SEEKING BUT NOT FINDING: A QUALITATIVE EXPLORATION OF THE INFLUENCE OF COLLEGE WOMEN'S PERCEPTIONS OF FEMINISM ON THEIR SEXUAL HEALTH SERVICE- AND INFORMATION-SEEKING BEHAVIORS

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ABSTRACT

The connection between feelings of empowerment and improved health behavior demonstrates the relevance of feminism in sexual health. A segment of the population that is at great risk of negative sexual health outcomes is college women. Health education and promotion efforts targeting this population could have many benefits, but those benefits could be even greater if feminist tenets are incorporated. Undergraduate public health women are in a position of expertise and possess a sense of agency related to this topic. This study utilized a Feminist Theoretical framework informed by bell hooks' understandings of feminism to explore the influence of college women's perceptions of feminism on their sexual health information- and service-seeking behaviors.

In eight narrative interviews, qualitative data related to perceptions of feminism and experiences with seeking sexual health services and information were collected from undergraduate public health women at a large southeastern university. Thematic analysis was used to evaluate the transcripts of those interviews, and found poetry was used to represent the women's experiences with seeking sexual health services and information.

Findings showed that these women have positive perceptions of feminism, which makes them feel frustrated with the experiences that they have had of "seeking but not finding" what they know they need when it comes to sexual health services and information. This caused the women to emphasize the impact of the quality of sexuality education that young girls receive, and stress the need for improved, quality, comprehensive sexuality education for all people.

Their understandings of feminism made them believe that this "seeking but not finding" is unacceptable.

Undergraduate public health women have a deep understanding of health and the influence that sociopolitical factors play on individuals' well-being. Their feelings of empowerment from feminism intensify this understanding of the need for health equity, and the changes that need to be made to get there. The "hush hush" taboo nature surrounding sexuality does more harm than good. The findings of this study, through the use of language and narratives, elucidate the experiences of these women and give examples of what must be done better in the field of health education to prevent future generations from "seeking but not finding."

DEDICATION

This dissertation is dedicated to the eight women who were brave enough to share their stories with a complete stranger in hopes of making the future a little bit brighter for all women and girls. This project is yours.

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"The transformative power of love is the foundation for all meaningful social change."

--bell hooks

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CHAPTER 1
INTRODUCTION

Sexual Health Issues in the U.S.

Women's sexual health issues, like sexually transmitted infections (STIs), unintended pregnancy, or sexual assault to name a few, create public health challenges every year in the United States. STIs, for instance, affect millions of Americans and have numerous adverse health effects (Centers for Disease Control and Prevention [CDC], 2018). In addition, over one million Americans live with HIV, many of whom are unaware (CDC, 2019b). Sexual assault affects one in six women, with almost 70% between ages 12 and 34 affected (Rape, Abuse, and Incest National Network [RAINN], 2019c). The negative effects of sexual assault are posttraumatic stress disorder (PTSD), depression, and suicide (Behnken, Le, Temple, & Berenson, 2010; RAINN, 2019a).

Unintended pregnancy rates are significantly higher in the U.S. than most other developed countries and cause both social and economic costs (Finer & Zolna, 2016). Reproductive cancers are prominent as well, with cervical, ovarian, uterine, vaginal, and vulval being those most typically found in women (CDC, 2017b). Cervical is the only of those cancers with a screening test to detect it early and is most often caused by human papillomavirus (HPV), an STI (CDC, 2017b; CDC, 2017a). Sexual health services and accurate information can help to prevent these issues, but rates of care-seeking behaviors and use of accurate sources of information are concerningly low (Cuffe, Newton-Levinson, Gift, McFarlane, & Leichliter, 2016; Hayes-Smith & Hayes-Smith, 2009; Murray Horwitz, Pace, & Ross-Degnan, 2018). For

example, a CDC study in 2016 found that only 26% of sexually experienced females had gotten STI testing (Cuffe et al., 2016).

Perceptions of Feminism

Past research has shown that young women's perceptions of and identifications with feminism have a direct positive impact on their health, particularly with regard to their body satisfaction and body image (Borowsky, Eisenberg, Bucchianeri, Piran, & Neumark-Sztainer, 2016; Rubin, Nemerogg, & Russo, 2004), but there is a lack of research on how perceptions of feminism can specifically impact service-seeking behaviors. Not all people have positive perceptions of feminism. Many consider feminism too marginalizing or stigmatizing and choose not to identify as feminists (Zucker & Bay-Cheng, 2010). Some may not identify as feminists, but still agree with and value many of the tenets of feminism: a discrepancy that can be problematic (Fitz, Zucker, & Bay-Cheng, 2012; Meijs, Ratliff, & Lammers, 2017). Feminism in health has mainly focused on social issues and has been concerned with reproductive health aspects of women's lives (Broom, 2014). Some studies have found positive connections between feminism and issues such as disordered eating and risky sexual behavior (Ackard, Kearny-Cooke, & Peterson, 2000; Fitz & Zucker, 2014). In these instances, women who had strong feminist beliefs had lower rates of risky sexual behavior and were more likely to plan on using condoms (Fitz & Zucker, 2014). Additionally, nursing research has shown that viewing sexuality with feminist ideals in mind can help women to feel less like they are to blame for sexual harassment (Cassidy, Goldberg, & Aston, 2016). These examples show that perceptions of feminism can be a factor in health outcomes. Most integration of feminism in public health has connected the two due to the reproductive health component of the feminist movement (Amaro, Raj, & Reed, 2001; Broom, 2014; Currie & Weisenburg, 2003; Hammarstrom, 1999; Travis &

Compton, 2001), rather than exploring people's perceptions of feminism. Integration is often done via methodology and justification of research or health promotion efforts. This lack of investigation of perceptions of feminism in sexual health is a gap that the current study aimed to begin to fill.

College Women

A segment of the U.S. population that faces adverse sexual health issues is college women. At an age full of major life decisions, new relationships are formed and challenges arise that can be unhealthy without adequate resources and guidance. In research on sexual hookups, it has been shown that over half of college women had experienced a hookup, and that most of them involved alcohol (Fielder & Carey, 2010). Fielder and Carey's study (2010) refers to hookups as behaviors ranging from kissing to vaginal, oral, or anal sex. Often, contraception use in hookups is low, with the withdrawal method used by 20% of college women (Lindberg, Santelli, & Desai, 2016). Other contraception methods that are more commonly used by college women include hormonal methods. These methods are used for reasons other than pregnancy prevention, such as to reduce menstrual bleeding, pain, and acne (Bearak & Jones, 2017). Additionally, high rates of STIs, sexual assault, and unintended pregnancies cause disparate health outcomes for college women (CDC, 2018b; Finer & Zolna, 2016; RAINN, 2019c). With so many sexual health concerns for women at this stage of life, it is crucial that they seek health services and accurate information when necessary. However, college women have severely low rates of care-seeking and do not access sexual health information from the most accurate sources (Cuffe et al., 2016; Hayes-Smith & Hayes-Smith, 2009; Murray Horwitz et al., 2018). Only 50% of sexually active college women reported using an effective form of contraception, and only 45% were seeking STI care, including testing, counseling, or treatment (Murray Horwitz et al.,

2018). It should be noted that this population has free access to readily available health services on their college campuses, which begs the question, why are these rates so low? Romo, Cruz, and Neilands (2011) found that it is much more likely that college women will seek sexual health services and vaccines if they are comfortable communicating about them with the people who are most important to them. Women need to feel comfortable asking questions about sexual wellness and seeking related services, and feel less of a taboo around the topic (Cassidy et al., 2018; Ollivier, Aston, & Price, 2018), which demonstrates a potential connection to feminism and the tenet of empowerment.

Statement of the Problem

College women have low rates of sexual health service- and information-seeking behaviors, but it is unknown why that is the case, or how they are seeking what they need for their sexual health. Based upon the evidence that positive perceptions of feminism can have a positive impact on health outcomes for women, it is imperative that health professionals, particularly health educators, begin to explore the potential connection of perceptions of feminism on sexual health.

Theoretical Framework

The feminist movement in the U.S. stemmed from the drive to abolish slavery and had its first wave[1] with the fight for women's suffrage, led by activists such as Elizabeth Cady Stanton, Lucretia Mott, and Susan B. Anthony (Kolander, Ballard, & Chandler, 2011). This was followed by the second wave amidst the Civil Rights Era, when feminism was once again at the forefront of the fight for equal rights; notable second wave feminists were Betty Friedan, Angela Davis,

[1] The wave metaphor, though questioned by some who would argue that there have not been separate movements, will be utilized here to distinguish between historical events and provide context for where feminism has been and where it is today.

and Shirley Chisholm (Kolander et al., 2011). The third wave, from the 1990s to the early 2000s, was marked by women such as Anita Hill and Senator Hillary Rodham Clinton, the Violence Against Women Act, and an emphasis on new goals and activist efforts (Cobble, Gordon, & Henry, 2014; Kolander et al., 2011). Modern feminism in the fourth wave is noted for its intersectionality, much like previous waves, though with more focus on including the rights and equality of all humans, regardless of their gender identity, race, class, sexual orientation, religion, or ability (Crenshaw, 1989; Weiss, 2018). Among all waves of feminism, central tenets of empowerment, equality, and social change are common. These tenets, along with bell hooks' understandings of feminism which emphasizes the importance of education, narratives, and pedagogical implications of feminist research, provide the theoretical framework for this study.

In her writings on feminism, hooks has tried to address the ways in which sexist oppression is permeated in society, and how it can be put to an end. In her 1994 book, *Teaching to Transgress: Education as the Practice of Freedom,* hooks presented ways that education can be used to provide students with tools to transgress against sexism and other forms of oppression. Rather than viewing classrooms as constraining, hooks emphasized that education can be liberating, and teachers -- specifically at the university level -- can collaborate with students to make the education process more relaxing (hooks, 1994). In hooks' view, teachers are catalysts, and can incorporate tenets of Feminist Theory to restore connections (1994). She called for a restructuring of social frameworks in her 1984 book, *Feminist Theory: From Margin to Center,* and argued that education can help to do this. In other words, hooks stressed that by teaching and learning from each other, societal gaps and inequalities can be reduced. This teaching and learning is, in her mind, best done through hearing each other's stories.

As previously mentioned, a central tenet of much feminist effort is empowerment, which had been common to most social justice movements in U.S. history as well. Empowerment can specifically allow health professionals to more effectively address the sexual health needs of women (Amaro et al., 2001). By moving beyond just teaching basic knowledge to take care of one's health, health educators can emphasize the connection between knowledge and empowerment by exemplifying women's experiences (Collins, 2000, p. 227). Equality has been valued and fought for due to the notion of some that biological differences are proof enough that men and women are not equal (Freedman, 2002, p. 203). When equality is emphasized in health education by sharing women's stories, an understanding of the similarities among individual experiences can be gained. This sharing of stories or narratives is an aspect of feminism that hooks emphasized in her writings. The ultimate goal of all of these efforts is social change, and much success has been due to reforms which have allowed more women to close the gap with men, regardless of their individual circumstances or societal beliefs and norms (hooks, 1984, p. 157). In order to improve the quality of life of women, social change is necessary.

Since the emphasis on social change through education as well as pedagogical implications of feminist work is central to hooks' brand of Feminist Theory, it follows that narratives, a method valued in hooks' feminism, are a logical approach to the study. Conducting this study within a Feminist Theoretical framework guided by hooks allowed the experiences and perspectives of college women to shine a light on ways to incorporate empowerment into health education, and strive for equality by creating social change that will improve the quality of life of college women.

Purpose of the Study

The purpose of this study was to utilize a Feminist Theoretical framework to gain an in-depth understanding of college women's perceptions of feminism, their experiences seeking sexual health services and information, and the ways in which their perceptions of feminism influence their sexual health service- and information-seeking behaviors.

Methodological Framework

hooks' writings on Feminist Theory emphasize the importance of using language and stories to educate masses of people (1984; 1994). In her view, conversation, dialogue, and narrative can provide the information that is needed to guide social change. hooks also stressed the impact that using language to disseminate feminist work and share women's stories can have on individuals as well as society (1994, p. 174-175). It is this focus on narrative that guides this study's methods. This method is common to much research done with a feminist lens, with qualitative interviews allowing for personal testimonies to be shared (DeVault, 1999). These testimonies typically come from methods such as qualitative interviews, with feminist interviews seen as "an encounter between women with common interests who would share knowledge" (DeVault & Gross, 2014).

Feminist interviews are conceptualized as an "encounter between women with common interests who would share knowledge" (DeVault & Gross, 2014, p. 211). Feminist research acknowledges that similarities and differences between interviewer and interviewee have much influence on the entire research process: questions asked and not asked, rapport, level of difficulty recruiting participants, and even the "lenses through which researchers produce and analyze interview data" (DeVault & Gross, 2014, p. 217).

In this study, I conducted a number of semi-structured narrative interviews with undergraduate public health women. Speaking to public health women allowed for conversation from which the most could be learned, since they have a health education background which enables them to speak to sexual health issues with agency. Interview researchers select participants who "have the knowledge and experience about the particular focus of the study" (deMarrais, 2004, p. 59). In these interviews, women were asked about their perceptions of feminism and their experiences seeking sexual health information and services, as well as influences and barriers. For this reason, interviewing women who either could not or would not talk about sex would have been fruitless.

Since I had questions to which the answers require sharing of thoughts, feelings, experiences, or beliefs, interviews were the most logical method (Nunkoosing, 2005). Social justice work has often utilized interviews to speak to individuals who have experiences and stories to share (DeVault & Gross, 2014, p. 210). Thus, feminist research finds interviewing very useful, because it allows for the telling of women's stories and sharing lived experiences.

In the current study, I interviewed eight college women from the undergraduate public health program. A specific sample size was not required for this type of exploratory qualitative study; rather, emphasis was placed on the interactions that are produced (Hennink, Kaiser, & Marconi, 2017; Tracy, 2010). Prior to beginning their conversation, I created a foundation for the interview by asking the woman to write down her own personal definitions of feminism and sexual health, as well as a drawn timeline of when she first heard of feminism, and any event that she thought was important to the conversation. These concrete artifacts provided a basis for the conversation and could be used by either the participant or myself to refer to throughout the dialogue (Glegg, 2019).

I asked follow-up questions to prompt more sharing, allowing the interviewees to talk about whatever came to mind in regard to the topic at hand. This allowed me to gain detailed insight into a topic otherwise unexplored in the field of public health. Since sexual health is such a sensitive topic, feminist interviews were beneficial because this style of interviewing creates room for open conversation. By using hooks' Feminist Theory as a guide, the interviews allowed me to hear women's stories and encourage them to share narratives.

I conducted member-checking to allow for collaboration between myself and the participants. Informal member-checking involved me asking women at the end of each interview whether or not I was understanding their message correctly and allowing them to make any clarifications they thought necessary. Formal member-checking was done by sending the women the findings chapter after it was completed, and allowing any input, feedback, or corrections that they thought of. I continued this reflexivity in a reflexive journal, where I maintained notes and thoughts that came to mind throughout the data collection and analysis process, allowing me to more clearly determine what I knew, and how I knew it (Watt, 2007). More about this process will be discussed in Chapter 5.

I transcribed interviews verbatim using the listen-and-type method. Analysis began with coding, an initial phase of thematic analysis. Thematic analysis is a useful tool because it is flexible, allowing me to identifying patterns of meaning across a data set (Braun & Clarke, 2006). For some data, this was followed by an additional analytic method, found poetry. This analytic method involves extracting the women's own words from interviews and using them to create poems that convey the message of the participants' narratives (Richardson, 1992). The benefits of using found poetry are the ability to use the women's own voice, combined with the researcher's voice in the interpretation of the interview (Glesne, 1997).

Research Questions

The following research questions guided the study:

RQ1: How do undergraduate women public health students at a large southeastern university describe their perceptions of feminism?

RQ2: What are the sexual health information- and service-seeking experiences of these women?

RQ3: How do these women's perceptions of feminism influence their sexual health information- and service-seeking behaviors?

Addressing the Problem

This study utilized a Feminist Theoretical framework guided by hooks' understanding of feminism to explore the thoughts, feelings, and perceptions of college women in regard to feminism, sexual health, and their behaviors seeking sexual health services and information. The specific areas of concern were service- and information-seeking behaviors. The resulting stories and findings from the narrative interviews provide new insight into the lives of college women that can be utilized to improve approaches to health and sexuality education, as well as college sexual health interventions.

The study incorporated hooks' Feminist Theory in the determination of the most appropriate methods to evoke narratives of the women's experiences. The qualitative semi-structured narrative interviews were done with undergraduate public health women. During the interviews, women shared their own thoughts, perceptions, experiences, and attitudes regarding feminism, sexual health, and seeking sexual health services and information. These methods coincide with hooks' Feminist Theory by utilizing a collaborative approach -- interviewer and interviewee -- to gain insight about individuals' experiences related to women's health. In

addition, these findings can inform future studies and interventions for sexuality education and health promotion efforts. This study produced invaluable information for health educators in the college setting and beyond. In addition, health educators may be able to make improvements in their practice and provide adequate, effective education to girls and women about the importance of sexual health information and services, while encouraging them to seek services when they want or need them, thus improving overall health of college women. These pedagogical implications are a goal of hooks' Feminist Theory.

Significance of the Study

This study applied a Feminist Theoretical framework to examine perceptions of feminism and sexual health service- and information-seeking -- something that has not been previously done. Additionally, the study added to the limited body of literature regarding the use of Feminist Theory in college women's sexual health research, providing information for future intersection of Feminist Theory and public health.

Limitations

Qualitative interviewing is not an objective process. Rather, I brought my own subjectivities to the study, and chose what to acknowledge verbally in an interview and what not to disclose. My own identity and interpretations influenced the results of the study. However, Feminist Theory acknowledges that interviews are as much influenced by the listener as the teller (DeVault & Gross, 2014, p. 213). In order to process these subjectivities, I strived to "actively seek them out" in an effort to avoid running into them later when analyzing the data (Peshkin, 1988). To do this, I made notes in a reflexive journal when feelings arose related to the study, documenting the reactions. This reflexive process allowed the results of the study to be a true

collaboration between myself and the interviewees, rather than solely my own reactions due to unchecked subjectivities.

While generalizability is not a goal of qualitative research, the homogeneity of the student population at the university where this study was conducted could be considered a limitation to how transferable and applicable the results are. Demographically, 83.7% of students at the university are white and 11.7% are black of African American (Office of Institutional Research and Assessment [OIRA], 2020a). This is far from representative of the U.S., where 76.5% of people are white and 13.4% are black or African American (United States Census Bureau, 2020) so some of the experiences shared by the participants in the study may not be transferable to many other universities or college women in the U.S. However, being done within a theoretical framework based on hooks' feminism, the study's findings may present potential pedagogical implications related to health and sexuality education. They can also be used to make recommendations for future research.

It is also important to note that women were recruited from undergraduate public health classes. This means that they more than likely already had some notion of the importance of sexual health services and accurate information. However, selecting students from this major was intentional because these women allowed for conversation from which the most could be gained.

Delimitations

The parameters of this study consisted of undergraduate women at a large southeastern university. Participants were required to be between 18 and 24 years old and identify as women and were recruited from public health courses during the Fall 2019 semester. The study involved qualitative research methods, specifically semi-structured narrative interviews.

Assumptions

This study assumed that students would not misrepresent themselves demographically, and that women would be open and honest in their interviews.

Operational Definitions

College Women: Undergraduate students who identify as women and were between the ages of 18 and 24 years old.

Empowerment: the capacity of individuals, groups and/or communities to take control of their circumstances, exercise power and achieve their own goals, and the process by which, individually and collectively, they are able to help themselves and others to maximize the quality of their lives (Adams, 2008, p. xvi).

Feminism: The effort to end sexist oppression, with central tenets of empowerment, equality, and social change (Collins, 2000; Freedman, 2002; hooks, 1984).

Feminist Theory: A framework that focuses on lived experiences as a basis for knowledge, and is often utilized to create social change (DeVault, 1999).

Information-Seeking: In this study, information-seeking includes any behavior that aims to answer a question or provide knowledge or resources that participants need for their sexual health.

Sexual Health: A state of physical, mental and social well-being in relation to sexuality; it requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence (World Health Organization [WHO], 2019).

Sexual Health Information: In this study, sexual health information could be answers to any questions related to sexuality or sexual health.

Sexual Health Services: For this study, services may include -- but are not limited to -- annual Well Woman visits, STI testing, contraception access, abortion, cancer screening, counseling services, and vaccines.

Summary

The connection between low rates of sexual health service- and information-seeking and poor sexual and reproductive health outcomes supports the need for improved sexual health education and promotion efforts. Similarly, the relation between feelings of empowerment and improved health (Currie & Wiesenberg, 2010) support the idea of perceptions of feminism influencing health as well. College women are at a stage of life when sexual health information- and service-seeking are vital. Health education and promotion efforts should be tailored to meet the needs of these women, while also taking into consideration their lived experiences, thoughts, and perceptions of the world they live in. Applying a Feminist Theoretical framework to examine the influence of college women's perceptions of feminism can help to identify the needs of college women, and results can be utilized for improved approaches to sexuality education and sexual health interventions.

CHAPTER 2

REVIEW OF LITERATURE

Sexual health is of particular concern for college women in the United States, and is linked to physical, emotional, and social consequences. Sexually transmitted infections (STIs), sexual assault, contraception, and cancer screenings are just a few of the main areas of concern for health professionals working with college women. However, college women are seeking sexual health services far less often than recommended, and seeking sexual health information from unreliable sources, if at all (Hayes-Smith & Hayes-Smith, 2009; Murray Horwitz et al., 2018). Past research has shown that when women feel empowered and/or identify as feminists, they are more likely to take better care of their own health and have more positive sexual health outcomes (Fitz & Zucker, 2014). Empowerment, along with social change and equality, is a central tenet of feminism (Collins, 2000; hooks, 1984). Thus, it would seem that feminism could influence sexual health service- and information-seeking; but there is little existing research on this connection. The purpose of this study was to utilize a Feminist Theoretical framework to gain an in-depth understanding of college women's perceptions of feminism, their experiences seeking sexual health services and information, and the ways in which their perceptions of feminism influence their sexual health service- and information-seeking behaviors. In this chapter, public health issues in sexual health will be discussed, including sexually transmitted infections, sexual assault, unintended pregnancy, cervical cancer, and HIV, as well as college women's sexual health, sexual health service-seeking recommendations and data, sexual health

information-seeking literature, perceptions of feminism, and Feminist Theory and its research foundations.

