields 2008; Fine and McClelland 2006; Garcia 2009).
Women’s bodies are seen as receptors for men’s, producing a stereotype that women do not seek sexual pleasure and do not want it (Fine 1988), and sexuality education does not address pleasure or sexual need in any way (Hirst 2013). Women are required to remain pure and passive in their intimate relationships (Douglas 2002). The framing of women’s bodies has been examined using an intersectional framework, in which sexuality education is severely lacking in its ability to incorporate race, class, and gender into teachings and discussions. This framing reinforces patriarchal norms of gendered behavior between men and women, and completely leaves out inclusiveness for people of different gender identities or sexual orientations, which can compromise LGBTQIA+ students’ safety at school and legitimate forms of bullying (Garcia and Fields 2017).

However, biopolitical policies have limitations to the control they have on populations. Governmentality takes a top-down, tiered-hierarchy approach, where the state mandates regulations and specific assemblages, such as schools and public health programs, promote and reinforce biopolitical control in an attempt to encourage individual internalization and submission. But, bodies can also be places of resistance that do not simply submit to power (Lorde 1984). This is seen through studies of how people utilize reproductive healthcare and resist laws and regulations through clandestine networks, and demonstrates that banning certain information (sex education) or procedures (abortions) does not eliminate the need for them or the utilization of them. These pockets of resistance, seeking to defy state mandates, whether individually or through group reproductive justice organizing demonstrate the ability to counteract governmentality and biopolitical control.
Results

For the online survey responses, 9% of students reported that they had abstinence only sexuality education, while 28% reported they had abstinence plus, and 36% reported they had full, comprehensive education. Almost 5% of students said that they couldn’t remember what type of instruction they received, and 20% said they were not given any at all. Of the 50 students who were interviewed, 44% said they had abstinence focused education in some capacity, while only 30% said they had comprehensive education, and 26% said they could not remember or had none. See Tables 10 and 11 in Appendix A for breakdown on survey and interviewee responses by school.

In the survey questions, there were definitions given for what abstinence plus and comprehensive education entailed. During the interviews it became clear that for those students, comprehensive sexuality education was actually a version of abstinence plus education. Students who were interviewed stated that because they were given some type of reproductive anatomy instruction and were told some type of information about STIs that they considered that to be comprehensive sexuality education. This may be an explanation for why comprehensive sexuality education was the largest percentage of education category in the survey, as this does not align with what the individual states mandate be taught and does not reflect the interviewed students’ experiences.

Students who were interviewed were asked to explain the sexuality education they received in middle and high school before they arrived at the university. Three main themes, described in detail below, focused on what students remembered from their experiences with sexuality education and the emotional impact the instruction had on them. The first prominent theme was the heteronormative nature of the instruction students received, including curricula that ignored
any people and their needs outside the gender or sexual orientation binary, the emphasis placed on heterosexual marriage, and the influence of Christian religious ideology. The second theme was the intense focus of abstinence, which students classified as lacking in providing them accurate information to have sexual encounters, using abstinence as a scare tactic, and that much of the information was a joke that students did not take seriously. The third theme that emerged was a recounting of sexuality education activities in which students were encouraged to participate. These included activities focused on purity narratives, virginity pledges, and the consequences of STIs/HIV and pregnancy.

**Heteronormative Instruction**

All students who were interviewed but one reported that they had heteronormative-based sexuality education regardless if the instruction was abstinence, comprehensive, or abstinence plus education. Several students specifically used the phrases “hetero,” “heteronormative,” and “heterosex” to explain the type of sexuality education they received. This framing largely focused on sexual encounters as only existing between a cis-gendered heterosexual man and a cis-gendered heterosexual woman. Within this context, most of the language students reported on was centered on waiting until marriage to participate in any type of sexual encounter, and this was directly linked to religious Christian ideology for many students.

Ignoring anyone outside the gender or sexual orientation binary

The heteronormative framework that controlled the dialogue between educators and students allowed the curriculum to either portray LGBTQIA+ people as not existing or “not being real people,” or provided instructions to not acknowledge them and their identities as
legitimate. This was especially apparent for students who had instruction that allowed for a questions portion of the program (many students reported not even being able to ask questions).

One student commented,

I don't know if the boys had, but the girls like, they like, had us write questions and then like, one girl was like, ‘I think I'm attracted to girls.’ And like, they read that question, they're like, ‘Oh, this is probably a joke.’ And they like, threw it away. And that's all I remember from that (UK, Interview 7).

While not a student who identified as a lesbian, this flippant disregard for others’ lived experiences remained with this student for years later, and sends a clear message to LGBTQIA+ students that their existence is a “joke” and should not be included as valid topics of conversation.

Another student also had a similar experience, “I had a friend and she was a lesbian and she tried to ask like a question about lesbian sex and they were like ‘we don’t answer those kinds of questions,’” (UK, Interview 3). While this educational setting did not go as far as to deny the existence of people outside the heteronormative structure, the educator did make it clear to all the students that any type of physical attraction to people outside heterosexual encounters is taboo, and thus deviant and misguided and cannot be addressed in a public setting.

Of all the students interviewed, only one reported that their sexuality education addressed sexual orientations outside the gender binary, and this was only due to the situation being forced upon school administrators to handle. A student at the time was having a lesbian relationship with another student and the administrators were trying to combat bullying towards the couple. In order to mitigate the bullying, the principal held an assembly that addressed different types of sexual relationships and said that not identifying as heterosexual was not a reason to hate or bully another person.
Marriage

Much of the information that was taught to students focused on sexual encounters being an activity that is reserved for marriage, and that students should not be participating in any type of sexual activity until they are in a heterosexual marriage. This is a common talking point for abstinence only proponents and curriculum, that focuses on sexual intercourse being linked to procreation through a responsible, societal approved venue: marriage. Many students mentioned the concept of marriage specifically during their interviews as one way in which educators tried to control the narrative of sexual intercourse and the importance of waiting to be sexually active until you are married.

One bisexual student likened her sexuality educational experience in a high school biology class to a “marriage advertisement,”

Um, so, and then, uh, one, like, huge memory that I have from biology is, um, I am a bisexual woman, and I knew that I was bisexual in high school. Um, and so there was, like a section on, like, sexuality. And, it just talked about, like, heterosexuality and, like, how you shouldn't, like, have sex with your partner until you're ready, and being ready is, pretty much, marriage. So, like, and it was, like, pretty much like a marriage advertisement. It was like, ‘Here's the benefits of marriage.’ And, like, ‘Here's why you should get married, and it's way better if you're married and everything's better if you're married.’ Um, and then, I was, like... uh, to my teacher, I was, like... I was just, like, a shit starter, I guess. So I was, like, to my teacher I was like, ‘Oh, but, um, what about, like, uh, gay and bi people? Like, they can't get married. So, what are you supposed to do?’ And, she went off script, and was, like, ‘Bisexuality isn't really real,’ so, um- Yeah, I'm serious. And, I was like, ‘Oh, really?’ And, she was like, ‘Yeah. I mean, I think there's probably gay people but bisexuality, I mean you're either one or the other.’ I was like, ‘Noted.’ So, yeah, that's what I remember about that (LSU, Interview 8).

As a bisexual student hearing an educator say that people like her do not exist, and promoting only heterosexual marriage as the ideal relationship for sexual encounters, this student, who was confident enough in her own identity at this point, took the entire experience as a joke. For other students however, who are still figuring out their own sexual and gender identities, instruction like this could have serious ramifications (see Chapter 5 for examples of
how exclusionary language and instruction can negatively impact people who identify as LGBTQIA+.

Marriage narratives in sexuality education are often directly tied to a focus on women’s bodies. Young women are taught that sex is forbidden and dirty until they are married, that they need to respect their bodies and keep them pure if they want to attract a husband, and to remain virgins by saving themselves for their husbands. Many students reported this language being directed at them through their sexuality education and school experiences. One student remarked, “Uh, and, you know, but you resp-, you don't respect your body if you have sex before marriage,” (LSU, Interview 6). And another commented that the “waiting until marriage theme” was a common occurrence both in their abstinence only education but within the larger school community as well,

…like people talking then they'd be like, oh well nobody's ever going to like marry you if you're like not a virgin when you get married. Or like they only want like virgins to marry or like date. Like they want like good pure girls. I'm like, that's stupid. First of all, if you didn't tell them, they wouldn't know. So…” (UK, Interview 15).

While several cis-gendered, heterosexual women expressed these concerns, and a few LGBTQIA+ students did also, no cis-gendered, heterosexual men who were interviewed mentioned any of these concepts, showing the patriarchal control and emphasis placed onto women’s bodies in order to obtain preferred sexual citizenship, while men are not subjected to the same standards of bodily control.

**Religious Influence**

Since the U.S.’s systems and institutions are structured predominantly on Christian values, its religious, hegemonic framework influences policies and programs from all levels of government. The religious influence can be vividly seen in sexuality education programs that are
largely focused on abstinence as a core tenant, and this is especially true in the U.S. southeast, where all three field sites were located. Christian themes are manifested through both heteronormative narratives of appropriate sexual encounters, but also directly tied with marriage, purity, and virginity constructs. Religious norms for each state were included in how students received and perceived sexuality education. In all occurrences of this theme, students' categorization of religious ideology was linked to negative portrayals and consequences associated with having sexual encounters.

One student who had attended a Catholic high school commented,

…it was like, like, you know, there was this underlying, ‘If you have sex, you're going to go to Hell and suffer eternal damnation’…Um, but yeah. And like, you know, even with like homosexuality, whereas like, you know, in high school it's like, ‘Oh, homosexuals are evil. They're going to die.’ And when, you know, even like, ‘Non-Catholics are evil. They're going to die and go to Hell,’ which I can't do because my family isn't all Catholic (LSU, Interview 6).

This narrative of sexual intercourse being linked to eternal damnation is one of the many scare tactics that Christian hegemonic religious ideology uses in an attempt to control and suppress young people from having sexual encounters until they are married. The cis-gendered, gay male student above reported that this harsh narrative of sex and sexuality being sinful, deeply impacted his journey of self-identity.

Another cis-gendered female student expressed the negative tone in which her school approached sexuality education and the detrimental impact it had on her growing up,

My town is so Southern, like Southern Baptist…so, in middle school, um, we were taught abstinence. They took us to church. The pastor prayed with us and we were taught abstinence…they told us that, ‘If you have sex, you’re going to get pregnant and then, uh, you’re like gonna go to Hell. Like, you’re never gonna like amount to anything. Like, you need to be married first.’ All this – all this very Christian stuff. Cause they told us that like periods – what was it – it was that, ‘Tampons are only worn by loose women.’ And that, ‘Birth control was the Devil’s work and we should not be using it and that it will make you infertile.’ So, that is what I got. I learned more about sex when I went to college than I did in the eighteen years I was in that town (USF, Interview 9).
The above quote illustrates sexual intercourse being directly linked to a sin that sends a person to Hell, but also the emphasis placed on women’s bodies through control of menstruation and contraceptive usage. The concept of virginity and purity is linked here to the negative connotations of tampon usage, and the social construct of women who do use them as being highly sexually active and dirty. It also conflates religious ideology with accurate medical information as birth control, such as oral contraceptives pills (to which the student was referring) or IUDs, do not have a negative impact on fertility, except when it is being used.

**Abstinence Focused Teachings**

Most of the students interviewed recounted that their sexuality education was largely focused on abstinence or abstinence plus teachings. From these students, three prominent themes emerged in how students classified their abstinence focused educational instruction: that it was lacking and not very informative, that the material was presented in a way to scare them from being sexually active, and that educators either did not take the information seriously or were uncomfortable with the material and so the students viewed the time as a joke.

**Lacking**

Students mentioned that the information they received left out key components of sexuality education or did not fully include the scope of options or situations that might arise. While many students reported that they were allowed to ask questions during the education time, students said that many questions either were not answered or were sidestepped around. One student recounted,
And I remember, they were all anonymous questions people were asking. Like one person ended up writing, um, ‘What is masturbation?’ and the teacher said ‘That’s something I can’t answer. That’s something you have to ask your parents,’ (USF, Interview 13).

The quote shows a few potential options of why the teacher responded in this way. They could have been uncomfortable with the question and therefore did not want to discuss it. They could have thought that masturbation is not linked to sexuality education. Or, they could have been told specifically by whoever mandated the sexuality education curriculum that conversation topics that include masturbation are forbidden to be discussed. Regardless of the reasoning behind the teacher’s unwillingness to answer the question, the students are left with incomplete information and an understanding that masturbation is a deviant topic that cannot publicly be addressed.

For those students who had strict abstinence only programs, the information is focused on not participating in any type of sexual activity until you are married. These students are not given any information on healthy sexual practices or keeping themselves or their partners safe. One student mentioned that “They didn’t even tell us what a condom was if that gives you any kind of idea,” (UK, Interview 9) while referencing the level of instruction students were given. Several students mentioned that their abstinence-focused education included talk about condoms and some even had condom demonstrations shown to them utilizing a banana, but that almost all other forms of contraception were excluded from the information.

Fear

Scare tactics are one way that abstinence only education seeks to control students’ sexual activity. The tactic is employed by linking sexual intercourse to diseases and pregnancy, making both seem horrific and sometimes life threatening in an attempt to discourage students from even
thinking they want to engage in sexual activity. This was reflected in the interviews with students:

So, I feel like the- what I remember most like, distinctly from sex education was just like, the how they would always show us the horrible pictures of like, the STDs and stuff (USF, Interview 19).

They taught us, like, it was a lot of, like, scaring us with STDs. It was like the majority of it, like, they would show us really gruesome pictures of people with, like, diseases that we could get and, like, warts and, like, really nasty stuff. Yeah, it was, like, very clearly, like, shock factor (LSU, Interview 8).

Um, I don’t know. I was, like, scared. I was really scared, and I think a lot of girls are because they make it seem really scary. Because they’re like, ‘oh, STDs’ or like, ‘oh, you can get pregnant.’ Like, yeah, I know, but it’s just like, everyone’s really afraid (USF, Interview 4).

These three quotes show the negative impact that scare tactics in abstinence only education can have. The approach of sexuality education instructors to demonize STIs leads to increased stigma and fear that is already associated with contracting an infection through sexual activity. The additional stigma of STIs paired with the lack of information on how they are contracted, places students at a disadvantage. They are not told the importance of regular STI testing, that many STIs are treatable, and the ones that are not can be managed. The social stigma and fear encourages students to not have open conversations with their partners about past sexual history, testing, or the importance of disclosing current STI status.

A Joke

In the U.S., open discussions about sexual activity are still largely considered taboo. The taboo often manifests itself in shyness, uncomfortableness, nervousness, and hesitation when the topic is brought up, and this manifestation was established in many of the interviews with
students who recounted the environment in which their sexuality education was administered.

When asked if students took the sexuality education in high school seriously, one female student remembered,

Definitely not. Like I remember there was at one point we had to like reenact these skits that were basically like a boy and a girl and like the girl would try to pressure the boy into like having sex, or the boy would pressure the girl, and it was like scripts that you like acted out, it was like an activity like how to basically say no to sex. And like I remember people like going off the script to like make them funny, like I remember once I was the girl and I was like trying to pressure the boy to have sex, and I was like ‘Okay, like let’s go upstairs’ and he was like ‘Alright, let’s go’ and I was like ‘That’s definitely not what your script says.’ People definitely did not take it seriously (UK, Interview 10).

Another male student when asked the same question commented,

The biggest thing is just like it was just kind of there, and at that age, you're still, like it's funny, you know. For a lot of students, it's funny. You know, they laugh at, we laugh at, I was that age too. We laughed at the pictures and then we moved on and that's it. And it, it's never brought up again. Because even the, the teacher is uncomfortable enough to talk about it. And you feel that, you know, if a teacher or professor isn't going in comfortable, then the students are gonna have the same reaction. And if it's like then, ‘Oh, let's just get this over with and then we don't have to talk about it again.’ So, it's just, it, it's like a taboo I think more so. And people don't want to talk about it (UK, Interview 11).

This quote shows the awkwardness and taboo of the topic. When adults are uncomfortable or do not address sex in any aspect to students that uneasiness transfers. It also makes it difficult for adults in education positions to effectively inform students about sexuality education.

*Sexuality Education Activities*

Many students reported that during their sexuality education the instructors had the students participate in activities, all of which were designed to discourage them from engaging in sexual activity, instead of informing them about healthy practices. These activities were largely centered on narratives related to keeping one’s body pure, making pledges to remain virgins until
they got married, and demonstrating the negative consequences of contracting an STI or HIV and becoming pregnant.

**Purity versus Dirty**

Purity culture in the U.S. places higher standards on women’s bodies than it does men’s bodies in heterosexual encounters. Due to the heteronormative sexuality education instruction that the majority of students who were interviewed received, the narrative of “sexual activity equals dirtiness” was stated in a variety of ways in the curriculum being taught. An emphasis on students remaining clean and pure, especially women students, was an essential component of many students’ abstinence only education. One way this idea was transmitted, was through the demonstration of activities that started with an object being “pure” and ended with it being “dirty.” One student explained,

> I remember coming in…at like the tail-end of it and one thing that stuck out was…um, it was horrible abstinence based and just completely like…awful. Um…but they did this thing with tape and it was like…um, every person that you touched, like, you know, made the tape less and less sticky and basically had the stigma of like, dirty (USF, Interview 17).

Not only does this quote illustrate how a person “becomes dirty” through sexual activity, but it also promotes monogamous sexual activity as the only way to remain “clean”; ideally with your wife or husband.

One participant explained a sexuality education activity a local nurse did while explaining sexual intercourse inside a church,

> She also took a cup, chewed up an Oreo, spit it out, and was like, ‘Do you guys want it?’ and we were like, ‘No. That’s disgusting.’ She was like, ‘That’s what happens when you – when you don’t have sex with your husband. You have sex with everybody else. Nobody is going to want you,’ (Florida, interview 9).
This activity is focused on the cultural concept of sex being dirty, and the rhetoric that saving yourself until marriage will make you pure and clean. It also provides a mechanism for which women will be able to attract a husband, by keeping their virginity intact and not making themselves dirty, they will be desirable enough for men to want to marry them. Additionally, this quote shows cis-gendered, heterosexual normative behavior for limiting sexual partners until marriage, and the consequences of societal stigma surrounding want, desire, and worthiness for sexual encounters.

**Virginity Pledges**

Another common activity for abstinence only based education is to have students sign or commit to a virginity pledge. This activity showed up numerous times in the interviews with students as well, however most of the students reported not taking the exercise seriously or admitting that they caved to peer pressure of either other fellow students or the educators leading the sexuality education. One student remembered, “And we had to sign a card that said we wouldn't have sex until we got married so it was pretty intense. We didn't have to do it but they were like you really should,” (LSU, Interview 2). This student’s experience in a Catholic high school turned sexual activity into something that should be feared and avoided at all costs until marriage. The student reported that it took her many years to understand that losing her virginity did not mean that bad things would happen to her and that her life would not be destroyed if she had sexual intercourse before marriage.

Another student, who lived in a small, conservative town also had a similar experience with a virginity pledge,
So, it was mainly abstinence and it was like, abstinence is the best policy like, we’ll want to wait until marriage, like put on the back of this card like how far you want to go. And everyone was writing kiss, or like make out, you know. Like, very conservative (USF, Interview 18).

Not only do sexuality educators invoke this type of activity to persuade students into not engaging in sexual activity, but the exercise is also designed to illicit peer pressure responses in order to get students to conform. If students do not sign a card at all (as in the first quote) then everyone in the class knows that. For the second example, the student was aware of what fellow classmates listed on the back of their cards, which provides a social control mechanism to keep everyone thinking in “conservative” terms about sexual activity.

**STI and Pregnancy Consequences**

Many activities students were exposed to demonstrated how STIs were contracted and how pregnancy effects the body.

I remember there being, we did like an activity of like, to demonstrate that you can catch something from somebody who doesn’t know they have it, we’re going to put food coloring in the like water, and we’re going to mix them around and like you’re going to have sex with this person by mixing your waters together. You know, and by the end of it, everybody had a little bit of food coloring. And I think the message was if you have sex with one person, you’ve had sex with everybody (UK, Interview 5).

This quote illustrates the narrative of STIs being not only dirty, but something that is inevitable if you have sex with multiple people. This framing of dirtiness is in direct alignment with the previous theme of using scare tactics in order to convince students to abstain from sexual intercourse.

Several students mentioned that they had to watch a birthing video as part of the sexuality education, and this was also shown in an attempt to scare students away from having sex. One student remembered,
And they're like, okay, now we're gonna like, watch a video of like a child being born and like, and they showed like them cutting her uterus and like, it was all gory and like. It was um, it was a natural birth, but like I forgot what it's called, but they cut like the thing. And so, and then they would tell us, talk about like all the horrors of pregnancy and all this and like, basically like if you have sex, you're probably gonna die (LSU, Interview 10).

This quote shows that not only was the threat of pregnancy used as a scare tactic for physical harm and even death, the showing of a video of a birth, instead of just talking about pregnancy, had a lasting impression on the woman as a student. Additionally, it demonstrates the current lack of knowledge, and the lack of instruction she received, of her own female genitalia, as the student confuses the uterus with the perineum during an episiotomy procedure during labor.

The episiotomy, an unnecessary procedure that was initiated from a male patriarchal healthcare perspective, is performed with the misguided view that women’s bodies are unable to fully open up for delivery and must be cut open to allow the safe passive of the baby. At the height of episiotomy practice in the 1980s, the rate was 64 per 100 vaginal deliveries, by 1998, that overall percentage of episiotomies for vaginal births dropped almost 40 percent, with white women as the highest percentage group for receiving the procedure and black women being the lowest (Weeks and Kozak 2001). Afterwards the sewing up of the woman’s perineum is often given an extra stitch(es) to make her tighter for future sexual intercourse. This has become colloquially known as the “husband stitch,” another example of women’s bodies being treated as receptacles and sexual objects for men’s pleasure and desire. The episiotomy and subsequent extra stich are often done without the woman’s consent, one of the many forms of obstetric violence women face from a patriarchal healthcare system (Kukura 2018). The tightness of women’s genitalia has long been discussed as a link to men’s sexual pleasure. Narratives of “loose” women are used to “slut shame” women who enjoy sexual encounters and used as a social control mechanism to keep women from participating in sexual activity (Braun and
Kitzinger 2001). This was directly seen in interviewees comments on social standards women are compelled to adhere to, even addressing the use of tampons as only being used by “loose women” (above).

**Discussion**

*Heteronormativity*

This project clearly shows the link between mandated governmental sexuality education programs and the hegemonic principle of heteronormativity. This is both explicitly and implicitly seen, with some students articulating the words “heterosexual” and “heteronormative” instruction, with others succinctly describing the curriculum as expressing the need to “save yourself” for your future partner. Student also mentioned the inability for educators to address questions outside the cis-gendered, heterosexual binary, and the concept of marriage only existing as “between one man and one woman.” While many of the students did identify as LGBTQIA+ (34%), the majority of those interviewed did not. This shows multiple layers of students’ perceptions and understandings of governmentality and sexual citizenship more broadly. As a college educated population, they are able to understand and articulate societal influences that impacted their sexuality education and self-identity perhaps better than others, as well as being able to recognize and articulate when they are being oppressed, deceived, or misguided by institutional educators.

Heteronormativity coupled with hegemonic ideas of maleness and Christian religious ideology clearly define for students what acceptable sexual encounters and relationships entail. Heteronormativity is a direct mechanism of governmentality that utilizes sexuality education as a tool to control the actions and relationships of young people to fit into a framework of
heterosexual, cis-gendered, Christian, white, monogamous relationships that result in marriage and the procreation of children. These ideas were seen in examples from students that mentioned negative and abusive language tied to Christian ideology focused on marriage (women being seen as dirty and impure for their husbands if they participate in sexual activity before marriage) and non-heterosexual behavior (such as “homosexuals are evil”). For many students, the uneasiness with being placed in this box of predetermined sexual citizenship negatively influenced their sexual history and trajectory (see Chapter 5 for further explanation). For those students who fit the prescribed heterosexual, cis-gendered ideal, many were left feeling confused and ill-informed about how to precede with sexual encounters and establishing healthy sexual relationships. Women students specifically mentioned that their instruction regarding sexual intercourse and contraceptive options was lacking, and that more emphasis was placed on fear associated with negative effects of sexual activity instead of how to handle specific situations in a safe and responsible way.

