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Interpersonal Barriers and Facilitators to Sexual and Reproductive Health Education in the Southern US

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An abstract of
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Abstract

Interpersonal Barriers and Facilitators to Sexual and Reproductive Health Education in the Southern US

By Chloe Hultman

Background: This exploratory qualitative study examines the major barriers and facilitators to sexual and reproductive health (SRH) education in the Southern US, defined topographically and socio-culturally as comprising 11 states/regions: Eastern Texas, Eastern Oklahoma, Arkansas, Louisiana, Tennessee, Mississippi, Alabama, Northern Florida, Georgia, South Carolina, and North Carolina. **AIM:** This study was conducted to answer the research question: *"What barriers or gaps did participants face in meeting their SRH educational needs, and what facilitated having these needs met?"* **Methods:** Participants were SRH professionals and undergraduate and graduate students interested in the SRH field. Participants were all purposively sampled adults who resided in Southern states and were recruited through snowball sampling in social networks and online. A team of four researchers conducted semi-structured in-depth interviews (N=16; 50% SRH professionals and 50% students) via videoconference software Zoom. Audio was transcribed verbatim using HappyScribe™ and transcripts were de-identified. The thematic analysis was conducted with MAXQDA using deductive and inductive codes. **Results:** Major barriers to SRH education were identified including emotional activation in pivotal experiences and social norms and external barriers, such as lack of educational spaces and logistics of continuing education. Major facilitators included supplementary resources, formal professional training, organized and facilitated educational interventions, and reflexivity of personal beliefs. **Conclusion:** Formal education and experiential learning were found to be significant in the SRH profession, and inclusive, evidence-based, and comprehensive SRH education is essential for the general public. This research study emphasizes the need for personalized, curated community spaces – online or in person – that include diverse identities, foster open dialogue, and are free of judgment, shame, and stigma. Future research should investigate the impacts of shame, fear, social scripts, and ostracization in SRH education. Future intervention recommendations include reevaluating laws and policies on sexual education curriculum, and developing online educational interventions for both SRH professionals and the general public that is free, inclusive, comprehensive, and evidence-based. Moreover, funds and workforce should be allocated to monitor and evaluate the efficacy and impact of these interventions and improve them regularly.

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Land Acknowledgement

This research was conducted in Atlanta, Georgia, which was built on unceded territory of the Mvskoke [Muscogee] Creek Nation. From 1821 through 1950, most of the Muscogee Creek people in present day Georgia were coerced to leave their ancestral lands by the U.S. Government and relocated to the states of Oklahoma and Alabama (Trail of Tears), where they continue to live today as federally recognized Indian Nations. As a non-indigenous and current occupant of this land, I pay respect to the Muscogee Creek people, past, present, and future, and their ancestral

lands. To learn about which indigenous community's land you are currently occupying, visit https://native-land.ca.

Positionality Statement

Background information regarding thesis author, Chloe Hultman, that is relevant to this paper includes that she was raised in the Southern US, was raised Christian, is the child of a United Methodist pastor [Mother], is the Grand-child of two United Methodist pastors [Grand-Mother & Grand-Father] and identifies with the LGBTQIA2S+ community. At the time of research, Chloe was studying at the Rollins School of Public Health (RSPH) at Emory University. In May 2023 she graduated with a Master of Public Health in Global Health (MPH-GH), concentrating in Community Health Development (CHD) and Certificate in Maternal & Child Health (MCH) from RSPH.

Content Notice & Call to Presence

This thesis contains and discusses content regarding sexual health, purity culture, religion, shame, stigma, and micro and macro aggressions – all of which can be activating for people on varying levels depending on personal identity and personal experiences. Take the time and space you need to read this. Moreover, if some things discussed are uncomfortable -but not activating- sit with your feelings and examine what arises. Regardless: take a few moments to ground yourself and your body.

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Introduction

Studies on sexual and reproductive health (SRH) education in the United States (US) have indicated an “overwhelming” support for having SRH education in school (Szucs et al., 2022), identified significant disparities in SRH education provision and quality (Caruso et al., 2022; Lindberg & Kantor, 2022), and recognized most and least effective evidence-based curriculums in SRH education (Kramer, 2019; Haberland & Rogow, 2015). Specifically, Comprehensive Sexual Education (CSE) has been shown to be far more effective than Abstinence-only Education (AOE) in achieving US public health goals such as delaying adolescent and general population sexual debut, decreasing adolescent and general population STI rates, and decreasing adolescent and unwanted pregnancy rates (Rabbitte & Enriquez, 2019). Despite this knowledge, most federal funding in the US and most state policy support AOE, not CSE (Rabbitte & Enriquez, 2019). Out of all the states which support AOE, most of them are in the Southern US.

While we have identified significant gaps in US SRH education and knowledge, and the subsequent implications for adverse impacts on public health, we have yet to understand on an interpersonal level the key barriers and facilitators to SRH education. Knowledge of these critical barriers and facilitators may provide stakeholders (parents, teachers, policymakers, and recipients of SRH education) key insights and tools to inform SRH educational policy, improve SRH educational delivery, and ultimately decrease and prevent adverse impacts on public health. Thus, due to the gap in knowledge mentioned above, this study will examine what barriers individuals in the Southern US have faced in meeting their SRH educational needs and what has facilitated meeting these needs.

Literature Review

A preliminary multicultural literature review (Eurocentric, non-Eurocentric, and cross-cultural) aiming to examine barriers and facilitators to SRH education identified forty relevant published peer-reviewed articles. However, most results focused on barriers to accessing SRH care services [9], SRH educational curriculums [11], use of SRH services [2], SRH health statuses and impact of SRH education [6], and assessment of SRH education and knowledge [12]. Notably, four of these articles were about stakeholders' experiences, but only one focused on the recipient of education; all other stakeholders were external entities such as parents, teachers, and SRH care providers. While 18 articles technically included aspects of education facilitation in the form of SRH educational tools, interventions, and comprehensive sex education (CSE)/need for CSE, only two articles specifically focused on assessing barriers and facilitators of how people obtained their SRH education (Mcharo et al., 2021). Thus, due to the gap in knowledge mentioned above, this study will examine what barriers individuals in the Southern US have faced in meeting their SRH educational needs and what has facilitated meeting these needs.

The final literature review was conducted to provide a multidisciplinary, intersectional foundation to contextualize better and examine the subject and implications of SRH Education in the Southern US. In order to better understand the present, we must first examine the past. Specifically, the past is a precedent and variable as to why and how things occurred, came to be, and may continue. The literature review conducted for this study explores and outlines seven relevant concepts, including:

1. Defining the Southern United States,
2. Sexual and Reproductive Health in the Southern US,
3. Evangelical Purity Movement in the United States,

4. Sexual Health Educational Curriculums in the US,
5. Impact of Abstinence Only Education vs Comprehensive Sexual Education,
6. Out-Of-School SRH Education, and
7. Impact of SRH Education

Ultimately, this study aims to explore the research question:

"What barriers or gaps did participants face in meeting their SRH educational needs, and what facilitated having these needs met?" Moreover, the subsequent sub-question: *"What strategies did participants use to overcome these barriers?"*

Methods

This study was conducted using cross-sectional qualitative methods using a phenomenological approach. The study aimed to explore abortion & SRH education experiences of SRH professionals and students interested in SRH in the Southern US. The recruitment strategy entailed contacting and scheduling interviews with SRH professionals and students (graduate and undergraduate) interested in or passionate about SRH-related subjects [N=16; 8 SRH Professionals, 8 students]. Data were collected via structured in-depth interviews and recorded via Zoom videoconferencing software (Archibald et. At, 2019). Audio recordings were transcribed via HappyScribe software, fidelity-checked manually, and de-identified manually to maximize accuracy, anonymity, and data richness. Open codes were created apriori, stored in a codebook spreadsheet, and developed inductively. The coding of transcripts was completed in MAXQDA 2022 (VERBI Software, 2021), and inter-coder reliability was established. Thematic and axial codes were derived by refining open codes to address the research question and sub-question.

Results

Barriers

In exploring barriers to education, responses from participants fell into two main categorical themes: interpersonal barriers and external barriers. With interpersonal barriers, participants cited explicit experiences during formative SRH education, which induced negative stress surrounding the physical and social consequences of engaging in sexual activity. Sub-themes that emerged within the theme of interpersonal barriers include “emotional activation”, in which pathos of fear and shame was used to convey information, and “social norms,” in which instillation of social scripts and socialized othering upon departure from scripts were used to convey information. With external barriers, participants identified sub-themes surrounding logistics as to why their sexual education needs were not being met.

Facilitators

Major facilitators identified in this study include supplementary resources, formal professional training, organized and facilitated educational interventions, SRH-positive dialogues, and reflexivity of personal beliefs. Attributes of supplementary resources deemed necessary by participants include multiple forms of media, the internet, and online community spaces. Necessary attributes of formal professional training include it being comprehensive, evidenced-based, & experiential.

Conclusion

This study explored the barriers and facilitators to sexual and reproductive health (SRH) education in the Southern US. Interpersonal barriers such as emotional activation and social norms,

and external barriers such as lack of educational spaces and logistical issues were identified. Facilitators included supplementary resources, professional training, and organized educational interventions. The study emphasizes the need for accessible and comprehensive SRH education resources, personalized community spaces, and formal education and experiential learning for SRH professionals. Future research should investigate the impacts of shame and fear in SRH education, while future interventions should reevaluate state laws and policies and allocate funds and workforce for developing, evaluating, and improving inclusive, evidence-based, and comprehensive SRH education for the general public and training for SRH professionals.

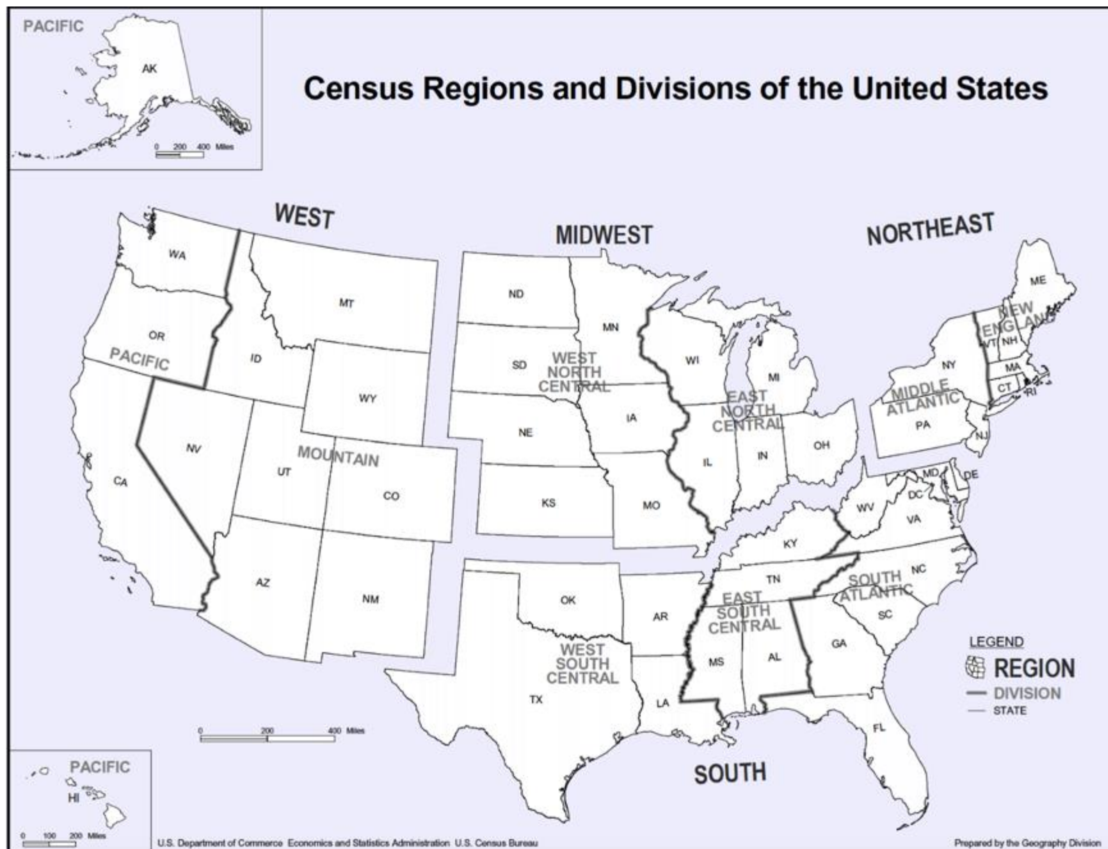
Literature Review

Defining the Southern US

The US is a vast and diverse nation with 50 states, the District of Columbia (Capital of the US, without statehood), and 14 territories (5 inhabited, 9 uninhabited) outside of the continental US. (World Population Review, 2023). The 50 states have informal, but recognized, subregions. The US is governed by state, not sub-region, and the logistical boundaries of these sub-regions are not unanimously agreed upon. This paper will define the Southern US subregion using socio-political and topographical definitions from the US Census and culturally regarded "regional belts" from historical precedent. Figure 2 illustrates this.