Sexual Health as a Public Health Issue

All humans are at risk of facing sexual health issues in their lifetime. In sexuality education, professionals are encouraged to recognize that "individuals are sexual beings from womb to tomb" (Bruess & Schroeder, 2014, p. 18). At an age of identity formation, exploring new opportunities, and building relationships, college students are at greater risk of adverse health outcomes (Cantor, Fisher, Chibnall, Bruce, Townsend, Thomas, & Lee, 2015; Krebs, Lindquist, Warner, Fisher, & Martin, 2007; Krebs, Lindquist, Warner, Fisher, & Martin, 2009). Specifically, many sexual health issues are more prominent for college students -- namely college women -- than the general population. Reasons for this greater risk include societal stigmas or taboo faced more often by women (Ollivier et al., 2018), as well as biological reasons like structure of female anatomy, or lack of symptoms of STIs (CDC, 2011).

Sexually Transmitted Infections

STIs, also sometimes referred to as sexually transmitted diseases (STDs), are a health burden for millions of Americans every year.[2] In 2017, there were 1.7 million cases of chlamydia, making it the most common notifiable condition in the U.S. (CDC, 2018). This is a 22% increase since 2013, and prevalence is highest among adolescents and young adults (CDC, 2018). Passed through vaginal, anal, or oral sex with an infected partner, chlamydia is often asymptomatic; some symptoms women may experience include abnormal vaginal discharge or burning when urinating (CDC, 2014a). Tests for chlamydia may be urine samples or vaginal

[2] While there are many STIs faced by women in the U.S., only those most common are discussed here.

swabs (CDC, 2014a). Chlamydia can be easily cured, but if left untreated can lead to negative health outcomes such as Pelvic Inflammatory Disease (PID) in women (CDC, 2014a). While PID can be asymptomatic, it can lead to infertility and other reproductive system damage, as well as ectopic pregnancies (CDC, 2014a). In addition, pregnant women can pass chlamydia on to their baby, potentially causing eye infections or pneumonia in the baby, and early delivery (CDC, 2014a).

The second most common notifiable condition, gonorrhea, had 555,608 cases in 2017 (CDC, 2018). Spread through vaginal, anal, or oral sex with an infected partner, gonorrhea is almost always asymptomatic in women; most symptoms that do occur are mistaken for a bladder or vaginal infection (CDC, 2014b). When symptoms are experienced in women, they include painful or burning sensation when urinating, increased vaginal discharge, and vaginal bleeding between periods (CDC, 2014b). A urine sample or swabs of the anus or cervix are used to test for gonorrhea, depending on the infection (CDC, 2014b). Gonorrhea is treatable, though some strains are becoming drug-resistant (CDC, 2014b). If left untreated, PID can develop in women, leading to the previously described adverse health outcomes and reproductive health issues (CDC, 2014b).

Cases of syphilis, another curable STI, are increasing every year (CDC, 2018b). In 2017, there were 30,644 cases of syphilis (CDC, 2018). Divided into primary, secondary, latent, and tertiary stages, symptoms for syphilis are different at every stage (CDC, 2017d). Primary syphilis is marked by sores at the site of infection, which are firm, round, and painless (CDC, 2017d). Symptoms of secondary syphilis include skin rash, swollen lymph nodes, and fever, all of which may go unnoticed (CDC, 2017d). Latent stage syphilis shows no signs or symptoms, while tertiary syphilis usually causes severe health issues, such as heart and brain problems (CDC,

2017d). Syphilis is spread via direct contact with a sore during vaginal, anal, or oral sex (CDC, 2017d). All pregnant women should be tested for syphilis, because the infection can be passed to the infant, lead to low birth weight, or stillbirth; babies born with syphilis often have cataracts, deafness, and seizures, and sometimes die (CDC, 2017d). Tests for syphilis are done with a blood sample, and it can be treated with antibiotics (CDC, 2017d).

Genital herpes is either caused by herpes simplex virus type 1 (HSV-1) or herpes simplex virus type 2 (HSV-2) (CDC, 2017c). Oral herpes is typically caused by HSV-1, and most often shows no symptoms; cold sores around the mouth can result (CDC, 2017c). Oral herpes is usually caused by contact with saliva as a child or young adult (CDC, 2017c). HSV-1 can be spread from the mouth to genitals through oral sex, which is how some cases of genital herpes are caused by HSV-1 (CDC, 2017c). Though very common in the U.S. with more than one out of every six people between ages 14 and 49 infected, genital herpes is incurable (CDC, 2017c). A person with herpes can pass genital herpes to an uninfected person through a herpes sore, saliva or genital secretions, and from skin-to-skin contact (CDC, 2017c). Even when no sore is visible, as is often the case, the virus can be transmitted. Taking anti-herpes medication every day, avoiding sex during an outbreak, and using condoms correctly can help reduce the chance of spreading the virus (CDC, 2017c). Pregnant women with genital herpes can pass the virus to the baby during delivery, causing a potentially deadly infection; anti-herpes medication should be taken toward the end of pregnancy and a c-section may be performed if sores are visible (CDC, 2017c). If left untreated, genital herpes can cause painful sores which, if touched, can transfer herpes to other body parts (CDC, 2017c). In addition, genital herpes increases the risk of HIV (CDC, 2017c).

HIV and AIDS

HIV progresses through three stages when untreated: acute, clinical latency, and acquired immunodeficiency syndrome, or AIDS (CDC, 2019a). Acute HIV is marked by flu-like symptoms for a few weeks, during which there are high levels of the virus in their blood; patients in this stage are very contagious, though they are often unaware of their infection (CDC, 2019a). Clinical latency is marked by HIV inactivity and very low levels of the virus (CDC, 2019a). Depending on whether HIV positive individuals are taking medication to treat the virus or not, this stage can last for a decade or more with no symptoms (CDC, 2019a). Finally, AIDS is the stage of HIV infection that is most severe, and people in this stage often get opportunistic illnesses; the typical survival of people with AIDS is only about three years (CDC, 2019a). While there is no cure for HIV, treatment can help to control it. Antiretroviral therapy, or ART, can allow HIV positive individuals to decrease the levels of HIV in their blood to an almost undetectable level that essentially eliminates their risk of passing it to their partner (CDC, 2019a).

While over 1 million people were living with HIV in the U.S. in 2016, 14% of them were unaware of their status (CDC, 2019b). Certain groups are affected more than others. For example, individuals in their teens and early 20s are especially affected, as well as gay and bisexual men; of the 38,739 HIV positive people in 2017, 66% were gay or bisexual men (CDC, 2019b). Among the 7,000 women with HIV in 2017 -- a number that has been decreasing over time -- 59% were Black/African American (CDC, 2019c). Nearly a quarter of HIV diagnoses were individuals who were infected through heterosexual sex (CDC, 2019b). Demographically, HIV is mainly found in Urban areas, with the South having the highest number of cases (CDC,

2019b). However, taking population size into account, the Northeast U.S. has the highest rate of individuals infected with HIV (CDC, 2019b).

Sexual Assault

Sexual assault can be defined as sexual contact or behavior that occurs without the victim's explicit consent (RAINN, 2019b). Of all victims of sexual violence, 69% are between ages 12 and 34 (RAINN, 2019c). In addition, women are more likely to be assaulted than men, and college women between ages 18 and 24 are three times more likely to experience sexual violence than women in general (RAINN, 2019c). Previous studies have found that one in five women experience attempted or completed sexual assault while in college (Krebs et al., 2007; Krebs at al., 2009). A study by Cantor and colleagues (2015) found that rape or sexual assault through physical force, violence, or incapacitation was experienced by 11.2% of students, whether undergraduate or graduate. The reasons these rates are higher for women connects sexual health directly to tenets of feminism. One reason is that sexual health is often seen as taboo, and power dynamics often lead to feelings of embarrassment and judgment (Ollivier et al., 2018). Another may be the way gendered behaviors shape access to services, as Happe (2006) found in a study of race and breast cancer services. The same gendered behaviors may influence services such as counseling in relationships or after sexual assault. These facts about stigma, gender, and need for empowerment further connect the influence of feminism on health.

Women who are victims of sexual assault are more likely to partake in risky behavior, such as binge drinking (Behnken et al., 2010; Rhew, Stappenbeck, Bedard-Gilligan, Hughes, & Kaysen, 2017; Ullman, Filipas, Townsend, & Starzynski, 2004; Woerner, Schleider, Overstreet, Foster, Amstadter, & Sartor, 2019). Other effects of sexual assault can include depression, flashbacks, and posttraumatic stress disorder (PTSD), as well as self-harm, STIs, substance

abuse, dissociation, eating disorders, sleep disorders, and suicide (Behnken et al., 2010; RAINN, 2019a). Depression is among the most common effects, which, along with the previously mentioned risky behaviors, can and often does lead to suicide in sexual assault victims (Behnken et al., 2010).

Unintended Pregnancies

In addition to STIs and sexual assault, American women are dealing with unintended pregnancies at staggering rates significantly higher than women in other developed nations. Unintended pregnancies are a major challenge for public health and safety, causing not only social but economic costs as well. In 2011, for every 1,000 women aged 15 to 44 in the U.S., there were 45 unintended pregnancies, making up 5% of the population of women of reproductive age (Finer & Zolna, 2016). Nearly half (2.8 million) of the 6.1 million pregnancies in the U.S. in 2011 were unintended (Finer & Zolna, 2016). Of all pregnancies that year, 27% were "wanted later" and 18% were "unwanted" (Finer & Zolna, 2016). Unintended pregnancies are most common among low-income women, college-aged women (18-24), cohabiting women, and women of color (Finer & Zolna, 2016). Not all women of reproductive age are sexually active, however. When unintended pregnancy rates are recalculated to include only women who were sexually active, the age-group with the highest unintended pregnancy rate was age 15-19 (Finer, 2010).

Adverse outcomes often result from unintended pregnancies. These include low birth weight (Hall, Benton, Copas, & Stephenson, 2017) and low breastfeeding rates (Wallenborn, Chambers, Lowery, & Masho, 2018). Herd and colleagues (2016) found in their study of women who had unintended pregnancies before Roe v. Wade that the mental health effects of live births from an unwanted pregnancy were persistently negative. These negative effects included more

depressive symptoms and a higher likelihood of depression (Herd, Higgins, Sicinski, & Merkurieva, 2016). Barber and colleagues (1999) had also previously found that unintended pregnancies were associated with depression and lack of happiness in women in their 30s. By analyzing the experiences of women who were unable to seek legal abortion, since their unintended pregnancies occurred before Roe v. Wade, Herd and colleagues' study (2016) provides insight into the effect of illegality of abortion on women's health.

Today, decades after Roe v. Wade, women have a constitutional right to access safe and legal abortion services, making it easier to track. Of all unintended pregnancies -- excluding miscarriages -- in 2011, 42% ended in abortion (Finer & Zolna, 2016). In the few years prior, between 2008 and 2011, live births that resulted from unintended pregnancies decreased across all racial and ethnic groups, though were more common among black women: 50% compared to 36-40% (Finer & Zolna, 2016).

Before Roe v. Wade ruled that abortion was a constitutional right in 1973, women were still terminating pregnancies; however, these abortions were often self-induced since they were illegal, and women often suffered from infection and blood loss -- sometimes even death (Hayden, 2011). The rates of these negative consequences dropped drastically after the Supreme Court ruling (Hayden, 2011). In fact, legal abortions post-Roe are one of the safest medical procedures, and the risk is no greater for women who have a first-term abortion than women who carry their pregnancy to term (Major, Appelbaum, Beckman, Dutton, Russo, & West, 2008; Upadhyay, Desai, Zildar, Weitz, Grossman, Anderson, & Taylor, 2015).

However, with legislation that passed in 2019 in Alabama, Arkansas, Georgia, Kentucky, Louisiana, Mississippi, Missouri, Ohio, and Utah, women's access to safe and legal abortions was greatly threatened in the U.S.; none were put into effect or are being enforced (Gordon &

Hurt, 2019). In Alabama specifically, abortion would only have been allowed in situations when the mother's life is at risk, with no exceptions in situations of rape or incest, had the bill not been blocked by judges (Gordon & Hurt, 2019). This goes against guidance from the World Health Organization [WHO], which states that "providing women across the globe with access to safe and legal abortion services is essential to realizing and protecting their fundamental human rights" (WHO, 2012). The WHO publication (2012) asserts that nearly all of the 47,000 deaths that occur every year worldwide -- as well as the five million injuries -- due to unsafe abortions, could be prevented with comprehensive sexuality education and access to safe, legal abortion.

The shame and stigma associated with abortion access is perpetuated in the media in the U.S. In a study analyzing television representation of abortion, Sisson and Kimport (2016) found that most plotlines linked abortion to violence. Addressing these aspects of seeking abortion and other sexual health services is necessary to ensure better health outcomes for women.

Cervical Cancer

Gynecologic cancer is typically found in women in five main types: cervical, ovarian, uterine, vaginal, and vulval (CDC, 2017b). Cervical cancer is the only gynecologic cancer with a screening test that allows women to detect it early on (CDC, 2017b). In 2016, there were 12,984 new cases of cervical cancer; 4,188 women died of cervical cancer in the U.S. that year (U.S. Cancer Statistics Working Group, 2019). In the state of Alabama, the age-adjusted incidence rate of cervical cancer was 9.8 per 100,000 women in 2016; the national incidence rate was 8 per 100,000 (U.S. Cancer Statistics Working Group, 2019). Cervical cancer is most often caused by human papillomavirus (HPV) but is highly preventable with screening tests and the HPV vaccine (CDC, 2017b). Screening tests are recommended starting at age 21 (CDC, 2017a). The age group

with the highest cervical cancer diagnosis rate is 40-44, with a rate of 15.7 per 100,000 (CDC, 2016).

College Women's Sexual Health

All of the previously described sexual health issues affect women adversely, and often college women more so than women in general. This, along with being at an age when major life decisions are being made, and women are discovering who they are as individuals, creates more challenges than are necessary, safe, or healthy. This section will discuss the existing literature that is specific to college women's sexual health.

Hookups

In a study consisting of 118 first-semester college women, Fielder and Carey (2010) found that 60% had experienced oral, vaginal, or anal sex hookups. Most of these hookups involved alcohol and were with someone the woman knew well, like a friend or ex-boyfriend (Fielder & Carey, 2010). Of women who had hooked up, 44% had hooked up with their most recent partner previously (Fielder & Carey, 2010). The term "hookup" was used to refer to a wide variety of behaviors, ranging from kissing to vaginal, oral, or anal sex, though kissing was most common (Fielder & Carey, 2010).

Other research on college sexual hookups has found that there is a clear gender component. When it comes to trust, Rachel Kalish (2018) found that trust means different things for women than it does for men. When college women hookup with male partners, they expect trust to involve a certain level of confidentiality, and also safety and precautions when it comes to their sexual health; men are more concerned about their reputation not being damaged by their female partners (Kalish, 2018). This uneven playing field, as Kalish describes (2018), makes sexual pleasure more difficult for women than men. Women are more concerned about trust for

their own emotional and personal health and safety (Kalish, 2018). Lack of trust in relationships has also been associated with lack of condom use and lower rates of STI testing (Teitelman, Calhoun, Duncan, Washio, & McDougle, 2016).

Contraception Use

Contraception use in hookups described in Fielder and Carey's study (2010) was low; none of the oral sex hookups used condoms, and only 69% of vaginal sex hookups did. A study done by Martinez, Copen, and Abma (2011) found that between 2006 and 2010, among women aged 15-19, 59% used a highly effective method of contraception. In addition, external condoms were the most commonly used method of contraception by both men and women at first and most recent sex (Martinez et al., 2011). Overall, in 2012 sexually active women aged 15-19 used the external condom most (55%), followed by the pill (35%) and the withdrawal method (20%); only 3% used IUDs (Lindberg et al., 2016). This high rate of withdrawal as women's main method of contraception is of particular concern, since typical use of this method has a failure rate of 20% (Sundaram, Vaughan, Kost, Bankole, Finer, Singh, & Trussell, 2017).

It is important to note, however, that contraception, specifically hormonal methods such as the pill, vaginal ring, patch, implant, and IUD, are often used for reasons other than preventing pregnancy. Often, these methods are chosen by women with the help of their health care providers to prevent excessive menstrual bleeding, menstrual pain, and acne (Bearak & Jones, 2017). An analysis by Bearak and Jones (2017) found that 70% of college aged women (18-24) reported using the pill for nonpregnancy reasons.

Sexual Well-Being

Past research has shown that college women's sexual well-being can be predicted by their sexual agency (Kaestle & Evans, 2018). Kaestle and Evans (2018) defined sexual agency as "the

ability to make sexual choices in line with one's preferences." In addition, communication influences sexual health for college women. College women are often more likely to seek vaccinations and other sexual health services if they are comfortable communicating with important people in their lives (Romo et al., 2011). Specifically, when college women have positive past experiences communicating with their mothers, they have been found more likely to communicate with family about sexual health problems (Romo et al., 2011).

Open communication, along with knowledge of sexual health issues, has been associated with higher confidence in college women talking to their doctors about such issues (Romo et al., 2011). On the other hand, when women do not have a history of communication and knowledge of sexual health, they are less confident in asking questions about their current sexual wellness (Romo et al., 2011). The consequences of this lack of confidence can be detrimental, especially in cases of sexual assault victims. Women who have experienced sexual assault use drinking as a coping mechanism more often, and are more likely to binge drink than women who are not victims of sexual assault (Woerner et al., 2019). However, it is known that treatment for sexual assault victims can improve coping strategies and improve long term health outcomes (Vickerman & Margolin, 2009).

Sexual Health Service-Seeking

Recommendations

To prevent sexual health issues like STIs, cervical cancer, and unintended pregnancy, it is crucial for college women to access sexual health services. Recommendations for college women's sexual health service use include those to address STI prevention and testing, vaccinations, and cancer screening. The Partnership for Prevention (2013) recommends that even if women do not have symptoms, screenings at a regular wellness exam or Well Woman visit can

help detect many sexual health issues. Well Woman visits should be received at least once a year as preventive care, beginning in adolescence (Health Resources & Services Administration [HRSA], 2017). This preventive care visit can ensure services necessary for optimal sexual and reproductive health can be obtained (HRSA, 2017).

All sexually active women under age 25 should be screened every year for chlamydia (Partnership for Prevention, 2013). In addition, women should ask their care providers if they should be tested for gonorrhea, since both of these STIs are asymptomatic and testing is the only way to know if they have an infection (Partnership for Prevention, 2013). Young adult women should be tested for HIV at least once even if they think they are not at risk, and at least once a year if they have unprotected sex, have had an STI, have a sexual partner who has had an STI, have multiple partners, share needles, or have a sexual partner who engages in these behaviors (Partnership for Prevention, 2013).

All women should have a Pap test, the screening test for cervical cancer, every three years between the ages of 21 and 65 (Partnership for Prevention, 2013). If they have had an abnormal Pap result, screening more often may be necessary (Partnership for Prevention, 2013). Since HPV is the leading cause of cervical cancer, the HPV vaccine is recommended for girls ages 11-12 and may be given up to age 26; it is a series of three shots (Partnership for Prevention, 2013).

In addition to the HPV vaccine, women should have the hepatitis B vaccine if they have multiple partners, have a sexual partner who has hepatitis B, have been diagnosed with HIV or any other STIs, share needles, or have a partner who uses injection drugs (Partnership for Prevention, 2013). Most young adults and children born after 1991 were vaccinated, but if young

adult women are unvaccinated, they should get the vaccine series (Partnership for Prevention, 2013).

Regarding contraception, the HRSA Women's Preventive Services Initiative (2017) recommends that women have access to "the full range of female-controlled contraceptives to prevent unintended pregnancy and improve birth outcomes." This full-range should include sterilization surgery, surgical sterilization via implant, implantable rods, copper IUDs, IUDs with progestin, the shot or injection, oral contraceptives, the contraceptive patch, vaginal contraceptive rings, diaphragms, contraceptive sponges, cervical caps, female condoms, spermicides, and emergency contraception, as well as instruction in fertility awareness-based methods (HRSA, 2017).

Existing Sexual Health Service-Seeking Literature

Compared to other groups, young adult women have lower levels of care-seeking and worse sexual and reproductive health outcomes (Murray Horwitz et al., 2018). Women between ages 21 and 29 were getting Pap tests for cervical cancer screenings at rates as low as 47.3% in 2016 (MacLaughlin, Jacobson, Breitkopf, Wilson, Jacobson, Fan, St. Sauver, & Rutten, 2019). In addition, African American women get Pap tests less than 50% as often as white women (MacLaughlin et al., 2019). However, sexual and reproductive health service utilization overall has been increasing over the past two decades, specifically when the Affordable Care Act was enacted (Murray Horwitz et al., 2018). Even though these rates have increased, studies have shown that sexual activity and risky sexual behaviors have not increased (Murray Horwitz et al., 2018).

College students perceive many barriers to sexual health service-seeking (Cassidy, Bishop, Steenbeek, Langille, Martin-Misener, & Curran 2018). Some factors that are associated

with service use for college students include year in college, ethnicity, sexual orientation, and social support (Cassidy et al., 2018). Additional factors such as psychological capabilities, opportunity, and motivation are also associated with service-seeking (Cassidy et al., 2018). Psychological capabilities influenced service-seeking because this meant students had the "necessary capacity to engage in necessary thought processes" regarding seeking sexual health services (Cassidy et al., 2018). Opportunity referred to both social and physical opportunity within Cassidy and colleagues' study (2018): social opportunity included factors such as cultural norms and social cues, while physical opportunity incorporated time, location, and resources available to students. Finally, Cassidy and colleagues (2018) found that motivation, which they defined as "brain processes that affect decisions and behavior," was determined by emotions and impulses as well as plans.