_Abstinence Focused_

It has been well documented over the last 30 years that abstinence focused sexuality education is not a good strategy to either prevent young people from engaging in sexual activity or to educate them on healthy sexual relationships (Boyer 2018; Garcia and Fields 2017; Perrin and Dejoy 2003; Rose 2005). The student narratives recorded in this research project support this body of work as well, as many were misinformed, scared, or not informed at all about sexual practices, including potential risks and how to mitigate them. Students reported that they had to learn information either on their own through trial and error, talking with friends, or taking university classes in order to round out their sexuality education, especially courses in Gender
and Women’s Studies and Public Health departments. Abstinence-focused sexuality education coupled with heteronormativity reinforce cis-gendered, heterosexual, marriage norms that are guided by sexual citizenship classifications.

The social stigma associated with discussing sex in public settings and the uncomfortable nature of the topic for most adults was described by students as impacting the level of quality instruction that they received. Because of this cultural norm, many students found the abstinence focused sexuality education they received to be lacking, scary, or turned in to a joke that neither the educators nor the students took seriously. Scare tactics were largely focused on disturbing images or horror stories of contracting STIs or pregnancy and birth, without information on how to get tested and treat STIs or options for handling an unwanted or unintended pregnancy. This strategy is employed to tie back into narratives of the importance of waiting to have sexual intercourse until you are married, as it’s the only way to protect yourself and stay healthy, while not damning yourself or your partner to hell.

**Sexuality Education Activities**

In addition to explicitly highlighting these negative consequences of pre-martial sexual activity, students were also shown and participated in various educational activities that were meant to reinforce the concepts of virginal purity and respecting one’s own body. Women students were specifically targeted by Christian religious narratives stressing the importance for one’s body to remain pure and untouched by men until they are married. By remaining pure and virtuous in order to attract a man who will want to marry them, women will also avoid the horrors of STIs and pregnancy outside of wedlock. All societies have some concept of what behavior and cultural norms are considered pure virtues and those that are considered taboo or
devious ones (Douglas 2002). So, it is not surprising that in the U.S. Southeast, virginity pledges and the rhetoric of sexual activity being dirty, help emphasize the ideal sexual citizen of one who is cis-gendered, heterosexual, white, virginal, and passive. While cis-gendered, heterosexual men are exempt from these same standards of virginal purity, there is still emphasis placed on them to also avoid sexual intercourse until marriage if possible, although they will not encounter the same negative social stigmas that women will if they do not meet the qualifications for monogamous relationships resulting in marriage. These two narratives collectively encompass the ways in which governmentality and policies around sexuality education impact sexual behavior of young people, which exclude anyone who is outside the gender binary or participates in sexual activity outside a heterosexual structure.

Findings from this research project reveal some important aspects of sexuality education that are missing in U.S. southeastern curriculum. This is largely in part because the main sexuality education curriculum in the three states of Florida, Kentucky, and Louisiana is abstinence only (sexual risk avoidance) or abstinence plus education. As defined above, these educational models are extremely limited in the information and detail they can provide when addressing sexual activity. None of the students who were interviewed mentioned that they had any instruction that addressed sexual pleasure or desire. The lack of sexual pleasure or desire is not surprising considering the scare tactics, focused on STIs and pregnancy, the negative implications of losing virginal purity by engaging in sexual activity, and the intense focus on abstinence until marriage. This leaves little room to have open dialogue about the benefits of healthy sexual relationships and how to establish and cultivate them, including the concept of pleasure as a benefit or at the very least a by-product of sexual activity. When a topic is framed as an absolute negative that has dire consequences associated with it, it is impossible to provide
information that might highlight a benefit, such as respectful and pleasurable sexual encounters. Many scholars have stated the need for desire, pleasure, and emotional intimacy to be included as part of sexuality education, but those assertions are not reflected in this sample population’s instruction (Fine 1988; Tolman 1994; Ward and Wyatt 1994).

One topic that is essential to having such an encounter, is the concept of consent, including a person’s ability to understand what consent looks like, embodying enough self-confidence to ask or deny it, and knowing how to stop an encounter or remove themselves from one in which their consent is being violated. Only one student who was interviewed mentioned being taught the concept of consent. This mention was in a class in which the girls were separated out and instructed on how to spot abusive behavior in boyfriends. The boys were given no such instruction on how not to be abusive, but instead attended a gym class. This separation of instruction reiterates the patriarchal hegemonic structure of women being held accountable for the actions of men, especially in sexual encounters, and the social pressures placed on women to anticipate the actions of men and mitigate their behavior. This can have lasting damage on how students sexually interact with others (see Chapter 4 for more information on this issue). Pairing information on consent with discussions of empowerment, sexual double standards, and equality between partners in sexual relationships can mitigate the patriarchal binary gender roles that guide current relationships (Rogow et al 2013). The inclusion of gender and power relations when addressing sexual activity in sexuality education can reduce STIs and unintended pregnancy (Haberland 2015).

Additionally, most students reported that they did not receive any type of comprehensive instruction on contraceptive options besides condoms. While some students said that they were told condoms prevent STIs and pregnancy, and a few received condom placement
demonstrations utilizing a banana, most students were unsure of how to effectively put a condom on or what the effectiveness rate of using a condom was. Women students expressed that having more information on oral contraceptive pills, IUDs, implants, diaphragms, and hormonal patches and injections would have helped them make better contraception choices. Male students only briefly mentioned condoms, but several stated that having instruction on how to use one would have been helpful. The concept of “safe sex” and how to participate in it was largely missing as a narrative for students who were interviewed, and no student reported that their sexuality education addressed oral sex in any way. Oral sex is often a first step in a person’s sexual exploration as a strategy to delay intercourse (Prinstein et al 2003), and putting an emphasis only on genital sexual intercourse, not only misinforms students about the ability of STI contraction orally, but consequentially (or ironically?) provides a loop-hole for many students, especially religiously affiliated ones, to participate in sexual activity that does not “count” as sexual intercourse and specifically keeps women’s bodies’ pure (Remez 2000; Vazsonyi and Jenkins 2010).

Conservative thought, fueled by religious ideology, is that by promoting the benefits of sex, students will want to engage more in sexual activity and will not be willing to wait until marriage, thus increasing their chances of contracting an STI or becoming pregnant. However, studies have shown that this is a false assumption (Dreweke 2019), as students who have well rounded, comprehensive sexuality education are more likely to delay sexual activity. The hegemonic narrative of ideal sexual citizenship does not allow currently for a deviation from the religious conservative mindset.

By only focusing on negative impacts of sexual activity, society is largely missing the ability to understand young peoples’ perceptions and lived experiences of sexual activity and
encounters. When designing sexuality education, the target population should be involved in the curriculum and implementation of the programs so that they are effective. This includes the incorporation of diverse perspectives along the gender and sexual orientation continuum. Heteronormative narratives, religious ideology, and abstinence focused education are reinforcing negative stereotypes of sexual citizenship, and by doing this, students are missing out on how to have healthy sexual encounters and relationships. Sexuality education needs to be comprehensive and rights-based focus, which specifically addresses consent, healthy and abusive relationships, reproductive anatomy the full range of contraceptive options, discussions on STIs and HIV that is free from fear, acknowledging and discussing a variety of sexual practices including oral sex, vaginal, and anal sex, and should include discussions on body positivity, self-worth, and pleasure.

**Conclusion**

This chapter shows that sexuality education in the U.S. Southeast is not adequately informing young people about healthy sexual activity and practices, often to their detriment. U.S. hegemonic narratives of abstinence and risk avoidance coupled with patriarchal norms, conservative politics, and religious ideology all influence the sexuality education that students receive. This sexuality education is often provided in heteronormative, cis-gendered frameworks that promote abstinence until marriage, frame sexual activity as dangerous, fearful, and dirty, and does not allow for open discussions on healthy sexual practices or healthy relationships. These narratives and teachings guide the sexual citizenship formation of students, which are idealized to be heterosexual, cis-gendered, and monogamous relationship seeking that results in marriage and children.
CHAPTER 4:  
SEXUAL VIOLENCE 

Introduction

Sexual violence is a common crime in the U.S., but the most underreported (NSVRC 2020). The National Sexual Violence Resource Center (NSVRC) estimates that in the U.S. one in five women will be raped at some point in their lives (while one in 71 men will be). Of those women, 51% will be raped by an intimate partner and 40.8% will know their rapist in some way outside of an intimate partner relationship. Ninety-one percent of rape and sexual assault survivors are women, with multiracial women (49.5%) and Native/Indigenous women (45%) having the highest rates of assault (NSVRC 2020). The National Intimate Partner and Sexual Violence Survey (NISVS), administered by the Centers for Disease Control (CDC), released a special report that examined sexual violence by sexual orientation in 2010. Findings concluded that bisexual women (46.1%; 74.9%) and homosexual women (13.1%; 46.4%) had almost equal or higher rates of rape and other types of sexual violence, respectively, compared to heterosexual women (17.4%; 43.3%), and that numbers of rape for gay and bisexual men were too low to provide estimates, but for other types of sexual violence were significant at 40.2% and 47.4% respectively (Walters et al 2013).

The NSVRC also estimates that between 20 - 25 percent of college women will be survivors of forced sexual encounters during their college years (15 percent for men), and that more than 90 percent of sexual assault survivors do not officially report their assault (NSVRC 2020). A study that compared the U.S. Bureau of Justice’s National Crime Victimization Survey
(NCVS) with the National Intimate Partner and Sexual Violence Survey (NISVS) and the
Campus Sexual Assault Study (CSA) from 1995 - 2013 found that women aged 18-24 had the
highest rates of sexual assault compared to other age groups, that in 80 percent of assault cases
the person knew their perpetrator, and that students enrolled in higher education were less likely
to report cases to the police that non-students were (Roebuck and Murty 2016).

There are many reasons why people do not report their assaults, including confusion
around reporting and law enforcement responses, victim blaming and shaming, and retaliation
and safety issues, among others. There are various ways that sexual assault is defined. The U.S.
Department of Justice currently defines sexual assault as “any nonconsensual sexual act
proscribed by Federal, tribal, or State law, including when the victim lacks capacity to consent,”
(DOJ 2020). In 2018, the Trump Administration changed the definition by shortening the
wording and allowing tribal or State laws to determine assault definitions (as well as limiting the
definition of domestic violence) (Nanasi 2019). The previous definition stated, “Sexual assault is
any type of sexual contact or behavior that occurs without the explicit consent of the recipient.
Falling under the definition of sexual assault are sexual activities as forced sexual intercourse,
forcible sodomy, child molestation, incest, fondling, and attempted rape,” (DOJ 2018).

Legally, states have the ability to define what constitutes as assault, what the age of
consent is, and what is considered consent. Because of this, it is possible legally for someone to
be sexually assault in one state and not in another. The new definition also removes the inclusion
of “behavior” and removes the “explicit consent” language, opening the door for legal challenges
that may uphold “implied” consent as a defense strategy. While the Obama Administration
expanded the DOJ definition of rape in 2012 to include men for the first time, the current DOJ
page for the Office on Violence Against Women does not list a definition of rape separately from the new sexual assault definition (Harvestion 2018).

Even though students in school are in the high-risk age group for sexual assault, for college and university campuses specifically, reporting is a complicated process. Through Title IX rules, enacted in 1972 as an anti-discrimination, civil rights law based on sex, schools that receive federal funding dollars must comply with federal guidelines for the reporting and handling of sexual assault cases that occur on campus property or under the educational system it oversees (such as sponsored school trips). Under the Obama Administration, Title IX guidelines were expanded and adjusted to be more inclusive and established recommendations for LGBTQIA+ students. However, under the Trump Administration, the Department of Education headed by Betsy Devos, is currently reworking the guidelines to provide further protections to those accused as well as reworking the case handling and adjudication process. These new rules would have the full weight of the law behind them, unlike the Obama era guidelines.

Proponents of the new rules say they will provide structure to an out of control system, while those in opposition say the changes will make it harder for victims to come forward (Gringlas 2019).

The instances of sexual violence in the U.S. and the current federal reworking of multiple definitions and guidelines surrounding these cases, speaks to a larger hegemonic narrative of sexual citizenship and the sub-narratives of patriarchy, toxic masculinity, and rape culture that support and reinforce controlling and oppressive systems of power.

The U.S. was founded and still operates through a patriarchal framework, which places heterosexual, cis-gendered, white, middle to upper class, and abled bodied men at the top of the power structure, both politically and socially. Through patriarchy, strict gender lines are defined
that delineate men and women’s acceptable behavior, including appropriate actions for romantic and sexual relationships. This system is based on a gender binary one that denies other people’s existence outside the binary and promotes non-heterosexual sexual orientations as deviant. It also denotes that masculine men should be rational while feminine women should be emotional (Gilligan and Richards 2018). These characteristics provide foundational support to sub-cultural notions of toxic masculinity and rape culture.

Gender is a performance that is socially constructed, allowing people to navigate their own gender identities on a continuum that is dictated in part by social situations and encounters, but most often are assumed to be male/female and heterosexual (Butler 1990). Toxic masculinity is one such way gender is performed. The foundation of toxic masculinity places the male, heterosexual, cis-gendered body in a state of deviance, violence, and marginality, and within the last 20 years, towards a realm of extremism. This extremism is often linked to the subversion and oppression of women through violence and control (Pearson 2019). Toxic masculinity rewards men both in power and prestige, even if their actions are considered violent or damaging to others. Even though this particular gender performance is not undertaken by all men, the majority of women still feel the impacts of it and learn from an early age how to navigate and adjust their behavior in attempts to avoid it, while it is the complicity of other non-participating men that help uphold it (Elliot 2018). Sexual violence, in all forms, is one area of life where women are taught these strategies early on, while men are, more often than not, not held accountable for their actions.

Sexual violence is often a by-product of toxic masculinity. The term “rape culture” has been used since the second wave feminist movement in the U.S. beginning in the 1970s as a way to denote violent sexual intercourse encounters committed by heterosexual men against women.
as a method of power, control, and oppression (Sielke 2004). While the term is often used in the context of comparing countries that have high rates of sexual violence to those who claim rape occurs less frequently, it is also used as a framework to analyze mainstream narratives of sexual acts and expectations for men and women in society (Brownmiller 1975; Sanday 1981). Rape and the cultural narratives surrounding it has been well documented in the discipline of anthropology (Baxi 2014; Hirsch and Khan 2020). In the context of college and university campuses, rape culture has been examined over the last 20 years (Beaver 2017; Pascoe and Hollander 2016). The strategy of victim blaming and shaming within rape culture has also been documented, specifically within student populations, and is a large driving force for why people do not come forward after an incident (Postmus et al 2011).

These three concepts – patriarchy, toxic masculinity, and rape culture – support the sexual citizenship framework that is currently the hegemonic narrative in the U.S. for ideal sexual behavior and relationship making. The focus on cis-gendered, heterosexual men who are white, upper-middle class, and able bodied reinforces the framework for these citizens as ideal ones to form lasting, monogamous, relationships, while at the same time, excusing violence against women and the LGBTQIA+ community. Resistance to these hegemonic structures have entered into a new phase in the U.S. within the last 20 years. Increased presence of political movements has produced the Women’s March/Movement organization, the Black Lives Matter movement, and a new push for sexual and reproductive rights and justice as political and religious conservatives have ramped up anti-choice rhetoric and laws (Klabusich 2016; Women’s March 2020). The reclaiming and promotion of the word “fuck” as in “fuck the patriarchy,” “feminist as fuck,” and “fuck the police” have all been used to resist patriarchal notions of male superiority, oppression, and systemic violence coupled with white supremacy (Wood 2019).
In 2016, Taryana Burke’s #MeToo Movement brought issues of sexual violence against women, and later others, into the national conversation in response to then presidential candidate Donald Trump’s leaked tape of himself proclaiming that he grabs women by the pussy (Brockes 2018), and continued with Hollywood producers and celebrities, and the Supreme Court confirmation hearings of accused sexual assaulter Brett Kavanaugh, nominated by President Trump. At the national level, these high-profile instances of reinforcing patriarchal notions of power over women’s bodily autonomy and the continued disregard of women’s accounts of lived experiences, illuminate the ways in which rape culture and toxic masculinity prescribe acceptable codes of conduct for both men and women in the U.S.

**Results**

From the online survey, almost 25% of students said they had experienced a forced sexual encounter, while 41% of students said they had endured an unwanted sexual encounter, and for the question on regretting a sexual encounter while at college, 31% said “yes.” See Table 12 for more information by school. From the students who were interviewed for this project, 50% (25 students) stated that they had been subjected to a forced sexual encounter at some point in their lives. See Table 13 in Appendix A for a breakdown of interview participants by school.

Of the 25 students who reported a forced sexual encounter, 15 of them recounted an experience during their interview. Of these students who spoke of a sexual violence event, 14 students were either already in an intimate relationship with the assailant or knew their attacker in some way previously. Only one student said that they were assaulted by a stranger, while at a party where they knew other people. None of the respondents reported being drugged by an assailant, but several mentioned that alcohol had played a role during the encounter by either one
or both parties. Of the 15 students who experienced sexual violence, only two reported the incident in an official capacity.

Several students mentioned that they had been in situations that were pressured or coerced. Of the 50 students interviewed, 21 of them recounted events that were classified as either pressured, coerced, or unwanted. These students did not consider these sexual encounters to be classified as sexual assault or rape at the time, even though by standard definitions of those events, they would be legally defined as such. Thirty-seven interviewees said they had had an uncomfortable sexual encounter, and 31 of them said they had regretted a sexual encounter while at college.

Only two students who were sexually assaulted or raped said that the encounter happened on university property or a university sanctioned trip, specifically in an athletic dorm room and at a fraternity event off campus in another state. Even if the other cases of the students who were assaulted off campus had been reported, the universities under Title IX would have had no jurisdiction or accountability in investigating those cases.

From the sexual violence portion of the interviews, three main topic areas emerged: sexual assault and rape experiences, emotional responses to these incidents, and students being pressured or coerced into unwanted sexual activity. Within each of those topics, two to four prominent themes emerged and are highlighted and discussed below.

Sexual Assault and Rape Experiences Themes

For students who experienced sexual assault and rape, three themes emerged in their recounting of events and the way they viewed and later handled the incident: the normalization of rape culture, wanting to protect the rapist, and not wanting to report the incident.
The students who mentioned information that is perceived as rape culture norms and behaviors were all female students. Their comments ranged from societal expectations to not realizing they had been raped until after the fact. One student while talking about lived experiences of women in general said,

…I was trying to explain to him as bad as it sounds, it’s kind of something as a female that you just go through sometimes. As horrible as that is. My best friend has been pressured into sex, my mom has been raped, like every female that I know has been pressured in some aspect (Interview, UK 6).

This idea of rape being something that women “just go through” was echoed in another student’s statement on how she was conditioned to constantly be alert and prepared for an attack,

I was raised to like, you’re gonna have pepper spray, if you don’t have pepper spray you’re gonna have a knife, if you don’t have a knife, you’re gonna have one of your keys between your fingers. If someone does do something, you’re gonna elbow them, you’re gonna bite them, you’re gonna do whatever you can. You’re gonna rip off an ear if you have to, to run (Interview, USF 3).

When asked about other types of sexual harassment, another student commented,

…I mean your typical, like, whistling type stuff. I’m not sure and ... I mean, I know it's considered some types of harassment, but I'm not really too bothered by it. To me, it's just kind of expected. Which sounds bad, but yeah (Interview, UK 14).

This quote shows the normalization of street harassment that women experience. For this student, having to hear whistling by strangers was an expected occurrence when she was out of the house, emphasizing the everyday reality that women encounter harassment.

The notion of acceptance that women will deal with sexual violence at some point and must always be prepared for it was mentioned by several students. The perceptions of what constitutes assault and/or rape were often classified differently by students who experienced these incidents. When speaking about her past rape, one student commented,
…because I always think like, ‘Oh, rape is like, you know, the big dramatic, crazy, scary thing that people always say it happens.’ Um, so I like wasn't okay with it, but at the same time I wasn't walking around being like, ‘Oh my God, I just got like sexually assaulted’….Um, but after awhile, um, I had a roommate at the time that she had been like viciously sexually assaulted. And so, like that conversation had kind of came up. And so, I guess like just talking about it I was just kind of like, "Wow." Like I realized like that's, that's kind of what happened that night. Um, and then after that I kind of like came to terms with it I guess, because I never really saw that as that, that it didn't affect me that much (Interview, LSU 3).

This student’s separation of her rape versus her friend’s vicious assault shows how some women compartmentalize and internalize sexual violence differently than others. It was not until the student had an open conversation about her friend’s experienced and learned more information about what took place during the vicious attack that she realized many of the same aspects occurred during her assault. The student originally classified the rape as unwanted but not traumatic, and was not shocked by what happened until she spoke with others about it.

Protecting the Rapist

A common theme among women who were raped was a desire to protect their rapist from harming his reputation, ruining his life, or getting him in trouble with people in authority positions. These students often made excuses for the man’s behavior, as a way to justify his actions.

I mean, looking back on it like it definitely, like it definitely wasn't okay. But like he was also super intoxicated, so like I didn't do anything about it and all my friends were like, I mean like you could report it, but like he was super drunk. So, like I don't think he even knew what he was doing and like at that point like I was like, that could like definitely ruin somebody's life. And I don't want to ruin somebody's life because they were like drunk and messed up. Like obviously still isn't okay. He actually, um, because where he's in a fraternity, he actually almost got kicked out of the fraternity because of it. Um, which was actually like a whole bunch of drama. But like half of the guys were like, no, that's like not okay. Like that definitely, it was like rape. And then like the other half was like, oh well she was drunk, like she probably wanted it. And I was like, yeah, I was asleep, but totally, totally wanted it (Interview, UK 15).
Women protecting and making excuses for their rapist is a common thread connected to society’s rape culture and the upholding of the patriarchy. U.S. patriarchal norms dictate that men’s lives are more valuable than women’s, so their attractions, even if detrimental to the woman, are taken into consideration more because women don’t want the men’s lives to be ruined. Instead of framing the situation as “the man ruined my life,” women rape victims often put the rapists’ needs before their own. This response is often coupled with making excuses for the man in order to absolve them of abhorrent behavior. As the previous student mentioned that he was drunk, and that he probably did not know what he was doing. These excuses not only protect the rapist, but situate the woman’s emotional and physical feelings as less important. The previous quote is also multi-layered, as it additionally speaks to victim blaming and the response of men to uphold patriarchal standards.

Yeah, more so. I was I think 15 when I started dating him and I think I was 17 when we broke it off, but it definitely wasn’t, like, a good situation at all and he was, like, yeah. He’s a nice guy, like, he’s a nice guy just that’s about it about him though. And he was just, you, I wasn’t comm-- you know I was 15 I wasn’t comfortable with anything he wanted to do. I was little, like, I wouldn’t want, like, my 15-year-old maybe older, but I wouldn’t want my 15-year-old to do that, so yeah. That was almost, like, for so. I mean he’s a nice guy, but yeah. That is definitely not something I wanted to do (Interview, USF 1).

This quote above additionally speaks to women protecting the men who assault them. In this quote, the student wanted it known that the abusive relationship she had been in was not because the guy was not nice. She had separated the negative behaviors, in this case, repeated forced sexual activity, and his personality.

Another student commented about the man who raped her,

I just didn’t want to relive the whole situation, have to continuously explain it. In addition to, um, he had already had to live with that and I didn’t want to ruin his life anymore with getting his - like putting on a record or anything. Cause I knew he had a really good, um, plan for the rest of his life. Cause he was going to join the military and everything, so I didn’t want to ruin that for him. Cause he already had to live with the fact that that’s what
he did. And he’ll lose my friendship with me, which he - I thought he had valued (Interview, USF 12).

This student expressed concern for the future of the man who assaulted her. Because they had been good friends before the assault, she knew his current life plan and did not want him punished for his actions. She stated that him losing her as a friend would be a bad choice that he would have to live with the rest of his life and she considered that punishment enough for his actions.

