Distribution Agreement

In presenting this thesis or dissertation as a partial fulfillment of the requirements for an advanced degree from Emory University, I hereby grant to Emory University and its agents the non-exclusive license to archive, make accessible, and display my thesis or dissertation in whole or in part in all forms of media, now or hereafter known, including display on the world-wide web. I understand that I may select some access restrictions as part of the online submission of this thesis or dissertation. I retain all ownership rights to the copyright of the thesis or dissertation. I also retain the right to use in future works (such as articles or books) all or part of this thesis or dissertation.

Signature:

_Veronica Joseph_____ _____

Date

Education and Empowerment: Internalized Racism, Stigma and Sexual Health Education and the Development of Black Women's Self-Esteem and Sexual Experiences in the American South.

By

Veronica M. Joseph

Degree to be awarded: MPH

Behavioral, Social and Health Education Sciences

_____

Dawn L. Comeau PhD, MPH

Committee Chair

_____

Jessica M. Sales PhD, MA

Committee Member

_____

Whitney S. Rice, DrPH, MPH

Committee Member

_____

Don Operario, PhD

Department Chair

Education and Empowerment: Internalized Racism, Stigma and Sexual Health Education and the Development of Black Women's Self-Esteem and Sexual Experiences in the American South.

By

Veronica Joseph

B.A. Sociology
The University of North Carolina at
Chapel Hill
2021

Committee Chair: Dawn L. Comeau, PhD, MPH

An abstract submitted to the Faculty of the Rollins School of Public Health of Emory University in partial fulfillment of the requirements for the degree of Master of Public Health in Behavioral, Social and Health Education Sciences 2023

Abstract

Background: Black women and girls face a significant number of disparities in sexual and reproductive health outcomes as the result of their experiences with sexual violence, racial and gendered discrimination created from racialized stereotypes and deficits in sexual health.

Methodology: 10 in-depth interviews from were conducted with self-identifying Black women between the age of 22 and 30 who received their sexual health education in the American South. The interviews were transcribed through Otter.AI transcription software. Using MAXQDA software, thematic analysis was performed to develop themes according to the experiences of Black women from the transcribed interviews.

Results: Analysis of data from ten qualitative interviews has resulted in the identification of eight themes: 1) participants first introduction to sex, 2) deficits in sexual health education, 3) the role of media and pornography in Black women's sexual development, 4) young Black women's journey to sexual empowerment, 5) the role of elders in Black women's sexual development, 6) negative perceptions of Black women, 7) young Black women's experiences receiving sexual healthcare, and 8) young Black women's recommendations to improve sexual health education. Additionally, young Black women's journey to sexual empowerment was described through three stages: 1) Passive role in sexual relationships, 2) Period of reflection and 3) Sexual empowerment.

Conclusions: The sexual health education Black women receive from formal and informal settings in the south during their formative years is inadequate in preparing them for their sexual experiences or protecting them from adverse sexual experiences, such as sexual violence or STI acquisition.

Education and Empowerment: Internalized Racism, Stigma and Sexual Health Education and the Development of Black Women's Self-Esteem and Sexual Experiences in the American South.

By

Veronica Joseph

B.A. Sociology
The University of North Carolina at
Chapel Hill
2021

Committee Chair: Dawn L. Comeau, PhD, MPH

A thesis submitted to the Faculty of the Rollins School of Public Health of Emory University in partial fulfillment of the requirements for the degree of Master of Public Health in Behavioral, Social and Health Education Sciences 2023

Acknowledgements

Before you delve into this thesis, I would be remiss if I didn't acknowledge and honor the people who have helped me with this passion project. First, I want to thank all the participants in this study for sharing your stories with me. I will cherish our conversations, our joy, our pain, and our understanding of each other forever. Without you, this project would not exist and for that I thank you endlessly. I hope that I make you proud and that we can continue to contribute to the field of sexual health research to bring light to our experiences as Black women.

Next, I want to thank my thesis committee team for believing in me when I didn't believe in myself. I want to thank them for their patience, their guidance, and their affirmations of my work. Dr. Comeau, thank you for being there and for understanding me. Thank you for the check-ins, the affirmations, and the gentle nudges to keep going. I am endlessly grateful to you. Dr. Rice, thank you so much for your kindness and all of your contributions to the literature in this study. Your guidance is indispensable, and it was an absolute pleasure being able to know you. Dr. Sales, thank you for your guidance with recruitment and avenues for exploration for this study. Thank you for the opportunity to work under you as well, as it informed the implementation portion of this project and shifted my perspective to be more solution oriented.