Regarding STI testing, a study by Cuffe and colleagues (2016) found that only 16.6% of college aged women sought STI testing in the previous 12 months, and 39.9% of women reported that their reason for not seeking testing was confidentiality concern. It was also found that women with a greater number of sexual partners had a higher rate of testing (Cuffe et al., 2016). However, the lack of testing is leading to many undiagnosed STIs, which, according to the CDC (2018b), account for infertility in 24,000 women each year.

Accessing contraception is vital for the sexual health and well-being of college women. A study done in 2015 reported a positive finding regarding contraception use: 99% of women who have ever had sexual intercourse have used contraception (Daniels, Daugherty, Jones, & Mosher, 2015). Over her reproductive years, a woman will use about three different methods on average (Daniels et al., 2015). As previously discussed, the pill is very common -- 26% of women in Daniels & colleagues' study (2015) were using the pill -- though there has also been an increase

in long acting reversible contraceptives, or LARCs, primarily the IUD. Those most likely to be using male condoms were younger women and women intending to have children in the future (Daniels et al., 2015).

In addition to cancer and STI screenings, and contraception access, many young women seek abortion services each year. According to the CDC abortion surveillance system report (2018a), 638,169 legal induced abortions were performed in the U.S. in 2015: a rate of 11.8 abortions per 1,000 women between ages 15 and 44. This rate was a 2% decrease from 2014, and a 26% decrease from 2006 (CDC, 2018a). The total number, rate, and ratio of abortions reached the lowest level in 2015 since the CDC surveillance began in 2006 (CDC, 2018a). Abortion is an issue of great importance for college women's health, since the majority of abortions are done for women in their twenties (CDC, 2018a). Most abortions are done early in gestation, with 91.1% at less than 13 weeks, 7.6% between 14 and 20 weeks, and only 1.3% after 21 weeks' gestation (CDC, 2018a). Nearly a quarter (24.6%) of all abortions done in 2015 were early medical abortions, which are non-surgical (CDC, 2018a).

Sexual Health Information-Seeking

Online resources of sexual health information are used often by college women, specifically for reasons such as safety, lack of offline resources, and accessibility, according to a study by Flanders and colleagues (2017). This study also found that information that is sought online typically is in regard to behavioral and physical health needs, community and interpersonal needs, and emotional needs (Flanders, Pragg, Dobinson, & Logie, 2017). The majority of college women come across sexual health information unintentionally, specifically about sexual assault (Champlin, Everbach, & Sarder, 2017). However, previous studies have

shown that many university webpages leave important information out regarding sexual assault, thus doing a "disservice to women" (Hayes-Smith & Hayes-Smith, 2009).

Contraceptive counseling should be included in contraceptive care (HRSA, 2017). Additionally, the Women's Preventive Services Initiative recommends that "counseling, education, harm reduction strategies, and referral to appropriate supportive services" be provided to women who are suspected victims of interpersonal and domestic violence (HRSA, 2017). Counseling for STIs should also be made available for sexually active women and those at risk of STIs, determined by sexual history and other risk factors; risk factors include age under 25, partner with an STI, recent history of STIs, a new sex partner, multiple partners, a partner with other partners, and inconsistent or lack of condom use (HRSA, 2017). This type of counseling can reduce the risk of further issues.

Perceptions of Feminism

Feminism can be defined as the effort to end sexist oppression, with central tenets of empowerment, equality, and social change (Collins, 2000; Freedman, 2002; hooks, 1984). Perceptions of feminism and feminist identifications among young women have been shown to have a direct impact on their health. In one study by Borowsky and colleagues (2016), women who self-identified as feminists reported significantly higher body satisfaction than women who "did not embrace feminism." This demonstrates the connection between feelings of empowerment from feminism and better health outcomes, specifically in this case mental health. Another study found that feminist women use "cognitive strategies" to challenge negative thoughts about body image and to feel good about their appearance (Rubin et al., 2004). This cognitive component related to feminism and its connection to health was also evident in Ollivier and colleagues' (2018) study on using a feminist approach to address sexual health in healthcare

settings by aiming to understand and challenge the social beliefs and values related to sexuality. In the nursing field, Cassidy and colleagues (2016) also emphasized addressing discourse related to women's sexuality to "challenge the status quo" in order to improve women's health, thus directly connecting women's health to the feminist tenet of social change.

However, not all perceptions of feminism are so positive. Often considered marginalizing, many activists do not identify with feminism but prefer more inclusive political movements (Zucker & Bay-Cheng, 2010). In addition, women with weaker self-view are less likely to identify as feminists (Meijs et al., 2017). Those who have negative perceptions of feminism but share feminist values are sometimes referred to as quasi -- or weak -- feminists (Duncan, 2010). Another term used for these individuals who reject a feminist identity but have similar attitudes toward gender equality is "nonlabeler" (Fitz et al., 2012).

Zucker and Bay-Cheng's study of feminist identity versus attitude (2010) showed that the main difference between feminists, non-labelers, and nonfeminists was whether they identified as feminist or not; there was common ground among all women. Some women may value gender equality, but not identify it as a feminist issue (Fitz et al., 2012). The discrepancy that arises when women value many of the tenets of feminism but do not identify as feminists can be problematic (Meijs et al., 2017).

While feminism has been incorporated into health research before, it has been mainly in social and population health regarding women's lives "beyond reproduction" (Broom, 2014). More importantly, most integration of feminism in the field of public health has surrounded methodology and justification of research and population health efforts due to the reproductive health connection with the feminist movement (Amaro et al., 2001; Broom, 2014; Currie & Weisenburg, 2003; Hammarstrom, 1999; Travis & Compton, 2001), rather than examining

people's actual perceptions of feminism. Björkman and colleagues (2016) incorporated feminism in health research when they studied patients' experiences of healthcare encounters in irritable bowel syndrome using narratives in a Feminist Theoretical framework. A study by Keedle and colleagues (2019), for example, utilized narrative analysis and a Feminist Theoretical framework to study women's experiences of planning vaginal birth after caesarean. In this study, narratives allowed researchers to gain deep insight into the personal feelings of control and confidence of women in a sensitive setting (Keedle, Schmied, Burns, & Dahlen, 2019). The lack of investigation of perceptions of feminism in sexual health is a gap that the current study can begin to fill.

Feminist Theory

While women have been fighting for equal rights around the world for hundreds of years, from working women in Paris to factory workers in Massachusetts (Weiss, 2018), feminist movement in the U.S. was born from the drive to abolish slavery and had its first wave with activists such as Elizabeth Cady Stanton, Lucretia Mott, and Susan B. Anthony fighting for the right to vote (Kolander et al., 2011). These women and the ones who fought before them drove the feminist movement forward. The Civil Rights Era brought feminism to the forefront again. Betty Friedan's *The Feminine Mystique* critiqued the stereotypes that women were pressured to maintain in their daily lives (Kolander et al., 2011). It was also during this wave that, though not ratified, the Equal Rights Amendment was approved (Kolander et al., 2011). In the 1990s, the third wave of feminism was signified by women such as Anita Hill; in addition, Senator Hillary Rodham Clinton reauthorized the Violence Against Women Act in 2005 (Kolander et al., 2011). Additionally, for the first time, women of color were some of the most notable feminist spokespersons (Cobble et al., 2014). Even with the progress made, this wave was thought to be

unstable at times (Cobble et al., 2014). Feminist activism at this time placed an emphasis on its differences from the first two waves, encouraging change through new goals and new activist efforts; critics believed continuity from those earlier movements would have been more productive than the generational conflict that it produced (Cobble et al., 2014).

In academia, multiple feminisms have been utilized (Campbell & Wasco, 2000). Liberal Feminism, Socialist Feminism, Radical Feminism, and Black Feminism, for example all stemmed from differing priorities of different groups of women (Campbell & Wasco, 2000). Liberal Feminism, for one, advocated for equal access to resources, and influenced many issues in the 1970s women's movement, such as the Equal Rights Amendment (Campbell & Wasco, 2000). Socialist Feminism believed that economic and class structure of society is problematic and leads to oppression; focus should be less on patriarchy and men's privilege, and more on capitalism (Campbell & Wasco, 2000). Radical Feminism had a central focus on gender oppression and called for restructuring social institutions (Campbell & Wasco, 2000). Black Feminism asserts that the reality of differential group treatment persists, and groups are not a problem, but discrimination against groups is (Collins, 2000).

In this study, bell hooks' understanding of feminism provided the theoretical framework. In her writings in the 1980s and '90s, hooks explained that verbally communicating stories and experiences should be included in educational efforts. In her 1984 book *Feminist Theory: From Margin to Center,* she stated that education must be made a feminist agenda (p. 107). This is because, in hooks' point of view, basic knowledge is too often taken for granted. Further, the incorporation of feminist education usually remains in women's studies programs, which is highly effective but does not reach wider masses of people who could benefit from it (hooks, 1984, p. 110). hooks explained that the information that feminist education teaches can change

views on the "nature of sex roles" and alter students' "perspectives on reality," showing the pedagogical implications of feminist work in education (1984, p. 110).

In order for these implications to become a reality, hooks stressed that narratives and dialogue can be incredibly effective, and making information widely accessible through the use of language can ensure that feminist work reaches more than just individuals in academia. In dialogue, hooks said, women can "ask questions and dispel stereotypes or fears" (1984, p. 110). This focus on verbal communication should be translated in the dissemination of feminist work as well, in order to make it accessible to more people -- not just to satisfy academic standards (hooks, 1984, p. 110-111). hooks' (1994) love for the use of narrative and language to convey ideas to the masses was evident in her description of Adrienne Rich's poetry:

> Language disrupts, refuses to be contained within boundaries. It speaks against our will, in words and thoughts that intrude, even violate the most private spaces of mind and body … words impose themselves, take root in our memory against our will. The words of [Rich's] poem begat a life in my memory that I could not abort or change. (p. 167)

Language, whether it be in narratives, poetry, or dialogue, can touch people and make them feel and experience passion in ways that society would, in hooks' view, typically deem "particularly difficult" or lacking in dignity, but it is this impact that makes it so powerful when disseminating information (1994, p. 174-175).

Central Tenets

Empowerment

A common theme among all of the previously mentioned waves of feminism, as well as most social justice movements in U.S. history is empowerment (Collins, 2000, p. 19). While many different terms may be used, depending on the source -- such as women's liberation

(Freeman, 1973) and female emancipation (Molyneux, 1981) in addition to empowerment -- it is mutually understood that all people, specifically women, should feel capable: capable of making their own choices and free to do so. It is important to note, however, that in order to increase empowerment, the "domains of power that constrain" women must be identified (Collins, 2000, p. 19).

Empowerment can specifically allow health professionals to "better contend with the sexual health needs of women" (Amaro et al., 2001). To take care of one's health, a basic knowledge is necessary, and the connection between knowledge and empowerment can be exemplified with interpretations of women's experiences (Collins, 2000, p. 227). Of course, gaining new understanding of these experiences and utilizing them to empower women also requires transforming injustices in society (Collins, 2000, p. 273).

Many scholars have written of empowerment in its various conceptualizations. Patricia Hill Collins' wrote of empowering black women through transferring power in communities (2000). Audre Lorde wrote of the importance of erotic power, and how it can "empower from within" (1984, p. 58). A final example of empowerment can be found in the following quote from bell hooks (1984):

> Feminist ideology should not encourage (as sexism has done) women to believe they are powerless. It should clarify for women the powers they exercise daily and show them ways these powers can be used to resist sexist domination and exploitation. (p. 93)

In other words, empowerment should highlight the power, abilities, and strengths which women already possess.

Equality

In addition, equality is valued by most feminists in some way or another. Be it health equity, the right to choose, equal opportunity for employment, or economic parity, just to name a few issues, it is believed and emphasized that all people are equal and deserve to be treated as such at home, in public, and in the workplace. The concept of equality, however, is relatively new in human history; the Seneca Falls women's rights convention in 1848 included equality in its vision for the future, but it had not been questioned before on any large scales (Freedman, 2002, p. 18; Weiss, 2018, p. 76-80).

Over the course of history, men and women have been seen as unequal due to theological and biological explanations (Freedman, 2002, p. 18). However, feminism has challenged that view in the past century and argued that women deserve to be seen and treated as equal. Different waves of the feminist movement have attempted to gain equality in different ways: the first wave emphasized the right to vote as a way for women to be seen and treated as equals, the second included the Civil Rights Act and Equal Rights Amendment, and the third fought for equal pay for equal work and sexual freedom (Freedman, 2002, p. 5, 182; Weiss, 2018). While these efforts created more opportunity and made progress toward equality, some fell short or did not solely focus on equality. For example, as Freedman explains (2002, p. 182), Affirmative Action does make an effort toward equal rights, but also specifically designates women as different, bringing their own "fresh perspective."

There are critics of feminism who argue that "biology is destiny" and that that in itself is a clear explanation for why men and women are, in fact, not equal (Freedman, 2002, p. 203). But modern feminist efforts toward equality acknowledge that even this biology is not constant or detrimental of one's life cycle. Rather, equality in fourth wave feminism is intersectional, like

previous waves, but different in that the basic human rights and equality that were fought for by and for women in previous decades now include rights and equality for all humans, regardless of gender identity, race, class, sexual orientation, religion, or ability (Weiss, 2018).

Social Change

Social change has always been the ultimate goal of feminism. When Parisian women protested the French class system and its rules in the late 1700s, they were seeking social change (Weiss, 2018, p. 40). Likewise, when women fought for suffrage in the 19th and early 20th century, they knew it was going to lead to social change. Much success in the feminist movement has been though reforms, and it is those reforms which, according to hooks (1984, p. 157), have allowed more women to move closer toward equality with men, regardless of the systems in which they were living, be they white supremacist or patriarchal. hooks believed that rather than reform, society should educate "masses of women and men about feminist movement, showing them ways it would transform their lives for the better," and that it was this lack of education -- and emphasis on reform -- that prevented the Equal Rights Amendment from being successful (1984, p. 158).

It is important to note, however, that social change and revolution does not occur overnight. Though it is and has always been a goal of the feminist movement, feminists and feminist scholars must acknowledge that the consciousness that they possess and the progress that has been made has been a process (hooks, 1984, p. 162). As Collins wrote of empowerment (2000, p. 289), this social change and transformation requires rejecting previous knowledge of "objectification, commodification, and exploitation" in order to identify the ways in which domination occurs.

Utilizing Feminist Theory in Research

Feminist Theory as a foundation of research considers women's experience to be a basis for knowledge (DeVault, 1999). Often, it focuses on helping women "understand the nature of sexism in personal life" (hooks, 1984, p. 159). hooks also argues that feminist research should address capitalism and sexist oppression (1984, p. 159). In order to appreciate and learn from women's experiences, feminist researchers must be able to form an "oppositional worldview" (hooks, 1984, p. 163). There are often pedagogical implications of feminist research, specifically when done with hooks' perspectives of Feminist Theory in mind. This is because hooks emphasized the benefits of feminist work and feminist education on changing the way students view gender roles, sexism, and other societal realities (1984, p. 110). Efforts to do this can be highly successful when narratives are used.

A key method in feminist research is personal testimony from individual women, typically via qualitative interviewing, life history, or narrative analysis (DeVault, 1999). Feminist interviews specifically are often conceptualized as an "encounter between women with common interests who would share knowledge" (DeVault & Gross, 2014). This dialogue can allow women to dispel stereotypes or fears, and share their stories through language (hooks, 1984, p. 110). This work is reflexive, as Acker, Barry, and Esseveld (1983) described analysis of feminist interviews as the interviewer "looking critically at their attempts to involve participants in the research, considering how they heard and interpreted women's accounts, and acknowledging their own concerns echoing through their analyses." Above all, feminist methodology attempts to minimize harm and control in the research process (DeVault, 1999).

Scholars who employ a Feminist Theoretical foundation often support research that is of value to women and has the potential to lead to social change, or any action that would be

beneficial to women (DeVault, 1999). In this study, this could be done by providing direction for future health and sexuality education efforts and identifying pedagogical implications that could improve women's lives. Using language to disseminate the findings of feminist work can help to reach wider audiences (hooks, 1994). By designing and conducting research within this framework, scholars have the goal of "ensuring women's control of their own bodies" (Amaro et al., 2001). In addition, when feminist scholars study feminist identity or perceptions of feminism, it can yield powerful insights regarding how personal and political identities intersect, and why women adopt or do not adopt a feminist self-identification (Zucker & Bay-Cheng, 2010).

Summary

In this chapter, public health issues in sexual health were discussed, including STIs, sexual assault, unintended pregnancy, cervical cancer, and HIV, as well as college women's sexual health, sexual health service-seeking recommendations and data, sexual health information-seeking literature, perceptions of feminism, and Feminist Theory and its research foundations. The gap in literature regarding perceptions of feminism and sexual health of college women was described; the current study addressed this gap. The methodology for this study will be discussed in Chapter 3, with findings from the analyses following in Chapter 4. Chapter 5 will present a discussion of the findings.

CHAPTER 3

METHODOLOGY

The consequences of the lack of knowledge acquisition and low service-seeking rates of college women are evident in the high rates of sexual assault, STIs, and unintended pregnancies previously described. However, open communication and increased knowledge of sexual health can help women to feel more confident to seek the care that they need (Romo et al., 2011). Feelings of confidence and empowerment are central to Feminist Theory, and the connection between feminism and health has been established. However, there is a gap in the literature regarding the connection between perceptions of feminism and sexual health. Aiming to fill this gap could in turn provide ways to improve women's health with a feminist approach. Thus, the current study aimed to expand this base of literature by examining the influence of college women's perceptions of feminism on their sexual health service- and information-seeking behaviors.

Because undergraduate public health women were identified as the population for this study due to the agency that their educational background provides, hooks' understandings of Feminist Theory provided the framework, since her writings (1984; 1994) emphasize the responsibility of education, the importance of hearing women's stories, and the pedagogical implications of feminist work. A Feminist Theoretical framework informed by hooks lends itself to narrative qualitative methods because of her focus on the benefits that language, dialogue, and stories can yield in disseminating feminist work (hooks, 1994). I conducted semi-structured

narrative interviews with eight undergraduate public health women, during which I asked them to describe their perceptions of feminism and their experiences seeking sexual health information and services, as well as influences and barriers. The interviews also explored the influence of their perceptions of feminism on their sexual health service- and information-seeking behaviors.

Semi-Structured Narrative Interviews

In order to gain an in-depth understanding of women's experiences, it is necessary to use methods that elicit more than simple, surface-level responses (DeVault & Gross, 2014; Roulston, 2010). The qualitative elicitation in this study allowed me to glean the desired level of detail from the population of interest. Semi-structured interviews are useful for exploratory studies such as this one (Roulston, 2010). Since hooks' Feminist Theory was identified as the framework for this study, the goal was to acquire narratives from women about their experiences with the topic at hand. The method that coincided best is narrative interviewing, because it includes questions that support the participants' descriptions of experiences, and narrative interviews have the "potential to reach and affect a wide range of people" (Shelton, 2014). In order to evoke vivid, detailed stories of women's experiences, I asked phenomenological interview questions that encouraged them to "describe a particular phenomenon related to their experiences" (Shelton, 2014).

"All conversations are highly structured events," but semi-structured in this sense implies a relinquishing of some control over the conversation in the interview (Nunkoosing, 2005). Semi-structured interviews are flexible, in that there is an interview guide with open-ended questions, but the interviewer asks follow-up questions that prompt the interviewee to share more detail (Roulston, 2010, p. 15). As previously described, much is unknown about the influences of college women's perceptions of feminism on their sexual health, and essentially nothing is

known about the influence on their sexual health service- and information-seeking behaviors. By utilizing these exploratory methods, interviewees could share whatever came to mind relating to the topic, allowing me to gain a personal perspective of something otherwise unknown.

Interviews used in health education research are typically done among groups within a community, which can provide information regarding attitudes, barriers, or beliefs about certain behaviors (Kidd & Parshall, 2000). While this can provide valuable insight, group interviews present a risk for the researcher. When seeking discussion regarding personal health topics, group settings may prevent participants from being fully honest and open about their beliefs, attitudes, and behaviors (McKenzie, Neiger, & Thackeray, 2009). While group interviews can be helpful to ascertain group norms, the purpose of this study was to interpret individual perceptions and experiences regarding a highly sensitive topic; focus groups and other group interviews are not theoretically sound for this study. Narrative interviews are beneficial for sensitive topics, because this style of interviewing leaves room for open conversation with a goal of allowing women's voices to be heard (Roulston, 2010). Throughout the interview, the interviewer aims to believe the interviewee, gaining their trust along the way (Reinharz, 1992).

Sample

The sample size sought for this study was approximately five to 10 women. This type of exploratory qualitative study design does not require a specific number of participants, because criteria such as generalizability and representativeness are not the goal (Tracy, 2010). Rather, emphasis is placed on the interactions that occur and the narratives that are shared. The number of participants that is deemed "enough" depends on the richness of interviews and the extent to which the participants' responses address the research purpose and questions (deMarrais, 2004, p. 60). A qualitative study can be deemed rigorous if there are enough data to support significant

claims, the researcher spent an appropriate amount of time collecting data, the sample was appropriate in relation to the purpose of the study, and procedures used in data collection were appropriate (Tracy, 2010). "Appropriate" requires that the researcher return to the research purpose of understanding a phenomenon and acknowledge when enough participants have been interviewed to gain that understanding; in many cases, "less is more" (deMarrais, 2004, p. 61).

Saturation is a term commonly heard in qualitative research as a "guiding principle" (Morse, 2015). Theoretical saturation is the point at which no new information can be yielded from gathering more data (Holton, 2007). This was discussed by Bowen (2008) as a challenge, but something to work toward by immersing oneself in data collection and analysis. Theoretical saturation is typically a concern for determining the rigor of grounded theory studies, (Bowen, 2008; Glaser & Strauss, 1967) however, which was not the purpose of this study.