**Not wanting to report an assault**

As seen in the last example, not wanting to report the assault for reasons that may not have anything to do with the person was common. This was expressed multiple times in many interviews. The previous student went on to mention about her rape,

So, I actually never reported it. Um, from the side of, I didn’t want to relive that embarrassment of it happening in the church. Because, um, I realized later that I actually shouldn’t have actually been in that classroom. Cause it was a closed - not like closed - it was a closed classroom. Like it was in the view of people. However, like the lights are off. People don’t really know you’re in there. And I should’ve either told someone I was in there just helping someone, so they would have been more aware that there’s people in there. So, I could have gotten in trouble from that side of it, but not in trouble for being assaulted. Um, so that could have gotten me in trouble from that side of it, in addition to, I just didn’t want to relive the whole situation, have to continuously explain it (Interview, USF 12).

Having to relive the memory over and over again during the reporting process was too much of a barrier for this student. In addition, being raped at not only her place of worship but also at the place she works, made the reporting situation even more burdensome, with further potential negative impacts to her since she was somewhere in the building that was closed off during this time and she did not want to risk getting in trouble for that or losing her job. This example shows
another way that victims blame themselves for their assault and use that blame as a reason to not report an incident, as discussed in further detail in the section below.

A gay male student also explained his multi-layered reasoning for not reporting the man who sexually assaulted him,

I think now like I've kind of worked through the pain that I felt then, um, with, you know, all of it. But like at the time, like knew I could report him, but I didn't really, I don't know, like I didn't really want to report him, because, you know, coming from Catholic school, where like if you have sex, you're a slut and you're going to Hell, like I didn't want to be judged for that. Um, and, you know, I didn't want him to say, ‘Well, he wanted it.’ And like, you know, plus, you know, me not being out to my parents, I don't want my parents to find out that I'm gay because A, I got HIV, or B, because I was raped by a guy (Interview, LSU 6).

This example shows the complex thought process that a survivor of sexual violence goes through, which often results in making the decision to not report the incident. The quote illustrates the fear of victim blaming, the influence of religious ideology and teachings the student experienced while growing up in both Catholic middle and high schools, as well as the fear of being “outed” as a gay man and the potential negative reactions his parents might have.

Emotional Responses to Sexual Assault and Rape

For students who had experienced sexual assault or rape, there were two main themes that emerged during the recounting of their stories: first, memories of being assaulted had negative effects on their emotional state and second, victim blaming, both from others and themselves, caused anxiety and shame.

Memories of Assault and Rape

For many, specific things could trigger past memories of the assault being brought to the fronts of their minds and those feelings would negatively impact their quality of life. Some
students were still dealing with the memories of their assaults years later. One student talked about her struggle with seeing her past abuser around the small town they are both from when she’s at home for holidays and summer break,

It just, it brings all the memories up again, and I know nobody knows and he might not even realize what he was doing was wrong just because nobody really thinks of it that way and we were in a relationship. But it just brings all those memories back and all the times I didn’t want to have sex with him that I did anyway just to make him happy and to basically get him to shut up because I was annoyed with him (Interview, UK 2).

The constant anxiety and worry about encountering her abusive partner deeply impacted her relationship to the place she grew up in and the people in her family and friend group because they did not know about the abusive side of her relationship. Her reasoning to not inform other of the abuse happening in her relationship was multi-layered. She herself was unable to put precise language to the situation while it was happening, and understood that societal views of sexual assault and rape within the confines of a romantic relationship are often met with disbelief. Additionally, rape culture is so normalized in society that she was not even sure he had the awareness or education to understand that what he was doing was hurtful and disrespectful to her.

Another student talked about her experiences with compartmentalizing her assault and how her emotions manifested a few years later,

Student: Like, it didn't affect me probably at all in high school. I mean, like whatsoever. We went on this retreat and I had a panic attack, like, the first one ever about, I don't even know what, but it was like feeling really dirty and like I had to shower and then like you're not allowed to. It's not time. And I said, I don't care [laughs] And I just like, left…Um, and then after that, like, kind of in college just affected me. Like, guys just make me feel way more gross than they did before. I think it's 'cause I'm taking a step back from it, 'cause I was dating someone in high school after that. But yeah, like, that was a pretty like, non-typical experience, I guess. 'Cause I didn't really experience like, a lot of issues from it, but I feel like now they're, I guess more coming up. Yeah.

Interviewer: Yeah. So maybe now you're a bit more like, cautious with just people in general?
Student: Yeah. Oh definitely. Yeah. So, it's like, well, it's hard 'cause it's like they always say like, "Oh, it's like usually never just some random stranger that grabs you off the street." I was like, “What?” Like, it definitely is always a random stranger, but like it's not (Interview, UK 7).

This student’s coping strategy was not to deal with the emotions from the assault when it occurred, which wound up affecting her later once she arrived to the university. Her mention of the feelings “coming up” and her body image issues of feeling dirty and gross around men has translated into her having trust issues with establishing new relationships. The additional layer of being assaulted by someone she knew and not a random stranger has also impacted her views of sexual assault and narratives that women are told while growing up.

For another student, it also took her a while to come to terms with her assault and be able to talk about it with others,

I was like, he's drunk, it's fine, but I was like, it's not fine. Um, and then like when I was seeing my therapist, I eventually brought it up. It took me awhile to like, actually like talk about it and like say that it happened. Um, but after like that and like talking about it in therapy, like that really helped and just being like, like it wasn't okay it happened. But like it doesn't mean anything about me. And like it's not my fault. Like any, like that kind of stuff like really helped and my friends were super supportive once I actually like did open up and talk about it. Um, so yeah (Interview UK 15).

This student’s experience highlights the need for emotional support that survivors need. This woman’s initial reaction to her rape was to ignore that it had happened, and to try to continue on with her daily routine. However, latent feelings resurfaced during a therapy session for an unrelated matter, showing the subliminal nature that emotions from assault can have on an individual.

While the previous student had a supportive network of friends to lean on once she disclosed her rape to them, another student was not as lucky, and had to handle the emotions of her rape as well as unsupportive friends,
And like even for my um, parents, part of it was like I didn’t want to tell people um, because then people would just, I feel like, you know, they’d look at me differently, um but like it’s just kind of a rough patch….Um, but it was just rough because like, my friends, who I ended up like leaving their friend group um, because they kept hanging out with him, and like you know, they kind of knew something had happened and like I told one of my friends and she just still like, was like ‘Oh, okay’ and I was like that’s not how this works. Yeah, so I was like “I can’t be friends with you guys anymore’ and then they were like ‘Oh my god! Like blah blah blah!’ and it was just so annoying (Interview, UK 3).

This woman felt the societal pressures of being a victim of assault and people viewing her differently because of it, including her parents, while at the same time experiencing her friends not taking her emotional and physical health seriously. Her friends felt that she was being overly dramatic about the situation, while the student felt that her friends were being disrespectful and not a solid support structure, which eventually caused her to sever her relationship with them, while her rapist suffered no social ramifications for his actions.

**Victim Blaming/Self Blame**

Themes of victim-blaming and self-blame were brought up in almost every account of sexual assault and rape during the student interviews, showing the deeply held societal perspectives of the victim being responsible for their assault and not the perpetrator.

One woman retold her experience of meeting a friend for coffee and video games, which later led to her friend repeatedly raping her that evening,

Um, but it was, you know, very forceful, it was very not consensual, so coming away from that situation was really strange because I didn’t, you know. Like, I mean you’re always questioning ‘was I making noises?’ like, you know, ridiculous things where it’s, like, that was absolutely non-consensual. But, you know, and especially feeling scared to tell [anyone] and I’m in a relationship and it’s like, ‘Well, why’d you meet a guy to go get coffee with a guy?’ Like, it wasn’t like that at all, you know, like, he thought it wasn’t like that and he reinforced that we were friends and all this stuff (Interview, USF 7).
This student questioned herself on the part she played during the rapes, and was worried about telling her current boyfriend what had happened for fear he would blame her for the assault. The man who raped her used reinforcing language of friendship and trust in order to provide an emotional safe and physical space before he raped her, leaving the student feeling confused and betrayed. The man deployed several of these deceptive techniques in order to lure her into a sense of false security before he raped her.

Another student encountered her rapist using victim blaming language a few days after the assault,

It wasn’t until like a couple of days later that I realized like what it was [rape]. And so, I messaged him and was like, ‘You just raped me. What were you thinking? Like why would you do that to me? I had done nothing to you.’ And he’s like, ‘I didn’t rape you. You wanted it.’ And initially, I was like, ‘I didn’t ask for that.’ Like I didn’t realize he, according to him, I was asking for it or I had been like, I had been sexual with him or like giving him those messages. Which I wasn’t. I didn’t think I was,. …Um, initially I was very like hard on myself just cause I was like, ‘What are you going to do now? Like it’s going to ruin all of your future relationships.’ Like and I had gone through kind of like a depressive side for a while and it, um I considered attempting suicide a couple times. I didn’t really go through with it just because I was actually scared of cutting myself. I had, um, done like self-harm a little bit, not to the extent of like making myself bleed, but like I would scratch my arms with my like, just with my nails. Hard enough just so I would feel pain and just cry and all that stuff, but not enough to like actually have to cause me to possibly be corrected or anything that could be detrimental to my future (Interview, USF 12).

This example shows the power of gaslighting, an emotional manipulation technique that anyone, but specifically, heterosexual men often use to control their partners’ reactions by making them believe their feelings, thoughts, choices, or memories are unfounded or even crazy (Abramson 2014). The influence that this emotional manipulating technique has in placing doubt into the mind of a survivor can be pronounced on their mental health. The phrase of “you wanted it” is a classic form of victim blaming that has been used by abusers, law enforcement, and lawyers and judges in order to discredit survivors claims of abuse and exonerate the accused.
One gay male student also went through a period of self-blaming, and is still working through the emotional response to the situation and his relationship with his assaulter.

And even afterwards, I was like, ‘I wasn't okay with that.’ Like, um, and like, you know, I did the whole like victim blaming of myself-and like, uh, I must've, I led him on. I, you know... And so, like now, it's like I know that's an issue and like I know he didn't mean it that way, and like I've forgiven him. Like he and I are still on okay terms, uh (laughs)- Like he thought I wanted it. Um, and, you know, he was, he was intoxicated. Uh, and like at the end of the day, like it's something that, for me with him, like I know that that's not who he is. He didn't sexually assault me to sexually assault me or because he thought he deserved something from me. He did it because that's what he thought that's what we both wanted, um, and it just happened to not be what we both wanted. Um, and so, like, you know, it's something that, uh, like going forward, like that's one of the things that really taught me to say, "No, I do not want to, uh, give you oral sex," or, "No, I don't want you to give me oral sex." Um, and, uh, so like that was really like, that really taught me that with him. And I mean, for it to have happened, I'm glad it happened like with him. Someone who like I, I trust more than a random person I meet online. Um, and it like taught me a lot of things. And like, you know, I still have flashbacks to it, um, and like, you know, it still bothers me a lot that it happened, but like there could be worse (Interview, LSU 6).

This illuminates the complicated nature of sexual assault occurring between two people who were and still are friends. This student’s knowledge of the perpetrator’s personality was enough to convince the student that the reasoning behind the assault was a misunderstanding brought on by the influence of alcohol and not an act of malcontent or aggression. This student has chosen to use the incident as a learning experience as a way to find his own voice during sexual encounters. The inevitability of sexual assault in society is dramatically seen in this situation, as the student is still upset about it but framed the experience as a lesser version of what could have happened and being glad that it happened with someone he knew instead of a stranger.

One cis-gendered, heterosexual man recounted his sexual assault experience from a woman, and the aftermath that followed during his recovery,

Because, you know, most people that I told wanted to know what happened or why didn’t I do something about it. You know, you’re six five, two twenty, what are you doing? You
know, are you gay? Or you know, why, why would you not want that, every man wants that. And that’s, that was. That was a tough part to navigate (Interview, UK 5).

This interview shows the often left out perspective of a heterosexual male being assaulted by a heterosexual female. Not only did this student go through the same emotional responses as other students who were interviewed; victim blaming, self-doubt, anxiety, insecurities in future relationships, but he also had to handle the cultural stigma attached to men being assaulted by women and the implications of not living up to traditional standards of male masculinity and power. Patriarchy implies that cis-gendered, heterosexual men have specific gender qualities when it comes to women and sexual interactions. This student experienced several of these cultural restrictions from people he confided in. By being asked if he was gay when he expressed negative emotions towards being raped is a common societal insult that links homosexual activity with not being a “real man.” It is the “real men” in society that always want sexual intercourse from women, as seen above from other comments people made towards him, and this student rejected that norm. While women are often blamed for their assaults, men are often seen as not being able to even be assaulted, per their nature of hyper sexuality and toxic masculine gender roles.

Consent Issues and Pressured/Coercion

From situations of sexual violence that students did not classify as assault or rape, three additional themes emerged: violation of consent, feelings of disappointment, and the physical control over bodies. All three themes rely on an unequal distribution of power between participating sexual partners, regardless of if the sexual encounter is a one-time hook up or is in an established relationship.
Violations of Consent

Chapter 3 addressed the lack of discussion on the importance of consent that was withheld in sexuality education programs. Due to this lack, it is not surprising that even when students reported their consent being violated, they verbalized their lack of understanding regarding how to give consent and how it is defined, how to understand if someone else has given it, and how to communicate a retraction of it.

One student recounted an encounter that had blurred consent lines,

Um, I know that, I think I ended up talking about him and I was like, ‘You do know, by definition that was actually, that was actually rape, you know’ and he ended up getting upset. And I was like, ‘You can be as upset as you want, like, I don’t really, really care that much, but, like, that was pretty shitty, my dude.’ Um, but, yeah, I know what it was between both parties. I know that I never gave consent and I was most definitely, like, I usually talk about it to other people as like people ignored, he ignored my consent. Um, I don’t really ever formally say that it was rape or assault or anything like that because I was still semi-participating; it was just, kind of, half-hearted. So, for somebody you maybe you, like, you know, like, maybe, he just wasn’t ever educated on consent and stuff like that. So, maybe to him, like, because I was somewhat reciprocating, like, it was consensual and things like that. So, it’s a little bit of a grey line there, um. I, personally, just, I never really define it as that. I’m just like, ‘Somebody pushed my boundaries and I did not want it to happen, but it happened anyways,’ (Interview, USF 5).

This quote illustrates the complicated nature of establishing consent between two people who do not have open communication. For the student telling the story, they felt their consent had been violated because they were not an enthusiastic participant, and that the other person was not educated enough and was not paying attention enough to understand that non-verbal actions do not equal enthusiastic consent. This student framed the encounter as a violation of their boundaries and not as assault, since they did not verbally express the word “no.” The lack of communication between the two people is clear in the aftermath discussion of the event, where the person who violated the consent does not appear to understand why the other person had an issue with the encounter.
Other students discussed more clearly define violations of consent, in which direct communication of not participating in a certain action was stated and the other person either ignored or pressured the person into relenting. One student’s story of having their consent violated encompassed both a direct disregard of the student’s wants and an attempt to emotionally manipulate the student from being upset about the situation,

And, he so, basically, we had sex, which I was like okay with having sex and then I told him not to, um, put his bare penis in me, like, don’t do that. Um, use a condom, but he, like, was fighting me about it. He didn’t want to use a condom. I was like, ‘No, use a condom’, because I was on Depo, but I was on my last days on it, so it was like, don’t do that. And, he did it anyways and I didn’t know because he was behind me and I was like, ‘What the fuck’ and I was really scared and really mad. He told me he would buy Plan B and he didn’t. I got it myself and then he was like saying, ‘why are you being so mean to me’ and stuff and I wasn’t talking to him. And I told him, ‘You did this, and I told you not to’ and how I was scared, and I was like, ‘So, I don’t want to talk to you. Fuck you. Leave me alone’. And I said, ‘fuck you’ to him. And, so, yeah, he’s just been blocked (Interview, USF 4).

This example shows multiple layers of violating someone’s bodily autonomy. The direct wish of not having something happen was verbally expressed multiple times and ignored. As a way to ameliorate his abusive behavior, he offers to protect her body after the fact by offering to buy an emergency contraceptive, of which he then fails to do, but does not feel the need to protect her body from potentially contracting an STI. The student is left with the emotional fallout of feeling scared and angry, while also having to provide her own, expensive, emergency contraception. The end of the situation results in the other person attempting to gaslight the student through emotional manipulation of claiming he does not understand why she would be upset about him violating her consent and the possibility of potentially impregnating her. In this instance, the students’ best way to remove herself from him and further situations like this is to block him; completely cutting him off from any communication.
Feelings of Disappointment

Some students mentioned that the needs of the other partner took precedence over their needs and boundaries, because they didn’t want to disappoint their partner.

Like he would always pressure me into having sex and I always said yes just because I didn’t want to disappoint him. And looking back on that I realize how wrong it is now and I would never do that now. If I didn’t want to, I wouldn’t just give in. And I never really looked into it that much until I came to school and I did that orientation thing here. I never really thought of that, how that could be a form of rape also even though it’s not like literal assault…Like there were just so many instances where I would say no for at least an hour and we would still end up having sex by the end of the night because I was just so annoyed with it that I gave into it (Interview, UK 2).

This student felt that they had no control or agency in the relationship to deny the other person sexual activities. Feelings of disappointment, annoyance, and relentlessness would finally pressure the student into acquiescing to their partner, just to make the advances cease. The student clearly drew lines between this relationship and the lack of knowledge she had been given around appropriate sexual behaviors and healthy relationships. This encounter shows the pressure that rape culture can enact in relationships. Men are often taught that if a woman says no, he must keep trying until he convinces her to say yes, instead of taking no as the end result and backing off.

Another student remembered similar emotional manipulation from a previous partner, …he was just very manipulative like, emotionally. And I was very naive. And I wanted to him to like me. So, I would do things that I thought he would want, things that I told him that I wasn't comfortable with. But that he kind of coerced me into thinking that I did want (Interview, LSU 9).

For this student, the need of male acceptance and wanting to please him, coupled with the lack of knowledge again about what defines a healthy sexual relationship, left this student vulnerable to emotional abuse and coercion.
Physical Control Over Bodies

Other students mentioned partners that had a disregard for their physical bodies and pressured them to go beyond their physical capabilities and comfort levels. This was often tied to emotional manipulation.

No, it wasn’t instances of rape, just him asking me to do things where he would, like, get really angry if I didn’t do them. Which, like, me being 15, I was like I don’t really have control of this situation. Like, I’m smaller than he is and I’m young and he probably knows what’s best. So, just kind of him telling me to do things that I didn’t want to do and then after being with him for two years it just kind of you know hurt me psychologically (Interview, USF 1).

This student suffered from intimidation and coercion through violence from an older partner who “probably knows what’s best.” This student, in retrospect, was able to explain how that relationship left her psychologically impaired, which further impacted her future relationships with other men.

One gay male student mentioned an encounter in which he physically feared for his safety, so he suffered in silence until the other person was finished and never saw them again, Like, and of course, being in presence with someone, you have to make sure you’re comfortable with that person. Cause I’ve had people that are very aggressive that I wasn’t really into at all. And like, I’m not a really very aggressive person in bed, in general. But like, they were very aggressive you know with slapping and, um, just lots of grabbing very violently. And there was one time where there was a guy that was doing that. I was bottoming for him and he like slapped me like kind of like I think he was aiming for the ass but he hit the leg and it hurt like hell. Um, and he was just grabbing me and digging his nails into me and I was in such pain. But I was kind of scared that I didn’t say anything and I just kind of let him finish and then we left and I was kind of just terrified just cause like he was so aggressive. He was a lot bigger than me, too. Um, very in shape guy. Like he could’ve beat the shit out of me if he even thought about it (Interview, USF 10).

Lastly, one female student’s story illustrates the complicated nature of sexual relationships and how power is distributed during encounters, even in established, long-term relationships,

It's so hard to explain. She wanted me to feel pleasure, but not for me, because it was like a, like a badge for her to wear. Like, she was like, "Mm-hmm, getting you to orgasm is an
achievement for me." And, I don't really care how it happens or, like, if, uh, but... And then, so I, like, would take a very long time to orgasm, and she would not be okay taking the time. And so, she would be frustrated if I didn't orgasm within a certain amount of time. Like, she would be very frustrated with me. So, I started faking orgasms (laughs) through our relationship. And, I just got used to faking orgasms, and it was like, when I left, I was like, ‘Oh, my God, I don't know how to not fake an orgasm.’ And that was really hard (Interview, LSU 8).

Discussion

The framework of sexual citizenship provides a way to conceptually understand the intersections of patriarchy, toxic masculinity, and rape culture, and how these narratives support the continued perpetration of sexual violence in the U.S., specifically among young people. Students who were interviewed for this project identified three main themes of sexual violence experiences: personal experiences with sexual assault and rape, the emotional handling and fallout from those experiences, and violations of consent and pressured or coerced sexual encounters.

Students who experienced sexual assault and rape mentioned three sub-themes that impacted their experiences: the normalization of rape culture, the need to protect their rapist from negative consequences, and the hesitation to report an assault to authorities. The language students used about their assaults displays the normalization of rape in U.S. society. Especially for women, sentiments of “it’s just something you go through” and “it’s just kind of expected,” speak to the emotional heaviness of these situations that women are primed to endure at an early age. Women are taught how to not get raped and how to defend themselves if needed, what type of behavior they should display in public, what types of clothes to wear to not attract attention, to never be alone, to not be out a night, to not attract attention but at the same time not be rude or aggressive to men, etc. Meanwhile, men are not taught to not rape women and never have their behaviors, attire, or location questioned. This normalization of rape culture defaults to men being
the unquestioned citizens in society, and places the onus on women to navigate around and not provoke men’s behavior.

This narrative that women must subsume the actions of men is dramatically seen above in the women’s need to protect their rapist, often at the expense of their own emotional and physical wellbeing. Recurring statements of “not wanting to ruin” a rapist’ life, or not wanting him to get in trouble with authorities, display how ingrained patriarchal constructs of rape culture and toxic masculinity are. The outcome of the thought process and emotional response of a woman who is violently raped by a man to be to first protect him from harm, is astounding and yet common in U.S. society. Patriarchy dictates that women are second-class citizens, in which men’s actions, thoughts, and status are the default to power and prestige. This hegemonic narrative is often completely displayed in the enculturation of women’s responses to sexual assault and rape. Students in this project excused bad behavior, even though women are never forgiven for the same or dramatically less “bad” behavior.

This is a direct tie to survivors not wanting to report an assault. The double standards of how women are treated versus how men are treated when claims are brought forth is striking and reinforces the patriarchal structure of rape culture and toxic masculinity through victim blaming and shaming. The legal structure in the U.S. upholds these norms by gaslighting survivors of sexual violence, and students in this project were keenly aware of those narratives and the social stigma it can create for people who come forward. Students mentioned being embarrassed that this event happened to them, that they did not want to go through the process of having to emotionally relive the event over and over again, the fear of retaliation from their abuser, or the anxiety of friends or family finding out and rejecting them. This stigma can last for months or
years after the event has taken place, due to the process of reporting and potential legal actions that can occur, including the high-profile cases of college rape and the media influence.

These experiences can impact emotional behavior and responses in survivors, sometimes with lasting effects. Victim blaming and the rhetoric surrounding survivors of assault paired with actual language their abusers told them made confronting their emotional responses challenging for some students. Since over 90% of survivors previously know their abusers in some way, and the students in this project were no exception, these students mentioned the difficulties of seeing their rapist in classes they shared, when they went home for holidays, or saw them walking around campus. This created an environment of constant anxiety and worry, with some students unable to continue going to class, having to drop classes due to failing grades, and one student had to completely change schools. For other students, there was a delayed reaction to their assaults. They employed coping mechanisms that compartmentalized their feelings, sometimes for years. These students reported adverse emotional responses later that negatively influenced their future relationships with partners, friends, and parents.