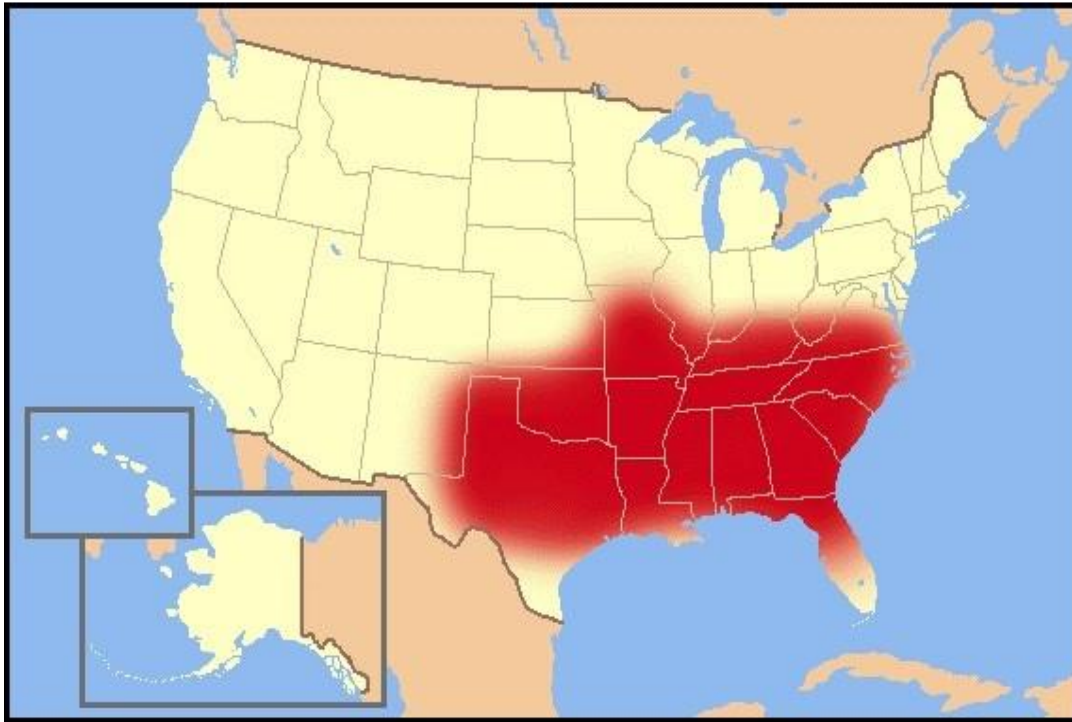
The US Census divides the continental US into four regions with subdivisions. The US Census classifies the "South" as "West South Central" (Texas, Oklahoma, Arkansas, & Louisiana), "East South Central" (Kentucky, Tennessee, Mississippi, & Alabama), and "South Atlantic" (West Virginia, Maryland, Delaware, District of Columbia, Virginia, North Carolina, South Carolina, Georgia, & Florida).

Figure 1. Census Regions and Divisions of the United States (US Census, 2020)



The US has formalized regions and regional divisions based on geographic characteristics and state lines, however geographical areas are additionally referred to as "belts." These "belts" are geographically linked yet not bound by state lines. Instead, these "belts" are based on socio-political and economic historical precedents of creating, extracting, and spreading resources and ideologies - the echoing effects of which are still heard today. Evangelical Christianity's historical and current prevalence of "evangelical Christian sentiment and high [rate of] church attendance" gave rise to the "Bible Belt" (Figure 2) as a major defining "belt" of the Southern US. (Garcia & Kruger, 2010).

Figure 2. The United States "Bible Belt" (Garcia & Kruger 2010)



Cumulatively, this understanding of the Southern US being defined socio-politically by "belts" informs how the Southern US was defined for this study. Specifically, this study defines the Southern US as the state areas and whole states of Eastern Texas, Eastern Oklahoma, Arkansas, Louisiana, Tennessee, Mississippi, Alabama, Northern Florida, Georgia, South Carolina, and North Carolina.

Sexual and Reproductive Health in the Southern US

The United Nations Population Fund (UNFPA) defines sexual and reproductive health - specifically good sexual and reproductive health (SRH) - as a state of being healthy physically, mentally, and socially in all ways that affect the reproductive system. This means that people have the right to a safe and happy sexual life, the ability to have children, and the choice of whether, when, and how often to do so. To keep their sexual and reproductive health in good shape, people

need to have access to correct knowledge and a way of birth control that is safe, efficient, financially affordable, and socially acceptable. They need to know about sexually spread diseases and be able to protect themselves from them. And if and when they decide to have children, pregnant people must have access to skilled health care workers and services that can help them have a healthy pregnancy, safe birth, and healthy child (UNFPA, 2022).

When narrowing in to examine SRH outcomes, states in the Southern US have consistently demonstrated having the highest rates of teen and unwanted pregnancy, teen birth, and sexually transmitted infections (STIs) in the entire country (Jozkowski & Crawford, 2016). Racial disparities permeate these statistics: Black and Hispanic teens experience pregnancy and STI rates twice as high as their White counterparts in the Southern US (Jozkowski & Crawford, 2016). Although many STIs are curable and/or treatable, when left untreated, they can lead to various short and long-term adverse health outcomes: including infertility and even death. People who become pregnant as a teenager are less likely to graduate high school, less likely to go to college, and more likely to live in poverty – exacerbating the cycle of poverty that we see plaguing much of the Southern US (Jozkowski & Crawford, 2016).

Giving birth as a teenager, in addition to creating hardship in various aspects of one's life, has a significant financial toll on the US economy. In 2010, the US spent $9.4 Billion (US $9,400,000,000) on social programming to support childrearing for teen parents - hundreds of millions of dollars of which were procured and used within states in the Southern US (Ventura et al., 2014). While such social programming is a beneficial investment for the well-being of teen parents, their children, and our future as a nation- it must be recognized that such funds could be used elsewhere for teen pregnancies that were unintended and could have been prevented via upstream programming and education.

How Sex "Became" Immoral: Evangelical Purity Movement in the United States

In the 1990's in the US, a cultural phenomenon known as the "Purity Movement," or "Purity Culture," emerged from and within the evangelical subsection of American Christianity. This movement:

> *"...sought to provide moral and religious-based sexual education through private and public policies to both Christian and non-religious youth. This movement directly stressed the concept of abstinence-only until [heterosexual] marriage education, while covertly spreading sexual scripts promoting sexual double standards, the mind-body split, female objectification, and sexual shame"* (Estrada, 2022).

Thus, the cultural and internalized stigma and shame which occurs surrounding discussion of sex is not inherent, but rather, invented. Moreover, the root causes of this invention are incredibly insidious, political, intersectional, and multi-disciplinary. Between the late 1970s to 2000s, Protestant, evangelical Christianity in the United States experienced a banking model [taught as fact] of theology centered on perpetuating power structures and ideals benefitting white supremacy and heteronormativity (McKeegan, 1993; Dowland, 2009; Natarajan et al., 2022). This influx of such models and ideologies, although arguably present throughout Christianity's historical creation and expansion via colonialization, was uniquely exacerbated beginning in the late 1970s due to cultural and legal movements. The results of this influx and exacerbation set an ideological precedent in US culture and politics, which systemically permeate many aspects of society including but not limited to the US public educational system.

Notably, the recent origins of such cultural and legal movements can be pinpointed to a backlash which occurred from socially conservative Christians (who would come to identify themselves as the "Moral Majority") in reactionary response to landmark judicial and legislative

decisions (McKeegan, 1993; Dowland, 2009) - one poignant case of which relating to the tax-exemption status of church-affiliated educational institutions and racial discrimination (Bob Jones University vs. US, 1983). To maintain tax exemption, such Church-affiliated educational institutions attempted to covertly uphold racially discriminatory political views and practices under the guise of conservatively theologizing and assigning moral weight to topics including abortion, LGBTQIA+ identity, and pre-marital sexual activity (Dowland, 2009). One salient output of this era is the actualization of the "Evangelical Purity Movement" and "Purity Culture" beginning in the 1990s (Estrada, 2022).

Due to this movement's recency, the reverberating impacts are only now beginning to be seen and studied. Preliminary research findings have indicated this movement to have harmful effects on an individual level "...that result[s] in physical, emotional, and sexual dysfunction and dissatisfaction" (Estrada, 2022). This cultural era and movement surrounding such ideologies informed and set a precedent for introducing, developing, and emphasizing abstinence-based sexual and reproductive health education in the US – specifically, the Title V Abstinence-Only-Until-Marriage (AOUM) Program, established in 1996 (Kaiser Family Foundation, 2023).

In summation, harmful rhetoric (anti LGBTQIA+, anti-abortion, anti-sexual activity, anti-body, and pro-control) begun to be spread in the 1970's by Protestant and Evangelical Churches under the guise of irrefutable theology for purposes of control and power within their networks. Because of the Southern US' religious identity make-up being highly Christian, particularly highly evangelical and protestant, this rhetoric was spread disproportionally within the Southern US. Individuals born and raised in the Southern US during the 1970s and 1980s who were inundated with such messaging created mental schemas surrounding these topics. Upon "growing up," these schemas translated in adulthood to impact all aspects of life – from how people raised their children

and spoke about sex, to how they developed policy to implement mass-scale sexual education, such as Title V Abstinence-Only-Until-Marriage (AOUM) Program which was introduced, taught, and continues to be funded and taught within public schools in the US today.