Finally, I'd like to extend my gratitude to my supportive friends and colleagues. Thank you for the late-night study sessions, venting spaces, and friendship you have provided me with during this process. It provided me with the extra push I needed to make it through. Thank you for inspiring me through the passion you all have for your own work, I can't wait to see how we change the world.

Table of Contents

Chapter 1: Introduction 1
Chapter 2: Literature Review 13
Chapter 3: Methodology 29
Chapter Four: Results 35
Chapter 5: Conclusions, Implications and Recommendations 69
References 86
Appendix A: Interview Guide 94
Appendix B: Journey to Sexual Empowerment Diagram 100

Chapter 1: Introduction

Background: Sexual Health Disparities

Young Black women in the American South face disparities in HIV/STI acquisition because of racial and sexual stigma and inadequate sexual health education. According to 2020 CDC data, Southern states lead in STI acquisition for Chlamydia, Gonorrhea and HIV.[1-3] Relatedly, nine Southern states practice abstinence only education in schools and subsequently have the highest live birth rates between 15 and 19,[4] and many consistently land within the top 20 states for STI acquisition in 2020.[4] Consequently, the combination of multiple marginalized identities that Black women have, including their racial identity, young age, and socioeconomic status, subsequently affect their access to resources and knowledge about their bodies and thus exacerbate the inequalities in STI/HIV acquisition that they experience. This, in combination with a lack of adequate formal educational resources, leaves young Black women at a disadvantage in sexual and reproductive health knowledge that can empower them in their sexual health decision making. Moreover, the intersectionality between Black women's race and gender exposes them to unique experiences of discrimination, especially within healthcare systems. These combined factors all contribute to young Black women's disempowerment and subsequent differences in health outcomes.

The sexual health disparities that Black women experience at exponential rates compared to their racial counterparts are caused by their multitude of experiences with violence, racism, discrimination, and stereotype messaging.[5] The incidence of both sexual violence and HIV acquisition in Black women are much more common in comparison to other racial groups;

according to a 2017 article on violence against Black women reported that 20% of Black women are raped during their lifetime compared to white women.[6] Additionally, the incidence of HIV acquisition was 20 times greater among Black American women in 2016, compared to their other racial counterparts. Moreover, as a result of experiences of sexual violence, a lack of access to sexual health information, resources, and discriminatory experiences with healthcare providers, Black women disproportionately experienced or report unintended pregnancy compared to white women.[7]

Young Black women face difficulty in acquiring sexual health information and resources that would empower them to make safer decisions for themselves and about their bodies. The sources young women utilize for information to guide their sexual health decision-making include their teachers, peers, parents, and healthcare providers, yet Black women often report that they have limited communication about sex within their families and communities.[8-9] In 2021, an intergenerational dyad study found that Black women's mothers did not discuss reproductive health issues with their daughters, making it more difficult for them to communicate their needs with their providers.[7] Another similar study reported that Black women received little sexual health information from their parents because the parents were focused on preventing pregnancy through scare tactics and confusing information about sex.[9] Women in this study also acknowledged the limited resources available in their communities, caused by historical and structural racism that affects Black or non-white communities, as well as limited support from healthcare providers because of biased assumptions about their perceived sexual promiscuity.[9] The combination of structural and community barriers along with interpersonal barriers work to keep young Black women in a knowledge deficit, which in turn limits the

knowledge that can help to empower them in their sexual health decision-making and thus furthers their disparities in sexual health outcomes.

The intersections between racial and sex-based discrimination create the complex forms of stigma that Black women face within and outside of their communities. The stigma that Black women face denies them the acceptance that would guarantee them fair and equal treatment in their communities and by those in different positions of power, such as men and healthcare providers.[10] Such stigmatizing behaviors and experiences can include comments made by peers, family members, and healthcare providers about Black women and girls bodies and sexual behaviors, which effectively 'other' Black women from other racial groups and cause their differential treatment in various settings.[10-11] Therefore, in order to examine the unique experiences of Black women, we must view their experiences through an intersectional lens.