For several students, fear of victim blaming was a reason to try to ignore or suppress their emotional and physical reaction to their assault or rape. Students were worried about what their social support networks might think of them, that they were asking for it, or that they were being dramatic and overreacting to a situation. One student was worried that her boyfriend might blame her for the assault, saying that she should never have met up with another man in the first place, while another student lost an entire friend group because they did not take her concerns seriously. One heterosexual man who was raped had to handle numerous people asking him if he was gay, since he did not “want it.” Still other students had abusers who directly blamed them through language and made them question their own participation in the event.
For those who had their consent violated or were pressured and coerced into participating in sexual activity in which they did not want to be a part, the sub themes of abusers physically controlling their bodies or gaslighting their victims into feelings of disappointment, show the way toxic masculinity influences the abusers’ actions. For students who experienced pressured or coerced sexual encounters, many of them did not want to label their experience as an assault or a rape, even though some later stated that it was. Students stated that they felt betrayed, angry, and disappointed in the actions of their partners and the inability of them to listen to direct communication, perceive negative body language, or give them control during the encounter. During these encounters partners would consistently emotionally manipulate students, such as relentlessly pressuring them to acquiesce to participating, or would get angry if partners would not sexually perform in a desired way. These students reported that partners did not respect their bodies or their boundaries and were consistently crossing their comfort levels.

From Chapter 3 on sexuality education, it was reported that students were not given any instruction (except one student) on the topic of consent, how to ask for it, how to give it, or how to revoke it. Nor were students given information on what a healthy relationship entails, how to know if you are in one or are in an abusive one, and methods to get out of an unhealthy and/or abusive relationship. Without this knowledge, students who experienced consent violations or bodily or emotional manipulation are not equipped to handle these encounters or remove themselves from them.

The national narratives of sexual citizenship and the governmental structures that support those narratives through policies, such as the proposed reworking of Title IX, and people in power, such as the Trump Administration and conservative Supreme Court judges, reinforce and help perpetuate patriarchy, rape culture, and toxic masculinity. Resistance against deeply
enculturated norms takes time and progress can be slow. Throughout all 50 student interviews, only two students mentioned the #MeToo Movement in relation to their comments on sexual violence experiences or perceptions. The lack of knowledge about sexual violence movements speaks to the divide of national narratives versus localized awareness and illustrates how long it takes for popular resistance movements to impact change (conversations, actions, etc.) on the local level.

However, there are some notable signs of change with regards to media attention and mainstream perception of sexual violence. The most recent nationally high-profile case of college rape was Stanford student Brock Turner in 2015 and his lenient county jail sentence of only six months, of which he only served three months in 2016. Chanel Miller, who Brock Turner raped, has recently come forward to tell her side of the assault and to address the emotional impact the rape and the trial had on her life. Public sentiment expressed overall outrage at the sentence of six months, instead of the 14 years he could have received. The judge, who was worried a stronger sentence would damage Turner’s future life opportunities and who said he did not pose a threat to others, was recalled in a California election in 2018 after a statewide campaign (Neary 2019). Bill Cosby was tried and convicted in 2018 of raping a woman, after over 60 women came forward with identical stories of being drugged and raped by the former comedian over the course of 30 plus years, and in December 2019 he lost his appeal (Chappell 2019). Currently the trial of entertainment Hollywood producer Harvey Weinstein is under way, who is accused of intimidating, sexually assaulting, and raping dozens of women, but has been charged in New York with the rapes of two actresses (Dwyer 2020). The number of women who have come forward from the entertainment industry specifically has sparked the additional #TimesUp Movement, to hold those in Hollywood accountable for sexual violence.
against women. These three cases of men’s abhorrent behavior exemplify the narratives of patriarchy, rape culture, and toxic masculinity, while their convictions and the public outrage that has accompanied the accusations is slowly shifting the framing of sexual violence in the U.S.

Conclusion

Hegemonic narratives of sexual citizenship deeply impact the ways sexual violence is committed in the U.S. The underlining cultural constructs of patriarchy, rape culture, and toxic masculinity all influence perpetrators who commit acts of sexual violence and the survivors that endure it. Themes of normalizing rape culture, protecting rapists, and the barriers that influence people not reporting, all tie into how people react and emotionally handle experiences of sexual violence. Additional layers of negative emotional responses and societal victim blaming and shaming increase barriers to coming forward and encourage survivors to stay silent. This chapter has shown the complex nature of students’ responses to sexual violence and how sexual citizenship frames responses and influences behavior of both abusers and survivors.
CHAPTER 5:
SEXUAL AND REPRODUCTIVE HEALTHCARE EXPERIENCES OF LGBTQIA+
STUDENTS

Introduction

In the West, heteronormative, cis-gendered relationships are the dominant portrayal of healthy, positive sexual relationships and experiences (Coates 2013). Coined in 1991 (Warner 1991), heteronormativity is the ideal social standard for natural relationships, which normalizes gender binary dominant structures (Cameron and Kulick 2006). In the U.S., the traditional nuclear family unit is predominantly portrayed in advertisements, entertainment, social media, and proclaimed as the ideal family structure through religious ideology and governmental programs and policies. Heteronormative, cis-gendered sexual citizenship is the hegemonic structure that mandates U.S. citizens conform to this framework through monogamous, romantic marriages that result in children (Kimport 2012; Wolkomir 2009). Even though large strides in activism for LGBTQIA+ rights have made substantial progress in the last 30 years, LGBTQIA+ people still are excluded from this narrative of citizenship (Herdt and Kertzner 2006).

Generationally, there is a large split in viewpoints between those who are older and opposed to LGBTQIA+ rights and younger generations who are more accepting and open of lifestyles and choices that fall outside the heteronormative, cis-gender binary (Marzullo and Herdt 2011).

Within the last four years, the current presidential administration has reversed policies and programs focused on inclusive sexual and reproductive healthcare broadly speaking, and specifically targeted LGBTQIA+ rights and protections. The defunding of the Title X program
through the implementation of the Domestic Gag Rule, reinstatement of the International Global
Gag Rule, refusal of transgender persons serving in the military, increased funding of crisis
pregnancy centers, refunneling of comprehensive sexuality education programming into sexual
risk avoidance programs, removal of employee workplace protections, and removal of
transgender and non-binary language from CDC websites, and refusal of the U.S. to condone
“sexual and reproductive healthcare” language in United Nations security council votes are just a
few examples from the last three years that support and mandate a framework of heterosexual,
cis-gendered, monogamous citizenship, while excluding and oppressing LGBTQIA+ people
specifically (ProPublica 2019). This structure is largely implemented under the guise of
“protecting” traditional family values and heterosexual, cis-gendered lifestyles.

For LGBTQIA+ people, this exclusionary culture can be detrimental in embracing gender
identities and sexual orientations outside the heteronormative, cis-gender binary. For young
people, leaving home and venturing out on their own, embarking on sexual encounters and
establishing relationships can be a difficult process to navigate; increasingly so in today’s
political climate. This chapter applies the theoretical framework of sexual citizenship to
understand the sexual and reproductive healthcare needs of young people ages 18-24, in the U.S.
southeast, who identity as LGBTQIA+. The themes that emerged are directly connected to young
peoples’ comfort with seeking out information regarding sexual and reproductive healthcare
knowledge and information, and how previous lived experiences influence future decision
making regarding their sexual health and practices.

The main findings are threefold: 1) students are less likely to communicate with parents
about sexual and reproductive healthcare needs if they have had negative experiences “coming
out” with their parents; 2) students need accurate and sensitive gender identity and sexual

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orientation based healthcare with unbiased providers so that they can make healthy decisions for themselves and their partners; 3) the lack of support and accurate medical information from parents and healthcare providers directly influences how students communicate and interact with partners during sexual encounters and establishing lasting sexually healthy relationships.

**Sexual Citizenship**

Until the mid-1990s, gender identity and sexual orientation had been largely missing from the academic discussion on citizenship. After the HIV/AIDS “epidemic” of the 1980s, the status of gay men in society was brought to the forefront as both an activist movement and a new area of social science research. Sexual citizenship became a new branch of citizenship literature in the 1990s, beginning with the examination of gay and lesbian peoples as they related to the larger hegemonic structure of heterosexual citizenship, predominately focused on white men. This institutionalized heteronormativity in the West centers white men in monogamous relationships as the members of society that enjoy all rights that go along with traditional categories of citizenship produced by the State, namely those of social, political, and civil rights and accommodations (Richardson 1998; Sibley 1995).

People who identify as outside the heteronormative structure have been barred from the same rights access available to heterosexual couples, including marriage equality, adoption options, tax benefits and inheritances, and reproductive healthcare access (social rights), workplace protections, military service, and housing (civil rights), and engaged actors and influencers of lawmaking (political rights). In this structure, gay/lesbian people are allowed to exist in a state of partial citizenship, such as through civil unions instead of marriage, and “don’t ask don’t tell policies” in the military and the workplace. These people are allowed to exist in a
world of tolerance in some areas, as long as they do not actively contest those allowances by seeking full, equal rights of their heteronormative counterparts (Richardson 1998).

This somewhat “hidden” population contests foundational notions of citizenship as the private lives of people have often been considered non-essential in the public frameworks of citizenship classifications and debates (Walby 1994). However, gay and lesbian couples, while remaining private, do not enjoy unconstrained rights within the home, as the right to marriage, adoption, and ideal family structures are largely dictated by governmental mandates that prescribe to heteronormative, nuclear family ideals (Richardson 1998).

In response to this heteronormativity framework and the struggle for equal rights, some subsections of the LGBTQIA+ community within the last 30 years have transitioned into homonormative cultural acceptance in some social groups and settings. This is seen most prominently in gay, white men of middle to upper class status, where consumption of capitalism through products and a re-working of domesticity, has depoliticized white, gay men (Duggan 2002). This homonormativity signals a reworking of the heteronormativity of sexual citizenship that is only able to exist through a hierarchal power structure: white, able-bodied men who have money are able to be more open sexually as opposed to, for example, black women who are poor and differently abled. It confines and limits homosexual activity to white, maleness, while pushing out men of other race/ethnicities (Murray 1996; Teunis 2007), while excluding women or other genders completely. This homonormativity is also linked to societal perceptions of “good” homosexual traits, such as cleanliness, impeccable and high-class attire and grooming habits, as well as luxury spending on extravagances (Meek 2012; Richardson 1998; Evans 1993). Additionally, the concept of homonormativity does not threaten heterosexuality, like queerness does (Walks 2014).
Queerness or being queer, is put forth as a juxtaposition to homonormativity, in which intersectionality pushes back against the white, gay, middle class, able-bodied man, and centers people who identify as transgender, non-binary, pansexual, bisexual, and queer within lenses of race/ethnicity, class, ability, and more recently, nativity (Piontek 2006). Homonormativity also trends toward more traditional gender roles of mono-sexual couples who are in committed long term monogamous relationships, thus pitting sexually fluid and gender fluid people (pansexual, bisexual, gender fluid, non-binary) as the deviant cultural group (Meek 2012). Homonormativity has defined acceptability conditions for gayness, while queer has become a less than worthy category (Walks 2014). This push-back also helps reclaim the word queer, and thus the identity, as a positive and accepted place of belonging, a process that has been building since the 1970s in the U.S. (Meek 2012) coinciding with the second wave feminist movement, and refocusing the discipline of anthropology on sexuality studies (Walks 2014). This started three phases of anthropological inquiry into LGBTQIA+ studies, the first mostly centered on defining and exploring homosexuality around the world (1960s - early 1990s), the second coinciding with postmodernism and the HIV/AIDS epidemic of the 1980s (late 1980s - early 2000s), and the current phase, which has expanded to include lesbianism, transgender identities, and queerness (late 1990s - present) (Walks 2014).

However, neither homonormativity nor queerness are static categories, as people continuously negotiate their own identities within personal and public spaces. As such, both frameworks are essential to understand how LGBTQIA+ populations resist and conform to heterosexual constructions of sexual citizenship (Teunis 2007). Both homonormative and queer cultural constructs contest the hegemonic heteronormative sexual citizenship framework that LGBTQIA+ students are receiving through sexual education in middle and high school, provider
care and recommendations when accessing sexual and reproductive healthcare, and relationship/partner encounters and decision-making surrounding sexual activities.

This queerness resistance, however, is often left out of academic studies which is why multiple LGBTQIA+ perspectives are included in this paper. This framing refuses to conform to institutional and patriarchal perspectives that the only acceptable cultural construction of LGBTQIA+ identity is homonormative.

Results

Of those students who took the online survey, 23% of students identified as LGBTQIA+ and of the 50 students who were interviewed, 17 (34%) identified as LGBTQIA+. See Table 14 for demographic breakdown of LGBTQIA+ participants who were interviewed. Three distinct themes emerged from the LGBTQIA+ population of interview participants: 1) how gender identity and sexual orientation “coming out” experiences impacted them and their family members, 2) difficulties accessing healthcare services and receiving gender/sexual orientation sensitive care from providers, and 3) how gender identity and sexual orientation influences decision-making in sexual encounters and established relationships. All three themes overlap and build upon each other, as gender identity and sexual orientation help establish the foundation for someone’s sexual decision-making, which influences how individuals seek healthcare and construct sexual relationships.

Gender Identity and Sexual Orientation: “Coming Out” Narratives

When prompted about the sexuality education participants received in middle and high school growing up and their family social support system during puberty, all interviewees
brought up their “coming out” stories as a defining moment in their lives. This is a prominent theme in LGBTQIA+ literature, and several of the specific stories that were told in this project have been documented elsewhere (Leap 1999). Many stories were focused on negative encounters they experienced either through sexuality educational teachings that denied their gender identity or sexual orientation, or focused on the negative reactions of close family members. One transgender male student recounted the harmful and confused reactions of his mother and father.

I came out to my mom, I think it was, October of my junior year. And like two weeks later, I told her I wanted to come out to my dad. Well, when I came out to her first, my dad was out of town. He had a job where he traveled at that point. I remember I was so nervous. I ended up crying and she was just like, ‘Oh. There, there. It’s okay.’ She probably didn’t understand what was going on. Um, and so then I told her, ‘I want to come out to my dad.’ And she said, ‘No. No. Don’t do that. It’s probably just a phase.’ And then she told me to watch this movie, um, Boys Don’t Cry, and I’m like, ‘Great. If that’s what you think about transgender people, cool. So, I won’t say anything then, huh. And, uh, and then I ended up coming out to him I think May of my Senior year. Like right when I was about to graduate. My dad took it very hard cause he was born and raised in Colombia, Roman Catholic. He had a problem when I told him I was bisexual in middle school. He was like, ‘You don’t know what you want. You’re too young.’ So, I knew this was going to be a problem. He didn’t lash out, though, like I thought he would. But he still said like some really nasty things. He said, ‘Seeing a man dressed as a woman, um, gives me the same feelings as seeing a black guy in an alleyway.’ So, not only transphobic, but also racist. Um, and he says, ‘Same for seeing a woman dressed as a man.’ And I’m like, ‘Cool. So, I won’t say anything to you either. Got it,’ (transgender man).

This quote illustrates multiple levels of heteronormative, cis-gendered frameworks and the close connection those have in U.S. to identity (Leap 1999). The mother thinks it’s a phase that her child will eventually grow out of and not something that needs to be expressed to anyone in the family since it is a temporary situation, while the father reduces the gender identity to confusion and being young. This demonstrates the powerful and normalizing nature of the male/female binary in Western society, as parents don’t frame children as “knowing” they are heterosexual
and cisgender because it is the dominant identity and not a phase or confusion simply because they are a child or teenager. Even though the father does not “lash out” in an aggressive way, as the student feared, he still links transgender identity with being deviant and scary, and draws a comparison to the stereotypical racist character of “seeing a black guy in an alleyway.” This example also demonstrates the strict gender binary roles that people are expected to conform to when presenting as their gender, including what is appropriate attire to wear for women or men. The student is given clear warnings that his parents do not believe this is actually who he is, and that if he “chooses” to be this way, then he will be considered threatening and unworthy. This blocks off all roads for communication between the student and his parents related to questions on sexual and reproductive healthcare. The student is well aware that his parents disapprove of his gender identity and sexual preferences and therefore, he is unwilling to communicate with them further about any partners he might have.

Another student who identifies as demi-girl, recounted their negative coming out experience with their mother.

It was to say the least madly traumatizing. I was 13 and she found out because she had gone through my cousin's phone... I was never the person who hid it. It was if you asked me, I was honest. I didn’t feel like, like, people don’t announce when they’re heterosexual, I shouldn’t have to announce when I’m pansexual. I basically remember when my mom took me to Steak ‘n Shake and we sat in this back little corner and in that very hushed mom yell she was like, ‘So, Saline told me you like girls today’ just very casual conversation, so no one would notice and I’m sitting here like, ‘Oh, crap’. And she’s cutting her food and she’s like, ‘You’re not allowed to. You’re too young to know what you are’ and the waitress walks up and she’s just like, ‘Yeah, I’ll have a refill’. ‘We’re gonna have this discussion with your father later’ and I’m like-- I remember I went to the bathroom, I started crying...And the entire time I’m like, ‘My mom literally just told me that I’m not allowed to like girls.’ It-- I was outed when I was 13. She just accepted it, no joke, maybe a month ago (demi-girl).

Again, in this example, parental reactions to a gender/sexual identity outside of the heteronormative, cis-gendered framework are stated as confusion and explained away as being
too young or immature to understand who they really are or who they are sexually attracted to. This parental response was also framed as an attempt for the mother to forbid her daughter from expressing these emotions and to control her behavior through the threat of “discussing this with your father,” falling back on patriarchal norms of fathers controlling their daughters’ choices through the promotion of virginal/purity culture. This framing sends clear messages to the student that participating in deviant behavior will not be tolerated, and if they were to find themselves in a position where they needed help, that parental advice would not be supportive.

One gay male student’s mother was accepting, but also worried about what other members of the family might think, and how that could negatively impact their relationships with relatives.

When I first came out of the closet like at all to anyone, um, I told my mom first. And like she didn’t care – like I knew she didn’t care that I was gay, but I knew she worried instantly like what the family was going to think, cause my family is typical – like mostly Republican, very conservative…But like I knew she would care what my family was going to think. Um, and that kind of hurt me. But I was kind of just like, ‘Forget about it. Like I don’t care.’ Um, you know they are my family. It’s just if they can’t accept me, then it is what it is. But, um, so that hurt (gay man).

This example shows the impact that family viewpoints and political values can have on their lived experience within the larger family structure. While this student had a supportive home life, he was still hurt by other members in his extended social network not accepting him, which influenced his relationship with his mother, who was unwilling to embrace his identity and advocate for him outside the nuclear family structure. He was able to have conversations with his mother when issues arose with partners later on, but he was unable to be fully open about his relationships with the rest of his extended family.

Worrying about being judged and how family members and close friends will react is a common theme for LGBTQIA+ people who openly express their non-heteronormative sexuality.
For more religious, conservative areas, young people in this study experienced a heightened sense of apprehension in being open with their gender identity or sexual orientation, because the heteronormative, cis-gendered narrative is heavily linked to family life, religious ideology, and politics. This is especially true in the U.S. southeast where conservative “traditional family values” dictate parental reactions to their children “coming out,” and this is often paired with a level of religious influence and intolerance. Religious, conservative overtones were expressed by a bisexual student,

My mom... I told her (laughs), the way I told that I liked girls was, ‘By the way, I have a girlfriend.’ And, that didn't go very well. She was very, like, rollercoaster of emotions... She didn't hate me, by any means, for it. And, 'cause she doesn't consider herself someone who dislikes homosexuality, but... She had grown up in a very Catholic household, so she was clearly experiencing... like, a conflict of everything she knew. I think her, like, internalized homophobia from her parents came out in her being mad at me for other reasons than that I was gay. For the rest of my high school experience, she was strict anti-public displays of affection. She didn't like to see me snuggle with a girl or hold hands in the house or out of the house, especially. And, I had never had a boyfriend through that time period, so I didn't have anything for comparison. But, when I was older, when I was just leaving high school, I had a boyfriend, and she wasn't like that with him. So, it was kind of telling (bisexual woman).

Another gay male student discussed his experience coming to terms with his sexual orientation while attending a Catholic high school and the messages that school officials, teachers, and clergy promoted,

One of the things that I still remember is, ‘If someone is bullied or if someone is bullied or abused, they're probably gay.’...So that was very angering to me. And like at the time, I still wasn't sure with, you know, who I was or anything, but even at the time, I was like, ‘Yeah. I was bullied but like this isn't all stemming from daddy issues and this isn't all stemming from the fact that I was bullied.’ I was like this before the bullying started. I didn't even know what gay meant at the time... So, like I just knew gay was bad. Like, you know, the, ‘That's so gay,’ comments from like early 2000. And so, like I, I knew gay was a pejorative thing (gay man).

In these two examples, religious upbringing is a prominent influence on how parents interact with their children when they assert their identity that goes against, in this case, Catholic
teachings of heterosexual, monogamous relationships that lead to marriage and procreation. For those parents who conform to those teachings, it can be a challenging structure for them to break away from and immediately accept their children for existing outside religious ideology. This type of family response can isolate the person, and have them feel excluded as part of the family structure, a position that they are allowed to hold and maintain, but cannot fully exist in.

Healthcare Issues and Access

The second emerging theme was the intersection of gender identity/sexual orientation and the interactions students had with healthcare providers and accessing quality care. When asked about specific encounters with providers understanding their gender identity, many students said that doctors either didn’t address their gender identity as a topic that might influence sexual and reproductive healthcare decision-making, or the provider seemed confused by what questions they should be asking patients in order to illicit correct information in order to provide them a spectrum of options. One non-binary student recounted the interactions with a doctor during a routine contraception appointment, and her hesitation to use a hormonal method of birth control, in this case a hormonal IUD versus a copper one.

I didn’t know if I was nonbinary and I was like, ‘I don’t want to do anything that might increase my estrogen levels’ and she was like, ‘Yeah, no it won’t. I got you. Like, this won’t do that.’ Um, so, yeah, that’s kind of how it went…I think that, I think that I was the one who brought up my gender because I was like, ‘I don’t want to, I don’t want to increase my levels of estrogen. Like, I’m already very feminine looking,’ (non-binary).

In this situation, the nurse practitioner who they were seeing did not initially take the patients’ gender identity into consideration when discussing hormonal contraceptive options. The lack of gender sensitivity training that this specific provider had received could have had ramifications on how the student interacts with their own body and how that presentation impacts their space
in society. The student had enough experience already advocating for themselves, that they were able to vocalize hesitations and concerns about hormones that the provider did not know needed to be discussed.

This lack of knowledge showed up in another student’s interactions with numerous healthcare providers, and the ways that medical offices frequently misgender them,

I’ve had good experiences and I’ve had bad experiences. Its fifty–fifty whether they say my preferred name. Sometimes, it’s more like, seventy, where they say the wrong name. Even though it’s literally on the sheet (transgender man).

For transgender and non-binary people specifically, being misgendered is a constant microaggression that they must endure, frequently reminding them that they are outside of mainstream society. Many students expressed feeling vulnerable in healthcare situations and worried about being misunderstood and not respected. For these students, having a provider misgender them at the beginning of an appointment was a clear indicator that they would not be respected as a person during the consultation, and signaled that the provider was not properly trained in administering transgender/non-binary sexual and reproductive healthcare.

While some interactions with providers were due to ignorance, other students experienced negative stereotyping. One gay male participant recounted their experience trying to get their PrEP prescription refilled,

…I’m filling out the info thing with the nurse and she, um, she and I pow-wow back and forth. We get to the sex part, she’s like, ‘Are you sexually active?’ I’m like, ‘Yep.’ And she’s like, ‘Alright, girls?’ And I’m like, ‘Nope.’ And she’s like, ‘Oh.’ And just her whole demeanor changed. She finished it as quickly as she could, got out. The doctor comes in and the first thing she talked about is PrEP and me having AIDS. Cause that was the main reason I was there. I was running out of PrEP and I needed more and I had to get tested again before I could get my new prescription. And she’s just like, ‘I’m going to send you to the CDC. I don’t know anything about this. Like I don’t know about like you

7 Microaggressions are subtle or unintentional statements or actions that are committed against a marginalized group, such as a sexual or racial minority. In this chapter it refers specifically to those students who identify as LGBTQIA+.
people and your AIDS.’ Like I can’t…I don’t want to think about it. And that was the most negative kind of thing that I’ve ever experienced when it comes to – like I’ve had people that are like, ‘I don’t want to be around you.’ And I’m like, ‘Okay.’ Like that, for some reason, that actually bothered me more. I was like, you don’t want to be around me? Cool. Like you’re a professional. A medical center, like do your job. Like, you don’t have to be my best friend, but I need you to do your fucking job (gay man).