Similarly, another recommendation to determine when "enough" data has been collected is theoretical sufficiency. Using theoretical sufficiency as the intended stopping point, the researcher collects data until she believes that the results would allow an adequate explanation of the research topic, given the selected theoretical framework (Marshall & Rossman, 2016). Past research has found that approximately nine interviews typically provides saturation when using the coding process (Hennink et al., 2017).

Research Questions

RQ1: How do undergraduate women public health students at a large southeastern university describe their perceptions of feminism?

RQ2: What are the sexual health information- and service-seeking experiences of these women?

RQ3: How do these women's perceptions of feminism influence their sexual health

information- and service-seeking behaviors?

Setting

The undergraduate public health program at the large southeastern university at which this study was conducted, and from which participants were recruited, includes courses that address a variety of health topics, typical to most public health programs. Personal Health, Health Disparities, Drug Awareness, and Community and Public Health are a few of those courses. Demographically, the university is comprised of students who are 83.7% white and 55.7% female (OIRA, 2020a). Regarding financial status, 15.3% of students received Pell Grants in 2019 (OIRA, 2020b). However, many students -- over half of the student population (57.8%) -- come from out of state (OIRA, 2020a). This is worth noting, since this means that many cultural backgrounds are represented at the university. The variety of the student population, in this respect, increases the applicability of the study throughout the U.S., thus increasing the trustworthiness of the study (Krefting, 1991). Applicability refers to the possibility of the study's findings being applied to other contexts or groups and is considered a component of the trustworthiness of the study, "ensuring rigor without sacrificing relevance" (Krefting, 1991).

This university offers women's health services in its student health center. On campus, women have access to services such as routine annual exams, pelvic exams, breast exams, Pap tests, contraception, treatment of STIs, pregnancy testing, and counseling (The University of Alabama, 2020). However, these services are by appointment only.

Regarding the southeastern region of the U.S. where the university is located, it is necessary to note the reality of women's health within the current political climate. Specifically, when women need an abortion, they must abide by a policy which requires abortion providers to have a consultation with the woman, followed by a 24-hour waiting period before an abortion

can be performed (White, Turan, & Grossman, 2017). Additionally, many women in the state in which this study was conducted travel as far as 100 miles to an abortion clinic (White et al., 2017). These circumstances in which women live are undeniably relevant to the current study.

School health education standards in the state of Alabama include a list of minimum contents to be included in a sex education curriculum. These include information on abstinence as the only completely effective protection method and the "expected social standard for unmarried school-age persons" (Alabama Department of Education, 2009). Additionally, curricula must include emphasis on self-control, ethical conduct, and laws related to childbirth and parenting, to name a few topics (Alabama Department of Education, 2009).

Participants

Eight women were interviewed for this study. Inclusion criteria consisted of college aged (18-24 years old) women currently enrolled in the undergraduate public health program at a large southeastern university, who had not had the primary investigator as an instructor. Students were eligible for the study if they met these criteria and identified as a woman. Participant demographics and pseudonyms can be seen in Table 1 (Appendix E).

Recruitment

I selected public health students for potential participation because of their assumed background knowledge regarding health. This was an attempt to fill the gap in the literature regarding Feminist Theory in public health. Recruitment was done using convenience and snowball sampling via email, which can be seen in Appendix A. Convenience samples are used in research when participants are to be recruited from a "portion of the target population that is easily accessible" (Sharma & Petosa, 2014, p. 233). By allowing participants to assist in

recruiting other women who could be included in the study, snowball sampling could increase the reach of the recruitment efforts (Maxwell, 2013).

Public health students were recruited from classes other than my own since I also teach in the program. This was determined so that students would have had no prior connection to me in a student-teacher relationship, thus creating less of a power imbalance, though it would be impossible to eliminate since I was the "privileged knower" throughout the interview process (Nunkoosing, 2005). Feminist research acknowledges, however, that there is always some difference in lines of power, and identities and relations are never simple (DeVault & Gross, 2014, p. 217).

Data Collection

I used in-depth face-to-face semi-structured narrative interviews to collect data. An interview guide can be found in Appendix B. As part of a course requirement, I developed and used this interview guide in two doctoral courses in qualitative methods to interview undergraduate college women. Three women were interviewed using this guide for my courses. It was always a possibility in my mind that the guide could be utilized for this dissertation, so adjustments were made each time in order to improve the guide's usefulness.

Informed Consent forms for this study can be seen in Appendix C. Institutional Review Board approval was granted in September of 2019, as can be been in Appendix D. The interviews were conducted in locations of the participants' choosing, to which I agreed, such as my campus office and a quiet local coffee shop. Privacy is important for a sensitive topic such as sexuality, since "the interview makes public what is often considered private" (Nunkoosing, 2005), and thus was a priority for the duration of the study.

The most commonly used method of data collection in qualitative research, interviews allow the researcher to "communicate with people to create stories" (Nunkoosing, 2005). This method makes the most sense when the researcher has questions to which the answers require hearing people's thoughts, feelings, and experiences about a certain event, person, idea, or behavior (Nunkoosing, 2005). Interviews in research have been utilized often in social justice work, making them an especially useful method in feminist research, when considering the goal of telling women's stories of their lived experiences (DeVault & Gross, 2014). These tellings are not predetermined; rather, they are "emergent in the moment" and are shaped as much by the listener as by the teller themselves (DeVault & Gross, 2014, p. 213). Indeed, the interviewer and interviewee "are both changed by the dialogue of the interview" (Nunkoosing, 2005).

Narrative Interviews

The purpose of interviews in Feminist Theory is essentially for researcher and interviewee to collaborate in the meaning making process, regardless of their individual identities (DeVault & Gross, 2014, p. 216). This process of making meaning together is considered a rigorous process of subjectivity (Paget, 1983) and was applied in the current study. While there is certainly overlap among feminist interviewing and other ways of interviewing (Roulston, 2010, p. 22), there are certain data collection strategies that feminist interviews use which coincide well with Feminist Theory. One strategy, according to DeVault (1990, p. 101) is to use terms that the interviewee uses in their everyday life, rather than scientific or academic terms. In this study, the handwritten definitions of terms (discussed later in this chapter) allowed me to do just that and refer to sexual health and feminism in ways that made sense for the women. The main distinguishing feature of feminist interviews is that they are utilized to do feminist work and advance women's causes, while showing genuine interest in the interviewee

and having open conversation (Roulston, 2010, p. 23). To do this, the results of this study can be incorporated into sexuality education and health promotion interventions, as well as advocacy efforts to improve the lives of women.

In order to evoke stories from the women's experiences regarding feminism and sexual health, narratives make sense because of the political nature of the topic. In narrative interviews, women are able to share comfortably, allowing them to feel safer and more capable of sharing political thoughts than in more traditional interviews (Shelton, 2014). Narratives also work well with Feminist Theory -- specifically speaking of hooks' Feminist Theory -- because the fact that they are so language-based gives them the "potential to reach a wide range of people" (Shelton, 2014).

To encourage participants to share stories and recall experiences in as much detail as possible, I asked phenomenological interview questions. These types of questions invite the interviewee to go into detail and describe, tell, or talk about specific phenomena (Shelton, 2014). Often, they begin with "think about a time when" and end with "tell me about that." Framing questions in this way granted interviewees the opportunity to decide what stories they wanted to share, and the direction they wanted the interview to go based on the experience they were recalling (deMarrais, 2004, p. 57).

It is helpful for the rapport of the interaction if the interviewer acknowledges her own social identities, privileges, or differing locations rather than asserting similarities (Edwards, 1990). Rapport is sought after in interview research because it allows for more data (Nunkoosing, 2005), since participants are more willing to share. Simply asking and answering questions does not help to tell the story of women's lives, so I incorporated approaches to build rapport, from using phenomenological interview questions that allowed them to determine the

flow of conversation, to allowing participants to choose the location, and offering them beverages and breaks. I also welcomed the women to the interview space in as friendly a manner as possible and attempted to make small talk prior to any formal interview activities.

Rigor

To add layers and rigor to the data collection process, I asked interviewees in this study to provide written definitions of feminism and sexual health in their own terms at the start of the interview. I also asked them to draw a timeline of when they had heard about feminism and any events in their lives which they deemed important when discussing sexual health services and information-seeking. These concrete artifacts, which sat on the table for the duration of the interview, were visual tools for us to refer back to throughout the conversation; visual tools in qualitative interviews have also been found to aid in representing the data, enhancing data quality and validity, and facilitating the relationship between interviewer and interviewee (Glegg, 2019).

Member-checking was done by sending the findings chapter of the study to each of the participants to review. They were given one week to respond. This allowed the interviewees and I the opportunity to make agreed-upon changes to the product of the analysis together (Kidd & Parshall, 2006). In addition, informal member-checking was done at the end of each interview, to allow for both myself and interviewees to revisit what was discussed in the interview, and make necessary clarifications (Kidd & Parshall, 2006). Member checking -- which some call “member reflections” -- throughout the research process increases the quality of qualitative studies (Tracy, 2010).

I also maintained a reflexive journal throughout the data collection, transcription, and analysis process. This journal contained notes and thoughts, as well as biases that came to mind.

Expectations as well as reflections from interviews and coding were written. This reflexive process allows researchers to more clearly determine what they know and "how they came to know it" (Watt, 2007).

Data Recording & Storage

Interviews were recorded onto a USB audio recorder as well as my cell phone. Audio files from both devices were then transferred and stored on Box, a cloud storage account; phone files were immediately destroyed. Storing the files on Box was the most secure method, since it is a password protected software.

Transcription

Interviews were transcribed verbatim using the listen-and-type method. This method can allow for more accurate transcription than alternate methods, such as computer software. In order to hear precisely what is being said, as well as how it is said, the physical acts of recording, listening, and transcribing allowed me to listen to the conversation over and over again (Sidnell, 2010, p. 23). This way the "subtle nuances" could be heard and noted, providing an additional layer to the data to be analyzed (Sidnell, 2010, p. 23). It is the responsibility of the researcher not to attribute what is said by individuals to the exact lived experiences; rather, it is necessary to "address how the stories are told" (Nunkoosing, 2005). Transcripts were saved on my Box account and interviewees' identities were coded; only I had access to the files.

Analysis Plan

Overview

Analysis in this study aimed to make meaning of the talk of college women regarding their perceptions of feminism and their sexual health service- and information-seeking behaviors. This inductive form of analysis interprets findings from "close examinations of data" (Roulston,

2010, p. 150). Narratives are often analyzed thematically, allowing the researcher to compare and contrast topics that were brought up "within an interview or across multiple interviews" (Shelton, 2014).

Feminist analysis required that I be critical of my own efforts to involve participants and how I was hearing and "interpreting women's accounts" (Acker et al., 1983). The reflexive journal maintained throughout the research process assisted in this effort. By being reflexive, I was able to "connect theory and practice," and view the research holistically (Watt, 2007). More on the outcome of this reflexive process will be presented in Chapter 5.

Coding

Analysis began with coding. While there are many approaches to coding, in this study it involved identifying words or short phrases that captured the essence of a given portion of data (Saldaña, 2013). In the analysis of interview transcripts for this study, I entered units (short paragraphs or passages) of talk into one column of a spreadsheet. These units were what I considered to be complete portions of the stories that the women told, not the whole stories. I then entered initial codes into the next columns that described my interpretation of what was happening in that unit of talk. I entered these preliminary codes as I began to process the data, to avoid having to rely on memory (Saldaña, 2013). After initial codes were completed for a given interview, I entered final codes into a third column, which were identified from common preliminary or initial codes. These final codes were slightly less specific descriptions that I believed narrowed down the message that was being sent by the women.

Thematic Analysis

Codes are different from themes in that codes are explicit descriptions of specific segments of data, whereas themes are an outcome of coding (Saldaña, 2013). Thematic analysis

is useful for narrative studies because it allows for comparison of popular topics that come up within an interview or across multiple (Shelton, 2014). This analytical method allows flexibility to find other results, as well, by identifying similar codes and clustering them into groups, creating themes (Roulston, 2010, p. 150). To identify themes, I reviewed the final codes of all interviews and wrote memos of the messages that were being sent often. I thought through the many themes and noticed that the overall message of "seeking but not finding" was common to all interviews. Thus, the themes presented in Chapter 4 all relate to that message.

Found Poetry

Finally, found poetry is an analytic method that involves extracting words from interviews, and using them to create poems from the stories told by participants (Richardson, 1992). This method gained popularity in the 1990s among sociologists and was adopted by feminists to retain their participants' voices and produce evocative results (Butler-Kisber, 2017, p. 82). Glesne (1997) used found poetry to share the results of interviews with a professor of education from Puerto Rico and stressed the benefits of the act of combining the participant's and researcher's voice to create a nontraditional product, allowing the participant to "come alive." Feminist work lends itself to poetry due to the history of the women's movement pushing its causes forward with poetic writings by such authors as Adrienne Rich and Judy Grahn (Whitehead, 1996). In this study, found poetry was an effective way to represent the interview data and the women's perceptions of feminism since the narrative interviews evoked emotional narratives, the meaning of which was best conveyed using the women's own words. At times, I noticed the women themselves sharing emotion in their language, while in other instances it was me who was feeling emotion from the story. Nevertheless, I made the choice to portray those messages with the women's words using found poetry.

Specific Research Questions

RQ1: How do undergraduate women public health students at a large southeastern university describe their perceptions of feminism?

This question was analyzed through the interview transcripts. After reading and re-reading transcripts, I created codes and identified themes related to perceptions of feminism.

RQ2: What are the sexual health information- and service-seeking experiences of these women?

Through analysis of the interview transcripts, I identified codes regarding the descriptions of information- and service-seeking behaviors. Thematic analysis was done to answer this question. I also used found poetry to represent the women's perceptions using their own words.

RQ3: How do these women's perceptions of feminism influence their sexual health information- and service-seeking behaviors?

This question was answered similarly to the first two, with thematic analysis.

Subjectivities Statement

The researcher is not just that -- a researcher; rather she has other identities that align her with certain beliefs, presumptions, and groups (Nunkoosing, 2005). Considering the nature of this study, I am incredibly similar to the potential participants. I am a woman in my mid-twenties, thus immediately connecting me to this research. In addition, I am a middle class, heterosexual, white woman, making me demographically similar to most of the students on this campus. I also identify as a feminist, which is something that I had to remember may lead to bias or impact the interactions that I had with my interviewees.

The topic of this study was deliberate, because I have experienced and observed instances in my own life of women, particularly while I was in college, who neglected to take care of

themselves in the ways they should -- care that is recommended by health and medical professionals across the globe. I also noticed that many of these same women who did not access an annual Well Woman visit or get the HPV vaccine when they should have, did not feel empowered. They did not feel that asking questions about sexual health was "appropriate" or "normal." I recognize, now, that my health education background was a privilege that caused me to take this comfort with topics such as sexual health for granted.

Similarly, when I was in college, the #MeToo movement had not happened yet, nor had the Women's March. Most of the women in my life saw feminism in a negative light and did not themselves identify as feminists. Still, many of my friends and family members who are women have misconceptions about feminism, causing them to think of the movement as "radical" (in a negative way) and feminists as "man-haters." These women are generally seeking sexual health information and services much less often than the women in my life who do identify as feminists, or see feminism in a more positive light.

More recently, there has been a noticeable shift in attitudes surrounding feminism. Perhaps because I and the women in my life have gotten older, or perhaps because of the political climate and societal movements that we are experiencing, I see less hesitancy to discuss feminism and/or identify as a feminist. The women in my life who didn't know the answer to "Who's your gynecologist?" five years ago now have annual visits. This has made me incredibly curious, both as a health educator and as a feminist, about the connection between feminism and sexual health. I acknowledge that my own experiences are just anecdotes regarding the influence feminism can have on sexual health, and that this may not always be true; thus, the current study aimed to investigate these ponderings, with the ultimate goal of improving the quality of life of women.

Summary

Through a series of in-depth semi-structured narrative interviews, qualitative data related to the perceptions of feminism, sexual health service- and information-seeking behaviors, and the influence of the former on the latter were collected from college women at a large, public southeastern university. This information was analyzed using methods such as thematic analysis and found poetry to better understand the influence of perceptions of feminism on sexual health of college women. Chapters 4 & 5 present the findings and discussion of the study.

CHAPTER 4

FINDINGS

Undergraduate public health women were determined to be a population who have the knowledge and agency to speak of their experiences related to sexual health information- and service-seeking behaviors. These women's perceptions of feminism were considered worth investigating due to the potential connections of Feminist Theory's central tenets to health behavior. To gain a deeper understanding of these women's perceptions and behaviors, I conducted narrative interviews with the following research questions in mind, guided by hooks' understanding of Feminist Theory (hooks, 1994) as described in previous chapters:

RQ1: How do undergraduate women public health students at a large southeastern university describe their perceptions of feminism?

RQ2: What are the sexual health information- and service-seeking experiences of these women?

RQ3: How do these women's perceptions of feminism influence their sexual health information- and service-seeking behaviors?

The findings of the thematic analysis, as well as eight (8) poems created using the found poetry analytic method, are organized in this chapter by research question. This organization of research questions and corresponding themes and subthemes can be seen in Table 2 (Appendix F). I noticed an overall theme of "seeking but not finding" from the very beginning of the study, as is evident in my memos. "Seeking but not finding" was prominent among all interviews, so this

presentation of results will focus on that overarching theme. To select the data that would be presented in this chapter, I identified the most prominent themes which demonstrated "seeking but not finding"; these are the main themes for this chapter. Then, I identified subthemes by examining the most prominent focused codes within those themes. Only those instances within the data which apply to and demonstrate the "seeking but not finding" theme are included. I will discuss the meanings and relevance of main findings in Chapter 5.

Perceptions of Feminism

To evoke narratives related to the first research question, "*How do undergraduate women public health students at a large southeastern university describe their perceptions of feminism?"* I included the following question in the interview guide: "Think about the time when you first heard of feminism, and tell me about it." The women participants supported this dialogue with events that they had noted on their timelines. Upon analysis, I identified themes that related to the overall message of "seeking but not finding": 1) learning from family, 2) defining feminism, 3) feelings from feminism, and 4) frustrations.

Learning from Family

When asked about their first recollections of feminism, most women told stories about their mothers, aunts, or grandmothers talking about feminism when they were small children. These family conversations often sparked an interest in these women at a young age. They often identified instances of meaning-making when talking about feminism with their moms, which led women like Taylor to feel that feminism was a normal part of life. Taylor learned from her family, specifically her mom, that women are still seeking equality and it is something that should be strived for, saying:

> There was also kind of a background in everything my mom would say that … that we kind of had to like keep working on certain aspects. I mean, when I was young she definitely didn't talk about heavier things like the wage gap or how skewed domestic violence is towards women. Like she wouldn't talk about heavy issues like that, but just there was always kind of a hint that we were like still working on equality for women. But um, yeah, it was kind of just always addressed as like something that you should, should strive to be almost.

While this lesson in feminism provided a level of comfort and deeper understanding, it also showed Taylor that while equality for women is being sought, it is something that has yet to be found. This acknowledgement of the challenges that women face today is important to note. Many current health disparities, for example, could be discussed in the same breath as the struggle that Taylor was describing.

Defining Feminism

The conversation about feminism continued in most interviews with women describing the many connotations that come along with the word depending on the situation. Again, these stories were often events from the women's childhood or young adulthood when they were beginning to seek an understanding of what it meant to be a feminist in today's world. In an effort to expand on these understandings and perceptions, many women turned to discussing what feminism is *not.*

Connotations of Feminism

Most women acknowledged that not everyone agrees on the topic of feminism, and some people have very negative connotations of the word itself. Lauren and Taylor described specific experiences they had had with others regarding feminist identity, and the feelings and

connotations that come along with that. In both instances, Lauren and Taylor described that they did not understand or agree with the negative connotation. Lauren told a story of hearing about feminism from boys at school, saying:

> Boys would be like, 'Oh, you must be a feminist.' And I was like, 'What does that mean?' And I was like, 'No I don't, I don't know what that is. I don't want to be whatever that is. 'Cause you said it like that.'

Lauren went on to explain that she felt that she should have had more knowledge about feminism before boys her age. She was describing seeking an understanding but finding only false information when she said "it was already being handed to me in a negative way." Now, as a young adult, Lauren explained that a more accurate definition of feminism should be provided for young girls in order for them to understand what it means for them as they grow up as women.

Similarly, Taylor described the "horror" around the word "feminist" when used by a friend:

> She was like, (whispers) 'Yeah, I'm pretty sure she's a feminist' and stuff like that. And I was like, are you, are you joking? This is not a bad thing at all. And so I feel like it's a curse word. She said it with like such a horror around it.

Taylor also emphasized that the negative connotations held by some people about what it means to be a feminist is dangerous and misleading. Her example and using the word "horror" demonstrate the misinformation that exists surrounding feminism today.

What Feminism is Not

Women often resorted to describing, based on their experiences, what feminism was *not*. Rachel and Lauren's descriptions of what feminism is not depicted their essential narrowing

down of information regarding feminism in their search for the truth. Lauren explained that she learned what a feminist is *not* when she finally saw what a feminist *is* in her teachers, who she described as "very liberal":

> I learned from them what a positive image of a feminist looks like. Someone that educates and not yells, but there never was anyone yelling in the first place. It was just my perception of it.

Lauren had been living with the understanding of a feminism as someone who yells, but now describes a feminist as someone who educates and *not* yells. She had been seeking this clarification but had not found it until her experience with those teachers. Because of this, she had an inaccurate representation of feminism in her mind. It was not until she saw what a feminist *was* that she realized what a feminist was *not*. This showed her the values that she had been missing out on.

Rachel took the opportunity to debunk the assumption that feminism is essentially a pass for women "just because they're women," saying "Feminism isn't about women should get this just because they're women you still have to work just as hard but we should be able to do whatever we wanna do because we work hard." Rachel, like many other interviewees (n = 5), emphasized the importance of opportunity to do hard work and strive for success. This made shutting down what feminism is *not* a common theme that I identified in her interview.

Feelings from Feminism

In addition to defining feminism for me in their own words, participating women often discussed how feminism made them feel. These feelings were overwhelmingly positive, as they described that they felt empowered to both take control of their lives as well as talk about

feminism with others. Women also talked about feeling the right to be independent and make their own choices in their futures, because of their perceptions of feminism.