Sexual Health Educational Curriculums in the US

Within the United States, educational curricula about sexual and reproductive health can be grouped into three categories: “Abstinence Only Education” (AOE), “Abstinence ‘Plus’ Education” (APE), and “Comprehensive Sex Education” (CSE). Within AOE, abstinence is taught as the “expected standard,” - and discussion of contraception is only included as federally mandated (Kaiser Family Foundation, 2023). Alternatively, APE stresses abstinence but provides information about contraception. Conversely, CSE “Provides medically accurate age-appropriate information about abstinence, *as well as* safer sex practices including contraception and condoms as effective ways to reduce unintended pregnancy and STIs... also usually include[s] information about healthy relationships, communication skills, and human development, among other topics” (Kaiser Family Foundation, 2023). As of 2018, within the 50 US states and the District of Columbia (DC): 24 states + DC require sex education for youth, 13 of which require the information to be medically accurate (Kaiser Family Foundation, 2023). When sex education is taught, 37 states require abstinence to be included – 26 states of which require it to be stressed (APE), and 18 states + DC require information on contraceptives (Kaiser Family Foundation, 2023). In 2017, one-third of federal funding for teen sexual education programs was for abstinence education, the majority of which was abstinence-only education (totaling ¼ of said federal funding) (Kaiser Family Foundation, 2023).

As of 2022, of the 11 states in the Southern US (per above definition of Southern US), 7 of 11 (7/11) mandate sex education, 9/11 mandate STI education, 6/11 mandate “some” healthy

relationship education, and 1/11 mandate detailed healthy relationship education (SEICUS, 2022). If sex education is provided, 11/11 states mandate stressing abstinence, 1/11 require the content to be evidence-based, 3/11 require all content to be medically accurate, 3/11 require some content to be medically accurate, 3/11 must include contraception in a limited capacity, 1/11 must cover contraception extensively, 6/11 must be actively discriminatory against LBGTQIA+ people, 4/11 prohibit discussion of abortion as an option after pregnancy, and 8/11 must promote heterosexual marriage (SEICUS, 2022).

In an analysis of the impacts of AOE, AOE has been found to be ineffective at decreasing pregnancy and STI rates, stigmatizing, unethical (defined here as knowingly withholding knowledge while also providing inaccurate information), and even harmful (Guttmacher, 2017). Health experts agree that "Access to accurate and complete information about sexual health" should be a *fundamental* human right – which AOE does not meet (Guttmacher, 2017). On the contrary, research data has indicated that CSE is incredibly effective and beneficial when implemented: decreasing pregnancy and STI rates and providing guidance on navigating relationships, partnerships, and sexual choices (Guttmacher, 2017). Over the past two decades, over $2 Billion (US $2,000,000,000) has gone to AOE - and despite bodies of evidence indicating the findings mentioned above, federal funds continue to be allocated to this programming – funds which could be allocated to CSE or other initiatives (Guttmacher, 2017).

Impact of Abstinence Only Education vs Comprehensive Sexual Education

Numerous research analyses have been conducted to compare and contrast the impacts of AOE versus CSE. Notably, adolescents who received AOE *or* no sexual health education had an increased risk of adolescent pregnancy compared to those who received CSE (Kohler et al., 2008). Not only does this indicate a positive behavioral impact resulting from CSE, but it suggests that,

in terms of impact on adolescent pregnancy, AOE is comparable to having *no* sexual health education whatsoever. Furthermore, AOE was associated with unfavorable attitudes towards condom usage, and recipients were more likely to engage in unprotected sex, which is associated with an increased risk of pregnancy [in heterosexual sexual encounters] and STI transmission (Sheperd et al., 2017). Moreover, the type of sexuality education received (CSE or AOE) is not associated with significant differences in recent sexual behavior – in other words, people have sex at similar rates *regardless* of which education they receive. However, there are differences surrounding risk behavior and age of sexual debut [having sex for the first time] (Sheperd et al., 2017).

Research does indicate that type of sexual education does impact the age of sexual debut, number of sexual partners, and condom or contraceptive usage – while there is not inherent moral value to these behaviors, they are associated with an increased risk of some adverse health outcomes, including but not limited to STI transmission. Specifically, 2/3rds of CSE programs that encouraged both contraceptive use *and* abstinence were shown to have a positive impact on delaying sexual debut in adolescents, decreasing the amount of sex or sexual partners, and increasing contraception and/or condom usage (Kirby, 2007). The starkest positive impact in reducing teen pregnancy rates (reduced by ½ for three years) resulted from a highly intensive, comprehensive, and long-term educational program (Kirby, 2007). Additionally, teaching about contraception was *not* associated with an increased risk of adolescent sexual activity nor STI transmission (Kohler et al., 2008). Based on the literature comparing the impacts of CSE and AOE, the evidence does not support AOE's widespread application and dissemination. However, this literature *strongly* supports the widespread application and dissemination of CSE.

Out-Of-School SRH Education

Unfortunately, there is very little literature about and/or assessing out-of-school SRH education within the United States, such as at home or through community-based initiatives. One study identified as relevant was about both at-home and at-school SRH education (not explicitly re out-of-school) and mainly explored the attitudes and perceptions of parents and adolescents in New Brunswick, Canada (Weaver et al., 2002; Byers et al., 2003). Results of this study provided evidence twofold: adolescents reported higher satisfaction with in-school SRH education compared to at-home SRH education, and parents reported being under-involved in their child's SRH education but wished to be more involved (Weaver et al., 2002; Byers et al., 2003). Moreover, these parents indicated not knowing how to discuss the subject of SRH education with their children. The parents desired guidance from schools about the curriculum, sexuality overall, and effective SRH communication strategies with their children (Weaver et al., 2002). Another study interestingly indicates that teens desired parents to be one of their primary sources of SRH education, and parents indicated the same. However, parents reported experiencing difficulty and discomfort in having these conversations with their teen children (Koren, 2019). This study calls upon the "... need for culturally sensitive and innovative interventions aimed at creating a safe place for parents to gain knowledge, resources, and strategies" to speak with their children about SRH (Koren, 2019).

The most research literature on SRH education interventions identified took place in non-US contexts: while this is beneficial for expanding such programmatic design and implementation within the US, the analysis and explicit findings of impact and efficacy of such programs are location-specific and not necessarily generalizable to the US (Chilambe et al., 2023; Zulu et al., 2018). One research study was identified as US-specific and assessed barriers and facilitators of

[Christian] African American Church-based SRH education programs in Baltimore, Maryland (Powell et al., 2017). The findings of this qualitative study support feasibility and desirability of SRH educational programs within religious institutions; however, significant barriers were identified, including congregation resistance, youth discomfort, and competing messages between home and Church about SRH behaviors (Powell et al., 2017).

It must be recognized that this intervention was within a specific population and may not be generalizable throughout the US, especially with time. While most of the US does currently identify as religiously Christian (70%), this has been in stark decline over the past 50 years, and "Nones" (those who identify as "none" or "no religion") has been exponentially increasing in an increasingly secular world (Nadeem, 2022). Statistical projections predict that by the year 2070, "Nones" will surpass Christianity as the majority religious affiliation and that Christianity will fall into a minority religious affiliation in the US (Nadeem, 2022). Therefore, to be sustainably accessibly to the largest amount of people, it is recommended that educational interventions be explored and studied outside of a religious context.

Impact of SRH Education

While SRH education can vary in method, quantity, and quality, some general salient themes and outcomes were found in the literature on the impact of SRH education. Studies support that SRH education has -and has not- had an impact on attitudes, depending on the delivery of the education (Doyle et al., 2010; Van et al., 2015). While SRH education may not always impact attitudes, studies consistently indicate such education to have positive, beneficial impacts on increased knowledge and behavioral changes (Doyle et al., 2010; Van et al., 2015). In a cross-cultural meta-analysis, it was found that SRH education 1) does not hasten sexual debut or increase sexual behavior, 2) does delay sexual debut or decrease sexual activity, *and* 3) increases condom

or contraceptive usage (Kirby et al., 2007). In turn, SRH education leads to lower risks of HIV and STI transmission (Doyle et al., 2010).

Culturally and ideologically speaking, SRH education has been linked to increased progressive attitudes toward women and girls and decreased harmful attitudes surrounding hegemonic masculinity (male dominance) (Grose et al., 2014). SRH education which includes a discussion of gender and power dynamics has been shown to be exponentially (500%) more effective at disseminating information and association with lower STI and unintended pregnancy rates than SRH education which did not include a discussion of gender and power dynamics (Haberland, 2015). Overall, the literature considers SRH educational interventions to have a *net positive* impact on recipients of education (Van et al., 2015).

Methods

Setting of Researchers

Data were derived from a research study evaluating the Global Elimination from Maternal Mortality (GEMMA) Community Workshop conducted by six researchers from the Center for Reproductive Health Research in the Southeast (RISE). The research team included two principal investigators (PIs), Drs. Subasri Narasimhan (Researcher 1) and Anna Newton-Levinson (Researcher 2), and four Graduate Research Assistants (GRAs), Chloe Hultman (Researcher 3; Thesis author), Jessie Lane (Researcher 4), Melissa Cobb (Researcher 5), and Dora Durak (Researcher 6).

Positionality of Researchers

Positionality is a concept defined as “an individual’s world view and the position they adopt about a research task and its social and political context [...] that are shaped by their political allegiance, religious faith, gender, sexuality, historical and geographical location, ethnicity, race, social class, and status, (dis) abilities and so on” (Holmes, 2020, pp. 1-2). Notably, although some aspects of positionality are stagnant, many may often be considered fluid that may change with time and/or according to the context and relation to those around us, especially when considering social constructs that hold and impose both explicit and implicit power dynamics. Reflexivity “is the concept that researchers should acknowledge and disclose their selves in their research, seeking to understand their part in it, or influence on it” (Holmes, 2020, p.2). Because all individuals hold unique positionalities, it is imperative in research -especially qualitative- for researchers to engage in reflexivity and critical examination of their positionality so that they and others may better understand how this may explicitly or implicitly impact and interact with their research.

All researchers identified as female/assigned female at birth, four out of five of the research team racially identified as White, and one researcher identified as a BIPOC. Researchers 1 & 2 have obtained higher education degrees, including a Master's and Doctorate in Philosophy (Ph.D.). Researchers 3, 4, & 5 obtained a Master’s degree at Emory University when the research was conducted. Researcher 6 was not involved in the data analysis process.

Study Population and Setting

Due to the nature of this exploratory study, our convenience sampling was centered on geographic region and key informant status on SRH education, with a goal sampling composition of 50% SRH professionals and 50% graduate/undergraduate students. Researchers were not

concerned with meeting additional specific demographic requirements. As a result, demographic details that were referenced, recognized, and/or discussed by participants in their key-informant interviews were only collected. Final sample population entailed 16 individuals [N=16], 8 of which were SRH professionals and 8 of which were undergraduate or graduate students interested in SRH, therefore meeting the goal sampling composition established by researchers apriori.

Study Design, Sampling, and Participant Recruitment

This research study utilized a semi-structured interview design, defined as a one-time interaction with the participant and use of a semi-structured interview guide with researchers able to probe interviewees when appropriate and relevant to the research project's goals, research questions, and research sub-questions.

The team worked hybrid between remote and in-person, with the predominant work being remote. Although remote, all researchers were based and worked out of the general vicinity of Atlanta, GA, USA. Researchers 1, 2, 3, 5, & 6 were involved with sampling and recruitment. Researchers 1 & 2 were involved with developing interview guides, Researchers 1, 3, 4, & 5 interviewed participants, and researchers 1, 2, 3, & 4 were involved with data analysis.