This experience illustrates the deep-seated stereotypes that gay men specifically still face when trying to access any type of sexual or reproductive healthcare that can be linked to HIV/AIDS. While PreP and other HIV mitigating drugs are becoming more common on the market, providers, especially older ones, may not have the education and cultural awareness to effectively prescribe them in non-offensive ways.

Non-evidence based medical treatments for LGBTQIA+ people are still promoted in some states where conversion therapy has not been outlawed yet. Conversion therapy (or reparative therapy or sexual reorientation) is a pseudoscience that has no medical, evidence-based support. Conversion therapists use a variety of immersion techniques, such as shaming, using painful stimuli, or evoking emotionally traumatic responses in patients to suppress or change a person’s sexual orientation, most often used to target homosexuality, or a person’s gender identity that falls outside the male/female binary. The “treatment” has provided no evidence to support that it works in changing a person’s sexual orientation or gender identity, and can in fact produce harmful risks to patients who undergo the therapy, including depression, anxiety, drug use, homelessness, and suicide (The Trevor Project 2020). Currently 19 states have legal bans against the practice of conversion therapy, however, the three states in this dissertation are not among the 19 that have banned the practice.

One student spoke about her mother’s negative reaction to her sexuality, her experience getting “tested” for homosexuality, and her luck of finding a mental healthcare provider who understood her.
She [her mother] put me in therapy. And what I say was God’s will was my therapist was a lesbian. She had just gotten married to her wife in New York. She had pictures all over her office of her and her wife, like, kissing on vacation, rainbow flags everywhere, but my mom was so focused on me she didn’t notice anything else. So, my mom is in this bright red, Willy Wonka, rainbow room did not see it. At all. And I remember she was like, ‘I just want you to find out what’s wrong with my daughter, this and that’. It got to the point where my mom got me tested once ‘cause they say if you have an extra chromosome that you are, you are a homosexual and she had them test me. I remember like one that’s illegal because I did not consent to that. I was like, ‘And number 2, you’re not born with an extra chromosome that makes you homosexual (demi-girl).

This quote shows the classification of a narrative outside heterosexual identity as being “wrong” and a situation that needs “fixing” through biomedical testing. The narrative of homosexuality resulting from an abnormal chromosome mutation is popular among evangelical Christians, and is part of the conversion therapy movement, in which locating a genetic mutation and using a targeted treatment can “cure” someone of their homosexuality.

Finding a mental health care provider who is understanding of LGBTQIA+ healthcare needs is essential for students who need mental health services. For transgender people who want to physically change their bodies through gender reconstructive surgery or hormonal therapy, access to gender sensitive care is sometimes difficult. These services are extremely expensive, and many doctors are not certified or comfortable in providing hormonal treatments. Young people, especially students in a university environment where the healthcare is administered on campus, are required to be evaluated by a mental health provider, usually a psychiatrist, in order to be cleared to proceed with any type of body modification/transition procedure or drug regimen. One student expressed concerns about being able to access treatment after they leave their undergraduate institution and move out of state (to a lesser transgender friendly state) for graduate school.

The law school I’m looking at, they have like, an LGBTQ um…what do you call it, I think I saw on their page that they have like trans health care. Which was really awesome, so I’m hoping there is where I can start. Um…my issue with starting still
is…is um, the fact that I’m like…only out to like, one of my family members. And even though I don’t really have a lot of contact with any of my other family members, um…it’s still like, a matter of…her trying to say, hey, you should like, get started in your career and then transition, but…that’s very difficult, wouldn’t you rather have been transitioned in your career so that you don’t have to face any either, a. stigma or you know, b. like, any legality. And especially with moving out of state, I’d have to…I don’t know if I can get…my name ch- uh, I can get my name changed but it has to be in Florida. Um…and my gender marker has to be done in Florida. But it can only be changed if I’m on testosterone (transgender man).

This demonstrates the uncertainty transgender people face by simply moving. Access to sexual and reproductive healthcare can vary greatly by state, as well as the state’s acceptance of transgender people, and what qualifies as a “legitimate” transgender person. In this person’s case, being on a hormone (testosterone) is a legal requirement in order to proclaim yourself as transgender on a state issued identification card. This quote also demonstrates the complicated nature of coming out to family members and the anxiety physically changing your body to match your gender identity can cause both within the family support system and the healthcare system.

Navigating Sexual Encounters and Relationships

For LGBTQIA+ students, early sexual encounters and establishing relationships can be difficult to negotiate. For the third emerging theme, many students mentioned the need for inclusive sexuality education in order to have their identities and orientations validated, as well as securing communication tools to discuss issues with their partners. These topics centered on the approach to sexual encounters, contraceptive usage and STI/HIV testing, and pleasure and body comfortability and communication. Due to the lack of sexuality education that exists for people outside the heteronormative cis-gender binary, people who identify outside the mainstream narrative are often left to figure out contraception, sexual pleasure, and effective
communication strategies. When discussing trying out different barrier methods, one student explained their process:

No, I had never used them before [female condoms] and I was like, interested in using them for unintended purposes. Like seeing if I could – if they could be used for anything else other than like, internal vaginal use. I think I have like three in a drawer that I never even opened. It’s just like…you know, having them and being like, okay, maybe you know, we can see with this or we can you know, do it with this because sometimes you’ve got to be really inventive. Cause there’s not much like…nobody tells you how to have trans sex. You know? (transgender man).

Most students interviewed had been taught abstinence-based sexuality education in school, in which sexual activity is discouraged until marriage. This heteronormative, cis-gender framing of sexual relationships makes it difficult for those outside this hegemonic structure to learn appropriate methods of engaging in sexual relationships. Many students expressed sentiments of having to “figure sex out” for themselves and their partners. For people who identify outside the gender binary, being sexually intimate with another person can have increased vulnerability and anxiety. For transgender people in particular, the naming of body parts is important, because sex is so closely linked to gender in heteronormativity.

Well, we’re both very open about…like what we like, what we don’t like and definitely one of the major things that we talked about going into a relationship or at least before any sexual encounter was like, what do you like to call your parts, you know. What are you comfortable with, can I refer to this as that…is this comfortable for you? Can I touch you here? Is this okay? Do you like vaginal stimulation or is that like completely off limits? You know. I think it’s very important- it’s important in any relationship but…I would say like, very emphasized [in] trans relationships. Because you definitely don’t [want to] call something something else and it be like, oh, that’s – that’s not sexy. Like don’t remind me I have that (transgender man).

Many students expressed the need for open communication with their partners in order to have respectful and trustful sexual encounters and relationships. This applied to healthy sexual practices and the concerns with STI/HIV transmission. When addressing contraceptive use and
oral sex, most students who were interviewed said they did not use a barrier method, but those same students did insist on barrier methods for genital sex.

It wasn’t until after I came out that it had become a conversation piece. Um, there was a, uh, guy who was a friend of mine and I knew he was gay. And ultimately, he and I ended up in a relationship. But he refused to use condoms. Which was an interesting conversation because, um, I didn’t know the last time he had been tested. So, that was a conversation I had raised with him. I was like, ‘When was the last time you got tested?’ And he didn’t know. I was like, ‘Are you okay with getting tested before we do anything?’ And we actually ended up sleeping together before, um, he got tested and before I got tested. Cause it had been probably five, six people and several months since I had been tested. Um, but with those people, I was relatively safe. Um, and I hadn’t bottomed for any of them. But for him, I was a bottom for him. And so, the first time we slept together, he was about to actually finish inside me. And I was like, ‘Fuck that. No, you’re not.’ Like, um, it was like mid-sex I was having this conversation with him. He was like, ‘Why not?’ And I’m like, ‘What the – what do you mean ‘Why not?’? ’” Um, and then after that, we both got tested. We both came back clean. So, I was like, ‘Okay. Now I’m fine with it,’ (gay man).

For these students, the knowledge of STI/HIV transmission through genital sex is known and discussed, but less information is conveyed and understood about the impacts of transmission through oral sex. Many students reported that they discussed these issues with their partners, but usually the need for protection during oral sex was deemed less important than the need for it during genital sex.

**Discussion**

Each of the three themes above show clear linkages to the hegemonic framework of heteronormative, cis-gendered citizenship that the U.S. promotes when mandating young peoples’ sexual and reproductive healthcare and decision-making in relationships. The U.S. is still largely a traditional, nuclear family structure of heterosexual, monogamous couples who procreate within a marriage union. Parents are one of the most influential entities in a young person’s life, and their reaction to a child’s “coming out” can have lasting impacts on their self-
identity and interactions with people outside the family unit. Parents who immediately proclaim that their child is confused or too young to know who they are or who they want send clear signals that they do not trust their child to make informed choices regarding their gender identity or sexual orientation, and that it is a phase they will eventually grow out of. This brings the default of heteronormative, cis-gendered identities to the forefront, as any deviation from this norm is considered the choice of young and naive children who have not completely matured yet.

Several of the participants mentioned that while their parents were accepting of them, they were still concerned about other members of the extended family not being as willing to include different positionalities outside the heterosexual, cis-gender framework. Families who adopted policies of “don’t ask don’t tell” and parents who shielded their children from telling other family members to protect the nuclear family’s traditional values send children mixed messages about acceptance, love, respect, and trust. Adding a layer of religious intolerance over those categories as well can include narratives of eternal damnation, providing further mental and emotional harm. Parents that only accept children within the household, but not outside of it, reinforces to young people that while their deviant behavior will be tolerated behind closed doors, it’s not something to be proud of or “shown off” to other family members. Essentially relaying the message that other people’s feelings are more important than their child’s self-identity. This directly relates to heteronormativity and the limitations of sexual citizenship for LGBTQIA+ individuals.

In this study, parents who rejected different gender identities and sexual orientations of their children were less likely to be willing to approach conversations regarding sexual and reproductive healthcare practices and decision-making. For many parents, social and religious conformity to heteronormative, cis-gendered relationships, coupled with views on child rearing
and parental guidance, provided barriers that were difficult to overcome when a child “came out.” Normalizing a sexual citizenship framework that is inclusive of different gender identities and sexual orientations is one way to help parents become comfortable with children identifying outside the hegemonic gender and sexual binary. This can be accomplished through inclusive sexuality education, and more diverse representations in television, movies, and music that both children and parents consume.

Secondly, young people need access to accurate and unbiased sexual and reproductive healthcare. Going to the doctor for sexual and reproductive healthcare information or issues already entails a stress and vulnerability for young people, but people outside the heteronormative, cis-gendered identities expressed more apprehension and emotional distress when dealing with providers who were lacking training in LGBTQIA+ healthcare needs or who were critical or biased towards their sexual and reproductive healthcare choices. By consistently misgendering patients, not taking into account peoples’ gender identity, or being judgmental about sexual practices, providers have developed the reputation that they are uninformed and ill equipped to handle LGBTQIA+ needs. In the southern U.S., the normative social and religious ideologies that parents are bound by can also influence provider care as well. As a few students mentioned, many providers based gender identity on how a patient physically represents relating to cis-gender constructions of identity, and did not feel the need to ask questions regarding the intersection of gender identity and medical choices. For example, when considering a hormonal contraception versus the impacts it can have on a person’s body, it is essential that a provider discuss this with a transgender or gender non-conforming person when they are inquiring about contraceptive options.
The need for providers to understand different sexual orientations and sexual encounters was expressed by participants in order to receive both appropriate testing and medication. Participants demonstrated the need for unbiased and appropriate treatment, including hormonal and transitioning options, regardless of the providers’ personal viewpoints and opinions regarding different gender identities or sexual orientations. Expanding sexual citizenship narratives through homonormativity and queerness frameworks can bridge this gap in quality sexual and reproductive healthcare by normalizing the experiences of LGBTQIA+ populations and including those viewpoints in healthcare provider educational and training curricula.

Finally, participants who did not receive inclusive sexuality education or who did not have parents openly talk to them about sexual relationships and decision-making, expressed confusion and uncertainty when approaching issues such as relationship communication, contraceptive decision-making, STI/HIV testing, and body image/comfortability. While open conversations about sexual relationships are still taboo in U.S. society, LGBTQIA+ people experience further difficulties in seeing and hearing experiences and information that directly relates to their perspectives and needs. The heteronormative, cis-gendered framework forces those outside that structure to “get creative” with navigating relationships and sexual encounters. Because of this, participants had open and honest communication with most of their partners, and were willing to express feelings and emotions more freely when sexually interacting with someone who was also not heterosexual or cis-gendered.

Conclusion

These results of this chapter demonstrate the need for deeper understandings of how heteronormative, cis-gendered frameworks impact the lived experiences of young people who
are LGBTQIA+, specifically in the realm of sexual and reproductive healthcare and decision-making. Each theme – gender identity and sexual orientation “coming out” stories, interactions with healthcare providers, and navigating sexual encounters and relationships – illuminate the constant negotiating that young people undertake while establishing their gender identity and/or sexual orientation in a hegemonic structure that is actively working against them. Using a theoretical framework of sexual citizenship, while including a homonormative and queer perspective, can help advance the understanding of sexual citizenship’s heteronormative lens and redefine what constitutes “normal” and “ideal” sexual encounters and relationships within the U.S. context.
CHAPTER 6:
CONCLUSION

This dissertation has examined the sexual and reproductive healthcare experiences of university students aged 18-24 at three schools in the U.S. Southeast. The original purpose of this project was to understand how students interacted with campus resources providing sexual and reproductive healthcare and information based on their previous lived experiences. However, the project gradually evolved into an examination of past experiences regarding sexual health and access to information. The students who filled out the online survey reported not using campus resources often, and the students who were interviewed reported much of the same. Therefore, the project morphed into an analysis of a population of young people who happened to be located on university campuses instead of an examination of their lives while being enrolled at three specific schools.

In this conclusion chapter, I summarize findings as they relate to the three research objectives and I explain how those results interact with the social ecological model and reproductive justice framework. I then supply my contributions and advancements to both disciplines and discuss my anthropological and public health recommendations, including the potential for future research on this topic.

Discussion of Research Objectives

This project was focused on three research objectives: 1) to understand the sexual and reproductive healthcare knowledge of college age students 18 - 24 years old, including the key
stakeholders and gatekeepers of information; 2) to analyze how past lived experiences with sexual and reproductive healthcare education and partner interactions impact their views and self-conceptualizations of identity and needs in future sexual encounters and relationships; 3) to explore how policies of national and state governments influence the production of sexual citizens, and identify the sexual narratives that guide identity formation and choices. These three objectives will be discussed separately below, although due to the nature of the questions and the project some overlap of analysis and theoretical implications are inevitable. The below sections are discussed through the lenses of governmentality, biopower, and sexual citizenship.

**Research Objective One:** To assess the sexual and reproductive healthcare knowledge of college age students 18-24 years old; including the key stakeholders and gatekeepers of information.

As discussed in Chapter 3, students who participated in this project, both through the survey and in interviews, reported a severe lack of high quality, sexuality education. Most of the respondents reported abstinence only based education, which did not provide them with accurate information or where to access sexual and reproductive healthcare services. The politically and religiously conservative U.S. Southeast tends to promote conservative viewpoints within its institutions, and the middle and high schools that these students attended were no exception. Because abstinence only, or sexual risk avoidance, sexuality education is focused on repressing and discouraging any type of sexual activity, students are not provided information on healthy sexual practices. The discourse that sexuality education is taught through is one of risk and risk avoidance, in which sexual activity of any kind is considered potentially harmful to the individual.
The themes that emerged regarding abstinence based teachings were that it was lacking in accurate information that students could use and apply in real life situations, that fear and scare tactics were used as a tool to emotionally manipulate students into abstaining from sexual activity, and that educators were uncomfortable or not knowledgeable about the curriculum and information, leading students to not take the education seriously. Students reported receiving very little information on contraceptives outside of condom usage, and even then, they were often not shown how to use one or not told where to obtain them, as no students mentioned that they were handed out at school and a few students even said educators were prohibited from distributing any type of contraception or emergency contraception on site.

Additionally, students were not given information on STI/HIV testing, how to have conservations with partners about past sexual history, or how to handle a diagnosis. Several students were shown images of STIs as an attempt to scare students away from sexual activity, as well as a birthing video to show the horrors and pain of childbirth. Given that rates of STIs and HIV are on the rise, specifically for asymptomatic ones like chlamydia and gonorrhea, not receiving information on barrier contraceptive use and testing information is a gaping hole in students’ sexual and reproductive healthcare knowledge.

Only one student reported that the topic of consent was covered, and only one student reported that healthy versus abusive relationships were covered, but only for girls in the class. As Chapter 4 shows, many students who have been sexually assaulted or raped struggled with their own reactions both during and after the incident. Many of the students expressed that they did not know how to communicate their feelings of hesitation to participate in sexual acts or were repeatedly ignored when they said “no.” Teaching consent and how to effectively communicate with partners would help all young people understand what consent looks like, how to ask for it,
and how to revoke it, and also what is appropriate behavior in a healthy relationship versus an
emotional or physically abusive one.

Of the students who were interviewed, most received heteronormative focused instruction
that ignored gender identities outside the male/female binary and denied the existence of other
sexual orientations. For students who identified within the LGBTQIA+ spectrum, this had a
negative impact on their early stages of self-identity. Educators were listed as denying the
existence of lesbians and bisexual people, or claimed that they were not allowed to talk about
those types of people or situations, including homosexual ones. Only one student reported an
instance where different sexual orientations besides heterosexual ones were mentioned.

Overwhelmingly, the heteronormative foundation of the sexuality education was focused
on the benefits of marriage and/or conforming to religious ideology. Students were encouraged
to stay abstinent until marriage, with an emphasis placed onto women’s bodies to remain pure for
their husbands. While several cis-gendered, heterosexual women expressed these concerns, and a
few LGBTQIA+ students did also, no cis-gendered, heterosexual men who were interviewed
mentioned this concept, showing the patriarchal control and emphasis placed onto women’s
bodies in order to obtain preferred sexual citizenship, while men are not subjected to or punished
for the same standards of bodily control. These marriage narratives are heavily tied to religious
ideology and teachings of both protestant and Catholic persuasions, most prominently featured in
interviews from Kentucky and Louisiana, and a little less so in Florida. Students reported that
religious ideologies that were promoted in sexuality education settings linked sexual activity
with sinfulness, the end result being damned to hell or not living up to good, Christian standards
of behavior. For LGBTQIA+ students, this rhetoric was often directly tied to existing in a
heterosexual and cis-gendered world, where marriage is the ultimate goal. Heteronormative
instruction paired with religious ideology taught students to frame sexual encounters as dirty and abstinence as a way to remain pure, again largely directed at girls and their choices which could have negative impacts on them securing a future husband. This was often paired with virginity pledges as a way to induce peer pressured social conformity.

The lack of information and misinformation regarding anything related to sexual and reproductive healthcare that students described is largely due to people in positions of power who have the authority and ability to withhold information or superimpose political or religious beliefs into the information that is being taught or the care that is being provided. This was most prominently displayed in interactions students had with educators in their school systems who were assigned to provide some type of sexuality education. As shown in Chapter 3, this education promoted heteronormative behavior and ideals about what is expected of students’ sexual activity and identity. This was often paired with judgmental assertions of what types of people exist (bisexual people do not exist), what types of behavior are acceptable or not (men only want to marry virgins), and what information that is presented as factual, may in fact, be inaccurate and damaging (only loose women wear tampons).

As people not in positions of power and authority, students are unable to challenge or refute lacking or misinformation. By teachers taking on the role of “educator” for sexuality education, many students assumed that their teachers, who are responsible for advancing their learning in other subjects, were equipped to handle sexuality education. Many students claimed that they took what these educators said as factually accurate. Due to many state laws not mandating that sexuality education be medically accurate, including all three states in this dissertation project, this is deeply concerning. Those students reported having to learn information on their own once they were at the university, many of who said that their sexuality
education in middle and high school damaged them in some way, either through self-identity crisis or negative sexual experiences.

As discussed in Chapter 5, LGBTQIA+ students had additional issues with understanding and accessing sexual and reproductive healthcare services. This was largely impacted by parental responses to “coming out” events, which were often less supportive than students hoped or were even traumatic. These students reported not feeling comfortable in speaking with their parents regarding their gender identity or sexual orientation in general, and even less likely to have conversations about sexual and reproductive healthcare needs. For those students who had negative sexuality education which denied their existence, they were hit with a double dose of feeling unaccepted and lacking knowledge to have safe and healthy sexual encounters with future partners. These concerns were all reiterated with healthcare professionals, of which a few students described negative encounters with providers not taking their gender identity into consideration when talking about contraception or feeling discriminated against when providers refused to treat them due to heterosexual bias or due to fears of HIV.

*Research Objective Two:* To investigate how past lived experiences with sexual and reproductive healthcare education and partner interactions impact their view and self-conceptualizations of identity and needs in future sexual encounters and relationships.

Lived experiences with sexuality education and the people in power promoting sexual citizenship narratives have been influential, for better or worse, in the self-conceptualizations of students’ identity formation. This project revealed both positive and negative experiences that continue to guide and shape students’ sexual encounters. Many students, regardless of gender
identity or sexual orientation, mentioned that the lack of accurate medical information that they were not provided during their formative years (10 - 18 years old) had a negative impact on their sexual activities and how they approached relationships. Without having clear guidelines for acceptable and safe ways to explore their sexuality, students were more likely to make choices that potentially had negative consequences, such as contracting an STI or not being able to identify “red flags” in abusive relationships. For many students, peer support and the internet became key sources of information to help them navigate future choices for sexual activity.

Without instruction on consent or healthy relationships, students who were involved in abusive situations or who were assaulted or raped, were ill-equipped to handle the physical and emotional response they had. For students in abusive relationships that involved pressure or coercion to participate in sexual activity, several students reported that they were unable to see many of the warning signs early on or they thought that love and affection was expressed through emotional manipulation and violence. This is a direct tie back into toxic masculinity and rape culture in which submissiveness, compliance, and deferment to men’s needs are portrayed as the way to keep a man happy and to be a supportive partner. Students who were in these situations said that those experiences have impacted how they meet and form relationships with all future partners. For those students who were sexually assaulted or raped, many initially after the incident did not perceive the event in those terms. By legal definitions of sexual assault and rape, all of the students who recounted an event would be classified as a survivor, but several did not want to self-identify as such. For others it took several months or even years to fully understand their assault and why they reacted the way that they did. These students were able to identify larger narratives of patriarchal behavior and rape culture manifestations, including victim blaming and shaming, the reluctance of people in their lives to believe them, and the
common cultural catch phrase of “boys will be boys” that excuses male accountability for the overwhelming number of assaults that take place. A positive outcome of these situations is that students reported being able to find their voices and advocate for themselves more effectively by using direct communication instead of giving in or being passive participants in their future intimate relationships.

For those students who identified as LGBTQIA+, their “coming out” experiences with parents had lasting impacts on how they self-identified outside of the household and how they approached sexual relationships. Many students reported negative “coming out” circumstances in which parents either rejected them, completely misunderstood them, or considered their different gender identity or sexual orientation a phase that they would eventually grow out of. These students reported feelings of rejection, low self-worth, and hesitation interacting with other family members. In some cases, this negative reaction lead students to hide their identities from the public, especially in high school, while in other cases, students came out to friends and found a support system of acceptance. The transgender men who were interviewed experienced negative reactions from their parents, but said that these experiences actually made communication and intimate relationship building with others easier and mutually beneficial. All the transgender and non-binary students who were interviewed were either currently or had just recently been in relationships with other transgender or non-heterosexual or non-cisgender people and reported more open lines of communication within their intimate relationships due to past negative experiences.
Research Objective Three: To explore how policies of national and state governments influence the production of sexual citizens, in this project, young people specifically, and identify the sexual narratives that guide identity formation and choices.