Empowerment

Interview participants (n = 7) often described feeling empowered – whether they used the word "empowered" or it was my interpretation of their words. They told stories of feeling empowered to discuss women's issues with others when they had adequate knowledge. They related this to feminism, many by explaining that it meant they could use their voice as women confidently. Madeline, who defined empowerment as "giving tools like support and encouragement to people so they have power," described that her understanding of feminism and the history of the women's and civil rights movements "encouraged" her because those groups of people, like women today, were "just searching to be equal."

Lauren told a story about a conversation with a male classmate about women's health issues, saying she felt comfortable actually debating the issue with him because she "had more actual information." For her, feminism was about knowing other women's stories and having empathy, which empowered her to speak up. She described:

> At this point in my life I've heard from so many women that I know personally that I was able to like draw from their experiences and be like, I know that you think that all women are doing this or whatever. But I know five women personally that've told me about this … And so I was able to give him like real life examples. I think that helped cause it's always like statistic based and sometimes like I think people just need to hear like from someone personally to really understand like, I don't know, like the statistics aren't there to like manipulate you. It's just like what's happening.

For Lauren and Madeline, feminism meant feeling empowered to share truth and seek equality and understanding, in themselves and others. While this search often comes up short, both women emphasized the feeling of empowerment that they get from feminism and knowledge about feminism. In public health and health education, these feeling of confidence and empowerment to discuss issues that may sometimes be uncomfortable or against the norm is crucial.

Independence

Participating women (n = 5) also described feminism as the right to independence and making one's own life decisions. Gabrielle explained that for women today, seeking independence often only leads to not meeting society's expectations. However, her understanding of and goals for feminism make room for this independence and freedom for women, as she described:

> The things we want, not, like I said before, like not every woman wants to just work a regular job. Some women want to be entrepreneurs, some women want to be stay at home moms. You know, like some women want to travel and don't have kids, like whatever that is for their desired goals and their desired lifestyle.

Gabrielle's explanation of why she thinks independence is so important shows that seeing feminism as a positive thing can have a freeing effect on women's livelihood. In her description, she acknowledged that the alternative means women are locked into traditional, stereotypical gender roles. Similarly, Emily explained feeling judged for wanting to make independent choices about her future, but connected that choice to feminism, describing:

> I never want kids, which I guess that that plays into feminism because that pisses me off so much … whenever I tell people I don't want kids, it's always like you'll change your

> mind. And I've also had like a doctor that we went and saw during, um, when I was in high school, we got to go on a cadaver anatomy trip. And he told, he basically said like, girls shouldn't be doctors. 'Cause the second you get out of medical school, you're going to have a kid. I don't want to take care of that.

Emily's feelings regarding feminism tell her that she should have the independence to make choices for her future without being judged. However, the reality of being judged and being expected to have children is another example of her seeking what she knows to be right for her, but not finding the acceptance that she feels she deserves. She sees feminism, like Gabrielle, as a freeing mechanism that can allow women to feel okay about being independent.

Frustrations

I noticed that when women told me about their understandings of feminism, they expressed frustration. The misunderstandings of feminism, as well as the reasons that they felt that feminism was so necessary, caused much of the conversation to have a frustrated undertone. The main cause for this appeared to be gender inequality.

Gender Inequality

These women were frustrated by certain issues that are central to feminism. Gender inequality came up often when women were describing what frustrates them and emphasizing the importance of feminism. Madeline and Taylor described seeking and expecting equality, but finding reinforced gender roles -- no matter how old they were at the time. Taylor began her interview with a story about when she was four years old and frustrated that she could not be a Shriner, because as her mother explained to her at the time, they do not allow women. Taylor said her mother tells the story saying the four-year-old was angry, describing:

> Already I was mad that like there were organizations that didn't include me because I was a girl ‘cause I said she talked about like how they help children in hospitals. I was like, ‘Oh, I want to do that.’ And then she was like, ‘Oh, well it's an only male organization’ and I got really upset apparently.

While this story took place many years ago and Taylor only recalls the story as her mother tells it, she went on to explain that she thinks those values have always been central for her, and gender inequality still frustrates her today. The fact that there are still instances when women are not allowed to participate simply because they are women, or that they are denied certain privileges for that reason, was a point of frustration when these women discussed the need for feminism.

Similarly, Madeline recalled an instance when she was in a hospital and gender inequality caught her attention, describing:

> I noticed that, um, a bunch of surgeons were on break and every single one was a boy. And that just like really upset me. Um, because it just, I don't understand. Um, and so like, just like little things like that have definitely driven me.

The emotional reaction to seeing gender inequality in the workplace is an example of the effect of the seeking of equality but not finding it -- only finding reinforced gender roles, and in Madeline’s case, more inspiration to continue striving for the feminist value of equality. It appeared that frustration, stemming from feminist values, can actually be a spark that would light the women’s path for their futures. This is just one example from these interviews of the positive effect that feminism can have.

Sexual Health Information- and Service-Seeking Experiences

To address the second research question, *"What are the sexual health information- and service-seeking experiences of these women?"* I asked women questions such as, "Think about your experiences with sex education, and tell me about them," "Think about a specific time when you had a question about sexual health, and tell me about it," and, "Think about the ways that you feel about seeking sexual health services, and tell me about it." This dialogue, like that which supported the first research question, was often supported by events from the women's timelines. When presenting findings related to information-seeking, I will include both active and passive forms of information-seeking together, because those are the types of behaviors that the women's stories focused on. Upon analysis, the themes that I identified that relate to the overarching theme of "seeking but not finding" and answer the second research question were: 1) barriers to services, 2) need for communication, 3) community, 4) education and knowledge, 5) frustrations, 6) information, 7) sociopolitical factors, and 8) types of services. I used the women's own words to best portray the findings regarding the theme "frustration" by creating found poetry.

Barriers to Services

A common barrier to services experienced by these women was due to their being at school for the majority of their time, while their gynecologists were in their hometowns. Having a doctor at home but not being able to access their services during the school year caused problems with women's contraceptive prescription access, and the timeline of when they needed another visit and new prescription. This caused added stress for women like Lucille and Lauren. Lucille described missing her summer appointment and not being able to see her provider until the following spring, as she explains:

> I straight up didn't go to the doctor this year because I missed it because I was down here because I'm from like two hours north … so my doctor's over there and I missed my appointment because it was on like the fifth of August and I was down here working and they didn't like call me or anything which is weird … I called them and I was like 'Oh can I make another appointment?' and they were like 'Oh yeah uh we have an opening in April.' I was like 'Oh okay.' So now I'm just going without birth control currently.

Lucille's service-seeking experience while at school is very similar to Lauren's experience of seeking but not finding when it came to accessing contraception:

> So then I just kept taking birth control until like actually two weeks ago. Then I stopped because … I was just having trouble getting my prescription refilled and I gave up … Because I want to go see my gynecologist back home, but with my work schedule, school schedule, group projects, all of that, it's really hard to get back home on a week day and that's the only time they're open.

Lauren, like Lucille, has a gynecologist to whom she wants to go for services, but the barrier of distance while at school keeps her from being able to renew her contraception prescription.

In other instances, there is a physical barrier -- an actual locked glass box. Rachel told a story of going with her friend to seek emergency contraception from a drug store, but found these extra barriers. To access the emergency contraception pills, she explained "you have to bring it up to the front desk" for the cashier to unlock before you can purchase it. Rachel described this as excessive, saying that when people are seeking emergency contraception, "Why can't you just let people do it as low key as they want?"

Other women, like Madeline and Emily, told stories about the social barriers faced when seeking services. These women described feelings of shame regarding sexual health in their

hometowns, and for many of them talking about things like birth control and gynecologist appointments was unacceptable in the eyes of the adults in their lives. Madeline explained that while there was a free clinic in her area where high school girls could have gone for contraception without their parents, the risk of being caught, and "uncertainty of if it was actually not legit but like the same kind of thing that you would get from your doctor" prevented most girls she knew from seeking their services. She went on to explain:

> One of my friends has a chronic illness, so she was worried, like they might not necessarily know how it interacts with that if they're only educated about like the birth control, um, or the contraceptives. So I know like for her that was an issue. Um, I feel like for some of my other friends it could have been like that their parents, they were worried their parents would find out.

For Madeline and her friends, there were simply too many barriers to seek contraception. The fear of what their parents might do, say, or think was too great. Emily reiterated this concern of keeping birth control a secret from parents, and the barrier it presents, describing:

> How are you going to hide your birth control if like, your family's against that? Like, how are you gonna have like your pill pack that you take every day and when are you going to take it? Like at the school?

This conundrum of when to take a daily birth control pill, which Emily was explaining, creates yet another barrier to taking contraception, and thus seeking the service altogether. Emily was putting herself in the shoes of women who were not allowed by their parents to seek contraception and would then have to take it secretly. She explained that this would be incredibly stressful and understood that many women would just rather not to use contraception at all.

Need for Communication

Often, participating women told stories about the lack of open communication regarding sexual health in their lives. However, this caused them to emphasize the importance of and need for communication in order for people to be healthy. Lucille described what children and teens are often seeking when they talk to adults about sex, saying they want adults who care about their health enough to have a conversation about sex. Most children do not find this, as she described:

> Instead of talking to your kids about 'Don't have sex until you're married,' I think we should start the conversation with like, 'Hey I don't feel comfortable with you having sex until you're older and can make those decisions, but if you are I want you to be safe.' I feel like safety's a much greater concern.

Lucille went on to ponder the possible reasons for the lack of open conversation, and reiterate the seeking but not finding of many of today's youth, saying:

> It's just like a cycle people don't wanna talk about it so then they feel shameful when they do talk about it … cuz the last person that talked to them about it … our teachers were uncomfortable talking to us about it so we just thought it was an uncomfortable subject … but when we talk about it we're also like well is this okay? We just need to change the conversation I guess.

As Lucille explained, the cycle of shame and deferring conversation about sex is perpetuating from generation to generation. She identified this as an area that must change in order for people to be healthier.

Emily's sentiments about the need for young adults to have somewhere to go when they are seeking information and services without feeling ashamed summarize the subtheme of a need for communication:

> Normalize it and make it not so taboo like I was used to. That's important, um, for people to be able to talk about stuff and come in. Like I think that's super important.

This perspective was also seen in Lauren's interview, when she described:

> When I started going through like weird or different experiences, like on my timeline, it just made me realize that I wished that there were more people that were there to like answer those questions or like guide you or like give you more solid material for that.

Lauren's wishes for more open conversation illustrate her experiences of seeking information and guidance, but not finding what she knows she needed. As these women demonstrated, it is far too difficult to find the answers and information that is needed. They emphasized their hopes that people who have the information will become more willing to share.

Community

Many times, women described seeking information and learning about sexual health services from other people in their lives. This was very common on the women's college campus, as well as in their family. However, not all information- and service-seeking experiences were positive. Rather, they served as more examples of seeking but not finding, as the women explain below.

College Experiences

In our conversations about information-seeking, many women explained their reactions to learning about sex or sexual health in college after having experienced much seeking but not finding while they were growing up. Elizabeth, for example, talked about realizing the reality of

sex in college, saying, “Everybody's having sex, a lot of it.” She went on to explain that she had to learn how to take care of herself quickly, but encourages sexual health responsibility among her friends, as she described:

> Like my friend, um, she had to go to the doctor ‘cause she thought she had strep. She went out to like urgent care. And then, um, I was like, Oh, how was your visit? Like did they tell you what you have yet? And she was like, no, they don't know what I have. But while I was waiting, I decided to get STD tested. I'm like, good for you … And she was like, I'm clean. And I was like, yeah, high fives.

Many women (n = 5) described this sexual health responsibility when it came to being a college student. Emily described being glad that she is surrounded by people who try to normalize safe sex, which is very different from the seeking but not finding atmosphere in which she was brought up. In her words, campus events promote contraception so much that it seems as if the message is, “Here's some condoms, take a billion.” In both of these instances, these women were explaining that their prior service- and information-seeking experiences led them to not finding what they needed, and in turn provided a shock when coming to college.

Family

Some women (n = 4) learned about sex from their family, often because they were not learning about it in school. Lucille had older cousins and said she “got all of their hand me downs and all of their conversations.” For her, much of her sexual health information-seeking was done through her cousins. She described:

> That’s actually like besides TV all of my sexual education came from them because they had experience.

Other women who did not receive the information they needed in school turned to their moms, as Lauren described:

> I was like, 'Okay mom, I need you to help me. I don't know where to go. I don't know what the issue is, but I need to like go see someone, do I need to see a gynecologist or do I need to go to primary-' 'cause I wasn't sure and she's the one that like helped point me in the right direction.

Madeline also sought information from her mom about contraception but explained that she wishes her mom had been more open to talking about sex when she was younger. She described:

> My mom, she was like, 'Yeah, I mean I was on birth control for like all of high school.' But she had never said anything where it would've made my sister and I more comfortable to kind of talk to her. Um, and I feel like that's just something that would have been nice to be more open about because I do think a lot of people are, I know a lot of my friends didn't start till college just because they were like too scared, um, to, to bring it up to their parents.

Madeline expressed sadness for what she considered a missed opportunity. She sought this information from her mom but did not find what she needed until later.

Lauren and Madeline also both expressed gratitude for their older sisters, who had served as information sources when they were seeking information or help. Lauren, whose sister is married to a doctor, explained that she was glad to be able to "have a consultation" comfortably, since she does not get the necessary information elsewhere. Madeline's sister, who as she described "goes through all the hoops first", talked to her mom about Madeline needing contraception:

> My mom actually approached my sister and asked if I needed to be on it, which again my sister took had to take the awkward conversation fall.

Of course, not all family conversations ended with women finding what they sought. Elizabeth was particularly upset with how her conversation with her mom went. She described:

> I was having a lot of like period trouble. I was like, 'Mom, I can't be doing this.' And so I tried to talk to her about like going on some form of birth control to help with that. And she basically like threw back in my face and she was like, 'I'm worried that you're going to use it to be a whore.' And I was like, 'Oh, thank you Sandra for that, that, that wasn't very nice of you.' So I just like dismissed it as like whatever a guess, that's not happening.

For Elizabeth, like Madeline, not being able to talk to their moms about contraception was disappointing. They knew they should be able to seek information from their parents, but found only challenges. It appeared that while family was a valid source of information for some of the women, as described above, their search still did not yield the results that they were hoping for. Rather, women found feelings of discomfort or shame, or resorted to asking other family members instead.

Education and Knowledge

When discussing possible reasons for seeking and not finding what they needed for their sexual health, women talked about their education experiences and what changes could and should be made to improve the sexual health of women. As I identified this theme, the message became clear: there is a need for improved, quality sexuality education. This was evident to me upon listening to women's stories of abstinence only education, their description of the

importance of education in general, and their opinions of their insufficient sexuality education experiences.

Abstinence Only

For women whose school-based sexuality education prior to college was abstinence only, much of their discussion focused on their views of such education as ineffective and/or problematic. Gabrielle told a story of having to sign an abstinence contract in school. She described:

> Yeah, I guess I'm a very logical person … So things that are pushed that aren't being realistic is kind of problematic. It's heavily problematic actually. So yeah, like signing, it was just a deed I had to do to get a grade. Not because, not that it was something that I didn't want for myself or something that I wasn't aspiring to be, but it just, it just was not realistic.

As Gabrielle explained, it was not the idea of being abstinent that was problematic in her eyes, but rather the fact that she was required to sign the contract and was taught nothing else. When other women talked about their abstinence-only education experiences, they described that this lack of learning regarding anything else having to do with sex is what sticks with them today. Lauren described:

> They were like, 'Don't have sex. Put your hand in each other's pocket.' And those were the two things that I remember.

Madeline's experience with a religion-centered abstinence-only program had a similar effect. She described:

> We didn't have the conversation about other options for birth control other than abstinence. So then there was definitely that risk of like, people were too afraid to talk to

> their parents about getting on birth control and things like that, which like I definitely can speak to that because I was terrified. Um, and I think that that was kind of just an unhealthy, I understand it was part of our religion. Um, but also like, I feel like it's better than the alternative.

Emily described her abstinence-only sexuality education as too little, too late, describing:

> We only learned about abstinence and that was freshman year, which also seems super late now in retrospect. I mean, um, people have sex in middle school, like, um, so I definitely think that that should happen earlier, but yeah. Um, freshman year abstinence, so we didn't learn about birth control. We don't learn about, you know, like rates of anything, STDs or anything.

For many of these women, they did not find the quality, comprehensive sexuality education that they wish they had gotten. Rather, they found only a few memorable but uninformative lessons that do not serve them today as young adults. Through their stories, women told me that they felt they were deprived of the comprehensive information that they needed.

Importance of Education

Many women discussed the importance of education when talking about their experiences with seeking -- but not finding -- sexual health services and information. As children, these women placed trust in their teachers, but described that in hindsight they were let down. Lucille described:

> I was very like she’s gonna tell me everything I need to learn, like ever. I have a lot of trust in teachers and I was very like I read all the time and I did all my homework, um and so if my teacher wasn’t gonna talk about it that means no one’s gonna talk about it to me. ‘Cause my dad sure as hell wasn’t gonna talk about it and my friends didn’t know

about it ‘cause they went to the same school as me so they were getting the same education as me.

This trust in her teacher is important to acknowledge, because it shows the impact that teachers have on children from a very young age. Lucille’s story emphasized the fact that since family is not always the primary source of information, educators have a responsibility to provide that information in school.

Women also emphasized the importance of education by describing more examples of seeking but not finding. Taylor told a story of being in a college health class and being shocked by some students’ lack of knowledge, saying about a student who did not know what an STI was, “You're 18 like how do you not know?” But these stories were not always about young adults. Emily explained her reaction when she realized her mother did not know about female anatomy and the “three holes.” She described:

> My mom didn't even know like that just made me so mad. I'm like, mom, that is your body. I think that shows a lack of education in our system. But like you need to be aware of what's going on down there. ‘Cause how are you going to know, like if, um, you're having like, is your bleeding vaginal or urinary? Like if there's a problem, do you even know the difference? Um, do you know what your cervix is? Do you know different things to look for? Um, in terms of keeping yourself healthy or like knowing which way to wipe? ‘Cause that's just like, that's an actual issue.

Emily said this acknowledgement of the importance but lack of education is what made her “really passionate about education.” She explained that many people do not have the resources and cannot seek information at home either, making her ask, “Who are you going to go to?”

Other women also acknowledged that people are lacking options of where to seek information, thus emphasizing the importance of education. Elizabeth explained that knowing the many options of contraception is something that she values because some methods would not work for her, but she did not know that in high school. She described:

> I didn't know that … it comes down to education. Like not everyone knows what it does or what the options are or anything of the sort.

Elizabeth was explaining that she would have been grateful to have had this education growing up. Some women were that lucky and acknowledged that privilege of having quality sexuality education. Rachel's sexuality education was relatively good, in her opinion, and she now sees how important that was to her overall health. She described:

> I took my education so much for granted. Going through school … I kinda just assumed that they were all like set at a standard and we all had to follow that but that is not the case obviously. So it changed my mind a lot on the disparities in other people's education and how that affects what they think about sexual health. Like we've learned about HIV and things like that it's just a lack of education and knowledge on the subject.

Having this knowledge now about the importance of education, some women explained that improvements can be made to create a better reality for future students. Lauren described:

> If I could like develop curriculum that was better than the Gift of Life program that I was given, then maybe I could make some like really informed eighth graders and then I would be interested to see how that would influence the rest of their life. So I think, um, I just think education is very important and I've learned being here that people need just more education.

As Lauren explained, being young adults has shown these women what they should have known, but were never taught.

Insufficient Sexuality Education

The above examples portrayed the subthemes of the impact (or lack thereof) of abstinence only education and the women's opinions of the importance of education. In this section I will provide examples of the women's feelings as a result of what they considered insufficient sexuality education. Those women who considered their sexuality education experiences insufficient often discussed the fact that they knew or had some idea of what they should have received, but what they did receive just left them needing more. When asked about her sexuality education experience, Lucille, who went to Catholic school, described:

> Oh hoo. I grew up in Catholic school for elementary school um which ah god sex ed is … there's a lot of work to be done there, um which is good because at least people realize it and they're like this is not good.

Lucille's statement that "there's a lot of work to be done there" shows that the education that she received was insufficient. However, she noted that while she did not find her education practical, there are clear areas for improvement. Many women expressed this feeling of hope for improvement, because their experience and those of people they knew were so lacking. Gabrielle explained the poor quality of her sexuality education, describing:

> Education, public schools or just in general in the U.S. is like horrible. So it, it showed we have like different sections of it and it was like a PowerPoint and some videos that were like, from the 90s and pictures, it was just like, this is what this is, you know, and just don't have sex. And that's just not personally now as an adult, that is not healthy at all.

Again in hindsight, Gabrielle sees the unhealthy nature of her insufficient sexuality education. Taylor described similar insufficiencies in her experiences:

> We only had to take one more official class after that in high school. And that one was more just like textbook based, like information. And they literally just say like abstinence is the only way, is the only method that's 100% effective against or 100% effective birth control and against STDs. So that's like all they say.

I identified Taylor's description of "that's all" as meaning the education she received was insufficient; she was left wanting more. Women like Gabrielle and Taylor expressed feelings of dissatisfaction with what they had received. They explained what they wished they had learned in their sexuality education, and the impact of not learning enough. For example, Madeline described:

> That was definitely a struggle in high school just because it was hard to know kind of where, what was reliable and what was without going to the doctor and then having to explain why you needed to go to the doctor and that kind of situation because you never really were taught about how to find those things.

As Madeline explained, it was often not health content that the women were lacking, but skills regarding how to seek information, and where to go for help that made their sexuality education insufficient.