Inclusion criteria entailed identifying as an SRH professional in the Southern US and students (graduate and undergraduate) enrolled in a private or public university in the Southern US who were interested in or passionate about SRH-related subjects. Inclusion also required the participant to identify or be identified by a source external to self as a key informant on SRH and abortion education, either personally or professionally, informal or formal. Exclusion criteria entailed participants that did not identify with the above criteria, if the participant was under 18 years old, or did not consent to the study. The sampling strategy included the research team identifying key informants, snowball sampling with members of the reproductive justice

community in the Southern US, snowball sampling based on interviews with identified key informants, emailing key informant groups, and posting to media platforms. The sample size was limited to 16 participants based on the standard practice of key informant interview sampling to ensure the richness and diversity of data.

The recruitment strategy included the research team contacting key informants directly for recruitment, contacting SRH and reproductive organizations in the Southeast inquiring about key informants and interest, emailing SRH-related offices and organizations in public and private universities in the southeast, and posting to SRH-related groups on media platforms including GroupMe, Facebook, and LinkedIn. All contact methods included a standardized contacting template and graphic visual containing information about the study, inclusion, and exclusion criteria, contact information for interest and referrals, and compensation information for participating in an interview. Study participants were compensated for their time with a one-time $50 electronic VISA gift card with expiration. They were provided this immediately after the interview and were sent a reminder to use the card before expiry. Subjects were screened before interviews about their experience, interest, and rationale for participating in the study. Upon screening, researchers contacted key informants who qualified and proceeded with the study by scheduling Zoom video conference (Archibald et. At, 2019) interviews with interviewees.

Tools, Data Collection, and Data Storage

Researchers developed interview guides before interviews, and two research guides were developed: one for interviewees who identified as students (Appendix B) and one for interviewees who identified as non-students because they were SRH professionals (Appendix C). Semi-structured interviews were conducted via Zoom videoconferencing software (Archibald et. At, 2019) by designated interviewers using one of two developed interview guides, one for student

status and the other for professionals. The interview guide for students included 17 questions divided up into four sections: “Opening Questions” [introduction & inquiry of personal background], “Abortion Discussions and Abortion Training in your University/School,” “Course Curriculum and Format” [regarding the development of an educational community course on abortion], and “Closing” [final comments & snowball sampling]. The interview guide for non-students / SRH professionals consisted of 17 questions divided up into five sections: “Opening Questions” [inquiry on professional background], “Needs for abortion education/training in your organization,” “Components of a training” [a course on abortion for community & other SRH professionals], “Need for abortion education/training in the community?,” and “Closing” [final comments].

Data were collected via structured key-informant interviews and recorded via Zoom videoconference software (Archibald et. At, 2019). At the beginning of the interviews, interviewers read a standardized script of informed consent to the interviewees, answered any questions the interviewees had, and requested the interviewees' consent to proceed with the interview and record the interview. After the interviews were complete, interviewers downloaded Zoom videoconference recording data to their personal private server, deleted all data output aside from audio mp4 files, and uploaded audio files to a secure Emory OneDrive folder only accessible to the research team with Emory University login. Participants were assigned participant identification numbers, which served as mp4 file names within OneDrive. Audio recordings were transcribed via HappyScribe™ automatic transcription software using the secure and private login of the PI. Audio transcriptions were cataloged using participation identification numbers, fidelity checked manually, and de-identified manually to maximize accuracy, anonymity, and data richness.

Analysis

This study utilized a qualitative methodological approach with analysis methods rooted in a combination of approaches, thematic analysis, and framework analysis. Open codes were created apriori, stored in a codebook spreadsheet, and developed inductively over time as transcripts were coded. The coding of transcripts was completed in MAXQDA 2022 (VERBI Software, 2021), and inter-coder reliability was established between two coders, researchers 3 & 4. Thematic codes were derived by refining open codes to address the research question and sub-question. After the coding was completed, researcher 3 selected significant themes of "Interpersonal Barriers," "Interpersonal Facilitators," and "Resources and Tools" to explore further. Upon theme examination, sub-codes were inductively generated, developed, and refined. Content summaries were created of these three themes and subsequently identified sub-themes. A cross-sectional analysis examination was conducted about individual themes, the intersectional reality of these themes, and the potential correlative impact of their compounding intersectionality.

Theoretical Frameworks

This study used two equity-informed theoretical frameworks to assist in contextualizing, understanding, analyzing how and why health and education outcomes occur and what changes can be made to create a more equitable future. The Systems Health Equity Lens (SHEL) of Figure 3 demonstrates an expansion of the socio-ecological model of health behavior to understand how levels of systems interact and impact one another. Notably, this framework centers on health systems rather than individuals (Pauly, 2018). Moreover, this framework uniquely recognizes the presence of variables contributing to health inequities while emphasizing the need to create actionable systems change to promote health equity (Pauly, 2018). ETR's Health Equity Framework, as visualized in Figure 4, demonstrates a more abstract way of understanding the

impacts and outcomes of health and education. Instead of levels expanding outward, factors of influence interact within a three-dimensional space, complex and unable to be disentangled (Peterson, 2020). While this study examines all factors of influence, this recognition, understanding, and demonstration of relationships and networks as a factor of influence was invaluable in the analysis and discussion of our qualitative data. Mainly, SHEL's framework allowed nuance, complexity, and intersectionality to be at the forefront of contextualizing and understanding data. Moreover, the SHEL framework informed discussion of results centered on actionable suggestions and recommendations to create systems changes in order to better achieve holistic, intersectional, and sustainable health equity. Furthermore, utilization of ETR's conceptual framework emphasized within analysis the dimensionality, complexity, and systematic entanglement of factors impacting the lived experience of participants, and discussion calling upon multi-dimensional systems interventions based on the findings.

Figure 3. The Systems Health Equity Lens (SHEL) (Pauly, 2018)

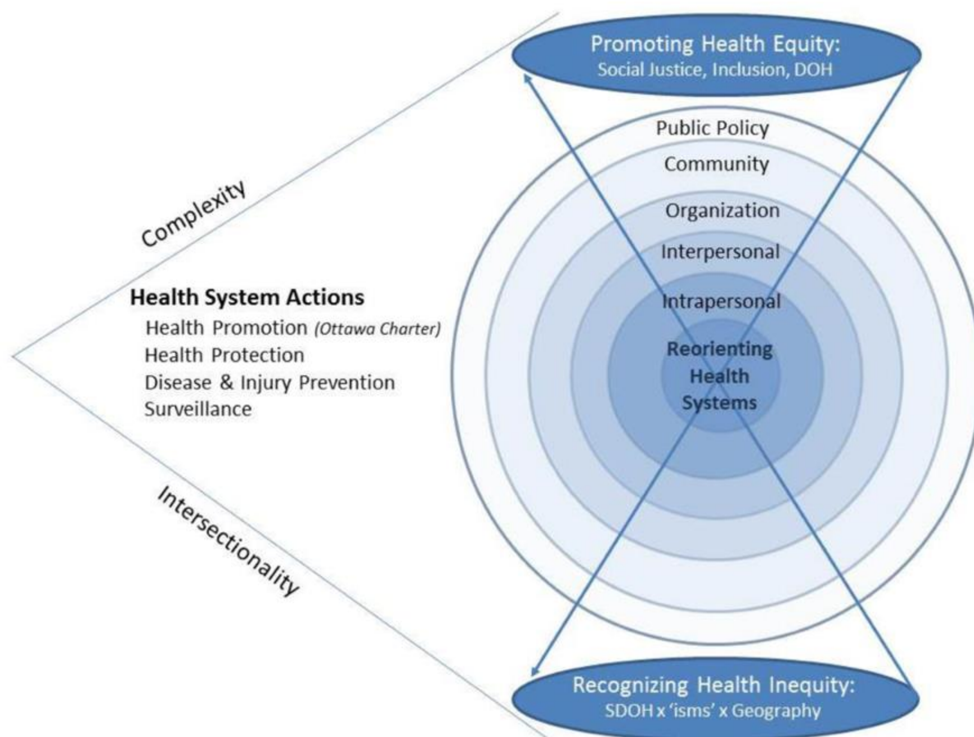


Figure 4. ETR's Health Equity Framework (Peterson, 2020)

Institutional Review and Ethics

` This research was deemed Exempt by the Emory University Institutional Review Board (IRB) in 2022. All researchers were CITI Certified in Human Subjects Protection with a Social/Behavioral Focus. All researchers who interviewed participants were trained in interview protocol surrounding sensitive subjects. Interviews began with researchers reading participants an informed consent, and participants were asked to consent before recording the Zoom videoconference and proceeding with the interview. All participants were informed that interviews were voluntary; they could opt out of any questions at any time, take a break during the interview if needed, and withdraw their consent at any time without repercussions. No participants declined

consent at the beginning or throughout the interviews. The protection of participants was prioritized, and all researchers adhered to the guidelines for data security and ethics as outlined by Emory University. All data were stored in password-protected accounts, including Emory OneDrive. The anonymity of participants was prioritized as outlined above in de-identification methods.

Results

Barriers to Education

When examining the barriers to sexual and reproductive health education, the responses from participants were categorized into two main themes: interpersonal barriers and external barriers. Under interpersonal barriers, participants reported experiencing negative stress during their formative sexual and reproductive health education. This induced fear and shame surrounding the physical and social consequences of sexual activity. Two sub-themes emerged: "emotional activation," referring to using fear and shame to convey information, and "social norms," referring to the instilling of social scripts and othering when individuals deviate from those scripts. On the other hand, external barriers identified involved issues related to the logistics of accessing information about sexual education, leading to unmet needs.

Interpersonal Barriers to SRH Education

Interpersonal Barrier to SRH Education #1: Emotional Activation and Pivotal Experiences.

In sexual education, feelings of emotional activation, including fear and shame, were observed as a byproduct of pivotal experiences in participants' SRH education. Participants

reported the presence of conservative religious rhetoric, with Christianity being the only religion discussed or referenced, emphasizing the importance of *"sexual purity."* They were warned that failure to adhere to these principles would result in metaphysical, cosmic, and spiritual repercussions; These consequences included losing their relationship with their higher religious power/entity and facing eternal exile after death in a place of torment and retribution known as *"hell."*

One 27-year-old non-binary participant, an MSW-MPH graduate student, described how these norms were established in their childhood. Their parents had told them that babies were gifts from God, making abortion equivalent to murder and something only *"bad people"* do. The participant linked spiritual consequences with abortion, stating that *"people who have abortions go to hell."* This portrayal of hell as a scary place one does not want to go to led said participant to commit, as a child, not to become a *"bad person"* by having an abortion.

Several participants reported departing from such ideologies with age but recounted many instances where fear of sexual consequences was used as a tool of control in sexual education. One female participant, an SRH professional, explained that she initially became so interested in sexual health education because she attended an all-girls Catholic school, and her SRH education there was *"really strange and really shaming and not helpful."*

Participants reported that using fear as an educational tool was psychologically distressing and caused anxiety during their youth. Even when their beliefs changed with time, the longitudinal impacts of fear-based teachings remained with them. While many participants spoke specifically about fear tactics used in religious doctrine and ideologies, this was not always the case. For instance, some participants were warned that "if they engaged in X behavior, negative result Y would happen to them." While some participants believed that fear-based teaching was rooted in

a desire to protect them, they ultimately found it more harmful than helpful. Sometimes religious gatherings came with other social supports to alleviate food insecurity and loneliness. One participant, now an SRH researcher, who experienced food insecurity growing up, shared their experience walking the line of attaining social support at the expense of receiving negative messaging, which they internalized.