Through forms of governmentality in the U.S., sexuality education is used as a biopolitical control tool, both on the national level and the state level. Federally, the government has increased its focus on sexual risk avoidance (i.e. abstinence only education) during the Trump Administration by withholding Title X funds, instituting the global and domestic gag rule, diverting money to crisis pregnancy centers, and removing policies and protections for LGBTQIA+ people. On the state level in Florida, Kentucky, and Louisiana, conservative legislators have mandated abstinence only education be the norm in schools, with a focus on heterosexual monogamous relationships and marriage. These two levels of governmentality, which work together, help cement the narratives of ideal sexual citizenship. Young people are taught, through authorities in power, that white, heterosexual, cis-gendered, monogamous relationships that result in marriage and procreation are the ideal sexual behavior strategies in order to achieve full citizenship status. This must be accomplished without access to all the available information on how to form healthy sexual relationships and how to keep their partners and themselves healthy. While students may see an explicit link to sexual citizenship narratives through direct encounters with educators, parents, and healthcare providers (Chapter 3), they may not identify the subtle links of those same narratives through interactions with their peers or partners (Chapters 3, 4, and 5). Most students did not identify a direct link to national policies and ideals, while a few students made connections to state level policies regarding conservative family values and Christian ideology.
Sub-narratives of patriarchal control, toxic masculinity, and rape culture additionally promote and support these hegemonic narratives. Patriarchy is ever present in all realms of U.S. society, and young people experience and interact with this structure daily. Sexuality education teaches a heterosexual and masculine perspective, that places heavy emphasis on the decisions women make regarding their sexual practices, without the same level of scrutiny for men. In none of the interviews did anyone, especially women, mention the negative impacts that men would face if they participated in sexual encounters. Framings of purity and dirtiness were never explicitly directed at men only, and men were never told that their actions could one day cost them the love or affection of a wife. LGBTQIA+ students were completely left out of these narratives that were introduced in sexuality education, except in instances of denying their existence or treating their existence as sinful. For gay men and transgender men, this is often coupled with societal expectations of what “real” men are and how “real” men behave, further promoting notions of toxic masculinity.

This display of toxic masculinity impacts everyone. For the ideal sexual citizen, heterosexual and cis-gendered men are shown appropriate ways to behave along gender binary lines, which can disproportionality promote assertiveness, aggressiveness, poor communication, and even violence (Pearson 2019). This is linked directly with how society at large, under patriarchy, treats women as sexual objects and promotes rape culture (Elliot 2018). This is most expressly discussed in Chapter 4, in which numerous students recounted their sexual assault and rape experiences, as well as violations of their consent and feelings of sexual coercion. The normalization of rape culture through the interviews is striking, as students discussed the need to protect their sexual assailters and rapists over their own physical and emotional wellbeing and the self-blame they placed onto themselves for their “part” of the assault demonstrates the
patriarchal narratives of survivors being responsible for their assaults and not the perpetrators. This narrative is reinforced by people close to the survivors through victim blaming and shaming or not believing survivors’ experiences.

With notable exceptions, a gay man being assaulted by another gay man and a heterosexual man being raped by a heterosexual woman, all the other reports were by women (n = 13) who were assaulted or raped by heterosexual men. For those women, only two reported their assault or rape in an official capacity. They either wanted to avoid further victim blaming, did not want to deal with people in power positions not believing them, or did not want to harm their perpetrators’ reputation or future life plans. These narratives were also apparent in discussions of consent violation and feelings of sexual coercion. Students mentioned that partners, mostly heterosexual men, ignored the word “no,” applied physical pressure, or an emotional nagging technique in order to get women partners to finally acquiesce to participating in sexual activity. These experiences demonstrate the tangible hold that patriarchy and rape culture have on the actions of people who are assaulted and how socio-cultural constructions of protecting the patriarchy are upheld and reinforced.

The Social Ecological Model (SEM)

The Social Ecological Model (SEM) is a public health schema that analyzes influences from multiple levels of society. There are several varieties of this model, but the one incorporated in this analysis uses a public policy - community - organizational - interpersonal - individual structure. This model was used to understand how sexual and reproductive healthcare interacts on each level of society, from the top down, starting with the federal government, to the
bottom of the model, where the students’ individual lived experiences and interactions are represented.

Public Policy - This level encompasses both national level and state level policies. Nationally, narratives focused on abstinence and sexual risk avoidance sexuality education and countrywide narratives of sexual citizenship defined as white, cis-gendered, heterosexual, middle to upper class, and abled bodied, provide strong representations of how sexual and reproductive health issues are accepted or not in society. This level, which incorporates governmentality, is the guiding force determining who is included in mainstream society and who is considered deviant based on different identifications of gender, sexual orientation, race/ethnicity, class, and ability. It also defines the sub-cultural themes of heteronormativity, patriarchy, toxic masculinity, and rape culture. In this dissertation, some of the classifications are overt, such as policies denying the right to exist in public spaces to transgender individuals. Others are more subtle, such as the ability of white, middle to upper class, gay men actively internalizing heterosexual ideals in order to be accepted in society, such as through marriage.

On the state level, public policies regarding sexuality education, who makes those decisions, and what is incorporated in the curriculum can have lasting impacts on young people. In the U.S. southeast specifically, these programs and policies are often abstinence driven, do not have to be medically accurate, and are not required to teach consent, healthy relationship characteristics, or contraception or abortion.

Community - For the purposes of this dissertation, community is broadly defined to incorporate the areas where young people grew up during their formative years for middle and high school. As many students recounted experiences from those years, this influence is separated from the state level of public policy. This level was where students listed impactful
factors on their sexual and reproductive healthcare journey such as interactions with educators, religious teachings, and low access to sexual and reproductive healthcare resources, for example condoms and birth control pills.

Organizational - Organizationally, this dissertation tangentially incorporated university campuses as sites of an organizational environment that has the potential to be influential. However, most students who completed the survey and those who were interviewed did not express strong sentiments regarding how their respective university influenced or provided sexual and reproductive healthcare services.

Interpersonal - Young peoples’ relationships with their social support network, including friends, parents, and partners, play a vital role in their interactions and reactions with sexual encounters and accessing information and care for sexual and reproductive healthcare issues. These relationships can have both positive and negative impacts as seen from a variety of examples in this project.

Individual - Impacts of public policies, on the national and state level, community pressures, and interpersonal interactions were all felt by and commented on by students who were interviewed, either directly or indirectly. This speaks to the power of the model in order to understand a specific topic and the influence it can have on multiple levels of society. Internalized and then expressed behaviors of conformity dominated student’s memories and interpretations of past lived experiences with people in positions of power as well as intimate partners, and these interactions greatly impacted their future choices.
Reproductive Justice

Reproductive justice is one of three components that work together to combat reproductive oppression, and actively promotes the experiences of people as an advocacy tool, predominately through storytelling (Price 2010) in order to center the voices of reproductive oppression. This is one way to disrupt the hegemonic narratives of sexual citizenship and contest their power. The framework uses the voices of black women in particular to draw attention to past reproductive oppressions including forced sterilization, forced birth, and the withholding of sexual and reproductive healthcare. Because this project was comprised of a privileged population, university students, the dynamics of race and ethnicity were not as prominent in the results as the intersections of gender identity and sexual orientation. In attempting to remain true to the justice model, I have incorporated a diverse number of voices in their own words as a way to highlight lived experiences of marginalized populations, specifically those voices of LGBTQIA+ people.

In this project, I have paired reproductive justice with access to sexual and reproductive healthcare to show gaps in students’ education, information, services, and knowledge. Using a reproductive justice model can help advance sexuality education policies, advocate for sexual and reproductive healthcare services, especially on college campuses, and can help shift narratives and discourse guiding sexual assault and rape. It actively seeks to dismantle hegemonic heteronormative, cis-gendered, white, upper-middle class structures that are the current norm for sexual citizenship identity and formation.

new Title IX laws

This justice model works together with a feminist methodological strategy by promoting and advocating for an intersectional approach to contest, resist, and reframe power dynamics that
are informing policies, laws, and narratives on sexual citizenship and young peoples’ access to sexual and reproductive healthcare. This can be done by promoting and protecting policies and laws that provide rights and access to LGBTQIA+ people. For this project specifically, the contestation of heteronormative, cis-gendered only sexuality education, conversion therapy programs that seek to remove gayness or non-binary gender identities, and stereotypes of sexual actions and healthcare concerns, such as STIs and HIV. For the population of young people in general, promoting laws that require affirmative consent for sexual assault cases, strengthen Title IX regulations that protect and validate survivors, and shift narratives of rape culture and toxic masculinity.

This project highlights the ways U.S. culture, especially in the South through conservative politics and religious ideology, shapes women’s identity and relationship with sexual activity. Patriarchal views of women’s worth through a lens of sexual objectification reinforce to young people stereotypical norms of power dynamics in (heterosexual) relationships. Rape culture and toxic masculinity promote narratives of weak, pure, virtuous women who must curtail their actions to suit those of men, even when they are attacked by them. These themes have direct implications on women’s actions, including self-blaming themselves for the actions of men and acquiesce to sexual activity in which they do not want to participate. These narratives can be dismantled through reproductive justice and feminist methodology by centering the voices of those outside these structures as well as the voices at the bottom of the power hierarchy.

**Applied Anthropology and Public Health Contributions**

This dissertation continues the feminist led medical anthropology lineage of Nancy Scheper-Hughes, Rayna Rapp, Faye Ginsburg, Robbie Davis-Floyd, Brigitte Jordan, Marcia
Inhorn, Elise Andaya, and more, who have influenced my approach, theoretical frameworks, and analysis. It also incorporates other feminist anthropologists and feminists working in other disciplines such as Lila Abu-Lughod, Sara Amed, Veena Das, Angela Davis, Audre Lorde, bell hooks, Dorothy Roberts, Judith Butler, Loretta Ross, Faye Harrison, Donna Haraway, Crista Craven, Dana-Ain Davis, and Betsy Hartmann.

I have taken these two lineages of feminist and queer women as the foundation to build upon a new trajectory in feminist, medical anthropology. One that incorporates an intersectional and reproductive justice framework to tackle new realms of dismantling patriarchal structures in sexual and reproductive healthcare knowledge and information.

This project advances the anthropological and sociological theory of governmentality and biopower by incorporating another sociological concept, sexual citizenship, in relation to an understudied population of young people 18 - 24 in a semi-privileged environment of university campuses. The overarching theory of governmentality and biopower provides a framework to elucidate how national policies around sexuality education and narratives around patriarchy, toxic masculinity, and rape culture interact to form ideal or deviant sexual citizens. Applying the theory of sexual citizenship to the discipline of anthropological study, allows us to understand how heteronormative and cis-gendered hegemonic structures trickle down and impact peoples’ realities and lived experiences when navigating sexual encounters and forming relationships. Combined, these two approaches give a broader perspective on sexual and reproductive healthcare negotiation and the importance of taking into account the early formations of sexual ideals, identity, and behaviors of young people.

The incorporation of reproductive justice into this model provides a new direction for what sexual citizenship should look like outside of a heteronormative, cis-gendered framework,
and provides an advocacy roadmap on which to begin resisting, contesting, negotiating, and destroying those cultural constructs that uphold patriarchal values.

This project has used foundational modes of anthropological inquiry (surveys, interviews, and field site immersion) and highlighted longer quotes from participants in order to provide a space for their voices to be heard instead of speaking for people who are often presumed voiceless. I tried to incorporate marginalized voices from participants who are often deemed as “statistically not significant” in studies that use both quantitative and qualitative data, such as people who identify outside the gender binary and those whose sexual orientation is not hetero- or homo-sexual. This is one way a feminist methodology can be displayed in research projects, and a way that anthropological work can become more inclusive and representative of the populations we study.

Combining these aforementioned theories and methods into the public health Social Ecological Model provides a way to understand how young people make decisions about their sexual and reproductive healthcare in relation to multiple societal levels of influence and identifies where theories and methods become pronounced in lived experiences. Using a holistic anthropological approach to studying a topic that is of concern to public health allows a different viewpoint and analysis to emerge that provides understanding at multiple levels. This is in contrast to the public health approach of siloing topics of concern into disparate areas of study (i.e. specific types of contraception usage or rates of STIs by geographical region). Combining anthropological perspectives and methods, theories of governmentality and sexual citizenship, the advocacy model of reproductive justice, and the public health Social Ecological Model allows for a holistic understanding of the sexual and reproductive healthcare needs of young people 18 - 24 and is the first project of its kind to incorporate these viewpoints.
Recommendations

Given the results of this project, I have several recommendations on how to positively influence and change young peoples’ perceptions, interactions, and decision making for sexual and reproductive healthcare. I have indicated which level of the Social Ecological Model the recommendations target, some of which can be incorporated into multiple levels separately or simultaneously.

Sexuality education recommendations: public policy, organizational, individual

The first recommendation is that sexuality education needs to be comprehensive, rights-based, and medically accurate. This process needs to start well before middle school, with conversations and information about bodily autonomy, body parts, consent, and how to establish open lines of communication with anyone you have close relationships with (sexual or not). By the time students reach middle school, many of them have already encountered situations or heard rumors that spread false information about sexual practices. Information should be given in non-judgmental and non-religious settings, where students are encouraged to ask questions and educators should provide detailed explanations.

Comprehensive sexuality education can include abstinence, but must also include information on healthy sexual practices. The full scope of contraceptive methods, including the different options, their effectiveness, how to use them, and where to get them should be covered, as well as emergency contraception. Discussions of pregnancy should be free of fear mongering and all options of how to handle an unintended and/or unwanted pregnancy should be covered, including abortion and adoption. Sexually transmitted infections and HIV should be discussed in accurate medical terms, including how testing works, and where to go for testing, in addition to
how to have a conversation with a partner(s) in order to disclose status and encourage others to be treated. This education should be delivered using a rights-based approach that recognizes different gender identities and sexual orientations, and does not promote a strictly heterosexual, cis-gendered model of abstinence until marriage, but incorporates transgender, non-binary, gay, bisexual, pansexual, queer, and asexual orientations. This should include addressing other types of sexual activity besides male/female genital penetration, such as oral sex, anal sex, and intercourse options for lesbians.

Sexuality education should also include further discussions of consent as it relates to respect, trust, and building healthy relationships as well as what types of behavior are considered appropriate. Past inventions show that more content, delivered more often can yield better results on levels of understanding and self-efficacy, including the use of demonstrations and motivational exercises (Johnson et al 2011). Sexuality education is linked to better sexual health outcomes when gender and power dynamics are explicitly addressed, including content that helps students critically analyze gender stereotypes and how they influence, manifest, and personally impact students (Haberland 2015). Other studies show that more information does not equal more or riskier sexual activity, but can increase contraceptive usage and decrease unintended pregnancy rates (Kirby et al 2007).

Having more education and conversation about acceptance of people who identify outside the gender binary or sexual orientation binary is one way to normalize people who are currently on the margins of sexual citizenship. Educator and peer acceptance can help mitigate home life factors that may be detrimental or traumatic for students who have had negative “coming out” experiences or are afraid to come out to family members. Implementing these
areas of conversation in sexuality education, spread throughout the 12 years of school students attend, is also a way to effect change on a local level.

Rights-based, comprehensive sexuality education, including information on sexual violence, gender norms, and stereotypes on sexual encounters and relationships can be advanced by reconstructing discourse that guides these areas of society. The specific terminology and tactics that sexuality education uses, risk, risk avoidance, fear, disease, etc. can be shifted to promote more positive views of sexual activity and provide more knowledge and power of individuals to contest and resist biopolitical controls from the State (Foucault 1990). Some research shows that even though students may internalize cultural sexual stereotypes of heteronormativity in a sex-negative framework, there is room within sexuality education for students to resist these norms (Frieh and Smith 2018).

Another way to locally confront these issues is to design sexuality education inventions and programs that take into consideration the aforementioned curriculum needs while also addressing politically conservative and religious ideology. Comprehensive, rights-based sexuality education does not need to ignore or deny the existence of these hegemonic narratives that currently influence how young people in Florida, Kentucky, and Louisiana are taught, but can instead provide a holistic view to students, allowing them to decide which courses of action are right for them and their needs. Additionally, it is important to listen to what young people have to say and give them open forums that allow them to express their needs or questions, including in group settings with peers, one on one availability of counselors or educators, or anonymous avenues such as online forums or chat helplines.
How university campuses can fill the sexuality education and sexual violence education void: organizational

There are steps that can be taken to address the needs of students on university campuses currently. The student health centers can promote and encourage more student participation and access. While there are events on campus that give out free condoms or provide free STI/HIV testing days, these resources could be promoted more and expanded to include other types of contraception, including emergency contraception, and other sexual health resources such as relationship counseling or disseminating information on healthy versus abusive relationships. More information could be distributed about consent issues and how to report assaults through Title IX offices or Victim’s Advocacy Centers in conjunction with “Take Back the Night” sexual violence awareness campaigns.

Young people need clear guidelines on what constitutes sexual harassment, assault, and rape, and how to report an incident if they choose. On university campuses specifically, this means clear information on how to report an incident through the Title IX process. The hegemonic narrative of rape culture is currently being contested and resisted nationally, through the #MeToo Movement and #TimesUp initiative, but patriarchal powers, including the Trump Administration and the Supreme Court are attempting to reinforce systems that continue to victim blame and release perpetrators of wrong-doing or accountability. Organizing through reproductive justice movements and continuing to talk about these issues while trying to hold people in power accountable is one way to renegotiate normalized narratives of rape culture. This is a long process, as all but two students who were interviewed did not mention national
narratives surrounding sexual assault or rape, including the #MeToo Movement, highlighting the
divide between national level politics and policies and lived experiences on the local level.

Having conversations and programs on campus that address sexual assault and rape, in
addition to highlighting national narratives of addressing these issues, can help bring the national
level to the local level and reach students in a way that news or social media cannot. In 1991,
Antioch College in Ohio established the nation’s first “Yes Means Yes” campaign in response to
the cultural normative “no means no” slogan to decrease instances of sexual assault (Mintz
2014). This campaign had some success in shifting narratives of gaining consent. In 2014,
California implemented the nation’s first law mandating that consent follow “yes means yes”
standards (Kuylman 2016) and later that same year New York followed with its’ affirmative
consent legislation called “Enough is Enough” mandating that all schools in the state enact a
“Sexual Assault Victims’ Bill of Rights” to help survivors come forward and receive fair
treatment through the investigation and trial process (Delamater 2015). Reframing how educators
approach the discourse of consent and rape and assault can contest hegemonic narratives of
patriarchy, rape culture, and toxic masculinity. These laws and policies are one way to shift
discourse on sexual assault from placing the burden on survivors to negatively reject advances to
partners obtaining verbal affirmation before proceeding. As of now, Florida, Kentucky, and
Louisiana do not have any laws or pending legislation on passing bills that make affirmative
consent the standard in sexual assault cases.

Finally, more counseling appointments and times could be added to accommodate student
needs. Student health services are in a prime position to fill a gap in sexual and reproductive
healthcare access, but public state universities may encounter barriers to providing such
resources due to current political demands, especially in the conservative and religiously
influenced U.S. Southeast. Additionally, resources may be disproportionately available to white, heterosexual students, as opposed to reaching a variety of racial/ethnic and sexual orientations, also due to hegemonic political narratives of heteronormativity (Williams et al 2017, Wyatt and Oswalt 2014). It is important for university administrators to use an intersectional framework to address discrepancies in different groups of students’ access to sexual and reproductive healthcare resources.

*How healthcare providers can fill the sexuality educational void: organizational, individual*

Healthcare providers, including family physicians and pediatricians are in a good position to help young people understand and make informed choices regarding their sexual and reproductive healthcare needs. Healthcare providers need to give accurate and unbiased sexual and reproductive healthcare information. This educational training must start during their medical school and residency or advanced training programs, so that physicians, physician assistants, and nurses are equipped to inform students on sexual and reproductive healthcare options regardless of the patient’s gender identity or sexual orientation. Small mentions in conversations during check-up appointments or physical exams addressing sexual health needs or concerns can provide students an opportunity to discuss issues with a trained adult in a safe and confidential environment. For those young people who are still under 18 years old, healthcare providers should first inform parents that sexual health is an important part of their child’s healthcare and stress the need for the provider to have confidential conservations with the student about their healthcare if the student is comfortable with that arrangement. This tactic can relieve some of the stress and anxiety that both students and parents may have in addressing sexual and reproductive healthcare needs.
Applying the results

As part of this project and keeping with a feminist methodology, an executive report will be given to each university on main findings as they relate to each school. These reports will be given to offices that expressed interest in the project and wanted to see information on what students’ needs are concerning sexual and reproductive healthcare and how these can be met by university resources. This will include Student Health Services and the Victim’s Advocacy Center at USF, Student Health Services and the Dinkle-Mas LGBTQ Suite at UK, and Student Health Services and The Women’s Center at LSU. The hope is that these reports will provide potential opportunities to further sexual and reproductive healthcare access for students on campus.

Future Research Opportunities

There are numerous potential future research projects as well as interventions or programs that could be designed based on this dissertation project. More research is needed on the intersection of transgender, non-binary, homosexual, bisexual, pansexual, and asexual people and sexuality education programs, including the needs of these groups, and how policies and curriculum that are heteronormative and cis-gendered focused impact these individuals both during middle and high school, but also years later. Additionally, it would be beneficial to interview educators who deliver sexuality education to understand what their needs are, if they are uncomfortable with the topic, wish that it was not part of their job, or if they wish it was more comprehensive and not limited by officials and/or state mandates. Because all three states have policies regarding guidelines of what sexuality education can or cannot contain, it would be
beneficial to also research existing programs that are available to schools and how schools make decisions regarding which program, if any, is selected.

Conducting research within this same age group of people, 18-24, but outside the university environment would shed light on how young people with potentially limited access to healthcare resources in more conservative political and religious environments make decisions regarding their sexual and reproductive healthcare.

Conducting discourse analysis on sexuality education curriculum and how programs reinforce or resist heteronormative, cis-gendered ideals of sexual citizenship could provide further insights on how to create inclusive content for young people. This could also include an examination of how hegemonic narratives such as risk, disease, pregnancy, and sexuality influence larger cultural norms such as rape culture and toxic masculinity. Looking at the framing of healthy versus abusive relationships and how power dynamics are constructed is equally important in examining discourse on sexual and reproductive health.

Another avenue of future research is to examine undergraduate medical education and graduate medical education that medical students receive in their curriculum on sexual and reproductive healthcare. This project could also include exploring the advice that primary care doctors, family physicians, pediatricians, and gynecologists, provide to young people about their sexual and reproductive healthcare. This could be done through interviews or long-term participant observation. Students in this project relayed that if they saw a doctor, they did not get much information from them in terms of different contraception options or sexual health advice. It would also be beneficial to research further the student side of doctor interactions through participant observation of clinical encounters. Determining the viewpoints of these doctors and
how they interact with patients could help provide valuable evidence for the best ways to reach young people and address their sexual health concerns.

Finally, a larger in-depth study on the needs and viewpoints of university administrators and offices on campus would help substantiate successful programs and inventions that can be implemented on campuses. This can include pilot testing of increased access to sexual and reproductive healthcare services or knowledge and awareness campaigns focused on disseminating accurate medical and relationship behavior information.