Frustrations

When telling personal stories of their own experiences with sexual health service- and information-seeking, many women shared emotional and passionate perspectives. In an effort to share their message using their own words, I will present the theme of "frustration" using found poetry that I created from the women's interview transcripts. To do this, I read the segments of

interviews that were coded for each subtheme, and selected words or phrases that the women said which were most evocative, descriptive, or emotional. I chose found poetry to present the findings for this theme because of the emotional stories that the women shared with me. This is what found poetry is best used for: retaining participants' voices while producing evocative results (Butler-Kisber, 2017, p. 82). Additionally, my decision to use this method was guided by hooks' Feminist Theory. As previously discussed, hooks emphasized the benefits of using language to disseminate information because it is so powerful and accessible (hooks, 1984, p. 110-111). She also encouraged the use of language, such as narratives or poetry, when the experiences being shared are "particularly difficult" (hooks, 1994, p. 174-175). As can be seen below, many of the women's stories were about difficult experiences in their lives. I identified subthemes of "hush hush," "seeking but not finding," and shame in sexuality education for the "frustration" theme. Following each poem is my interpretation of it, which aims to further explain the woman's message.

“hush hush”

From Lucille

“hush hush 1”

I guess that’s just how it is

Hush hush

Not an open and honest conversation

About anything

Without any kind of base

How they should be treated

Should look for

Watch out for

Interpretation: Going to the gynecologist is veiled in mystery as described by Lucille. She explained the feelings associated with these visits as “hush hush,” because no one wants to talk about it openly. This causes women to have no basis for what they should be expecting or looking for in choosing a provider or seeking services.

From Madeline

"hush hush 2"

Abstinence

Nobody talked about it

Everybody knew it was happening

We didn't have the conversation

Options for birth control

Abstinence

Risk

People were too afraid to talk

About getting on birth control

I was terrified

Unhealthy

Swept under the rug

Don't ask, don't tell

Hush hush situation

Interpretation: Madeline explained the effects that abstinence only education had on contraception seeking for teens in her hometown. She expressed her frustration with the lack of conversation and the unhealthy approach to sexuality education.

From Elizabeth

"hush hush 3"

We've had that conversation

Many a times

But it's one of those

Hush hushed

If you're pro-life

Don't talk about your views

The thing is

I feel

That it is not black and white

Interpretation: Elizabeth is frustrated by not being allowed to voice her own thoughts on abortion services. These frustrations are continued in the following poem.

From Elizabeth

"Grew up in a small town / I have a lot to say"

I grew up in a small town

Went to Catholic school

If your beliefs weren't

Far right

Conservative

You were wrong

One of those things

Don't talk politics

Don't talk your beliefs

I have a lot to say

Interpretation: When expressing her frustration surrounding the ability to communicate about sexual health services and information, Elizabeth explained that the feeling in her small hometown was that there was only one "right" way of going about one's life. She went on to say that this led her to view a lot of things differently, and that now she has a lot to talk about regarding the issue.

"seeking but not finding"

From Lucille

"seeking but not finding 1"

'Cause you're a bad person

Sex before marriage

Women should know

Uncomfortable

Trouble

This is how it is

I didn't know any better

Seeking but not finding

They just don't know

Interpretation: Lucille explained that sex and sexual health service seeking are accompanied by shame. Women are not sufficiently educated about sexual health, so they do not know what they should be finding when they seek services. This lack of knowledge, according to Lucille can make service-seeking uncomfortable, and can lead them into health trouble because they simply do not know the answers.

From Lucille

"men have sex and women get sex done to them"

Family didn't educate you

Have no education

Trouble

Men here

Grown up thinking men have sex and women get sex done to them

Unhealthy

Terrible

She might be unhappy

He might be unhappy

But they're not gonna talk

Interpretation: When discussing the importance of knowing where to seek information and services, Lucille described the importance of sexuality education including relationship education, and the impact of a lack thereof. She explained that sexist understandings of relationships cause children to become adults who do not know how to have healthy relationships, and do not know where to go for information that would help them.

From Lucille

"my daughter"

I would feel really bad

If my daughter

She doesn't know

Super sad

She's just gonna feel worse about herself

Frustrated

She can't find a doctor

She doesn't even know where to begin

Interpretation: The impact of lack of sexual health knowledge when students come to college was a concern of Lucille's. She described that she worries that not knowing where to find help will hurt young women, and empathizes with parents of college women.

From Lauren

"seeking but not finding 2"

Worried

Panicking

And I called

Tried

They just did not respond

So hard to get in touch

I need to

Get this figured out

Interpretation: When telling the story of her STI scare, Lauren recalled the frustration of trying to get in touch with the student health center for help and not succeeding in a time of worry and panic.

Shame in Sexuality Education

From Lucille

"a terrible question"

We would all write questions

She'd read 'em from a box

"I won't read if they're not appropriate"

I asked on a piece of paper

In fourth grade

And my question didn't get answered

It was a terrible question to ask

Maybe I shouldn't have asked it

Interpretation: Lucille told a story of asking a question about sex in elementary school that her teacher did not answer, after saying she would not answer inappropriate questions. This made Lucille feel that her question was shameful and inappropriate, when she was only seeking information from her teacher.

From Taylor

"the point was made"

I remember being so angry

Only girl volunteers

They had them unwrap a mint and put it in their mouth

Then spit it in a bag

Walked over to the guys

Asked if they wanted that mint

Or a brand new wrapped mint

Use that as the example

You don't want to sleep with somebody that's not a virgin

It was horrible

These girls

They didn't tell them what they were doing

The point was made

Lick this piece of candy

Offer it to guys

In front of everybody

Just horrible

Interpretation: Taylor's story of sexist sexuality education and the shame that was placed on girls in order to teach students about virginity made her recall feelings of anger. She described feeling frustrated that that was what students were receiving for sexuality education.

Information

When seeking information about sexual health, since women described rarely receiving what they needed to know in school, many reported going to their friends, the internet, or media outlets to teach themselves.

Information from Friends

In instances of seeking but not finding, women often turned to their friends to find what it was that they sought. Lauren described learning from her friends during an STI scare:

> Well I was trying to do it on my own and I was trying to get the student health center, 'cause I know for sure that they did like testing and they could help and when I couldn't get ahold of them I was like, um, I'm not sure where do I, where do I go from this point? And I asked my friends and they're like, 'Oh just go to a clinic.'

Lauren explained feeling lost when trying to take care of herself. Her friends ultimately pointed her in the right direction, after not being helped elsewhere.

Similarly, Elizabeth learned about contraception from a friend when she was having trouble with the method she was using. She described:

> I like met my friend Bryce. I was like talking to her about just kind of about it in general. And … that was whenever she mentioned like, 'Oh yeah, like I have an IUD, it works for me like much better.'

In conversation with friends, women often learned what they needed to know about sexual health that they were not finding elsewhere. Emily described learning by "hearsay or friends who are more mature." She went on:

> And then just like gossip at school, you kind of learn what stuff is like, did you hear? She did blah, blah, blah, blah, blah. And I'd be like, what's that?

These examples show the women learning about basic contraception information or other sexual health facts from their friends. Sometimes, however, the gossip and learning from friends was not entirely comfortable. Emily described an STI scare:

> The reason that I even found out that like he had something was at like, I worked at a ski resort that a bunch of high schoolers worked at and like I walked into the break room and when everybody started clapping at me and I was like really confused. Like I didn't even know that like gonorrhea is called the clap and then somebody like explained it to me.

In this example, Emily had not been taught about STIs. It took a rumor and being taunted by friends and coworkers for her to learn about what might have been a serious health issue. This is another example of the effects of women seeking but not finding the information they need.

Internet

When women had questions and did not know where else to go, they explained their turning to the internet. Often women went to the internet for information because they were not getting the information they needed elsewhere. Gabrielle described:

> There's a lot of questions that I had about my body. I'm like, I don't know what's going on. And I get like, I wasn't taught sexual health at home, so I had to figure that out like I said by myself and like, whether it's Google, whether it's YouTube videos, whether it's asking friends, um, that's just how it happened for me … There's a lot of information. It's like on web MD like you get a cold and like, it's like you're supposed to have cancer and it's never, you don't know what's for sure.

Gabrielle acknowledged that the internet is a risky route to take when she needs information. I noticed many instances when women explained that they knew that some sources of information

on the internet were not reliable, but they still used the internet as a source of information when they needed it. Taylor described:

> From sources like CDC and Planned Parenthood you get pretty like just by the book, procedure information from it. It's not like, I mean I feel like a lot more information on the internet could be more opinion-based, which is where you get a little dangerous.

This uncertainty and acknowledgement of the risk in seeking information from the internet is another example of women seeking but not finding exactly what they are looking for, or what they know they need. While they are seeking information when they need it, they find a sense of uncertainty rather than confidence. The problem remains that some people are unaware of this risk.

Media

In other instances, women learned about sex from TV and movies. Again, they discussed that they know that these sources do not send the best messages, but they are learning from them nonetheless. Lucille explains:

> I watched the worst shows in middle school and like my dad had no idea, like I watched Degrassi and Skins and it was the worst thing ever and I would never want my kids watching that. But that's where I got all my information from. Which is terrible, well actually that was actually pretty good because now I know like hey use condoms, STDs are a thing, pregnancy, here's what you do in case that happens, here are the resources.

Lucille acknowledged that her educational experience from TV was not ideal, but it was one way for her to find what she was seeking. Other TV shows were mentioned by women, like Emily who said she learned about sex from That '70s Show and the Dr. Oz show. Additionally, Lucille went on to describe what she learned from a favorite movie:

> I was watching Juno the other day for like the ninth time and I remember her going to the clinic, and I think that my education from that 'cause even like it shows that she's going in for an abortion- she doesn't get it but I guess it was just like 'abortions are skeevy' and 'women's clinics are skeevy you shouldn't go there 'cause you're a bad person and that means you're having sex and if you're having sex before marriage then ew' so a lot of it is just people women should know there are resources and what those resources are.

In this instance, Lucille explained that there was a negative message being sent from the movie, but that it taught her about women's sexual health services nonetheless. Her message seemed to be to take information from media with a grain of salt.

When it came to social media, women emphasized the caution that should be taken when finding information from certain sources. Taylor discussed the "skewed ideas" that can be portrayed on some social media sights if people are not cautious:

> But I feel like a lot of people stop at the social media and then they get like skewed ideas about sexual health or sex in general. And so I feel like you kind of have to, you have to be careful with what you figure out. And again, there is good information out there, but if you're just looking at it on social media base, I feel like you can take incorrect or skewed information and believe it and not like understand.

Again, this example sends the message that if people do not know how to identify reliable sources, they may believe everything they see online. Taylor explained that she sees social media as a double-edged sword for this reason. Similarly, Elizabeth cautioned against the "propaganda" that she has seen on some social media platforms:

> And like there's this one girl that I had to unfollow her like last week, she's a senior this year I'm at my high school and she's like very pro-life, which is like fine, you have your

> own viewpoints, do your thing. But she always is posting like anti-abortion like propaganda on her story and it's like very false.

Elizabeth told me about the negative consequences that she sees from being able to share just any information on social media. She expressed concern about the misinformation that people tend to believe without any hesitation. However, discussion sometimes included the notion that social media can also be a teaching opportunity for topics that are not taught in school. Taylor explained learning about female anatomy through something that she saw on Twitter:

> I don't remember if they tried to show us any anatomy pictures in like eighth or 10th grade. I don't think they did. 'Cause I feel like I would have remembered. But yeah, I didn't know all the like official names for everything until I saw something … on Twitter. I saw something and I was like, I don't know what that is, so I looked it up.

In this instance, Taylor is an example of women using social media to their benefit when they are seeking information but not finding it via traditional educational modalities.

Sociopolitical Factors

Certain factors that women described influencing their sexual health information- and service-seeking behaviors had to do with the social, cultural, and political characteristics and norms in the contexts of those behaviors. Often, women told me very early on in the conversation about their region of upbringing and certain stereotypes and stigmas that they had experienced. While somewhat unexpected, I found many of these stories relevant to this research question because of the impact that these factors had on their sexual health service- and information-seeking behaviors.

Region of upbringing

Women described factors related to the region of the country in which their experiences took place that they felt impacted their sexual health or the sexual health of others in their lives. Lucille argued against the disparities that exist in education between different regions, describing:

> I think everybody should have access to knowledge ya know? Instead of like 'I grew up in the south so where I come from this is okay' or 'I grew up in California so this is okay.' I think that everybody should have the access to it so they're not just like 'Well this is what I grew up around.'

Lucille expressed frustration with the fact that some things are accepted as normal just because of the region in which they take place. She gave an example of an observation in the south, saying, "I feel like there's this weird thing in the south where like you can talk to your mom about sex once you're married." This example explains Lucille's understanding of how one's region of upbringing can influence what is "okay" to talk about, thus impacting their chances of success when seeking information about sexual health.

These differences among regions were further emphasized by Madeline, who explained to me that she believed that what women find when they are seeking services -- ease of access, lack of stigma, etc. -- is all determined by the region. Discussing the high availability of free condoms on campus, she described:

> This would never happen at home. Like even on the college campuses, they're like, it just wouldn't happen. It's just very interesting seeing the difference.

Madeline's example showed that while condoms might be readily available on one campus, they may be nearly impossible to access on another solely because of the norms in that region. She

also went on to tell me that even when resources are available, certain regional norms prevent many women from seeking them:

> Kinda nearby was Planned Parenthood … also kind of controversial in our area just because of the pro-life pro-choice, um, debate. So I think that that was something that people, I don't think any of my friends actually did go to the clinics, like the public ones where they could get it for free. But I know that several people have looked into it and then never really followed through with them.

To provide further detail to this point, Madeline told a story of a friend who purchased emergency contraception and received shaming comments from someone in the store, who said, "I hope my daughter never makes that mistake." This "nasty comment," Madeline said, "Reflected just the overall attitude of our area." This shame was experienced by other women in their hometowns, like Emily who said in her conservative state it was "abstinence and the Bible belt … you get made fun of for everything," and Elizabeth who described the difference between her hometown and being on campus:

> I was like, Oh, like I can be a little more open about this and like my friends here definitely share the same sort of beliefs. And it's not that I have to be surrounded by people with the same beliefs as I have to feel secure in them. But it helps to not be like, back in high school, if I was surrounded by just like the guys that, um, only believe what their dad taught them and they're going to talk down to me every time I bring up like political beliefs, I'm not going to bring it up.

Elizabeth explained feeling that she could not use her own voice in her hometown, but that there is a noticeable difference on campus that she is grateful for. While this is a positive finding for

this college campus, women made clear to me that they know that it is not standard across the country. They emphasized the reality of seeking but not finding in other regions.

Stereotypes & Stigma

Another sociopolitical factor that women discussed in relation to their service- and information-seeking experiences was the stereotypes of stigma of such behaviors. Often these stereotypes or stigmas were related to the religious or political beliefs and values that were prevalent in the women's lives. Lucille pondered the effect of religious values on the sexual health of women. She described:

> I did grow up Catholic so it might just be the stigma behind sex and Christianity in general. So like 'Ew that's gross I don't wanna talk about it, you shouldn't be talking about it.' 'Cause it's just it's one of those things we sweep under the rug like most Catholic things.

As Lucille drew this connection between religion and accepted conversation topics, it showed me that often these norms become an unspoken or unwritten policy of what children can be taught. Lucille went on to explain that the stigma that comes from religious beliefs causes many people to not communicate, thus making it hard to seek information and services when they are needed. She explained:

> Sex is still a no-no for a lot of people especially in the south … I don't know the statistics but I know the south is generally more religious. So I think a lot of it just stems from like the idea that sex is bad, God says no. I remember not wanting to do anything with my body 'cause I thought 'Nope that's illegal in God's eyes.'

This stigma, as Lucille explained, presented a lot of challenges when it came to navigating relationships and accepting her own sexuality. She went on to say that sexual acts other than

“straight up intercourse” made her “feel shameful,” because of what she had been taught in school. This “taboo,” as Lucille called it, was a common topic among other women’s discussions as well. Lauren explained that in her experiences of seeking information or simply just trying to communicate about sexual health, things typically get hostile. She explained:

> I think it's because there's a lot of, okay, like it's socially not acceptable to talk about, you know, your sexual health and reproduction. Like, abortion is really, it's not a light coffee debate. It's like, uh, people get angry and everyone's like fighting each other. Or like if you talk about porn, everyone is like really weird about that. It's just for some reason like sex is, it's just very like, you don't talk about it.

Hearing Lauren’s phrase “not a light coffee debate” led me to identify the examples she was giving as stigma-related, because it demonstrated the lack of comfort when discussing these topics. As Lauren describes it, many services and information topics related to sexuality have so much stigma attached to them that people feel that they simply cannot talk about them at all.

This stigma and the stereotypes surrounding certain sexual health services led to discomfort for some women. Taylor explained that while condoms are widely available on campus, she still feels hesitant to take some because of the stigma.

> Like the health huts, no one cares if you walk up and grab a condom. But I can't imagine myself walking up and grabbing one. I would probably rather like go buy a box in secret later just- and that doesn't make sense to me ‘cause I know that shouldn't be my thought, but there's still like a tiny bit of stigma in my head … I think it's because sex is still such a societal stigma and especially on women. I feel like there's a heavier stigma on women who have sex rather than guys who have it.

In this story, Taylor was telling me that she knew that there was nothing truly wrong with just "grabbing a condom," but there was still a voice in her head – there since childhood – that she should not allow people to see her doing so. Again, the "taboo" around sex that these women were brought up with is something that they said has influenced their own sexual health service- and information-seeking behaviors.

Types of Services

When I asked them to write their own definition of sexual health and include any related events on their timeline, participating women acknowledged that sexual health services can include a variety of things that women may seek for their sexual health. However, conversation overwhelmingly focused on contraception and services sought after sexual assault. It appeared to me that this focus and the lack of discussion of other services was due to the participants' age and stage of life. For example, only two women were of the age to begin receiving Pap tests, so it is logical that cancer screening was not brought up. Rather, contraception and sexual assault are much more common issues for college women.

Contraception

Many women described their experiences with seeking contraception, the reasons for doing so, and the challenges they faced. For Madeline, there was fear attached to the notion of accessing contraception, and a need for privacy. She described:

> I know there's like a few of my friends that would go out of their way to try to find like the public clinics [where] you could just get it for free. Um, but so that was like trying to find one of those clinics was a little bit more difficult just because people didn't want to go anywhere nearby where people can see that.

The idea of being caught accessing contraception held many women back from seeking those services. For this reason, the responsibility fell to the men in her area to have condoms since there was less stigma. Madeline said her "guy friends would just carry them around, just in case." This meant that she relied on her partner to have condoms, since seeking contraception meant she would only find shame and fear. She explained:

> I guess for us it was like a conversation. Like I'm not going to be able to get on oral birth control, so you're going to have to get condoms.

For other women, contraception was a "medical issue." Elizabeth explained that in hindsight she knows that the idea that women only use birth control "to be a whore" is only hurting them, and they can "use it for whatever they want and often it is a medical issue 'cause that's not easy." But this knowledge of the many benefits of birth control as well as the many options are something that many women said they wish they had been taught sooner. Emily told a story of when she first sought contraception:

> When I first went, I was young, like 16 and I didn't really have a say in what type I wanted. They were kind of like, here's the pill, and like start taking it next week. Um, so, and I didn't know about anything else and I probably would've gotten anything else. I mean, yeah, I probably wouldn't have gotten something as invasive. Maybe I would've gotten the patch.

Emily expressed disappointment that she had not learned about different options of contraception. She went on to explain that how her gynecologist treated her was detrimental to how comfortable she felt seeking contraception from that point forward.

> The second that she walked in, she treated me like I was like an adult and not a child. And, um, I think that's really important when it comes to sexual health. 'Cause if she

> treated me like a child, I probably would've like not asked her questions cause that feels gross.

Emily recognized the effect that the manner of communication had on her comfort with and willingness to seek services. These aspects of service-seeking – not learning about different options or being spoken to with respect -- demonstrate more ways that women are seeking but not finding.

Sexual Assault

Along with contraception, sexual assault services and information were brought up often in conversation with participating women. Many women had either experienced sexual assault themselves or helped a friend after experiencing sexual assault. For Lauren, helping her friend meant providing emotional support as well as attending Title IX appointments -- which she did not know was an available service until someone else told her. She described:

> It was her sister's idea to talk to the title nine people. Because I didn't know what title nine was and she didn't know what title nine was until, you know, she told us about it … It was good to have someone tell us where to go … I went with her just as like support, like when she was reading her case files and all of that … Um, it was very, I dunno, it was just a very like, sad time. So I was trying to be like, she was sad and so I was trying to be a little less sad and more like, like sturdy and like, I don't know, just trying to like be a base for her to check in with while she was doing her stuff … So that's what I tried to do for her. But it was just strange to be in there and hear some of the caseworker's questions and like it was just interesting ‘cause you could imagine how many people have also been in that office and like going through similar things.

Lauren explained that her secondhand experience of going through the aftermath of sexual assault showed her how little is known about those services. She and her friend sought help, but still found sadness because of the eye-opening experience. This experience of seeking knowledge and information about available services but not finding what they were looking for because they did not know where to go was one that I heard of from many women. In Rachel's discussion, she explained that the severity of the sexual assault problem could be because people are not being taught the skills necessary to acquire consent in sexual encounters. She explained:

> If you knew about it and you did it that is like shame on you ya know what I mean? Shame on you anyways, but like if someone has never ever heard of consent before and that's just how they were raised they didn't know. Like it's common sense but if you didn't get introduced to the topic like 'this is consent this is what you should do,' you don't have the ability to do that correctly.

Rachel described the importance of consent skills and sexual responsibility, as did Elizabeth. She shared the story of her own sexual assault experience, and then described being open to seeking services that would help her:

> I'm definitely open to it. It's, it's important. And like, if you're going to be responsible, it's like, I don't even find it embarrassing because it's just like, well, I'm going to be responsible, I'm going to do my thing.

Elizabeth's sexual assault story was in her mind another example of seeking but not finding, because she recalled telling people whom she trusted about what she had gone through but did not receive support. However, she also made a point of explaining to me that it is an ongoing recovery process, and that she is comfortable seeking counseling services to help her today.