> *"Yeah, there was a lot of purity content in those years because I just really wanted the community and I wanted food and they paid attention to me, which is really sad, but that was the reality of middle school for me"*

Several interviewees reported feeling shame as a result of their sexual education experiences. This shame was often instilled through activities or metaphors emphasizing abstinence and illustrating the spread of sexually transmitted infections (STIs). Interestingly, interviewees tended to remember how they felt emotionally during and after these activities rather than the specific information they learned. Overall, interviewees reported being emotionally impacted by their sexual education experiences, with feelings of shame being a common theme. Many felt that the emphasis on abstinence and STI prevention came at the cost of addressing other important topics related to sexual health and well-being.

A significant number of respondents recalled three specific in-class activities that they found particularly shameful. One such activity involved using an object that could be physically altered in some way, such as tape, tinfoil, or food. Although the details of the object varied among respondents, the activity's message remained consistent: the unused item was changed in a way that caused an irreversible physical alteration, and students were told that the item had lost its value, making it difficult to use in the future. This metaphor was presented as what happens when someone has sex.

For example, one female participant, a recent Master of Counselling graduate, recalled an activity her peers had experienced in which teachers took some tape and stuck it to multiple people's shirts: *“The like, ‘go stick this tape to everyone's shirt and like, see- its- the tape is ruined, now that you've done that’.”* The teachers showed the students that it became more challenging to stick the tape, which they presented as evidence that the tape was "ruined." The message that the students took away from this activity was that they and their sexuality were like a piece of tape: the more people they "stuck" to (i.e., had sex with), the less valuable they became, no one would want "used tape" (i.e., a person who has had sex with someone else), and it would become more challenging to "stick" to things in the future (i.e., forming emotional bonds and relationships with others).

The second in-class activity that many respondents recalled involved a role-play exercise simulating STI transmission. In this activity, students were instructed to swap unidentified liquids using containers, such as cups, vials, or similar items, to simulate sexual activity. At the end of the activity, the liquid content was tested in some way to indicate whether it was "positive" or "negative" for an STI. While this activity was more standardized across participants, some specific details varied. A female participant, a current graduate student, recalled this activity in 9th grade and ultimately being identified as “patient zero,” and reported not gleaning any educational knowledge of value. However, they did experience and remember feelings of shame and embarrassment.

> *“And the point was that someone in their vial had a chemical that would turn everyone else's purple once it mixed, and that was to simulate the spread of HIV.* ***And so I gave the whole class HIV, was what I remember from that****.”*

A different participant, a current SRH professional, also described having this same activity also 9th grade. Similarly, their experience was not described as having any educational value but rather an attempt to use fear, anxiety, and stigma surrounding STIs to deter all sexual activity.

> *"...Everybody would be revealed in the end to have an STD [STI]. Oh my goodness, don't have sex. That was the point instead of don't have unprotected sex. Don't have sex. You will get an STD [STI]."*

The third type of activity that numerous participants mentioned involved being required to view graphic images and videos related to childbirth and STIs. Several participants specifically mentioned the documentary *"The Miracle of Life,"* which depicted someone in active labor. However, rather than documenting the pregnant person's experience, participants noted that the documentary mainly focused on the mechanics and graphic nature of the labor itself. The film provided a complete view of the person's labia and vulva and showed the point-blank delivery of the child. One current graduate student participant recounted their experience in 6th grade and said it was their first time seeing such graphic material. They recalled many of their classmates screaming throughout, and the class lesson commenced, and they were sent to the next class without any discussion or debriefing. This experience served more as a frightening and emotionally activating experience rather than an educational one.

> *"...it was just a very traumatic experience. [...] I don't think I literally learned anything about it [childbirth] except for that it's scary, painful, and gross. And then we had no debrief, by the way, then class was over and we had to go to math"*

Several participants also reported being shown *"graphic"* images of untreated genital STIs during their sexual education classes. These images depicted the genitals of adults in a highly

inflamed or infected state due to untreated STIs. The participants were youth when they viewed these images. They described the commentary accompanying the images as focused on physical discomfort, pain, and the visual appearance of the untreated STIs. Interviewees reported that viewing graphic material as part of their sexual health education had a traumatic impact on them, making the experience memorable. Participants noted that these activities and content aimed to discourage sexual activity overall.

Interpersonal Barrier to SRH Education #2: Social Norms.

In addition to emotional activation and pivotal experiences, the sub-theme of social norms appeared within interpersonal barriers. Mainly, social norms were introduced, established, reinforced, and practiced via social scripts and othering. Participants described being told "social scripts" -what behaviors they should and should not do- and that negative repercussions would occur if said social scripts were not adhered to. Such social scripts perpetuated by teachers in the school context surpassed beneficial evidenced-based warnings of the risks of STIs from unprotected sex. These scripts included assigning moral value and personal worth to behavior, including disparaging pre-marital sex, promoting heteronormativity, and disallowing promoting abortion as a viable healthcare option.

One female participant, who identifies as Lesbian and is currently pursuing a graduate degree in social work, shared a vivid memory of receiving social scripts from a guest speaker during their middle school health class. Specifically, the guest speaker explicitly encouraged abstinence until heterosexual marriage and warned of the negative emotional consequences of premarital sex. These consequences were demonstrated metaphorically through *"crumpling up"* a foil heart and saying it would *"never be the same"* [due to primatial sex] – similar to the tape metaphor outlined prior. This participant also explained that, of the little sexual education she did

receive, it was poor quality, primarily abstinence-based, non-memorable, heteronormative (therefore unapplicable to her), and non-sensical. The participant noted that the social scripts she experienced at school were similar to those in other environments, particularly at Church.

> *"I mean, I was like, pre-pubescent at this point but I was still like, 'this literally makes no sense' […] And then at high school...We didn't really have any sex Ed, which is alarming because that's when most people start having sex, not middle school. But I mean, at Church I got messages about abstinence and being straight and not having sex and all that stuff."*

Social scripts were found to be shared amongst people's formative sexual health education. Frequently, individuals were told what they should feel about certain subjects, what behaviors they should or should not engage in, and what would happen to them socially and emotionally if they did not adhere to such scripts. These scripts were told to individuals within the curriculum at school, within religious contexts, and at home with their families. Most scripts surrounded adherence to abstinence and heteronormativity.

Othering was reported as being by several participants, the most prominent experience being of a female participant, now in law school, within their Judeo-Christian high school. Upon receiving a student leadership position, the participant stated that the group of student leaders participated in a kind of values-clarification exercise by the school's guidance counselors. In the activity, guidance counselors asked the student leaders to demonstrate their position (strongly disagree to strongly agree) on controversial subjects by moving to different room parts. At one point, the participant recalls that all the boys were asked to sit down, and only the girls were asked to rank their level of agreement with the values statements and situations. Specifically, these high school girls were asked if they were to become pregnant at this point in time, would they or would not get an abortion.

The female participant recalled being only one of two girls to say that she would get an abortion and that the remainder of the class held negative and stigmatizing beliefs surrounding abortion. The participant underscored that this question was unfairly heavily gendered and that the school's religious context of being Judeo-Christian was an impactful environmental factor on ideological beliefs within the student population. When the participant attempted to share feedback to the adult guidance counselors in charge that this question was *"highly inappropriate,"* the guidance counselor dismissed her concerns and doubled down on the validity and warrant of asking the question.

> *"We should not have had to declare, like, 'yeah, I would get an abortion.' Especially given the environment that we were in, which was Judeo-Christian like, again, everyone else was on, the like, "I would never get an abortion, it's evil", side of a room."*

Several interviewees shared their experiences of having received sexual and reproductive health education that was based on upholding and perpetuating social norms surrounding purity and abstinence, often influenced by religion. One female participant, a Master of Science in Mental Health Counseling student, described these "educational" experiences in religious institutions (Church and religiously-affiliated school) as harmful, poor quality, abstinence-based, non-comprehensive, and not inclusive. While this was a detriment during her upbringing, it, in turn, motivated her to develop an interest and passion for sexual and reproductive health education to help others have experiences different from her own.

> *"I think probably my personal experience of being raised in the Church and being exposed to purity culture is a major factor. I went to private Christian schools for preschool until 12th grade, so my sex Ed was not comprehensive.[...] And that affected my personal development and my self-discovery and experience of just growing up. And so I am really*

passionate about safe-sex and making sure that people have the information that they need to make the best decisions for themselves."

External Barriers to Education: Lacking in Educational Spaces + Further Education

Participants identified two types of external barriers that hindered their sexual education. The first barrier was a lack of initial educational spaces, including formal and informal spaces, earlier in life. The second barrier was limited access to further education, such as during post-high school or employment, which prevented them from obtaining additional knowledge and understanding.

External Barrier to SRH Education #1: Lacking Educational Spaces.

Although many participants expressed dissatisfaction with the limited availability of sexual education spaces within formal educational settings, they also reported a lack of such spaces in their homes or families. One participant revealed having no opportunities to discuss sex, sexual health, or sexual education with their parents or other family members, indicating a lack of "space" for such conversations. This participant also shared that they faced multiple stigmas related to various aspects of SRH, not just sexual education –including but not limited to negative messaging surrounding body weight [fatphobia] and teen pregnancy. This participant, who is queer, a child of immigrants from a country in West Africa (unspecified for anonymity purposes), and currently pursuing a dual graduate Masters's degree in public health and social work, recounted their first period and how their parent drove them to get mensural supplies but provided the participant, their child, with no further or additional information.

"Even when I started my menstrual cycle [..] [when I] learned about that in school, my mom never talked to me about it. And when it [their first mensural cycle] came, I was like,

'Mom, I'm on my period.' She's like, I''ll take you to the Walgreens.' Everything else, I had to read the packet or I looked online at the blog. There was no clear messaging about what labor is like, what birth is like, what pregnancy is like."

Many participants expressed that the lack of personal space to discuss topics related to sexual and reproductive health, particularly within the home and family, was a significant barrier to their SRH education. They found it challenging to speak openly with their family members or ask questions regarding SRH subjects.

External Barrier to SRH Education #2: Logistics of Continuing Education.

Participants identified barriers to accessing further education beyond high school as a significant external barrier to sexual health education. Some professionals employed in the SRH field expressed a desire to pursue continuing education activities but faced obstacles. For instance, a participant shared a hypothetical situation where the supervisor informs subordinates about an educational opportunity. However, accessing funding for it would require negotiation with their employer, which is a significant barrier, especially depending on organizational structure and if funds were not readily available. This SRH professional, who works with a highly regarded reproductive justice organization, outlined this multitude of barriers and, even if feasible to overcome, can be intimidating and dissuasive.

"...say a supervisor sends out an email on abortion access training [and] registration is two hundred dollars. So now that presents a barrier. And now that peer community health educator will then have to go to the finance [department to] ask for a budget or ask for permission for funds or be reimbursed for funds to pay for such webinar. [In my position]

that's typically not an issue. [...] but I could see if one saw that price, they would maybe click away or exit you know."

Many interviewees reported that when their sexual and reproductive health education needs were not met during their formative years, they attempted to seek further education later in life. Often, they were able to access this education at an institution of higher education they attended. However, barriers arose when individuals sought this education as part of their employment or via formal programs. Specifically, economic restrictions (personal or lack of funding from employer), lack of time off (paid time off), lack of knowledge of opportunities, and scheduling logistics were identified as barriers that hindered individuals from pursuing and completing such supplemental or further education.