Conclusion

In this dissertation, I have used the theories of governmentality, biopower, and sexual citizenship to examine young peoples’ sexual and reproductive healthcare experiences in the U.S. Southeast. My research design used feminist methodology, a reproductive justice framework, and the Social Ecological Model to guide data collection and analysis. An online survey and semi-structured interviews provided a wealth of information in order to analyze the influences and decision-making of undergraduate students at three universities in the southeast. The three main topic areas that emerged from this project, sexuality education, sexual violence, and LGBTQIA+ people’s experiences within those realms, demonstrate that U.S. hegemonic narratives of sexual citizenship continue to privilege heteronormative, cis-gendered frameworks. More research needs to be conducted on the intersection of how groups outside the current sexual citizenship structure navigate these challenging situations. This will help continue to transform, resist, and dismantle systems of power in the movement towards reproductive justice for all individuals.
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## Appendix A: Demographic Data

### Table 1A: Demographic Information for Field Sites (By University and City)

<table>
<thead>
<tr>
<th>Racial/Ethnic Breakdown</th>
<th>Total Enrollment</th>
<th>Undergraduate Only</th>
<th>Undergraduate Only</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Indian</td>
<td>0.20%</td>
<td>0.20%</td>
<td>&lt; 0.01%</td>
</tr>
<tr>
<td>Asian</td>
<td>8.00%</td>
<td>2.80%</td>
<td>4.60%</td>
</tr>
<tr>
<td>Black</td>
<td>10.50%</td>
<td>7.10%</td>
<td>13.41%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>21.20%</td>
<td>5.20%</td>
<td>7.09%</td>
</tr>
<tr>
<td>Native Hawaiian/Pacific Islander</td>
<td>0.20%</td>
<td>0.10%</td>
<td>&lt; 0.01%</td>
</tr>
<tr>
<td>White</td>
<td>52.00%</td>
<td>75.10%</td>
<td>68.56%</td>
</tr>
<tr>
<td>Two or More Races/Ethnicities</td>
<td>4.00%</td>
<td>4.00%</td>
<td>2.50%</td>
</tr>
<tr>
<td>Race Not Reported</td>
<td>4.00%</td>
<td>3.00%</td>
<td>1.17%</td>
</tr>
</tbody>
</table>

### Tuition Per Year (Fall and Spring Semesters)

<table>
<thead>
<tr>
<th>Tuition Only</th>
<th>Tuition and Fees</th>
<th>Tuition and Fees</th>
</tr>
</thead>
<tbody>
<tr>
<td>In State Residents</td>
<td>$6,410</td>
<td>$12,360</td>
</tr>
<tr>
<td>Out of State Residents</td>
<td>$17,324</td>
<td>$30,680</td>
</tr>
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</table>

### Median Household Income and Percentage of Residents Living in Poverty

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Population</td>
<td>385,430</td>
<td>321,959</td>
</tr>
<tr>
<td>Female</td>
<td>50.70%</td>
<td>50.80%</td>
</tr>
<tr>
<td>Male</td>
<td>49.30%</td>
<td>49.20%</td>
</tr>
</tbody>
</table>

| Median Household Income | $50,489 | $56,137 | $40,796 |
| Percentage of Residents Living in Poverty | 18.60% | 16.60% | 27% |

### Racial/Ethnic Breakdown

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>American Indian</td>
<td>0.20%</td>
<td>0.30%</td>
</tr>
<tr>
<td>Asian</td>
<td>4.30%</td>
<td>3.60%</td>
</tr>
<tr>
<td>Black</td>
<td>22.10%</td>
<td>14.20%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>26.40%</td>
<td>7.20%</td>
</tr>
<tr>
<td>White</td>
<td>44.70%</td>
<td>70.80%</td>
</tr>
<tr>
<td>Two or more races/ethnicities</td>
<td>2.10%</td>
<td>3.30%</td>
</tr>
<tr>
<td>Other</td>
<td>0.10%</td>
<td>0.60%</td>
</tr>
</tbody>
</table>

*City statistics are from City-Data.com*
Table 2A: Emails Sent for Online Survey Distribution for Recruitment and Confidence Levels of Sample Size

<table>
<thead>
<tr>
<th></th>
<th>USF</th>
<th>UK</th>
<th>LSU</th>
<th>Total Emails</th>
</tr>
</thead>
<tbody>
<tr>
<td>Departments</td>
<td>20</td>
<td>13</td>
<td>21</td>
<td>54</td>
</tr>
<tr>
<td>Professors</td>
<td>173</td>
<td>160</td>
<td>164</td>
<td>497</td>
</tr>
<tr>
<td>Offices on Campus</td>
<td>0</td>
<td>15</td>
<td>4</td>
<td>19</td>
</tr>
<tr>
<td>Clubs or Organizations</td>
<td>45</td>
<td>158</td>
<td>163</td>
<td>366</td>
</tr>
<tr>
<td>Misc.</td>
<td>4</td>
<td>2</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>Total</td>
<td>242</td>
<td>348</td>
<td>352</td>
<td>942</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Total Surveys</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Surveys Completed</td>
<td>425          183 170 778</td>
</tr>
<tr>
<td>Confidence Level Per Sample Size</td>
<td></td>
</tr>
<tr>
<td></td>
<td>95% 80% 80% 99%</td>
</tr>
</tbody>
</table>

173
<table>
<thead>
<tr>
<th></th>
<th>USF</th>
<th></th>
<th>UK</th>
<th></th>
<th>LSU</th>
<th></th>
<th>Total</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Table 3A: Demographic Data of Survey Participants</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Woman</td>
<td>312</td>
<td>73.41%</td>
<td>138</td>
<td>75.41%</td>
<td>133</td>
<td>78.24%</td>
<td>583</td>
<td>74.94%</td>
</tr>
<tr>
<td>Man</td>
<td>97</td>
<td>22.82%</td>
<td>39</td>
<td>21.31%</td>
<td>30</td>
<td>17.65%</td>
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Table 4A: Sexual History Data of Survey Participants

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<td>UK (n = 183)</td>
<td>LSU (n = 170)</td>
<td>Total (N = 778)</td>
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<td>0 (0.00%)</td>
<td>1 (0.13%)</td>
</tr>
<tr>
<td>Female Condom</td>
<td>0 (0.00%)</td>
<td>0 (0.00%)</td>
<td>0 (0.00%)</td>
<td>0 (0.00%)</td>
</tr>
<tr>
<td>Other</td>
<td>5 (1.18%)</td>
<td>0 (0.00%)</td>
<td>6 (3.53%)</td>
<td>11 (1.41%)</td>
</tr>
<tr>
<td>Don't Use a Method</td>
<td>21 (4.94%)</td>
<td>5 (2.73%)</td>
<td>3 (1.76%)</td>
<td>29 (3.73%)</td>
</tr>
<tr>
<td>N/A</td>
<td>96 (22.59%)</td>
<td>23 (12.57%)</td>
<td>34 (20.00%)</td>
<td>153 (19.67%)</td>
</tr>
<tr>
<td>Not Listed</td>
<td>15 (3.53%)</td>
<td>17 (9.29%)</td>
<td>9 (5.29%)</td>
<td>41 (5.27%)</td>
</tr>
<tr>
<td><strong>STI Testing History</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Time</td>
<td>68 (16.00%)</td>
<td>29 (15.85%)</td>
<td>29 (17.06%)</td>
<td>126 (16.20%)</td>
</tr>
<tr>
<td>2 Times</td>
<td>44 (10.35%)</td>
<td>20 (10.93%)</td>
<td>17 (10.00%)</td>
<td>81 (10.41%)</td>
</tr>
<tr>
<td>3 Times</td>
<td>31 (7.29%)</td>
<td>19 (10.38%)</td>
<td>16 (9.41%)</td>
<td>66 (8.48%)</td>
</tr>
<tr>
<td>4 Times</td>
<td>22 (5.18%)</td>
<td>15 (8.20%)</td>
<td>7 (4.12%)</td>
<td>44 (5.66%)</td>
</tr>
<tr>
<td>5 Times or More</td>
<td>26 (6.12%)</td>
<td>9 (4.92%)</td>
<td>7 (4.12%)</td>
<td>42 (5.40%)</td>
</tr>
<tr>
<td>Every 6 Months</td>
<td>9 (2.12%)</td>
<td>7 (3.83%)</td>
<td>3 (1.76%)</td>
<td>19 (2.44%)</td>
</tr>
<tr>
<td>Never Been Tested</td>
<td>160 (37.65%)</td>
<td>60 (32.79%)</td>
<td>65 (38.24%)</td>
<td>285 (36.63%)</td>
</tr>
<tr>
<td>N/A</td>
<td>50 (11.76%)</td>
<td>6 (3.28%)</td>
<td>20 (11.76%)</td>
<td>76 (9.77%)</td>
</tr>
<tr>
<td>Not Listed</td>
<td>15 (3.53%)</td>
<td>18 (9.84%)</td>
<td>6 (3.53%)</td>
<td>39 (5.01%)</td>
</tr>
<tr>
<td><strong>STI Results</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes, Once</td>
<td>8 (1.88%)</td>
<td>17 (9.29%)</td>
<td>10 (5.88%)</td>
<td>35 (4.50%)</td>
</tr>
<tr>
<td>Yes, More Than Once</td>
<td>32 (7.53%)</td>
<td>3 (1.64%)</td>
<td>2 (1.18%)</td>
<td>37 (4.76%)</td>
</tr>
<tr>
<td>No</td>
<td>248 (58.35%)</td>
<td>109 (59.56%)</td>
<td>108 (63.53%)</td>
<td>465 (59.77%)</td>
</tr>
<tr>
<td>Never Been Tested</td>
<td>59 (13.88%)</td>
<td>18 (9.84%)</td>
<td>22 (12.94%)</td>
<td>99 (12.72%)</td>
</tr>
<tr>
<td>N/A</td>
<td>62 (14.59%)</td>
<td>18 (9.84%)</td>
<td>20 (11.76%)</td>
<td>100 (12.85%)</td>
</tr>
<tr>
<td>Not Listed</td>
<td>16 (3.76%)</td>
<td>18 (9.84%)</td>
<td>8 (4.71%)</td>
<td>42 (5.40%)</td>
</tr>
<tr>
<td><strong>Vaccinated for HPV</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>253 (59.53%)</td>
<td>101 (55.19%)</td>
<td>97 (57.06%)</td>
<td>451 (57.97%)</td>
</tr>
<tr>
<td>No</td>
<td>81 (19.06%)</td>
<td>34 (18.58%)</td>
<td>34 (20.00%)</td>
<td>149 (19.15%)</td>
</tr>
<tr>
<td>Not Sure</td>
<td>74 (17.41%)</td>
<td>31 (16.94%)</td>
<td>30 (17.65%)</td>
<td>135 (17.35%)</td>
</tr>
<tr>
<td>Not Listed</td>
<td>17 (4.00%)</td>
<td>17 (9.29%)</td>
<td>9 (5.29%)</td>
<td>43 (5.53%)</td>
</tr>
</tbody>
</table>
Table 6A: Demographic Data of Interview Participants

<table>
<thead>
<tr>
<th>Gender</th>
<th>USF</th>
<th>UK</th>
<th>LSU</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n = 24</td>
<td>n = 15</td>
<td>n = 11</td>
<td>N = 50</td>
</tr>
<tr>
<td>Woman</td>
<td>17 70.83%</td>
<td>11 73.33%</td>
<td>7 63.64%</td>
<td>35 70.00%</td>
</tr>
<tr>
<td>Man</td>
<td>3 12.50%</td>
<td>4 26.67%</td>
<td>2 18.18%</td>
<td>9 18.00%</td>
</tr>
<tr>
<td>Transgender Woman</td>
<td>0 0.00%</td>
<td>0 0.00%</td>
<td>0 0.00%</td>
<td>0 0.00%</td>
</tr>
<tr>
<td>Transgender Man</td>
<td>2 8.33%</td>
<td>0 0.00%</td>
<td>0 0.00%</td>
<td>2 4.00%</td>
</tr>
<tr>
<td>Non-Binary</td>
<td>1 4.17%</td>
<td>0 0.00%</td>
<td>1 9.09%</td>
<td>2 4.00%</td>
</tr>
<tr>
<td>Gender Fluid</td>
<td>0 0.00%</td>
<td>0 0.00%</td>
<td>0 0.00%</td>
<td>0 0.00%</td>
</tr>
<tr>
<td>Demi-Girl</td>
<td>1 4.17%</td>
<td>0 0.00%</td>
<td>0 0.00%</td>
<td>1 2.00%</td>
</tr>
<tr>
<td>Gender Queer</td>
<td>0 0.00%</td>
<td>0 0.00%</td>
<td>0 0.00%</td>
<td>0 0.00%</td>
</tr>
<tr>
<td>Prefer Not to Say</td>
<td>0 0.00%</td>
<td>0 0.00%</td>
<td>1 9.09%</td>
<td>1 2.00%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sexual Orientation</th>
<th></th>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Asexual</td>
<td>0 0.00%</td>
<td>0 0.00%</td>
<td>0 0.00%</td>
<td>0 0.00%</td>
</tr>
<tr>
<td>Bisexual</td>
<td>2 8.33%</td>
<td>1 6.67%</td>
<td>1 9.09%</td>
<td>4 8.00%</td>
</tr>
<tr>
<td>Heterosexual</td>
<td>13 54.17%</td>
<td>13 86.67%</td>
<td>7 63.64%</td>
<td>33 66.00%</td>
</tr>
<tr>
<td>Homosexual</td>
<td>3 12.50%</td>
<td>0 0.00%</td>
<td>2 18.18%</td>
<td>5 10.00%</td>
</tr>
<tr>
<td>Pansexual</td>
<td>4 16.67%</td>
<td>0 0.00%</td>
<td>0 0.00%</td>
<td>4 8.00%</td>
</tr>
<tr>
<td>Queer</td>
<td>1 4.17%</td>
<td>0 0.00%</td>
<td>0 0.00%</td>
<td>1 2.00%</td>
</tr>
<tr>
<td>Demi-sexual</td>
<td>1 4.17%</td>
<td>0 0.00%</td>
<td>0 0.00%</td>
<td>1 2.00%</td>
</tr>
<tr>
<td>Prefer Not to Say</td>
<td>0 0.00%</td>
<td>0 0.00%</td>
<td>1 9.09%</td>
<td>1 2.00%</td>
</tr>
<tr>
<td>Questioning</td>
<td>0 0.00%</td>
<td>1 6.67%</td>
<td>0 0.00%</td>
<td>1 2.00%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>American Indian</td>
<td>0 0.00%</td>
<td>0 0.00%</td>
<td>0 0.00%</td>
<td>0 0.00%</td>
</tr>
<tr>
<td>Asian</td>
<td>0 0.00%</td>
<td>1 6.67%</td>
<td>0 0.00%</td>
<td>1 2.00%</td>
</tr>
<tr>
<td>Black African</td>
<td>0 0.00%</td>
<td>0 0.00%</td>
<td>0 0.00%</td>
<td>0 0.00%</td>
</tr>
<tr>
<td>Black/African American</td>
<td>1 4.17%</td>
<td>3 20.00%</td>
<td>0 0.00%</td>
<td>4 8.00%</td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>2 8.33%</td>
<td>0 0.00%</td>
<td>0 0.00%</td>
<td>2 4.00%</td>
</tr>
<tr>
<td>Pacific Islander</td>
<td>0 0.00%</td>
<td>0 0.00%</td>
<td>0 0.00%</td>
<td>0 0.00%</td>
</tr>
<tr>
<td>White Hispanic</td>
<td>1 4.17%</td>
<td>1 6.67%</td>
<td>2 18.18%</td>
<td>4 8.00%</td>
</tr>
<tr>
<td>White Non-Hispanic</td>
<td>12 50.00%</td>
<td>9 60.00%</td>
<td>8 72.73%</td>
<td>29 58.00%</td>
</tr>
<tr>
<td>Two races/ethnicities</td>
<td>8 33.33%</td>
<td>1 6.67%</td>
<td>1 9.09%</td>
<td>10 20.00%</td>
</tr>
<tr>
<td>Three or more race/ethnicities</td>
<td>0 0.00%</td>
<td>0 0.00%</td>
<td>0 0.00%</td>
<td>0 0.00%</td>
</tr>
<tr>
<td>Other</td>
<td>0 0.00%</td>
<td>0 0.00%</td>
<td>0 0.00%</td>
<td>0 0.00%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Religion</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Agnostic</td>
<td>3 12.50%</td>
<td>2 13.33%</td>
<td>2 18.18%</td>
<td>7 14.00%</td>
</tr>
<tr>
<td>Atheism</td>
<td>8 33.33%</td>
<td>0 0.00%</td>
<td>3 27.27%</td>
<td>11 22.00%</td>
</tr>
<tr>
<td>Buddhism</td>
<td>0 0.00%</td>
<td>0 0.00%</td>
<td>0 0.00%</td>
<td>0 0.00%</td>
</tr>
<tr>
<td>Christian: Catholic</td>
<td>3 12.50%</td>
<td>2 13.33%</td>
<td>2 18.18%</td>
<td>7 14.00%</td>
</tr>
<tr>
<td>Christian: Protestant/Non-Denominational</td>
<td>3 12.50%</td>
<td>9 60.00%</td>
<td>2 18.18%</td>
<td>14 28.00%</td>
</tr>
<tr>
<td>Hinduism</td>
<td>0 0.00%</td>
<td>0 0.00%</td>
<td>0 0.00%</td>
<td>0 0.00%</td>
</tr>
<tr>
<td>Islam</td>
<td>0 0.00%</td>
<td>0 0.00%</td>
<td>0 0.00%</td>
<td>0 0.00%</td>
</tr>
<tr>
<td>Judaism</td>
<td>2 8.33%</td>
<td>0 0.00%</td>
<td>0 0.00%</td>
<td>2 4.00%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Not an atheist, but not aligned with a religion</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>5 20.83%</td>
<td>2 13.33%</td>
<td>2 18.18%</td>
<td>9 18.00%</td>
</tr>
<tr>
<td>Other</td>
<td>0 0.00%</td>
<td>0 0.00%</td>
<td>0 0.00%</td>
<td>0 0.00%</td>
</tr>
</tbody>
</table>
Table 7A: Sexual History Data of Interview Participants

<table>
<thead>
<tr>
<th>Current Age</th>
<th>USF (n = 24)</th>
<th>UK (n = 15)</th>
<th>LSU (n = 11)</th>
<th>Total (N = 50)</th>
</tr>
</thead>
<tbody>
<tr>
<td>18</td>
<td>0 (0.00%)</td>
<td>3 (20.00%)</td>
<td>1 (9.09%)</td>
<td>4 (8.00%)</td>
</tr>
<tr>
<td>19</td>
<td>5 (20.83%)</td>
<td>4 (26.67%)</td>
<td>2 (18.18%)</td>
<td>11 (22.00%)</td>
</tr>
<tr>
<td>20</td>
<td>8 (33.33%)</td>
<td>3 (20.00%)</td>
<td>1 (9.09%)</td>
<td>12 (24.00%)</td>
</tr>
<tr>
<td>21</td>
<td>6 (25.00%)</td>
<td>2 (13.33%)</td>
<td>3 (27.27%)</td>
<td>11 (22.00%)</td>
</tr>
<tr>
<td>22</td>
<td>5 (20.83%)</td>
<td>2 (13.33%)</td>
<td>3 (27.27%)</td>
<td>10 (20.00%)</td>
</tr>
<tr>
<td>23</td>
<td>0 (0.00%)</td>
<td>0 (0.00%)</td>
<td>1 (9.09%)</td>
<td>1 (2.00%)</td>
</tr>
<tr>
<td>24</td>
<td>0 (0.00%)</td>
<td>1 (6.67%)</td>
<td>0 (0.00%)</td>
<td>1 (2.00%)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age at &quot;First Time&quot;</th>
<th>USF</th>
<th>UK</th>
<th>LSU</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>14</td>
<td>2 (8.33%)</td>
<td>2 (13.33%)</td>
<td>0 (0.00%)</td>
<td>4 (8.00%)</td>
</tr>
<tr>
<td>15</td>
<td>0 (0.00%)</td>
<td>3 (20.00%)</td>
<td>0 (0.00%)</td>
<td>3 (6.00%)</td>
</tr>
<tr>
<td>16</td>
<td>7 (29.17%)</td>
<td>2 (13.33%)</td>
<td>0 (0.00%)</td>
<td>9 (18.00%)</td>
</tr>
<tr>
<td>17</td>
<td>6 (25.00%)</td>
<td>3 (20.00%)</td>
<td>5 (45.45%)</td>
<td>14 (28.00%)</td>
</tr>
<tr>
<td>18</td>
<td>7 (29.17%)</td>
<td>3 (20.00%)</td>
<td>4 (36.36%)</td>
<td>14 (28.00%)</td>
</tr>
<tr>
<td>19</td>
<td>2 (8.33%)</td>
<td>1 (6.67%)</td>
<td>0 (0.00%)</td>
<td>3 (6.00%)</td>
</tr>
<tr>
<td>20</td>
<td>0 (0.00%)</td>
<td>0 (0.00%)</td>
<td>0 (0.00%)</td>
<td>0 (0.00%)</td>
</tr>
<tr>
<td>21</td>
<td>0 (0.00%)</td>
<td>0 (0.00%)</td>
<td>0 (0.00%)</td>
<td>0 (0.00%)</td>
</tr>
<tr>
<td>22</td>
<td>0 (0.00%)</td>
<td>0 (0.00%)</td>
<td>0 (0.00%)</td>
<td>0 (0.00%)</td>
</tr>
<tr>
<td>Not Listed</td>
<td>1 (6.67%)</td>
<td>0 (0.00%)</td>
<td>1 (6.67%)</td>
<td>2.00%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Number of Sexual Partners</th>
<th>15</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>0 (0.00%)</td>
</tr>
<tr>
<td>1</td>
<td>1 (4.17%)</td>
</tr>
<tr>
<td>2</td>
<td>3 (12.50%)</td>
</tr>
<tr>
<td>3</td>
<td>2 (8.33%)</td>
</tr>
<tr>
<td>4</td>
<td>2 (8.33%)</td>
</tr>
<tr>
<td>5</td>
<td>3 (12.50%)</td>
</tr>
<tr>
<td>6-10</td>
<td>5 (20.83%)</td>
</tr>
<tr>
<td>11-15</td>
<td>6 (25.00%)</td>
</tr>
<tr>
<td>16-20</td>
<td>2 (8.33%)</td>
</tr>
<tr>
<td>More than 20</td>
<td>1 (4.17%)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Currently Sexually Active (over the last year)</th>
<th>USF</th>
<th>UK</th>
<th>LSU</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>23 (95.83%)</td>
<td>15 (100.00%)</td>
<td>11 (100.00%)</td>
<td>49 (98.00%)</td>
</tr>
<tr>
<td>No</td>
<td>1 (4.17%)</td>
<td>0 (0.00%)</td>
<td>0 (0.00%)</td>
<td>1 (2.00%)</td>
</tr>
<tr>
<td></td>
<td>USF</td>
<td>UK</td>
<td>LSU</td>
<td>Total</td>
</tr>
<tr>
<td>---------------------------------------</td>
<td>------</td>
<td>-----</td>
<td>------</td>
<td>-------</td>
</tr>
<tr>
<td></td>
<td>n = 24</td>
<td>n = 15</td>
<td>n = 11</td>
<td>N = 50</td>
</tr>
<tr>
<td>Regularly Use Contraception</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>17</td>
<td>70.83%</td>
<td>12</td>
<td>80.00%</td>
</tr>
<tr>
<td>No</td>
<td>4</td>
<td>16.67%</td>
<td>0</td>
<td>0.00%</td>
</tr>
<tr>
<td>Sometimes</td>
<td>1</td>
<td>4.17%</td>
<td>2</td>
<td>13.33%</td>
</tr>
<tr>
<td>Not Sexually Active</td>
<td>1</td>
<td>4.17%</td>
<td>1</td>
<td>6.67%</td>
</tr>
<tr>
<td>Not Listed</td>
<td>1</td>
<td>4.17%</td>
<td>0</td>
<td>0.00%</td>
</tr>
<tr>
<td>Primary Contraceptive Method</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male Condom</td>
<td>6</td>
<td>25.00%</td>
<td>5</td>
<td>33.33%</td>
</tr>
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<td>0</td>
<td>0.00%</td>
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<td>0</td>
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<td>Other</td>
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<td>1 Time</td>
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<td>2 Times</td>
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</tr>
<tr>
<td>4 Times</td>
<td>4</td>
<td>16.67%</td>
<td>3</td>
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<td>5 Times or More</td>
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### Table 9A: State Statistics on Sexuality Education and Outcomes

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<th>Louisiana</th>
<th>United States</th>
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<td>Teen Birth Rate</td>
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<td>29</td>
<td>29.1</td>
<td>18.8</td>
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<td>(High School)</td>
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<td>Sexually Transmitted Infection Rate*</td>
<td>6297</td>
<td>5662</td>
<td>9881</td>
<td>6029</td>
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<tr>
<td>Experience Sexual Violence</td>
<td>9.90%</td>
<td>10.00%</td>
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<td>11.30%</td>
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<tr>
<td>(High School)**</td>
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<td>Experience Physical Dating</td>
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<td>Violence (High School)</td>
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<tr>
<td>LGBTQ Students Experiencing</td>
<td>27.50%</td>
<td>42.80%</td>
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<td>34.00%</td>
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<td>Bullying on School Property</td>
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**Sex Education**