Influence of Perceptions of Feminism on Sexual Health Information- and Service-Seeking Behaviors

To address the third research question, *"How do these women's perceptions of feminism influence their sexual health information- and service-seeking behaviors?"* I asked the women questions like, "In looking at the timeline and your definitions, how do you think they play into each other?" and "How do you think the way you feel about feminism impacts your sexual health?" Upon analysis, themes that I identified that relate to the overall message of "seeking but not finding" and answer the third research question were: 1) feminism and health, 2) frustrations, and 3) curiosity.

Feminism and Health

All women described their perceived connection between feminism and health. Feminism gave these women space to live a healthy life, while considering others' points of view and realities. They felt that empowerment can allow individuals to be healthier. While these women acknowledged that many people seek but do not find, they explained to me that their understandings of feminism have helped them to find what they seek. Gabrielle explained that the feminist act of "breaking down stereotypes" can lead to that healthier path. She described:

> Figuring out what ways to have positive interactions and limit negative interactions and properly communicate with each other and to have healthy relationships, whether it's physical, whether it's emotional, you know, breaking down the stereotypes and then having to like be hard all the time or be aggressive and women have to, having to be docile and saying no, we can have both energies and both personality types co-exist

Gabrielle described acts of freeing oneself to be whoever and behave however they want. She explained to me that feminism is what makes her believe that this is right, and that she sees

positive health outcomes, like healthy relationships, from having this attitude. I also heard this encouraging view of feminism and health in my conversation with Rachel, who explained that feminism to her meant independence and confidence, which leads to improved overall health and wellness because she takes care of herself. When asked how she feels her perceptions of feminism have impacted her sexual health, she explained:

> When I first started to like do things with boys … I got caught up in the stigmas like I thought 'Oh well you can't sleep with a lot of people' or 'You can't do this because people will think down on you.' And then once I was here longer I kinda formed my own opinions as an independent person … I kinda realized like no one really gives a crap. Like really no one cares you kinda should do whatever you wanna do.

Rachel explained that letting go of that pressure and realizing the stigmas attached to sexuality were not right allowed her mental health to improve, because she no longer placed as much value on what other people thought of her behaviors. Rachel's message for me had a heavy emphasis on the connection of mental health and sexual health. This story further demonstrated that point.

To other women, feminism related to health by making them want to empower others and allow them to have an improved chance at being healthy. Lauren described feminism as "reflective of being intersectional" and "including the people that often get left behind." Madeline echoed that sentiment, describing:

> I added the part about empowering women on my definition. I think that's a really big part about the people side of public health because it's a lot of like educating people so that they can make their own decisions. And I think that's a really big thing for me is like being able to make your own decisions and I don't feel like you can fully make your own decision unless you're fully educated. And I think that that is something that has like also

> very much made me want to do public health. Um, just because I want everybody to have the opportunity to make their own decisions and be on the same playing field as everybody else. Just because they're from a different socioeconomic background or a different religion doesn't mean that they should have less information than everybody else and like be at a disadvantage in terms of every health decision that they're making. I think a lot of people aren't aware of all the options for a lot of different, like even myself in terms of like contraceptive. Um, so I think that like the empowering part is really big for me.

Madeline's understanding of feminism aims to address the seeking but not finding that she sees occur so often. She explained that in order to do so, it is important that people are educated and "on the same playing field." Her message appeared to me to focus on the importance of health equity, and how feminism assured her that this was a cause worth fighting for.

Similarly, Taylor's experiences of seeking but not finding tied into her understanding of how feminism has impacted her sexual health. She explained:

> My personal beliefs on feminism helped my sexual health education because I never- I feel like a lot of women sometimes they're like, 'Oh, I shouldn't be having sex, I can't go ask people for information about it' or like 'I got myself into this mess, I can't go see a doctor or a professional that can help me.' So I definitely think that because I have the personal values in feminism that I do, that would never be an obstacle for me. And so I think it definitely just increased, maybe not my awareness but my comfort with sexual health and being able to talk about it and like it maybe helps me want more information on it too.

In Taylor's discussion, feminism was described as a solution to the causes of women seeking but not finding, because it encourages and empowers people to educate themselves. Emily shared this perception, describing:

> I remember saying my womanhood and that's just like taking charge of your body man. Like how can you be a woman if you don't even know what's going on down there? You don't know how you like to be touched and what you don't like.

This notion of knowing about one's body was common in many interviews, and as Emily explained, women described this knowledge as empowering them to do what was healthy. They acknowledged that a lack of knowing is what often led to seeking but not finding, but told me that their understandings of feminism encouraged them to prioritize education because of its clear connection to health.

Frustrations

Like the first two research questions, the final question is also answered with frustration among participating women. When asked how their perceptions of feminism influence their sexual health, many (n = 6) explained that they feel more frustrated about what they did not know or did not have access to growing up. It appeared that because feminism led these women to believe they had the right to information and services, they were even more frustrated when they experienced seeking but not finding. In other words, feminism prevented them from feeling the bliss of ignorance. These frustrations were commonly about stigma and knowing that there is more "out there" than they were taught as children and young adults, before having to learn on their own.

Stigma

In this section I will provide examples of how these women's perceptions of feminism specifically led them to feel frustrated with the stigma that is associated with sexuality, thus going beyond the previous findings related to stigma and sexual health. Women told stories of hiding their information-seeking behaviors, whether it was calling a hotline or reading a textbook, and feeling shameful when doing so. They explained that they thought that stigma came from sexist norms surrounding sexual behaviors. Lucille explained that as a teenager she was under the impression that "it's only normal for men to have sexual feelings." Gabrielle was frustrated with the stigma around sexuality because it leads to adults who are unaware of their own bodies, don't know when to seek services, or how to "have good communication with their partner."

Emily's perception of feminism as including strong women encouraged her to share stories of the strong female friendships that she had growing up. She explained that these friends enlightened her after her sexual assault, and showed her that the stigma associated with sexual assault victims is wrong. She explained:

> They pointed out that ultimately that's wrong. That's not losing your virginity. That wasn't a decision that you made together with someone. But yeah, I feel like a lot of girls are like that when they get sexually assaulted, they kind of like stop caring about what they do with guys because people are like, there's a whole stigma of like not being a Virgin anymore and stuff like that.

When Emily learned more about feminism and came to have a clearer understanding of what it means for women, she realized how wrong her experience after her sexual assault had been. The

stigma associated with sexuality in general frustrated Emily because she knew that seeking information was necessary to be healthy. She described:

> I feel like that's a stigma of like girls can't masturbate like that kind of thing or like be aware of their bodies and um, like there's this like that super big discrepancy between men and women. And I feel like girls are scared of anything going on down there. 'Cause it's like gross or perceived as gross.

Emily explained that the fear that many women have about their own bodies, while common, is unnecessary and should be dispelled by improved knowledge. These beliefs stemmed from her perceptions of feminism and led her to feel frustrated with the effects of stigma.

"there's more to sex than…"

Some women were frustrated with the simplistic explanations and views of sex that they had been exposed to growing up. Feminism showed many women that there was information and knowledge available, but they had not received it. Elizabeth explained:

> We learned a lot about that, especially like, senior year theology. 'Cause you know, we were finally mature enough to handle it. But um, we had this big long unit on our class's, beliefs on sex and stuff like that. And then compared to what the Bible actually says, because God, God created sex to be between a married man and woman for procreation and no other reason. And then so that's what we always have been taught basically. But then, I mean there's more to it than that … I think my beliefs on feminism, there's more to sex than just male and female for procreation and that's like, there's a lot more to it than that … There was just so much more to it rather than saying that this is a bad, this is a bad thing until you were married. Cause like, I mean cause I know it's not, I know it's not a bad thing.

Elizabeth was seeking a better definition of sex, knowing that there was more to learn. She explained that her feminist beliefs told her to be frustrated, because she knew there was more to sex than a married couple procreating, and that "it's not a bad thing." But this knowing that "there's more to it" was unacceptable to her, and she told me that she is still frustrated with the education she missed out on.

Curiosity

Women explained that their perceptions of feminism made them curious to learn more about everything, but specifically sexuality. Rachel described herself as "nosy," saying:

> With my opinions on feminism I'm also just nosy. I like to know things and I like to be informed. I like to be able to talk educationally- intellectually, and be able to help people too. So I do like a lot of research and I'll just out of curiosity to know what are options for me or for anybody else in case they ever do get in a situation when they would need help. So I just like to know.

This search for knowledge was common among women, like Taylor who said feminism makes her "want to know more information." Their upbringing and current reality of seeking but not finding led these women to discuss the confidence that feminism gives them to educate themselves. They explained that this thirst for knowledge will only help them -- and others -- to be healthier and more willing to seek sexual health information and services when necessary.

Conclusion

Undergraduate public health women are at a stage of life when sociopolitical movements and sexuality are highly prominent issues. Their perceptions of feminism play a key role in their feelings of empowerment, confidence, and their right to knowledge and health. However, the feelings of these women when seeking service and information related to their sexual health are

often those of frustration. Having an educational background that emphasized health, these women know the importance of education and the positive impact that quality, comprehensive sexuality education can have on individuals' sexual health. They are also in a prime position to see the consequences of insufficient sexuality education, which has led to many women seeking help, but not finding what they need. These women explained that their understandings of feminism make them hopeful for real change when it comes to education, stigma, and open conversation, so that the next generation of young women do not have to face the same challenges that they have themselves, but rather will find what it is they seek.

CHAPTER 5

DISCUSSION

This study aimed to investigate the influence of college women's perceptions of feminism on their sexual health service- and information-seeking behaviors within a Feminist Theoretical framework, specifically based on bell hooks' brand of Feminist Theory, due to her emphasis on the responsibility of education and potential pedagogical implications of the study (1984; 1994). The value hooks' feminism places on narratives fits well with narrative inquiry, a methodology that involves analyzing participants' tellings of their own experiences, in this case through narrative interviews. Findings from the study offer health educators and public health professionals a deeper understanding of what causes women to experience the "seeking but not finding" of sexual health information and services. The findings also provide insight as to how incorporating tenets of Feminist Theory in health and sexuality education can improve the overall health of women, as will be discussed in this chapter. It is known that college aged women do not seek sexual health services as often as they should or sexual health information from the most reliable sources (Cuffe et al., 2016; Hayes-Smith & Hayes-Smith, 2009; Murray Horwitz et al., 2018), but it is not known why this is the case or what their experiences with seeking these things actually are. Undergraduate public health women have the knowledge and agency to speak to this issue, have an understanding of the importance of health and sexuality education, and are currently living the phenomenon in question. It is also worth noting that, when

on campus, these women have access to free health services, so if they are not using them, why not?

I designed research questions to address both the perceptions of feminism of these women and their sexual health service- and information-seeking experiences, as well as a combination thereof. In the discussion that follows, I will highlight the aspects of these women's stories that show how perceptions of feminism influence their behaviors. First, women's feelings of empowerment and frustration will be discussed in relation to their experiences of seeking but not finding. Next, the women's emphasis on education will be discussed. I will then address the potential benefits of incorporating tenets of Feminist Theory in health and sexuality education -- with some suggestions from the women themselves -- in an effort to prevent future generations of women from seeking but not finding. Discussion will close with a reflexive statement about my journey through the research process.

Empowered

Women felt empowered and independent enough to seek the information and services that they need, which led them to feel frustrated when they -- too often -- did not find. As women like Madeline and Lauren described, feminism often empowered them to be more empathic and stand up for the well-being of others. For Madeline, this was due to her knowledge of the past and what women have had to face in order to gain more rights. This understanding made her take her own rights and freedoms much less for granted, and "encouraged" her to try to educate others and help them as much as possible. Taylor's conversations about feminism with her family from a young age also instilled this message and empowered her to "strive for equality for all women," especially when it comes to their health.

This sense of empowerment translated to health for many of these women, and they said it was reflected in much of their life decisions. For Gabrielle, it meant choosing a career based on her own interests and passions. For Rachel, it meant taking care of herself and encouraging others to do the same. The dialogue created for this study showed that many women's feelings of empowerment from feminism were completely intertwined with their contraception use, gynecologist visits, and comfort just talking about sex. This coincides with past research which has emphasized the importance of incorporating empowerment in approaches to improve women's health seeking behaviors (Amaro et al., 2001; Currie & Wiesenberg, 2003; Fitz & Zucker, 2014).

Frustrated

Often, women's perceptions of feminism led them to see certain aspects of the reality of sexual health in ways that caused frustration. The region of the women's upbringing came up in conversation many times, and it is important that this not be ignored. This sort of frustration has been written about previously; the frustrations of southern feminists were described as "bewilderment" after the 2016 presidential election (Maxwell, 2019). It is my understanding that the feelings of the women in this study have gone beyond bewilderment and are simply frustration; I heard them use the word themselves often. It was the feeling of these women that where they grew up should not have influenced the quality of education that they received when it came to sexuality, but it did. Whether it was in school or at home, the sociopolitical factors that were prevalent in their region of upbringing either helped or hindered these women's education about their own bodies, and this frustrated all of them greatly. Madeline's experiences in her hometown led her to the understanding that socioeconomic status and religious beliefs should not have as much influence on people's health as they do, nor should they put anyone at a

disadvantage. Her explanation, like many other women's, showed that most people in her life know that information, knowledge, and access to services should be available and easily found when women seek them; they are just reluctant to speak up. However, speaking up is what the women's perceptions of feminism encouraged them to do, so their frustration with their reality and the realities of others whom they knew only continued to grow.

Women also described feelings of frustration -- as seen in some found poetry -- with the stigma that is attached to sexuality. Specifically, the stigma associated with contraception as a tool to allow young women to have sex, like when Elizabeth's mother told her, "I'm worried that you're going to use it to be a whore," made her feel incredibly frustrated. Elizabeth was seeking but not finding what she needed when she wanted contraception. She was frustrated about the stigma attached to girls using birth control, and this frustration was only exacerbated by the fact that she actually wanted it to manage menstrual pain. These women's narratives related to stigma corroborate the findings of previous studies about the effects of stigma on service-seeking behaviors (Sisson & Kimport, 2016). Taylor's example of women's feelings provides another demonstration of how stigma leads to seeking but not finding. Her description of some women feeling that they "can't ask people for information" because they "shouldn't be having sex," or feeling as if they "got themselves into this mess" paint a picture of the reality that women face when all they really want are answers to their questions.

Additionally, women expressed that their perceptions of feminism told them that there is nothing inherently "wrong" about being sexually active or wanting to know more about their own bodies. They often explained that they felt there was a double standard when it came to the stigma surrounding sexuality for women compared to men. Lucille's statement of, "men have sex and women get sex done to them" explains this point poignantly, as shown in one of the

found poems from her interview. In these women's minds, if more people had clearer understandings of the values central to feminism, they would not have to face so many of these frustrations that are essentially caused by placing emphasis on the stigmas attached to sex, rather than a more realistic view that considers the overall health and well-being of all people. It appeared to me that when these women first gained a positive perception of feminism, they had a moment of, "Wait a second…" and could no longer live with the bliss of ignorance.

Education

Women are seeking the information that they know they need in order to be healthy, but only finding a "lack of meaningful access to truth" (hooks, 1994, p. 29). These discussions of seeking but not finding, like when Madeline said, "I don't feel like you can fully make your own decision unless you're fully educated," demonstrated the women's recognition of the powerful impact that education, or a lack thereof, has on health. When women described instances of information-seeking at school, many of their experiences were negative because of the restrictions that were placed on their school health and sexuality education curriculum. This means that whether a teacher is comfortable talking about a sexual health topic or not, they may be forbidden from doing so. Currently, seven southern states "either prohibit educators from discussing (or even answering questions about) LGBTQ identities and relationships" (Planned Parenthood, 2020b). The stories that these women shared with me about their insufficient sexuality education demonstrates the negative effects of such policies. However, an alternate picture was painted by Rachel, who described the comprehensive sexuality education she received at her all-girls high school. The benefits, as she described, were numerous. This contrast between limiting what children and young adults are allowed to learn and incorporating a broad, tolerant approach to sexuality education was stark. hooks (1994, p. 29) warned in her writings of

the danger of pedagogy and curricula which not only present inaccurate information but do so in a manner that "enables most effective communication," not effective education. In other words, insufficient sexuality education and abstinence-only programs allow teachers and schools to say, "We don't talk about that here," when students ask anything about sex. These instances are examples of effectively communicating basic information but not effectively educating students on the complexities of sexual health.

Lauren's story of seeing her teacher as a feminist is a good example of what hooks often tries to encourage in her feminist writings on education. As Lauren put it, a feminist is "someone who educates, not yells." To her, the teachers who answered their students' questions respectfully and did not shut students down when talking about sensitive issues were feminism personified. This positive educational experience clarified for her not only what feminism should be, but what education should be as well. But it is unrealistic to expect that children and young adults will receive the education they need related to sexual health solely at home. Rather, polls have shown that up to 57% of parents feel uncomfortable talking to their children about sex and sexual health (Planned Parenthood, 2014). While some children, including a few of these women, are lucky enough to be able to talk openly with family, others do not even consider it as an option. That message is sent and received from a very young age. For example, Rachel expressed sincere gratitude for being able to reach out to her mom, aunt, or sister about sexual health, but Gabrielle explained that she got no sexuality education at home, Elizabeth was shamed for asking her mom about contraception, and Madeline's mom had to communicate through her sister about whether or not she needed birth control. The responsibility must fall to the health educator for this reason, and as these women discussed, that responsibility is all too often left unfulfilled.

Implications for Health Education & Promotion

The findings of this study present many pedagogical implications. hooks' (1994) feminism emphasizes the responsibility of educators, and the women in this study echoed that importance in discussing the need for improved education. They were emphatic in their belief that change is necessary, and it needs to happen now. The findings of this study could inform health education and promotion interventions aimed at improving college women's sexual health. Incorporating tenets of Feminist Theory in health and sexuality education at any level has the potential to, according to this study's findings, empower women to seek the information and services they need, and hold educators accountable to provide the information that women seek but do not find. For example, both Planned Parenthood's (2020a) "Learn" categories, and the Sexuality Information and Education Council of the United States [SIECUS] (2004) Guidelines for Comprehensive Sexuality Education K-12 "Key Concepts" include relationships in their lists, which is when tenets of equality and empowerment could be incorporated. In addition, Society & Culture is a key concept on SIECUS's (2004) list, which could incorporate education on feminism itself, as well as the tenet of social change. Feminist pedagogical techniques, such as a checking-in period with students to acknowledge their lives outside the classroom, creative assessment techniques, and language-based teaching and learning can help to achieve these goals (Hedin & Donovan, 1989). By incorporating Feminist Theory tenets in health and sexuality education, we can answer back to the women who are seeking but not finding.

This study also shows the need to address the reality -- both today and historically -- of the service- and information-seeking experiences of women. Future health and sexuality education should include these stories and explain the ethical need for accountability in public health. This ethical responsibility to be accountable is identified by the American Public Health

Association in the Public Health Code of Ethics (2019) and has been identified as a way to address the challenges that these women face when seeking services and information (Jackson & Gracia, 2014). The impact of learning about the history of a given issue is evident in Madeline's interview. She shared that learning about the women's movement and the Civil Rights Movement empowered her to not take her rights for granted, but to also keep fighting for equality for all people, like the women who came before her had. Interpreting this study's findings within bell hooks' feminism suggests that the pedagogical implications of this study are numerous, and one of which is to include these historical realities of all women's health in health and sexuality education curriculum. One example of a way to do this is with a book club where students read books such as *The Immortal Life of Henrietta Lacks.*

Many women suggested improvements for sexuality education as well as the ways in which we as a society approach sex in conversation. Encouraging more open and realistic conversation about sex was a hope of all participating women. They felt that if there was less fear of speaking to those who they were closest to growing up and even now as young adults, they would have been able to find what they were seeking. This has inspired many of them to pursue careers in public health, because they want to be the person who they did not have when they needed help.

Relatedly, a few women stressed how critical it is that we teach skills related to sexual consent, not just knowledge. Rachel's comprehensive sexuality education experience included consent, but she stressed that people need to know how to ask for consent, not just what it is. Rachel's sentiments echo what has been written in recent literature regarding consent; the skill must be focused on, and creative efforts are necessary (Brady, Lowe, Brown, Osmond, & Newman, 2018; Ortiz & Shafer, 2018). Elizabeth and Emily, who shared their own stories of

sexual assault, are examples of the need for education on what women can and should do after a sexual assault. Both women explained that it took time for them to acknowledge that what had happened to them was not okay, nor was it shameful. The responsibility of health educators cannot be greater than in those instances.

Additionally, more comprehensive health and sexuality education was a clear suggestion from all of the women. Having gone through different types of curricula prior to college, the women were able to share many perspectives of the good and bad of the current state of health and sexuality education in the U.S. Currently, only 29 states require sexuality education at all, and less than half of all high schools are including the sexual health topics that the CDC calls "essential" for young adults' health (Planned Parenthood, 2020b). From the narratives produced in this study, the message was clear: abstinence-only is, to use Gabrielle's term, "problematic". Rather, the women expressed hope that if students are educated on a broader spectrum of sexual health topics from a younger age, they will be able to make healthier decisions as young adults. Lauren's hope to "make some really informed eighth graders" in order to positively influence the rest of their lives nicely summarizes the implications of the study. Health education and promotion professionals should advocate for comprehensive sexuality education nationwide.

Strengths

Quality qualitative research requires the researcher to reflect upon the data and assure that analysis and interpretations reflect the phenomenon being studied (Patton, 1999). Elements of credibility, dependability, confirmability, and transferability demonstrate rigor in qualitative work, and are central to much qualitative health care research (Cohen & Crabtree, 2008).

Credibility of a qualitative study has to do with data collection and analysis. Often, attention should be given to triangulation, which allows for consistency of data sources to be

examined (Paton, 1999). It also allows for corroboration of overall interpretations (Mays & Pope, 2000). In this study, I sought to triangulate viewpoints from multiple women by reporting alternative perspectives, such as Rachel's positive high school sexuality education experience and comfort speaking to family, with other women's insufficient education experiences and feelings of shame that they received from family members. This inclusion of multiple perspectives helped to provide an even deeper understanding. Additionally, informal member checking during interviews and formal member checking after the results chapter was written added a layer of rigor to the verification of the study (Cohen & Crabtree, 2008). This process of error reduction establishes correspondence between researcher and participants (Mays & Pope, 2000). In addition, reflexive memos were made throughout the entire research process. These memos allowed the experiences of participants to shape findings, rather than my perspectives alone. This helps to avoid confirmability bias (Mays & Pope, 2000).