Facilitators to SRH Education: New Ways of Getting Education

Although participants in this study encountered challenges in meeting their evolving SRH educational needs, they also identified several helpful factors. Participants noted that access to further education, including individual supplementary purposes and professional training purposes, was important. In addition, they found community-organized educational interventions, SRH-positive community discussion spaces, and personal belief reflexivity to be beneficial facilitators for SRH education.

Education Facilitator #1: Supplementary Resources: Media, The Internet, & Online Community Spaces.

Without adequate education during their youth, participants often resorted to seeking information independently. However, it had to be readily available for individuals to actively seek out and access such information. While some individuals pursued formal education through

college classes, others relied on on-demand resources such as via the Internet. However, participants pointed out that although the Internet provided a dearth of resources, online spaces were typically unmonitored and needed more community guidelines or oversight by an authoritative entity or individual.

One female participant in graduate school for social work shared that she started using online platforms, such as Tumblr and YouTube, to seek out information about sexual and reproductive health during her early high school years, around the age of 14. She used these platforms to access other individuals' stories, experiences, and knowledge, and follow specific content creators. The Internet provided real-time answers to questions about SRH that her parents or teachers did not address. Simultaneously, this participant recognized that as she aged, she became less religiously conservative and engaged in more critical thinking surrounding SRH for herself and others. She noted that while information was available within sub-circles and groups on these online platforms, there needed to be more monitoring or moderation to ensure the quality of the information. Nonetheless, she found the Internet a valuable resource that met her educational needs without formal education.

> *"Honestly, I think having access to the Internet in high school was, like, really big for me. [Laughs] [...]I think just getting older, I became less conservatively religious. And that [conservative religiosity] was where a lot of that [moralizing sex as "bad"] was from. [...] And becoming of an age where it's like, 'oh, I actually could get pregnant and I could have a baby and I really don't want to, and being pregnant doesn't make sense for me' and understand that it doesn't make sense for a lot of other people too. So I think just like maturity and having access to information, like, more accurate information."*

During the interviews, participants discussed various online and media resources they used to learn about SRH topics. The most commonly mentioned resources included published research articles, podcasts, media websites such as Tumblr and Gurl.com, books such as "The Caring and Keeping of You," "Come As You Are" by Emily Nagoski, and "All About Love" by Bell Hooks, radio stations like NPR, YouTube, Wiki How, Yahoo Answers, informational websites like PlanC.com and Plannedparenthood.com, and even pornographic materials such as erotic literature on Wattpad.com.

A separate participant who was also a graduate student shared that Tumblr and Gurl.com played a significant role in their SRH education as they did not have access to many resources growing up. These platforms filled the gap and provided a safe and open space for them to be themselves and process their experiences of growing up. This participant found the resources on Tumblr and Gurl.com to be impartial and non-judgmental, which profoundly, beneficially impacted their life. They even mentioned these resources in their graduate school application. Additionally, this participant mentioned using erotic literature on Wattpad.com as a source for learning about sexual encounters. While movies were also mentioned as a source of information, this participant expressed dissatisfaction with them as an informational source.

> *Yeah. Tumblr, but really gurl.com. I actually wrote about this in my entrance exam [for graduate school] [...] because it totally changed my life and changed the trajectory [...] Yeah, that blog was something that could be mine. It was a place where I could have access to information that was honest and not skewed so heavily and could talk about the messiness of growing up. So it was really helpful because I didn't have that growing up. And WattPad! [...] I think that's where I learned a lot about the sexual scripts.*

Online spaces often lacked formality and regulation in comparison to traditional educational institutions, making them less likely to adhere to evidence-based and factually accurate information and educational methods. Additionally, these spaces often lack individuals responsible for upholding organizational guidelines and moderating content. One participant in graduate school described their experience during high school on unregulated platforms like Tumblr and Yahoo Answers, where they witnessed a commentary thread discussing abortion. Anonymous users shared their different thoughts and perspectives on the topic in this thread. However, anonymity made it difficult to verify the information's accuracy and credibility.

"I feel like in high school, I also was learning about abortion. I feel like it was on Tumblr. [...] I used to be on Tumblr learning stuff and Yahoo Answers. [...] I remember seeing someone trying to decide whether or not they were going to get an abortion or something, and people were like, chiming in."

Education Facilitator #2: Formal Training: Comprehensive, Evidenced-Based, & Experiential.

Many of the participants interviewed are employed as SRH professionals, having undergone formal education and training to acquire the necessary career qualifications. Unlike their personal SRH education, which often involved informal online resources, these professionals received formal education and training from organized entities for professional purposes. These resources must adhere to evidence-based and factually accurate information and are monitored by individuals or entities responsible for upholding community guidelines. One participant, a current SRH professional in the nursing field, applauded the nurse practitioners and physician's assistant curriculum, which they found to be extensive, comprehensive, and holistic.

"And I always appreciated that it is pretty comprehensive in that it includes as learning competencies that the learner should graduate with or finish the curriculum with, not just the clinical, but how to talk to a patient, how to educate them about their options, I guess options, counseling as well as what to inform them about on their way out. I would say more holistic than what I've seen medical providers get and is a better for [...] anyone who wants to see how abortion care is or should be or can be delivered."

In this study, professional education is defined as the educational training received or provided to fulfill professional obligations related to SRH roles. A participant, an SRH professional, discussed their experience with professional training and orientation while working for several local and regional reproductive justice organizations. The participant explained that this training went beyond traditional job training and included multimedia resources and experiential learning, such as acting as a "mock patient" to gain a firsthand understanding of the patient experience.

"I believe that [regional abortion fund] has an orientation [for new hires] that may include training around abortion. [...] And similarly, with [local reproductive health clinic], I think that beyond the clinic staff training [...] all staff did have to go through an initial like, you read some stuff, you watch some videos, documentaries and stuff, and even they had you they would have you be like a mock patient."

Education Facilitator #3: Organized and Facilitated Educational Interventions.

Participants in the study reported receiving sexual health education in community settings later in life through various methods, such as college courses, job training, and educational interventions organized by community organizations. Although some participants noted that these

experiences supplemented incomplete or poor education they had received earlier, the educational content was standardized for all learners, regardless of their educational background. A vital attribute of these educational experiences that participants found helpful was that the resources provided were consolidated, evidence-based, and utilized various mediums, such as documentaries, readings, and videos, which were efficient and accessible to all learners.

One female participant in graduate school attended two sexual and reproductive health education sessions during her college years. The first session took place during their first-year ("freshman" year) student orientation at the university. During this same time, the second presentation was with Planned Parenthood and was organized, hosted, and sponsored by an on-campus student organization.

> *"I didn't take any classes where we talked about sex ed or anything, but during orientation, I know they talked about consent, they had the little skits and stuff. And then I went to a presentation by Planned Parenthood and they talked a lot about abortion rights and laws and how to get involved with Planned Parenthood."*

Education Facilitator #4: SRH-positive Dialogue: Undoing Early Fear and Shame.

Many interviewees emphasized the importance of intentionally curated community spaces as a primary facilitator of their sexual health education. The spaces themselves were not considered remarkable or facilitative, but rather the impact of intentionally curating them. Participants found it beneficial to have specific environments to discuss sexual health topics, which were most effective when moderated by a facilitator. These spaces had established "ground rules" or community guidelines and expectations that enabled participants to engage in dialogue, share their personal experiences, and collaboratively learn from one another. Living out these shared values

fostered a sense of community and vulnerability, creating a secure space to navigate new and culturally taboo topics.

During a collegiate class discussion about abortion, one female participant, a current SRH professional, noted that the information presented about abortion was unbiased without political or personal input. The professor leading the discussion emphasized that all political and personal beliefs were valid and set the expectation that the course was a space for *"conversation"* rather than persuasion. Although the participant disagreed with this approach, she acknowledged the importance of setting community guidelines to facilitate a conversation about a controversial topic in a public, academic setting.

> *"And it was really presented neutrally, like the Professor made sure before class, or before the lecture started, to say, you know, 'everybody's opinions are valid and we're not here to change people's minds, we're here to have a conversation' and all that stuff. She was great. She's a great Professor. And I understand why that is her role to do that. But I don't necessarily agree with that approach. But, yeah, I think that she handled that in a way that a professor at a public university in [State 1] has to handle conversations about abortion."*

Many interviewees emphasized the importance of constructive dialogue in discussing sexual and reproductive health education. They noted the need for an environment that was free of judgment and open to diverse identities and subjects, where conversations were non-agenda-driven, and participants had a relationship with one another. Additionally, understanding one's own values on the subject of SRH, including but not limited to abortion, was also deemed critical.

One female participant, a current undergraduate senior accepted to a graduate public health program post-college, who held more conservative beliefs regarding abortion, shared her

experience in an academic setting that aimed to have critical discussions about abortion. This participant mainly felt that the professor did not create an open and non-judgmental environment for exploring and learning about the subject from various points of view. Furthermore, she emphasized the importance of professors fostering relationships with students and suggested that if the professor had made such efforts, she and her peers might have had a different experience.

> *" I felt like the professor kind of had a negative attitude towards myself and some other students had a different viewpoint than her. [...] I feel like it really does take a professor that takes a little more time with their students [to foster a relationship]. And this particular professor didn't really make an effort to build relationships with students in that way."*

Notably, it is the presence of attributes such as relationality and non-judgment, not merely intentional constructive dialogue, that is necessary as a facilitator of SRH education. Participants pointed out that intentionally engaging in constructive dialogue without such attributes resulted in hollow, uncomfortable, inhospitable, and ultimately ineffective dialogue and spaces.

Education Facilitator #5: Reflexivity of Beliefs.

Humility and openness to analyzing one's own personal beliefs were identified as a third interpersonal attribute facilitating sexual and reproductive health education. While individual attributes and facilitators to navigate and overcome educational barriers are important, we must remember to not solely place this burden of responsibility on the individual. It must be recognized that it is possible to value personal reflexivity while also striving to address and alleviate the systemic issues that create these hardships and barriers in the first place.

Participants who demonstrated flexibility and personal growth in understanding their beliefs reported engaging in critically reflection upon being presented with new information.

Several participants discussed how their beliefs had evolved, with one participant sharing a specific experience that sparked a divergence from their upbringing. This participant, identifying as a Queer female in graduate school, was raised to believe that *"abortion should be safe, legal, and rare,"* with strict qualifications on when it would be acceptable: *"as infrequently as possible and only when absolutely necessary."* Before college, the participant associated abortion with being *"a bad thing"* [morally wrong]. However, during her time in college, she had a philosophy professor who published academic work exploring the intersection between reproductive health and Christianity. This experience led to the participant gaining new perspectives on the topic and being able to critically examine the beliefs she had been given, even exploring the concept that abortion could be *"morally neutral, or even good."*

> *"And reading her [Philosophy Professor's] book [on abortion] and then having her [the professor] come in and speak to the class gave me the perspective for the first time of, like, 'Oh! It's not bad [laughs]. It's not a morally bad thing to have an abortion.' Like, 'what if it's not morally bad? What if it's morally, like, neutral, or even good?' And so that opened me and my mind up to a new thoughts about it."*

While such an environment of gaining new information was an imperative catalyst to spark such exploration, learning, and growth, a required co-catalyst for this to occur was an openness to such information and an openness to change. Engaging in critical reflection, analysis, and expansion of one's personal beliefs requires vulnerability and humility in admitting (consciously or unconsciously) to not knowing everything or that your beliefs might not be "right." Simultaneously, such vulnerability only occurs when there is a level of stability and trust that such a growth mindset is safe and will not result in negative repercussions which would otherwise deter such exploratory activity.