<table>
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<th>Louisiana</th>
<th>United States</th>
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<td>Not Mandated</td>
<td>Not Mandated</td>
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<td>Culturally Appropriate/Unbiased</td>
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<td>Not Mandated</td>
<td>Not Mandated</td>
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<td>Mandated</td>
<td>Mandated</td>
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<td>Stressed</td>
<td>Stressed</td>
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<tr>
<td>Consent</td>
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<td>Not Mandated</td>
<td>Not Mandated</td>
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<td>Sex Violence</td>
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<td>Not Mandated</td>
<td>Not Mandated</td>
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<td>Importance of Sex in Marriage</td>
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<td>Mandated</td>
<td>Not Mandated</td>
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<td>Negative Outcomes of Teen Sex</td>
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<td>Mandated</td>
<td>Decision Making</td>
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*STI Rate is calculated by number of chlamydia and gonorrhea only cases per 100,000 people ages 15-24

**Sexual Violence is defined here as forced to do anything sexual

***Rollston and Grolling (2019)
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<thead>
<tr>
<th>Type of Sexuality Education Received</th>
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<th>LSU</th>
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<td></td>
<td>n = 425</td>
<td>n = 183</td>
<td>n = 170</td>
<td>N = 778</td>
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<td>Abstinence Only</td>
<td>33</td>
<td>18</td>
<td>19</td>
<td>70</td>
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<td>Abstinence Plus*</td>
<td>110</td>
<td>62</td>
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<td>220</td>
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<td>Comprehensive**</td>
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<td>74</td>
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<td>285</td>
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<tr>
<td>Did Not Receive Any</td>
<td>104</td>
<td>15</td>
<td>39</td>
<td>158</td>
</tr>
<tr>
<td>Does Not Remember</td>
<td>16</td>
<td>11</td>
<td>10</td>
<td>37</td>
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<td>Not Listed</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>8</td>
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</table>

*Abstinence Plus - mostly abstinence focused but may include condom and STI discussions

**Comprehensive - includes abstinence, contraceptive methods, organs and functions of the reproductive system, pregnancy, etc.
<table>
<thead>
<tr>
<th>Type of Sexuality Education Received</th>
<th>USF n = 24</th>
<th>UK n = 15</th>
<th>LSU n = 11</th>
<th>Total N = 50</th>
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<td>1</td>
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<td>Comprehensive**</td>
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<tr>
<td>Did Not Receive Any</td>
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<td>Does Not Remember</td>
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<td>2</td>
<td>3</td>
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</tbody>
</table>

*Abstinence Plus - mostly abstinence focused but may include condom and STI discussions

**Comprehensive - includes abstinence, contraceptive methods, organs and functions of the reproductive system, pregnancy, etc.
Table 12A: Forced, Uncomfortable, and Regrettable Sexual Encounters of Survey Participants

<table>
<thead>
<tr>
<th></th>
<th>USF (n = 425)</th>
<th>UK (n = 183)</th>
<th>LSU (n = 170)</th>
<th>Total (N = 778)</th>
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<tr>
<td><strong>Had Someone Force a Sexual Encounter</strong></td>
<td></td>
<td></td>
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<tr>
<td>Yes</td>
<td>106</td>
<td>106</td>
<td>50</td>
<td>193</td>
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<tr>
<td>No</td>
<td>284</td>
<td>106</td>
<td>114</td>
<td>504</td>
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<td>19</td>
<td>10</td>
<td>10</td>
<td>39</td>
</tr>
<tr>
<td>Not Listed</td>
<td>16</td>
<td>17</td>
<td>9</td>
<td>42</td>
</tr>
<tr>
<td><strong>Had an Uncomfortable Sexual Encounter (Not Forced)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>160</td>
<td>78</td>
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<td>No</td>
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<td>88</td>
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<td>17</td>
<td>9</td>
<td>42</td>
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<tr>
<td><strong>Regret Any Sexual Encounters While at College</strong></td>
<td></td>
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<tr>
<td>Yes</td>
<td>111</td>
<td>73</td>
<td>60</td>
<td>244</td>
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### Table 13A: Forced, Uncomfortable, and Regrettable Sexual Encounters of Interview Participants

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<th>USF</th>
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<td><strong>Had Someone Force a Sexual Encounter</strong></td>
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<td>11</td>
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<td><strong>Sexuality Education</strong></td>
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<tr>
<td>Didn't Receive Any</td>
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</table>
Appendix B: IRB Approval Letter

10/2/2018

Melina Taylor
Anthropology
3000 E Fletcher Ave
Union Park #60
Tampa, FL 33613

RE: Expedited Approval for Initial Review
IRB#: Pro00036958

Title: Reproductive Health Knowledge and Choices Among Undergraduate Students: Designing Educational Resources and Access to Services

Study Approval Period: 9/26/2018 to 9/26/2019

Dear M. Taylor:

On 9/26/2018, the Institutional Review Board (IRB) reviewed and APPROVED the above application and all documents contained within, including those outlined below.

Approved Item(s):
Protocol Document(s):
Reproduction & Biopower Protocol_V1_9.16.18.docx

Consent/Assent Document(s)*:
Employee Interview_V1_9.20.18.docx.pdf
Student Interview Focus group_V1_9.20.18.docx.pdf
Student Online Consent_V1_9.20.18.docx**

*Please use only the official IRB stamped informed consent/assent document(s) found under the "Attachments" tab. Please note, these consent/assent documents are valid until the consent document is amended and approved. **Online consents are not stamped.

It was the determination of the IRB that your study qualified for expedited review which includes activities that (1) present no more than minimal risk to human subjects, and (2) involve only procedures listed in one or more of the categories outlined below. The IRB may review research through the expedited review procedure authorized by 45CFR46.110 and 21 CFR
56.110. The research proposed in this study is categorized under the following expedited review category:

(6) Collection of data from voice, video, digital, or image recordings made for research purposes.

(7) Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies.

Your study qualifies for a waiver of the requirements for the documentation of informed consent for the online portion of the study as outlined in the federal regulations at 45CFR46.117(c) which states that an IRB may waive the requirement for the investigator to obtain a signed consent form for some or all subjects if it finds either: (1) That the only record linking the subject and the research would be the consent document and the principal risk would be potential harm resulting from a breach of confidentiality. Each subject will be asked whether the subject wants documentation linking the subject with the research, and the subject's wishes will govern, or (2) That the research presents no more than minimal risk of harm to subjects and involves no procedures for which written consent is normally required outside of the research context.

As the principal investigator of this study, it is your responsibility to conduct this study in accordance with IRB policies and procedures and as approved by the IRB. Any changes to the approved research must be submitted to the IRB for review and approval via an amendment. Additionally, all unanticipated problems must be reported to the USF IRB within five (5) business days.

We appreciate your dedication to the ethical conduct of human subject research at the University of South Florida and your continued commitment to human research protections. If you have any questions regarding this matter, please call 813-974-5638.

Sincerely,

Kristen Salomon, Ph.D., Chairperson
USF Institutional Review Board
Appendix C: Online Survey Instrument

By clicking on the button below, you are stating that you meet the study requirements (an undergraduate student age 18 - 24), are volunteering to participate, and understand that you can withdraw participation at any time by exiting the survey.

- Yes, I agree to volunteer to participate

Page Break

What gender do you identify as?

- Woman
- Man
- Transgender woman
- Transgender man
- Non-binary
- Gender fluid
- Prefer not to say
- Other or if you identify as more than one gender: please specify

________________________________________________
How do you sexually identify?

- Heterosexual
- Bisexual
- Homosexual
- Asexual
- Pansexual
- Prefer not to say
- Other ________________________________________________

What race/ethnicity are you?

- American Indian
- Asian
- Black/African American
- Black/African
- Hispanic/Latino
- Indian
- Pacific Islander
- White/Caucasian Non-Hispanic
- White/Caucasian Hispanic
- Other or if you identify as more than one ethnicity please list them here
  __________________________________________________________________
Which religion (or not) do you practice (or consider yourself affiliated with even if you are not actively or regularly practicing)?

- Atheism
- Agnostic
- Buddhism
- Christianity, please specify denomination (i.e. Catholic, Baptist, Mormon, etc.)
- Hinduism
- Islam
- Judaism
- I'm not an atheist, but I haven't aligned myself with a specific religion yet
- Other, please specify ____________________________________________

What is your major? (If you are a double major or have a minor list both).

___________________________________________________________________
What year status are you:

- Freshman
- Sophomore
- Junior
- Senior
- 5th year senior
- Other ________________________________________________

Are you an international student (you recently moved within the last 3 years to the U.S. for the purpose of attending USF)?

- Yes
- No

If yes, please list your home country: _______________________

What is your age?

- 18
- 19
- 20
- 21
- 22
- 23
- 24
What is your current living situation:

- Living with parents
- Living on campus
- Living off campus with a partner
- Living off campus with friends
- Living off campus alone
- Other ________________________________________________

In what state did you attend high school? (If you are an international student, list the country)

___________________________________________________________

During high school, which form of sexual education did you receive?

- Abstinence only
- Mostly abstinence only (but may have included condom and STI discussions)
- Comprehensive sexual education (that includes abstinence only as an option, but also explains contraceptive methods, organs and functions of the reproductive system, etc.)
- I didn't receive any type of sexual education
- I don't remember
At what age did you first become sexually active? (Sexually active being defined as whatever you consider your "first time" sexual experience to be. If you have not become sexually active yet, type "N/A").

________________________________________________________________

Are you currently sexually active or have been over the last year? (Sexually active is defined as whatever you identify for yourself as sexually active).

- Yes
- No

How many sexual partners have you had in total? (Sexual partner is whatever you consider a sexual interaction with someone else; includes everything from committed partners to one time interactions/hook-ups).

- 0
- 1
- 2
- 3
- 4
- 5
- 6 - 10
- 11 - 15
- 16 - 20
- More than 20
When you have a sexual encounter it is:

- Planned - before meeting up with someone I know whether or not any type of sexual encounter will be happening

- Spontaneous - I don't usually plan one way or the other, I just wait to see what happens

- It's a mixture of both planned and spontaneous depending on how I'm feeling that day/week and the situation

- Does not apply to me

Do you discuss sexual/reproductive health concerns and issues with your partner?

- Yes

- No

- Sometimes

- Does not apply to me

Do you discuss sexual/reproductive health concerns and issues with your close friends?

- Yes

- No

- Sometimes

- Does not apply to me
Do you discuss sexual/reproductive health concerns and issues with your parents or parental figures?

- Yes
- No
- Sometimes
- Does not apply to me
How often do you worry, stress, or feel anxious about the following?

<table>
<thead>
<tr>
<th></th>
<th>Often (at least once a week)</th>
<th>Sometimes (a few times a month)</th>
<th>Rarely</th>
<th>Never</th>
<th>Not applicable to me</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contracting an STI</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Contracting HIV</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Becoming pregnant (or a partner becoming pregnant)</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Being able to afford or access sexual/reproductive healthcare (testing, exams, counseling, etc.)</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Being able to afford contraceptives</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Being able to talk to your partner about your wants/needs</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Having your partner respect your thoughts/feelings</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Feeling pressured to have sex (any type) with my partner</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>My partner breaking up with me because I won't have sex (any type) with them</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>
Where do you go when you have a question about sexual/reproductive healthcare? (Check all that apply)

☐ Friends

☐ Partner(s)

☐ Parents or parental figures

☐ Doctor

☐ Student Health Services

☐ RA in my dorm

☐ Religious leader (including youth leaders/ministers)

☐ Undergraduate advisor

☐ Google

☐ Wikipedia

☐ Other internet sources or apps (incl. Facebook, Instagram, Tinder, etc.)

☐ Other ________________________________________________
Do you factor in the opinion of your partner when choosing your sexual/reproductive healthcare options (including methods of contraception)?

- Yes
- No
- Sometimes
- Does not apply to me

When you are sexually active with someone, who holds the responsibility for keeping you both safe and healthy?

- I do
- My partner does
- We both share responsibility in making sure we are covered (including the expenses)
- I don't discuss it with my partner, but I try to always have what I need for me
- Does not apply to me

Do you regularly use a form of contraception?

- Yes
- No
- Sometimes
- I'm not sexually active
- Does not apply to me
Which form of preventative contraception do you use as your primary method?

- Male condoms
- Female condoms
- Oral contraceptive pills (OCPs)
- Intrauterine device (IUD)
- Diaphragm
- Withdrawal
- Patch, Norplant, Injections
- NuvaRing
- PrEP (as preventative protection from HIV)
- Other __________________________________________
- I don't use a method
- Doesn't apply to me
Which form of emergency contraception do you use as a back-up method if your primary contraception (prevention) fails?

- Plan B (emergency oral contraceptive pill)
- Douching
- Abortion (surgical or medical)
- PEP
- I don't use a back-up method; I just hope for the best
- I've never had to use a back-up method before
- Other ___________________________________________________________________
- Doesn't apply to me

Where do you buy, access (pick up prescriptions), or receive your contraceptives? Select all that apply.

- Walgreens/CVS
- Walmart
- Target
- Publix (or other grocery store)
- Student Health Center on campus
- Pharmacy on campus
- Other (please specify) ___________________________________________________________________
Have you ever been pregnant before?

- Yes
- Maybe
- No
- Does not apply to me

Was the pregnancy:

- Planned
- Unplanned but I still wanted it
- Unplanned and unwanted
- Does not apply to me

What was the result of the pregnancy?

- Currently pregnant
- Live birth
- Miscarriage
- Abortion
- Does not apply to me
Would you consider having an abortion?

- Yes
- No
- Not sure
- Not applicable to me, but I would support a partner's decision to have one
- Not applicable to me, but I would NOT support a partner's decision to have one
- Would depend on the circumstances. Please specify: __________________________________________

Do you think the Student Health Center provides abortions?

- Yes
- No
- I'm not sure

Do you think the emergency contraceptive Plan B is an abortion drug? (Meaning if you are pregnant, it will initiate an abortion).

- Yes
- No
- I'm not sure
- I don't know what Plan B is
Do you have a yearly sexual/reproductive health exam performed by a doctor?

- Yes
- No
- Sometimes

Have you been vaccinated for HPV?

- Yes
- No
- I'm not sure

Have you ever had someone force a sexual encounter on you?

- Yes
- No
- I'm not sure
Have you ever had a sexual encounter that you were uncomfortable with but would not consider it as forced? (For example, a partner wanted to experiment with a new technique that you weren't fully on board with but did it anyways because you didn't want to disappoint them).

- Yes
- No
- I'm not sure
- Does not apply to me

Do you regret any sexual encounters you have had while in college?

- Yes
- Maybe
- No
- Does not apply to me
Where do you get tested for STIs (sexually transmitted infections) or HIV?

- Student Health Clinic
- Primary Doctor
- Planned Parenthood
- MedExpress or Urgent Care Clinic (or other type of clinic not associated with a primary care doctor's office)
- Ybor Youth Clinic
- I've never been tested
- Other ________________________________

Approximately how many times have you been tested for STIs?

- 1
- 2
- 3
- 4
- 5 times or more
- Every 6 months
- I've never been tested
- Does not apply to me
Do you discuss STI testing with your partner?

○ Yes
○ No
○ Sometimes
○ Does not apply to me

Have you ever had an STI?

○ Yes, once
○ Yes, more than once
○ No
○ I've never been tested
○ Does not apply to me

Did you seek treatment for your STI?

○ Yes
○ No
○ Currently treating it
○ I'm still deciding on whether or not to treat it
○ Does not apply to me
Where did you go for treatment?

- Student Health Services
- Clinic off campus
- Private doctor's office
- Other ________________________________________________
- Does not apply to me

When you have an STI, do you inform your partners (including past partners)?

- Yes
- Sometimes
- No
- Does not apply to me
Approximately how many times have you been tested for HIV?

- 1
- 2
- 3
- 4
- 5 times or more
- Every 6 months
- I've never been tested
- Does not apply to me

Do you discuss HIV testing with your partner?

- Yes
- No
- Sometimes
- Does not apply to me

Are you currently HIV positive?

- Yes
- No
- I haven't been tested
- Does not apply to me
If you are HIV positive - do you inform your partners (including past partners)?

- Yes
- Sometimes
- No
- Does not apply to me

Where have you received information on campus about sexual/reproductive health? (Check all that apply)

- Student Health Services (including special events such as blood drives, or free STI testing days)
- Recreation Center
- Marshall Center
- On campus housing (including events and RA information sessions/handouts etc.)
- On campus dining (programs, tables, flyers, etc.)
- Orientation Welcome Week events
- Sporting events
- Undergraduate advisor
- College or department
- Organization or club meeting/event (including fraternity/sorority events, multicultural clubs, professional organization chapters, etc.)
For what reasons have you used the Student Health Center? (Check all that apply).

- [ ] Physical checkup (including sickness related to colds, flu, coughs, stomach virus, etc.)
- [ ] Sexual/reproductive health exam
- [ ] Contraception prescription or contraceptive related
- [ ] STI testing
- [ ] HIV testing
- [ ] Mental Health Services
- [ ] Immunizations (including HPV vaccination)
- [ ] Other ________________________________________________
- [ ] I've never been to the Student Health Center

Did you feel respected during your Student Health Center visit (for any type of appointment)?

- [ ] Yes
- [ ] No
- [ ] I didn't think about it/can’t remember
- [ ] I haven't been to the Student Health Center
Did you feel comfortable (regardless of whether you did or not) asking the doctor, nurse, or staff questions about your appointment, the health advice given, or prescriptions that were given/recommended?

- Yes
- No
- Somewhat, but I refrained from asking too many questions
- I haven't been to the Student Health Center

Have you ever had a negative experience at the Student Health Center?

- Yes
- No
- I have never been to the Student Health Center

What type of health insurance do you currently have?

- Insurance through the open market (Individual coverage)
- Insurance through my job
- Insurance through USF
- I'm on my parent(s) health insurance plan
- I don't have insurance
- VA/military coverage
- Other ____________________________
Do you have a primary healthcare provider (not on campus)?

- Yes
- No

If the university had an online sexual education/reproductive healthcare information module that you could access, test your knowledge, and ask questions to healthcare professionals and counselors (confidentially) - would you utilize it?

- Yes - absolutely
- Yes - probably a few times a semester
- Maybe
- Probably not
- No

Would you be willing to participate in a follow up interview of approximately 30 minutes? (Interviewees receive a $15 Amazon gift card for participation, while supplies last). Approximately 40 students will be interviewed.

- Yes
- No
Would you be willing to participate in a follow up focus group of approximately one hour? (Focus group participants receive a $10 Amazon gift card for participation, while supplies last, as well as food). Approximately 50 students will participate in focus groups.

- Yes
- No

If you answered yes to the above questions on interviews and focus groups, please provide your name and contact information (email address is preferred). All interviews will be kept confidential with regards to personal identifying information. Please note that by leaving your contact information on this question that your survey responses are linked to your name/email address. You can volunteer to participate in both an interview and a focus group, but you will be selected to only participate in one or the other.

________________________________________________________________

If you need information or access to resources on sexual and reproductive healthcare, including if you have experienced sexual harassment/assault in the past, or are currently dealing with an issue, there are resources on and off campus to help you. Please visit the links below for more information:

The University of South Florida and Hillsborough County:

USF Health Counseling: https://www.usf.edu/student-affairs/counseling-center/

USF Student Health Services: https://www.usf.edu/student-affairs/student-health-services/services/index.aspx

USF Center for Victim Advocacy & Violence Prevention: https://www.usf.edu/student-affairs/victim-advocacy/

The Crisis Center of Tampa Bay, Hillsborough 2-1-1: https://www.crisiscenter.com/what-we-do/2-1-1-contact-center/

The University of Kentucky and Fayette County:

UK Student Health Services: https://ukhealthcare.uky.edu/university-health-service/health-education
UK Counseling Center: https://www.uky.edu/counselingcenter/

Lexington-Fayette County, Victim’s Advocacy/Survivors Resources page: https://www.lexingtonky.gov/safety
Appendix D: Semi-structured Interview Guide

1. Can you tell me your process of answering sexual/reproductive health questions you might have?

2. What do you do if you have a reproductive healthcare issue come up?
   - What if it’s an emergency issue? (What do you consider an emergency?)

3. Can you walk me through your thought process when you are choosing contraception?
   - What factors influence this decision – cost, partner wants and needs, how the method affects your body?
   - Which ones have you used before? How long?
   - Did you experience any negative or positive side effects?)
   - On average do you know how much you spend each month on contraception?

4. Have you used the Student Health Center on camps? If not, why not?
   - Was your experience good (did you feel respected, etc), why or why not?
   - What services have you used from there and why?
   - Is there anything you wish that the Student Health Center offered that they currently don’t?

5. Have you ever felt excluded on campus due to your race, ethnicity, gender, sexual orientation etc.?
   - Specifically, in regards to healthcare options?

6. Do doctors (anywhere, but including on campus sources) go through choices/options of sexual/reproductive healthcare with you that are appropriate for your race/ethnicity, gender, sexual orientation?
   - Do you feel like your provider respects you as a person and your lifestyle choices? Why or why not?
   - Do you have any suggestion on how providers could be more inclusive for your situation?

7. Do you talk openly with friends about sexual/reproductive healthcare? If so, what topics do you usually discuss?

8. Do you discuss dating and finding dates with your close friends, family?

9. How do you decide when is the “right” time to start a sexual relationship with a partner?
   - Can you walk me through your thought process?
   - What actions do you take? Etc.
10. Have you ever had a negative experience with accessing sexual/reproductive healthcare needs such as contraception, abortion, sexual health counseling? (For example: someone trying to shame you, etc.)

11. Have you ever had a partner who was pressuring or controlling you sexually?
   - How did you struggle or handle dealing with that relationship?
   - How did you realize you were being negatively influenced?
   - Do you discuss with your partner STD/HIV testing?
   - Do you place a priority on knowing your partner’s status?

12. Can you talk me through a good, positive sexual relationship you have/had?
   - How did you know it was healthy for you both?
   - What are some of the characteristics of a healthy, positive sexual relationship for you?

13. Is the current political climate in the U.S. influencing any of your reproductive healthcare decisions?
   - Why or why not?
   - If so, how?
### Appendix E: Codebook: List of Codes

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<th>Code Color</th>
<th>Codes</th>
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<tr>
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<td>Assault/Rape</td>
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<tr>
<td>GREEN</td>
<td>STIs</td>
</tr>
<tr>
<td>RED</td>
<td>Relationships</td>
</tr>
<tr>
<td>BLUE</td>
<td>Sex Education/Information</td>
</tr>
</tbody>
</table>

#### Misc. Codes
- Condom
- OCPs
- Implant
- DepoProvera
- IUD
- NuvaRing
- Patch
- Withdrawal
- None
- Two Types Simultaneously
- Women disclose birth control method
- Know name of method
- Type of OCP
- No periods
- Prescription Pick Up Location
- Experience on method

#### Birth Control Decision Making
- Initial Reasons
- Mom
<table>
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<tr>
<td>Friend</td>
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<tr>
<td>Partner</td>
</tr>
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<td>Doctor</td>
</tr>
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</tr>
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<td>Brother</td>
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<td>General Knowledge of Options Available</td>
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<td>Society influences</td>
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<tr>
<td>HPV Vaccine</td>
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<td>Interaction with other medications/conditions</td>
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<tr>
<td>Birth Control Switching</td>
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<tr>
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</tr>
<tr>
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</tr>
<tr>
<td>Side Effects/negative</td>
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<tr>
<td>Partner Preference</td>
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<td>Switched Multiple Times</td>
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<td>Emergency Contraception/Pregnancy</td>
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<td>Knowledge about Plan B</td>
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<tr>
<td>Process of deciding to use Plan B</td>
</tr>
<tr>
<td>Pregnancy scare</td>
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<tr>
<td>Emotions related to pregnancy scare</td>
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<tr>
<td>Pregnancy confirmed</td>
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</tr>
<tr>
<td>Abortion</td>
</tr>
<tr>
<td>Miscarriage</td>
</tr>
<tr>
<td>Sex Education in School</td>
</tr>
<tr>
<td>Educator</td>
</tr>
<tr>
<td>None</td>
</tr>
<tr>
<td>Perception of Comprehensive but Abstinence</td>
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<tr>
<td>Geographic location of school</td>
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<tr>
<td>In High School</td>
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<td>In Middle School</td>
</tr>
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<tr>
<td>Public School</td>
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<tr>
<td>Don't Remember</td>
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<tr>
<td>Good or Great</td>
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<tr>
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<td>Part of Gym/Health Class</td>
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