Along with the credibility of the data collection and analysis, the credibility of the researcher in preparation and presentation should be established. In qualitative studies, the researcher is the instrument, so information about her training and experience must be included (Patton, 1999). In this case, I was a novice, and most of my training came from coursework and self-study. Many skills were learned through experience, and I was guided by experts in qualitative research throughout the process. It should also be mentioned that I had a strong personal connection to the topic and population, being a white woman in my mid-twenties.

Transferability has to do with the extent to which the findings of the study can be applied to other contexts (Cohen & Crabtree, 2008). The results presented connections between perceptions of participants and the context of their experiences. For example, experiences of

women's sexual assault and feelings of shame were connected to the context of the insufficient sexuality education that they had received or were receiving at the time.

Participating women were past the point in their lives when they should first be learning about sexual health. This is what led many of them to feel frustrated, but it is also why they were the ideal population to speak with about their experiences with seeking sexual health information and services; they spoke from a standpoint which allowed them to be critical of what they were or were not finding. This is also why asking women to draw a timeline of important events was crucial to the success of the interviews, and why many of their stories were from their childhood or high school years. Being public health majors, these women were also acutely aware of the influence that politics have on women's health. This awareness of the intersection of politics and health allowed them to share narratives that spoke to possible causes of the experiences that they had, and the reasons for their seeking but not finding.

Limitations

Of eight participants, one was black and seven were white. Because I am a white woman talking to mostly white women, framing this discussion in the context of hooks' feminism is critical because it prevents our whiteness from becoming invisible. It is imperative, in hooks' view, for white researchers to "interrogate the location from which they speak" (hooks, 1994, p. 77). For this reason, the methodology will be examined here to identify how the recruitment strategies played into this lack of diversity when it comes to race. This examination is not, as McCorkel and Meyers (2003) described, an attempt to level the playing field, but rather to "demystify the rules and strategies by which the game gets played."

The sample was purposive, as previously described. Undergraduate public health women were invited to participate voluntarily because this would allow for the acquisition of participants

from whom the most could be learned (Suzuki et al., 2007). However, this did not result in enough volunteers to stratify for race. In the interviews, race did not come up in conversation often, except during the few times when women described learning about intersectional feminism. These descriptions included learning about Chicana Feminism and acknowledging that multiple identities are at work in women's lives, or simply acknowledging that race and socioeconomic status influence how women experience a given situation, but this was the extent of the conversation. Though striving not to let whiteness become invisible -- meaning that it was critical to acknowledge that race does influence sexual health information- and service-seeking experiences even if the women speaking about it were white -- resulting interview transcripts showed that race was at times invisible. This invisibility of race in the interviews could be due to lack of probing for more discussion on my end, a lack of interview questions that addressed identity issues, or a combination thereof. It is for this reason that race is not a point of discussion for the findings of the study. This does not, however, void the findings of this study when discussing the sexual health service- and information-seeking behaviors of non-white women.

While purposive sampling was necessary in order to speak to women who were willing and eager to share their experiences, it does not allow for the experiences of those women who are more reserved and less willing to share. Considering the topical nature of the study, it is entirely possible that women who held other views regarding feminism or who had experienced differing life events -- possibly serious sexual health events -- did not volunteer due to discomfort. This may slightly decrease transferability to other undergraduate women at this university or women at other colleges or universities.

With interviewing methods, there is a risk of power dynamics influencing the conversation. While impossible to avoid completely, I attempted to reduce imbalances of power

by dressing and acting casually, not sitting behind a desk if possible, offering beverages such as tea or water, and allowing the participants to choose the interview location to increase their comfort. Having women write their own definitions on cards at the beginning of the interviews also allowed the dialogue to include their own terms. None of the women appeared intimidated or uncomfortable, or showed signs of perceiving me as the person in power.

Qualitative research is inherently subjective. Therefore, all analysis and interpretation are based on the subjective understandings of the researcher. I chose what to include and exclude in the conclusions of the study (Suzuki et al., 2007). Alternate perspectives and interpretations may have been evident had another researcher conducted the study. However, the methods and attempts to increase rigor of the study assure credibility of the findings.

Future Research

As previously mentioned, the findings of this study provide significant insight into the perspectives and experiences of undergraduate public health women in the south regarding feminism and sexual health, but these may differ for students in other regions of the country, or of other genders. Students in other majors, though they would not have the health education background that these women do, would certainly provide additional insight into the influence of their perceptions of feminism on their sexual health service- and information-seeking behaviors. This type of additional research could help health educators better understand the age group under study.

It should be understood that many of the women were speaking of their white experiences, and the challenges that many of these women described when seeking services or speaking to teachers or other adults about sex, are *their* reality, but they are not the *only* reality. Just as my interpretation of these narratives is not the only possible interpretation. However, it is

by framing this discussion around the value expressed in bell hooks' feminism that studying whiteness is "crucial" in order for it to be "understood, discussed … whether or not people of color are present," that the whiteness of this study is not being ignored or portrayed as the norm (hooks, 1994, p. 43). This gives cause for recommending that future investigators talk to women of color about their experiences with sexual health information and services, especially since women of color face disproportionate burdens of many health issues (CDC, 2018).

Conclusions

The frustration of undergraduate public health women regarding the seeking but not finding of sexual health services and information should serve as a call to action to health educators. It is clear, based on the narratives provided by these eight women, that the responsibility of health educators to provide not only information regarding sexual health, but also the skills needed to access services and information, is not always being fulfilled. However, these women, through the emotional telling of their experiences, have provided invaluable insight into how this much-needed improvement can be made.

Similar to other studies about feminism and health, the findings of this study demonstrate that feminist tenets do indeed have the potential to positively influence health (Amaro et al., 2001; Currie & Wiesenberg, 2003; Fitz & Zucker, 2014). As this study found, these women's perceptions of feminism have led them to feel empowered; they are empowered to take care of their own bodies, and to take the initiative to learn for themselves what their teachers and families neglected to talk to them about as children. Women are frustrated with the current reality of seeking but not finding sexual health services and information when they need them, at the standards that they deem acceptable in today's world. They are frustrated because they know that these behaviors are necessary to stay healthy, especially as young women, but the hurdles

and stigmas in their way are too great. These women see the value of education and the impact that the level of quality of education can have on women's lives very early on. They see the lasting effects of insufficient education as well as quality comprehensive sexuality education. All this to say that these women know what needs to change in order for women to enter adulthood with the knowledge, skills, resources, and access to care that is necessary for them to be healthy sexual beings. These women's stories shine a light on the many realities that can exist depending on what girls experience before college, as well as the new challenges that arise when they enter adulthood.

"Researcher, know thyself": From Nine-Year-Old Feminist to Feminist Scholar

Practicing reflexivity throughout the process of this research has brought up many emotions for me, proving that it is entirely necessary in this type of qualitative work for me to define myself, as I did earlier in my subjectivities statement. But beyond that, as Wanda Pillow's (2010) words, "Researcher, know thyself," encouraged, it is vital that since I come from a position of privilege, I practice this reflexivity. Recognizing my privilege as a white woman is also especially important since I used hooks' Feminist Theory as the framework for the study. This final section will include personal recollections from the research process, in an effort to provide closure by both situating myself within the research, alongside the participants, and also questioning my own interpretations (Pillow, 2010).

When discussing and practicing reflexivity it is important to note the difference between reflection and reflexivity. Reflection does not include self-scrutiny, while reflexivity is an ongoing process of questioning what I know, and how I came to know it (Hertz, 1997, p. viii). To do this, the reflexive journal that I kept throughout the research process proved incredibly useful. The notes that I kept pertaining to how I was interpreting the women's stories, as well as

the personal connections that I found between us shined a light on the *how* part of the meaning making of this study. This act of situating my understanding of the research out of similar experiences with the participants was a reflexive process (Pillow, 2010) and is what caused me to process so many emotions.

I related to the women in this study on so many levels that I feel an immense sense of solidarity with them and from the stories that they were brave enough to share with me. First, like three of the women in this study, I went to a Catholic school for part of my K-12 education. This meant that I learned the very basics about the human body and was taught that abortion was a sin, and that sex was for a husband and wife. Like the women in this study, I too was taught to feel a sense of shame regarding sexuality, but this is what caused me to build up feminist values internally – even if I did not know it at the time. When I was nine years old, I wrote a poem for a competition in our diocese called "If he can be a priest, why can't I?" I do not remember everything about this blatantly feminist event in my life, but I know I did not actually want to be a priest; I just wanted the option, like four-year-old Taylor wanting the option to be a Shriner.

When it comes to high school sexuality education, I had additional similar experiences to the women in this study. My school district endorsed an abstinence only sexuality education curriculum at the time, so my memories include learning about why anal sex is "gross" and why (again) sex is for a husband and wife, and… that was about it. This "that was about it" recollection of high school sexuality education was something I had in common with the women in this study, as well. We all (apart from Rachel, who acknowledged her privilege of receiving comprehensive sexuality education all through high school) *knew* we were missing out on the education we needed and deserved. Even if, at the time, some of these women did not see anything wrong with what they were being taught, hindsight shines a light that is truly

frustrating. I knew, even in elementary school, that my mom could answer any question that I had that was not being answered at school. A few of the women in this study were as lucky, but many were not. They simply had nowhere to go. So, they either learned later (too late), like Gabrielle learning about urinary tract infections and Lucille learning about behaviors other than "straight up sex," or sought information secretively and with feelings of shame as young girls, like when Emily called a hotline from her backyard. It was in these instances that reflexivity caused me to identify myself and the women as "others" who did not share the same past but were learning from each other.

The stories that these women shared with me left me completely enthralled and, at times, on the edge of my seat. I will always feel that it was an honor that they were willing to sit with me, a complete stranger, for over an hour and talk about everything from boyfriends to family drama, from sexual assault to choosing contraception. The emotional processing that was required after hearing stories of assault, in particular, was something that I had not planned for. Often, I sat in my car in silence for a few minutes after I left an interview just to allow my mind to slow. The thing is, though, these stories are not just those of these eight women. I nodded my head along with so many things that they shared with me, because either I myself had experienced the same thing or I had known women personally who had as well. Their hand drawn timelines could have been my own, in many cases. In reflexively co-creating this research, the product is inevitably affected by the similarities and differences of our experiences. It is because I have gone through similar situations that I interpreted women's stories of frustration and the origins of their feminist values in the ways that I did.

It is from this shared experience between myself and these eight women that I came to realize that simply talking -- using language, as hooks said (1994) -- can form bonds and instill a

sense of empathy and compassion that numbers simply cannot. Every time I walk into a drug store and see emergency contraception in a locked glass box, I will think of Rachel and her wish for it be "as lowkey as you want." Seeing the tax on tampons will actually make me smile because I will remember Lucille's story of explaining the need for feminism to her boyfriend. When I see a scene in a movie or on TV of a girl at a party in the woods about to experience sexual assault, I will think of Emily and fight the tears that come to my eyes. Hearing Beyonce's *Flawless* will make me think of Gabrielle's journey with feminism. I have progressed from a nine-year-old feminist to a feminist scholar through this work, because what these women and this study have taught me will inform both my future research and my teaching. It is my hope that upon reading this, these stories and those mental images will stick with you, the reader, as well. I hope that those stories and images created by these women's words will inspire change, so that our daughters' generation can grow up with *all* of the information that they need to be healthy – not just the information that their health teacher is comfortable talking about, or that their church will allow. "Seeking but not finding" may be a common occurrence for women today, but it is the hope of these women -- and this researcher -- that if stories of survival are told with bravery, questions about sex are answered without shame, and the responsibilities of educators are fulfilled, women of tomorrow may just find exactly what they seek.

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APPENDIX A

Recruitment Email

Interview Research Invitation E-mail to Participants

Email Subject: Research Invitation

Hello (insert name),

My name is Rebecca Rich and I am a doctoral student of Health Education and Promotion in the Department of Health Science working under the advisement of Dr. Angelia Paschal on a study about college women's perceptions of feminism and sexual health service-seeking behavior (IRB # 19-02-2059).

You are being contacted because you indicated you would be willing to participate in this research study. I am asking you to participate in a one-on-one in-depth interview with me about your perceptions of feminism and sexual health. The interview will last approximately one hour, and will take place in a location where you feel adequate privacy.

If you are willing, please let me know via e-mail, and provide me with your demographic information (gender, age, race/ethnicity). My e-mail address is reaton@crimson.ua.edu. If you have any questions, I can also be reached at 570-660-5174.

Thank you in advance for your willingness to support my research efforts.

Best,

Rebecca Rich, MA

APPENDIX B

Interview Guide

A Qualitative Exploration of the Influence of College Women's Perceptions of Feminism on their Sexual Health Service- and Information-Seeking Behaviors

Research questions:

- How do undergraduate women public health students at a large southeastern university describe their perceptions of feminism?
- What are the sexual health information- and service-seeking experiences of these women?
- How do these women's perceptions of feminism influence their sexual health information- and service-seeking behaviors?

Introduction:

Welcome! Thank you for coming today. In this interview I'm interested in understanding your perceptions of feminism, your experiences with sexual health service-seeking and information-seeking behaviors, and how your perceptions of feminism have influenced your experiences with sexual health. Over the next hour or so, I'll ask you some questions about your thoughts on feminism, and your experiences with seeking sexual health services and information. If you feel uncomfortable answering a question, you're welcome to pass, and if you need a break, please let me know.

I'm using a USB recorder and my phone to record this interview. I'll also use a different name in my interview transcript to protect your identity, which you can choose. Do you have any questions?

Okay, let's get started!

*Begin with having them write on cards:

1) definition of feminism

2) definition/understanding of sexual health

Then, have them draw a timeline of when they first heard of feminism, as well as any experiences or events that they think relate to our conversation.

Follow by telling them what I think sexual health and sexual health services are. (Annual exam, STI testing, contraception access/information, reproductive cancer screenings, etc.)

Interview Questions:

1. Think about the time when you first heard of feminism and tell me about it.
    a. You described your own attitude toward feminism, can you tell me more?
2. Think about your experiences with sex education, and tell me about them.
    a. You mentioned _____. Can you tell me a little more?
3. Think about a specific time when you had a question about sexual health, and tell me about it.
4. Think about the ways that you feel about seeking sexual health services, and tell me about it.
5. In looking at the timeline and your definitions, how do you think they play into each other?
6. How do you think your public health major has influenced or been influenced by the timeline and definitions?
7. How do you think the way you feel about feminism impacts your sexual health?

APPENDIX C

Informed Consent Form

Study title: Influence of College Women's Perceptions of Feminism on Sexual Health Service-Seeking Behaviors

You are being asked to take part in a research study. Please read this sheet carefully and ask questions about anything you do not understand. This study is called "Influence of College Women's Perceptions of Feminism on Sexual Health Service-Seeking Behaviors". The study is being done by Rebecca Rich, who is a graduate student at The University of Alabama. The researchers are being supervised by Dr. Angelia Paschal, who is an Associate Professor of Health Science at the University of Alabama.

What is this study about? What is the investigator trying to learn?
The purpose of this study is to gain an in-depth understanding of college women's perceptions of feminism, and how that influences their sexual health service-seeking behaviors. The researchers are trying to better understand college women's perceptions of feminism and how that influences sexual health in order to help improve sexual health education, as well as the overall health of college students.

Why is this study important or useful?
This knowledge is important because understanding barriers to sexual health services and what influences college women's behavior can help inform future education and promotion efforts. Information collected from this study will provide public health professionals and health educators knowledge to improve education for college students on sexuality, including annual exams, STI testing, reproductive cancer screenings, and contraception.

Why have I been asked to be in this study?
You have been asked to be in this study because you are a woman of college age (18-24) and sexual health is an important issue for college women.

To be in this study you must be:
(1) A student at The University of Alabama
(2) Between the ages of 18 and 24 years old
(3) Who identifies as a woman
(4) And who speaks and understands English

How many people will be in this study?
Approximately 20 college females will be in this study.

What will I be asked to do in this study?
If you meet the criteria and agree to be in this study, you will be asked to participate in a one-on-one in-depth interview about feminism and sexual health with the researcher.

How much time will I spend being this study?
You will only be asked to participate in one interview, and the interview will last approximately one hour.

Will being in this study cost me anything?
The only cost to you from this study is your time.

Will I be compensated for being in this study?
You will not be compensated for being in this study.

Can the investigator take me out of this study?
The investigators may take you out of the study if they feel that the study is upsetting you, something happens that means you no longer meet the study requirements, etc.

What are the risks (dangers or harms) to me if I am in this study?
There are no physical risks from this study. However, you will face the risk of discussing topics of a sensitive nature, such as sexual health, experiences with sexual health issues, etc. The risk of emotional stress or discomfort will be minimized by allowing breaks during the interview, and you may choose not answer any questions, or stop at any time. Should you experience such discomfort, we will inform you about counseling services offered by The University of Alabama Counseling Center.

What are the benefits (good things) that may happen if I am in this study?
There are no direct benefits for participating in this study. However, participation in this study may increase your awareness and knowledge about feminism and sexual health topics.

What are the benefits to science or society?
Findings from this study may be used to design health education and promotion interventions and educational programs for college students, especially women. As a result, society could benefit from improved overall health of women.

How will my privacy be protected?
You will have a say in where the interview is conducted, so that you feel adequate privacy. You do not have to answer any questions that you do not want to.

How will my confidentiality be protected?
The interviews in this study will be audio-recorded. The recordings will be saved and password protected for up to five years, then destroyed (shredded). The number of people who can access data will be restricted to only the primary investigator, and raw data or identifiers will be destroyed after the interview has been transcribed. The results of this study may be presented or published for scientific purposes; however, the information you provide cannot be linked to you.

What are the alternatives to being in this study? Do I have other choices?
The alternative to being in this study is not to participate.

What are my rights as a participant in this study?
Taking part in this study is voluntary. It is your free choice. You can refuse to be in it at all. If you start the study, you can stop at any time. There will be no effect on your relations with the University of Alabama.

The University of Alabama Institutional Review Board ("the IRB") is the committee that protects the rights of people in research studies. The IRB may review study records from time to

time to be sure that people in research studies are being treated fairly and that the study is being carried out as planned.

Who do I call if I have questions or problems?
If you have questions, concerns, or complaints about the study right now, please ask them. If you have questions, concerns, or complaints about the study later on, please call the investigator (Rebecca Rich) at (570-660-5174). You may also contact my UA faculty advisor, Dr. Angelia Paschal, at 205-348-5708 if you have any questions.
If you have questions, concerns, or complaints about your rights as a person in a research study, call Ms. Tanta Myles, the Research Compliance Officer of the University, at 205-348-8461 or toll-free at 1-877-820-3066. You may also ask questions, make suggestions, or file complaints and concerns through the IRB Outreach website at http://ovpred.ua.edu/research-compliance/prco/ or email the Research Compliance Office at rscompliance@research.ua.edu.

After you participate, you are encouraged to complete the survey for research participants that is online at the outreach website or you may ask the investigator for a copy of it and mail it to the University Office for Research Compliance, Box 870127, 358 Rose Administration Building, Tuscaloosa, AL 35487-0127.

I have read this consent form. I have had a chance to ask questions. I agree to take part in it and have my interviews recorded.
I will receive a copy of this consent form to keep.

(Check one) Yes ____ No____

_____ _____
Signature of Research Participant Date

_____ _____
Signature of Investigator Date

APPENDIX D

IRB Approval Letter

THE UNIVERSITY OF ALABAMA | *Office of the Vice President for* Research & Economic Development
Office for Research Compliance

September 24, 2019

Rebecca Rich, MA
Department of Health Science
College of Human Environmental Sciences
The University of Alabama
Box 870311

Re: IRB # 19-OR-114-A "Influence of College Women's Perceptions of Feminism on Sexual Health Service-Seeking Behaviors"

Dear Ms. Rich:

The University of Alabama Institutional Review Board has reviewed the revision to your previously approved expedited protocol. The board has approved the change in your protocol.

Please remember that your protocol will expire on April 17, 2020.

Should you need to submit any further correspondence regarding this proposal, please include the assigned IRB application number. Changes in this study cannot be initiated without IRB approval, except when necessary to eliminate apparent immediate hazards to participants.

Good luck with your research.

Sincerely,

[redacted]

Carpantato T. Myles, MSM, CIM, CIP
Director & Research Compliance Officer

358 Rose Administration Building | Box 870127 | Tuscaloosa, AL 35487-0127
205-348-8461 | Fax 205-348-7189 | Toll Free 1-877-820-3066

APPENDIX E

Table of Participant Demographics

Table 1

Participant Demographics

Pseudonym	Gender	Age	Race
Lucille	woman	21	white
Gabrielle	woman	21	black
Rachel	woman	20	white
Lauren	woman	20	white
Madeline	woman	20	white
Taylor	woman	19	white
Elizabeth	woman	18	white
Emily	woman	20	white

APPENDIX F

Table of Organization of Findings

Table 2
Organization of Findings

Research Questions	**Themes**	**Sub-themes**
1. How do undergraduate women public health students at a large southeastern university describe their perceptions of feminism?	Learning from Family	
	Defining Feminism	Connotations of Feminism
		What Feminism is *Not*
	Feelings from Feminism	Empowerment
		Independence
	Frustrations	Gender Inequality
2. What are the sexual health information- and service-seeking experiences of these women?	Barriers to Services	
	Need for Communication	
	Community	College Experiences
		Family
	Education and Knowledge	Abstinence Only
		Importance of Education
		Insufficient Sexuality Education
	Frustrations	"hush hush"
		"seeking but not finding"
		Shame in Sexuality Education
	Information	Information from Friends
		Internet
		Media
	Sociopolitical Factors	Region of Upbringing
		Stereotypes & Stigma
	Types of Services	Contraception
		Sexual Assault
3. How do these women's perceptions of feminism influence their sexual health information- and service-seeking behaviors?	Feminism and Health	
	Frustrations	Stigma
		"there's more to sex than…"
	Curiosity	