Discussion

Participants described their experiences with formative SRH education in the southeast US as often centered on shame, fear, and stigma. There is a substantial body of literature describing this experience as commonplace. Shameful messaging and "education" surrounding sexual activity have permeated all levels of society – from more proximal, individual levels to distal, institutional levels (Ford et al., 2013; Scheinfeld, 2021; van Tijlingen et al., 2007). Notably, such messaging is heavily gendered: Women and/or people assigned female at birth are socialized using "negatively-valenced" messaging surrounding their SRH, which can impact how they understand their intimate health and sexuality (Gunning et al., 2020). Studies have additionally indicated that vulnerable youth, such as those who have experienced and survived sexual abuse (1 in 13 boys; 1 in 4 girls), are often emotionally harmed and re-traumatized if the sexual health education they are taught emphasizes shame (The University of Texas at Austin, 2015; CDC, 2022). Because of the systemic impact of shame-filled sexual health education, experts are calling upon sexual health education to not only have CSE as a bare-minimum standard of practice, but *also* to go beyond a trauma-informed approach and into "shame-sensitive" practice not to perpetuate such harm further (Dolezal et al., 2022). However, little research has been conducted on the public health impacts and implications of shame and fear within sexual health education. Further research is necessary and recommended to understand how shame and fear in SRH education may causally and longitudinally impact individuals and communities physically, behaviorally, emotionally, socially, and financially.

Additionally, participants in this study described harmful cultural and social scripts perpetuated in their SRH education by adults in positions of power. Adults, often identified as trusted and in positions of power (teachers, parents, etc.), fostered these environments of othering

and ostracization. Data show that sex ed is only legally required at school within 7 of the 11 states in the Southern US (SEICUS, 2022). If it is taught, only one out of the eleven states require the content to be evidence-based, six of the eleven require "some or all" content to be medically accurate, four of the eleven require limited to an extensive discussion of contraception, six of the eleven must teach discrimination and shame about LGBTQIA+ people, four of the eleven are not permitted to teach [actively prohibit discussion] of abortion as an option after pregnancy. Eight of the eleven are legally required to "promote," perpetuating the social script of heterosexual marriage (SEICUS, 2022). Such negative messaging is introduced into the curriculum through policy, which sets an environmental and cultural precedent, and even legal requirement, for these messages to be transmuted to pupils by their teachers. The findings of this study and supporting literature affirm that there is a need for school systems and groups concerned with the sexual education of minors to reevaluate the laws in their states and examine if these harmful social scripts are mandated within these legal contexts.

Some psycho-social research has been conducted surrounding social scripts and ostracization; however, not necessarily regarding SRH or public health. Data indicates that while social scripts provide insight into the relationship between beliefs and behavior, they are not always appropriate to employ (Ward, 2013). Exposure to ostracization and subsequent threat to psychological needs are associated with an array of responses when experienced, including physical, cognitive, and behavioral (Williams et al., 2011). Chronic exposure to such ostracization has been shown to lead to decreased coping resources, resulting in depression and helplessness (Williams, 2007). Due to the lack of triangulated literature on the intersection of these subjects, it is recommended that further research be conducted to gain a complete understanding of the full

and longitudinal impacts (including but not limited to public health) of social scripts and ostracization when employed within sexual health education.

Participants also conveyed needs surrounding SRH professional training and education beyond primary and secondary school. Mainly, there were administrative, personnel, and financial barriers to pursuing continuing education in this field. Moreover, SRH professional training appeared to be organization-specific and, although formal, non-standardized. Post-secondary education online curriculum interventions for SRH have been researched in community college settings and found to be effective (Skull et al., 2018). However, the content area still needs to be explored and studied regarding standardized SRH professional training (Skull et al., 2018). It is recommended that formal, online, inclusive, and comprehensive standardized training for SRH professionals be developed online, which is freely, readily, and easily accessible.

Participants in this study discussed the benefit of online platforms as a tool and space for information, conversation, knowledge sharing, and navigation of hardship. However, one salient limitation identified within participant recounts was a need for more educational quality standardization, factual correctness vetting, and safety/lack of moderation within online spaces. While there was measurable and immeasurable hardship of the COVID-19 pandemic, it did show us the potential capacity, novelty, and sincerity of accessible online community spaces when in-person activities were restricted. There is an extensive and robust body of evidence –including scoping reviews, systematic reviews, and meta-analyses- demonstrating high rates of efficacy, practicality, feasibility, and acceptability of inclusive online CSE programs among youth (Bailey et al., 2012; Bailey et al., 2015; Mustanski et al., 2015; Martin et al., 2020; Widman et al., 2020). However, sufficient monitoring and evaluation methods and peer interaction within courses must be developed, and longitudinal outcomes must be measured (Bailey et al., 2012; Martin et al.,

2020). Thus, there is founded and unexplored potential in the development and delivery of inclusive online comprehensive sexual health education – both synchronous and asynchronous, individual and in the community, and for youth and adults alike. These findings and data recommend that inclusive, interactive (although moderated and safe), and comprehensive online SRH education be developed and easily accessible to the general public of all ages and free of charge.

Public Health Implications

Due to a constellation of factors, there are broad-sweeping and grave public health implications of employing mainly abstinence-stressed curriculum and or non-comprehensive curriculum– especially surrounding unintended pregnancy, legality of abortion, forced birth, and maternal mortality. Upon examining details of state regulation on sexual health curriculum, only one of the eleven state policies legally mandate including instruction on consent, one of the eleven states must teach about the age of consent, and only one of the eleven states must teach age-appropriate SA/CSA awareness and prevention in kindergarten through grade nine (SIECUS, 2023).

Research has found that state policies that employ curriculums that are abstinence stressed have a higher incidence of adolescent pregnancy and birth than states with CSE (Guttmacher, 2021). This is particularly important due to the overturning of Roe v. Wade in June 2022 which dissolved the federal protection for abortion in the United States (Center for Reproductive Rights, 2023). At the time of this research (April 2023), the necessary medical care of abortion (procedural and medication) is heterogeneously criminalized and not legally permitted under any circumstance in 12 US states, seven of these states being in the Southern region of the US (as defined and studied

within this work) (Center for Reproductive Rights, 2023). Of the four remaining states in this region, abortion services are only permitted with major restrictions and stipulations (Center for Reproductive Rights, 2023). Further, the current legal restrictions on abortion, and the recent astronomical increase in maternal mortality in the US (CDC, 2021) - the reality of risks, health concerns, and personal dangers that youth and adults face within the Southern US – including the risk of death from childbirth- is possible. When critically considered within this context, this lack of sexual health education is a serious emergency and threat.

While it would be ideal for all states to adopt CSE, and to adopt it as soon as possible, there are many barriers to this being a realistic recommendation: the timeline of legislative processes, reservation and rejection by political individuals within the state legislature, and concern over the use of taxpayer funds. Thus, other options for education can and should be explored. It is recommended that funding and workforce be dedicated to developing, monitoring and evaluating, and improving online educational platforms for CSE. Online educational curriculum and delivery should be available for all ages (Kindergarten through adult) with age-appropriate content, accessible to the general public free of costs, be comprehensive, and include representation of all identities, sexualities and genders, and abilities. One CSE curriculum which has been developed that is inclusive of sexuality, gender, and ability is the FLASH curriculum of King County Seattle Public Schools- a curriculum which evaluation metrics and research have found to be incredibly effective (Coyle et al, 2021; Kesler et al, 2023). However, disability research and advocates indicate that adjustments should be made to FLASH special education curriculum to better serve individuals with intellectual and/or developmental disabilities (Winges-Yanez, 2014). Because disability is an identity that anyone can shift into (and out of, depending on the condition), and non-disabled people/people without disabilities can be sexual partners with disabled people/people

with disabilities, the FLASH curriculum and FLASH special education curriculum could be incorporated together to form one large curriculum. It is recommended that time, effort, and funds be dedicated to updating and improving the FLASH curriculum, translating its initial in-person delivery format into an online format, and monitoring and evaluating the effectiveness and longitudinal impacts of the curriculum implementation.

When discussing information available on the internet, some barriers discussed by participants included access to technology and access to the internet. While many of us consider these things a commodity, these are privileges that have their own associated costs that are not inherently accessible. Additionally, for youth, their technology may be monitored by their parent/guardian[s], who may hold discriminatory views or harmful ideologies. Thus, maintaining or increasing funding for public libraries or other ways of freely accessing information, while also ensuring protection of personal data (such as in states were seeking out an abortion is illegal) is recommended and imperative. Finally, many participants in this study cited the importance and positive impact of having a trusted, non-judgmental adult who they could speak to – it is recommended that investments go into the development, vetting, and legal protection of such adults surrounding these subjects such as teachers, librarians, and physicians.

Strengths

Major strengths of this study relate to methodology, participant demographics, and positionality of the author. This qualitative study was conducted using in-depth interviews of individuals identified as key informants who were professionals of, or students who had interest in, SRH, which resulted in incredibly rich and thorough interviews and subsequent data. A robust analysis was conducted in which inter-coder reliability was established, and two formal theoretical

frameworks were employed to contextualize and interpret the findings. Participant demographics were incredibly diverse: geographical representation of residence and education within the Southern US as defined in this paper included Texas, Georgia, North Carolina, South Carolina, and Tennessee. Educational training representation was also incredibly diverse, including Master of Social Work, Juris Doctorate [Law], Master of Public Health, Master of Science in Clinical Mental Health Counseling, Dual Degree Master of Social Work + Master of Public Health, Doctor of Philosophy [PhD], and Medical Doctorate [MD]. Additional notable participant demographics include representation of historically marginalized and oppressed identities, including BIPOC, immigrant populations, and the LGBTQI2S+ population. Additionally, the positionality of the author was a significant strength of this study in contextualizing, interpreting, and understanding the data and content area. The study's author was raised in the Southern US, attended school and received formative SRH education within the Southern US, was raised Christian and in the context of Purity culture, academically studied religion and inter-religious studies, and identifies within the LGBTQI2S+ population.

Limitations

Although this was many strengths within this study, there were notable reservations. Mainly, this research was qualitative, explorative study, While the data gleaned is incredibly rich, it is not representative of *all* SRH educational experiences within the Southern US. Moreover, while the findings may be used to inform research and practice, they are not generalizable or necessarily *directly* applicable to other regions in the US, the US as a whole, or outside of the US. Additionally, the demographics of participants were not formally collected and were only known in the context of what was shared visually or verbally during in-depth interviews. As a result, the exact demographics surrounding racial or ethnic identity, sexuality, and gender are in some cases

unknown. Only one participant self-identified as non-binary, and the remaining participants did not disclose identity but outwardly presented their gender expression as characteristically female. Although there was the presence of a historically under-represented gender identity, there was little gender diversity overall within the sample population. Moreover, there was the presence of historically under-represented racial identities, however there was little racial diversity overall within the sample population. Finally, there were some geographic locations applicable to the study which were not represented, including Oklahoma, Arkansas, Louisiana, Mississippi, Alabama, and Florida. If this study is replicated it is recommended that demographic information be formally collected and representation and diversification increase in the sample population including but not limited to racial and ethnic identity, gender identity, sexuality, and geographical location.

Conclusion

In summary, this exploratory qualitative study successfully identified major interpersonal and external barriers and facilitators to sexual and reproductive health (SRH) education in the Southern US. Emotional activation and social norms were identified as major interpersonal barriers, while the lack of educational spaces and logistical issues were identified as external barriers. Major facilitators included supplementary resources, professional training, and organized educational interventions.

Overall, the study revealed that 1) emotional activation, social norms, external barriers were not conducive to positive SRH education, and 2) the need for a shame-free and comprehensive range of on- and offline SRH education resources are crucial for promoting sexual health and well-being. Formal education and experiential learning were found to be significant in the SRH profession, and general public interventions that provide accessible, inclusive, evidence-

based, and comprehensive SRH education are essential. The study also emphasized the need for personalized, curated community spaces that are welcoming to diverse identities and foster open dialogue free of judgment.

Opportunities for future research in sexual and reproductive health education include investigating the causal and longitudinal impacts of shame and fear in SRH education, as well as the impacts of social scripts and ostracization. Opportunities for future interventions in SRH education include reevaluating state laws and policies and allocating funds and workforce for developing formal, online, inclusive, evidence-based, comprehensive, free of charge, and easily accessible 1) sexual education for the general public and 2) training for SRH professionals. Upon implementation, additional funds and workforce should be designated to monitor and evaluate the efficacy and long-term outcomes of these interventions and improve and update them regularly.

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Appendix A. Stratification of Quantified Resource Type, Resource by Educational Purpose, & Formality of Resources

		Resource by Educational Purpose				Formality of Resources	
		Personal	Professional	Both	Total by Type	Formal/regulated	Informal/Unregulated
Resource Type	Online/Media	**13**	**2**	**4**	19	13	**6**
	In Person	5	1	3	9	9	0
	Hybrid	1	0	2	3	3	0
	Explicitly community related	**5**	**5**	**5**	15	15	0
	Unspecified	0	1	2	3	3	0
	Total by Purpose	24	9	16			
Formality of Resources	Formal/regulated	19	9	15			
	Informal/Unregulated	5	0	1			
	% of sources informal	**20.833**	0	**6.25**			

KEY - Resource by:

Educational Purpose X Resource Type

Educational Purpose X Formality of Resources

Resource Type X Formality of Resources

Appendix B. *Student* Key Informant Interview Guide

Introduction

Thank you for agreeing to an interview today. My name is **[interviewer first name here]** and I am with the Center for Reproductive Health Research in the Southeast (RISE) and the Global Elimination of Maternal Mortality from Abortion (GEMMA) at Emory University.

We have asked you to talk with us today about needs for abortion education and training for students interested in sexual and reproductive health. Your responses will be used to better understand the current needs for non-medically focused abortion education for area college students and organizations that serve our community. The goal of the project is to support the development of an introductory evidence-based social science curriculum on abortion.

Your point of view is valuable to us, so, with your permission, we will be recording today's conversation. Afterwards, we will analyze the information in the recording to inform a three-day pilot workshop and its evaluation. We will keep all of your comments confidential and remove your name, or any other identifiers from any quotations, so please feel free to share your opinions.

Do you agree to participate? [**OBTAIN VERBAL CONSENT]**

Do I have your permission to record this session? **[BEGIN RECORDING HERE]**

Please remember, your participation is voluntary, and you can stop the interview at any time or choose not to answer any questions. If at any point you decide you no longer wish to participate, we may end the conversation immediately.

I have a list of topics I would like us to talk about, but feel free to bring up anything else you think is relevant. Our interview will last about **one hour**. Do you have any questions before we begin?

A. Opening Questions:

1. Can you tell me about yourself? (Prompts: hometown, major, career goals, any other aspects of your identity).

a. What is your major or course of study?

*What do you hope to do after you finish school?

b. Where are you originally from?

2. Do you have a religious affiliation? if so, do you feel more comfortable talking about some of your beliefs?

A. What led to you to your interest in sexual and reproductive health?

5. Can you tell me about any training or education you've had about sexual and reproductive health as you've been in high school or college?

a. Have you had any formal training or education on abortion specifically?
   i. Ask them to expand, give examples on what was learned
b. Have you ever participated in a training that addressed abortion stigma?
c. Did you have any sexual education in high school?

4. Could you describe your initial introduction to abortion, has your opinion changed from your initial introduction?

B. What changed your opinion?

B. Abortion Discussions and Abortion Training in your University/School:

4. How is abortion talked about in your school?

a. Formally/informally?
b. In class
c. Amongst peers? 5. How does abortion come up in your studies, if at all?

Is it more informational, opinion-focused, prevention-focused or lesson driven?

6. What do you perceive are the needs for abortion education or training in your school?

a. Amongst students at your school?
b. Amongst decision-makers at your school?
. 7. Do any students in your school have formal training on abortion?

a. Lectures with abortion as primary focus

b. Lectures on another topic in which abortion is mentioned

c. Small group sessions/tutorials

d. Clinical observations

8. Do different majors or student groups address abortion better than others?

A. Probe: etc. Tone, materials/resources, activities, thoroughness?

9. Is there something you want your school administration to know about abortion or abortion education?

C. Course Curriculum and Format:

10. What educational topics should be covered in a course? [Priorities]

[After each probe how it would be useful to their work/life]

a. The procedure works surgical/medical
b. Religious context
c. Legislation
d. Advocacy
e. How to communicate about abortion
f. how to research abortion
g. addressing abortion myths
h. reducing abortion stigma
i. increasing support for abortion personnel
j. any others?

11. Are there any topics you believe should be avoided?

12. In what format do you believe training would be best received?

a. In-person lecture, online, short course, multiple courses?

2. In your experiences, if you have taken an online learning course what has worked well for online learning?
3. What strategies have kept you engaged?
4. What strategies are helpful for talking about sensitive topics?

D. Closing

14. Is there anything else that we have not yet talked about that you feel is important?

<Don't turn off recorder until they really stop talking. This is usually when informants give good info> [Take notes beyond this]

15. Who else should we be talking to within your network?

Thank for you for your time. Can we confirm your email address? You will receive a gift card of $50 through email.

Appendix C. *Non-Student* Key Informant Interview Guide

Introduction

Thank you for agreeing to an interview today. My name is **[interviewer first name here]** and I am with the Center for Reproductive Health Research in the Southeast (RISE) and the Global Elimination of Maternal Mortality from Abortion (GEMMA) at Emory University.

We have asked you to talk with us today about needs for abortion education and training for stakeholders involved in sexual and reproductive health and in careers that may intersect with reproductive health. Your responses will be used to better understand the current needs for non-medically focused abortion education and training for groups like yours, for the members you serve, and for area college students. The goal of the project is to support the development of an introductory evidence-based social science curriculum on abortion.

Your point of view is valuable to us, so, with your permission, we will be recording today's conversation. Afterwards, we will analyze the information in the recording to inform workshop and its evaluation. We will keep all of your comments confidential and remove your name, or any other identifiers from any quotations, so please feel free to share your opinions.

Do you agree to participate? [**OBTAIN VERBAL CONSENT]**

Do I have your permission to record this session? **[BEGIN RECORDING HERE]**

Please remember, your participation is voluntary, and you can stop the interview at any time or choose not to answer any questions. If at any point you decide you no longer wish to participate, we may end the conversation immediately.

I have a list of topics I would like us to talk about, but feel free to bring up anything else you think is relevant. Our interview will last about **one hour**. Do you have any questions before we begin?

A. Opening Questions:

1. Can you tell me about your work?
    a. What is your current role and associated responsibilities?
    b. What other roles have you played in your career? In what types of organizations?
    c. Can you speak about how your current work intersects with abortion topics?

2. What led to you to work in this field?
    d. How long have you worked in your field?

3. Have you had any formal training or education on sexual and reproductive health?
    e. Have you had any formal training or education on abortion specifically?
        i. What was covered? How did they talk about abortion?
        ii. If no, was it ever discussed in your coursework in informal ways (i.e. not part of an assignment or reading but came up in discussion/lecture)?

    f. Have you ever participated in a training that addressed abortion stigma?
        i. What was covered? How did they address stigma?
        ii. Was there anything lacking?

4. Was abortion ever discussed in your education/training?
    g. Formally/informally/Not at all?

Thank you, next, -I am going to ask you a few questions about your group's needs for education and training on abortion.

B. Needs for abortion education/training in your organization:

5. How does abortion come up in your work?
    h. In topics, programs, student interests, client requests, funding sources?
    i. Does abortion access indirectly affect your work? (e.g. through lack of access to services, abortion policy restrictions etc.)

6. How is abortion discussed in your workplace/organization?
    j. Formally/informally/Not at all?
7. How is abortion discussed in professional organizations you are a part of?
    k. Formally/informally/Not at all?

8. Have you identified any gaps in abortion knowledge in your work?

    (Let answer first, but if struggling to answer, abortion knowledge can be things like information about the different types of abortion procedures, myths, the demand for abortion in the US and who gets abortions, abortion stigma, or abortion policy)

    a. Amongst colleagues?
    b. Amongst your field?
    c. Amongst staff at different levels?
    d. Amongst funders? board members? Decision-makers? Clients?

e. Are there knowledge gaps specific to the context you work in?
    i. Topic, location, population, legislation?

9. Can you describe the current training people you work with receive on abortion/ or abortion-related topics different levels in your organization receive different training?
    l. Does it differ across levels of work; job responsibilities, autonomy?
    m. Are there areas you hope to expand to in the future?
10.
11. What do you perceive are the needs for abortion education or training in your field or organization?

    (Let answer first, but if struggling to answer, abortion education can include things like information about the different types of abortion procedures, facts & myths, the demand for abortion in the US and abortion statistics, who gets abortions, cultural contexts and abortion stigma, or abortion policy)

    f. For yourself?
    g. Amongst colleagues?
    h. Amongst your field?
    i. Amongst staff at different levels?
    j. Amongst funders? board members? Decision-makers? Clients?

12. For someone entering your field what training or education on abortion would be helpful?

13. What would be helpful for someone entering your field to know about abortion?

C. Components of a training:

Thank you for those answers, now I would like to talk about what a potential abortion training course that would be offered to SRH professionals like you. As we discuss these questions please think about a training that could be offered to individuals in your organization or field what would be most helpful.

In what format do you believe training would be best received?

    n. In-person lecture, online, short course, multiple courses

14. What educational topics should be covered in a course?

[**After each probe how it would be useful to their work/life]**

o. The procedure works surgical/medical
p. Religious context (religious perspectives on abortion, how religious contexts influence abortion access and policy)
q. Legislation and policy related to abortion
r. Advocacy
s. How to communicate about abortion
t. How to research abortion
u. Addressing abortion myths
v. Reducing abortion stigma
w. Increasing support for abortion personnel
x. Any others?

15. Are there any topics you believe should be avoided?

Since we are interested in making this course community-focused and open to learners of all levels we would like to gather your thoughts on abortion education needs for the community you serve.

D. Need for abortion education/training in the community?

1. What training or education on abortion would be helpful for the community members you serve?
2. What should someone engaged in abortion work know about your context or field?
    a. Are there relevant curriculums you have heard about?
    b. Are there relevant research or reports we should know about?
    c. Are there relevant programs we should know about?
    d. What important legislation or policies should we know about?

E. Closing

3. What made you interested in participating in this interview?
4. Who else should we be talking to within your network?
5. Is there anything else that we have not yet talked about that you feel is important?

<Don't turn off recorder until they really stop talking. This is usually when informants give good info>!

Thank for you for your time. Can we confirm your email address? You will receive a gift card of $50 through email, we are experiencing a delay in gift card purchasing but will inform you when it is on it's way!