According to Patricia Hill Collins, the scholar who coined the theory of intersectionality, Intersectionality is a social justice framework that specifically focuses on individuals' intersecting identities and the ways those identities are connected to interlocking systems of oppression.[12] The oppressive system of racism can be described through three levels as presented by Dr. Camara Jones[13]; Institutional racism, personally mediated racism, and internalized racism. Institutional racism is characterized by the large organizations or government systems that negatively affect Black women's access to health services and thus resulting in the differential quality of care Black women experience in healthcare settings.[7,13] Personally mediated racism affects the ideas that healthcare providers' hold about Black women, such that they are more likely to be sexually active or have acquired and STI, and thus results in the substandard care Black women receive when interacting with them, like constant recommendations of birth

control while disregarding their needs.[7,13] Finally, internalized racism involves the internalization and acceptance of stigmatizing messages by Black women, such as internalizing messages about Black women being sexually available and thus perpetuating those defined behaviors.[13] The combination of racism and sexism create an environment where Black women and girls are more vulnerable to racial and sexual violence and requires us to examine the history and present behaviors that perpetuate violence against them.

Intersectionality

The effects of racism, sexual stigma, and the lack of adequate sexual health education on young Black women are wide-ranging and have been studied individually, but there is limited research that addresses the effect of these issues on young Black women's self-esteem and sexual development. Most notably, research that does exist shows that Black women and girls face much higher rates of racial and sexual violence at the hands of medical systems, their partners, and their communities, and the lack of information Black women and girls are provided makes it difficult for them to advocate for themselves and protect themselves from violence.[7,11,14]

Moreover, previous studies exploring Black women's sexuality have emphasized that Black women receive little to no information from parents about sexual and reproductive health growing up.[7,9,14] A phenomenological study that examined Black women's socialization and perceptions of sexual and reproductive health found that many Black women who participated in the study had limited access to sexual health information during their formative years, had experienced sexual violence, and suffered from adverse sexual health outcomes.[9] Women in the study also explained that because their bodies were problematized by their community, they lacked safe spaces to have conversations about sexual health and this led to further

misconceptions about sex and STIs', as well as a limitation in their ability to effectively advocate for themselves in their sexual interactions or with family planning providers.[9]

The prominence and pervasiveness of sexual stereotypes about Black women and their bodies can be hard to escape and can make it difficult for Black women to create sexual spaces outside of those stereotypes. The negative characterization of Black women as sexual workhorses; women whose sole purpose is to serve as self-sacrificing baby producers with an unlimited amount of love to provide for their children and the men in their lives,[15] works to dehumanize Black women and remove their power and agency. The perception of Black women and their sexuality as exotic, evil, and sinful leads to perceptions of Black women as sexually available thus contributing to the inaccurate ideas that Black women are more likely to acquire STIs or have more children, as well as creating barriers to healthy conversations about sex for Black women. Moreover, stereotypes that characterized Black women as promiscuous, sexually available, or having animalistic sexual desire, such as the Jezebel, Gypsy, and sexual siren archetypes,[16] are used to deny the reality of sexual violence against Black women during and after slavery and is perpetuated today through the continual denial of the pervasiveness of sexual violence against Black women as well as through the discriminatory practices in sexual and reproductive healthcare for Black women.[15]

The remnants of racism, in both its historical and contemporary forms, contribute to a need for more models that explore its relationship with the sexual and reproductive health outcomes of Black women. Black women experience discrimination in every facet of life,[11] and discrimination during Black girls' childhood, as well as in healthcare settings, can have harmful and even deadly ramifications for Black women and girls. A study that examined young Black

women's experiences with family planning care found that Black women continue to report mistreatment and negative interactions with healthcare providers during their family planning visits, regardless of their concerns.[7] Some women in this study shared that they felt humiliated during their family planning visits, felt their providers made assumptions about their sexual behaviors, and often felt as though their physicians would diminish them during when they explained their needs.[7] Moreover, some women shared that they believed the information their providers shared wasn't true or was influenced by the providers own biases.[7] Young Black women often have limited knowledge and skills to effectively engage in family planning/ sexual and reproductive healthcare and thus this mistreatment perpetuates Black women's lack of cultural health capital by becoming a barrier to access to sexual and reproductive health care, as well a sexual health information that could help Black women make informed choices about their bodies.

Black women's experiences with discrimination, especially during pregnancy, can result in an increased probability of adverse birth outcomes such as preterm birth and low birth weight, as well as increased post-partum complications, even after controlling for all other known predictors of those outcomes.[7,11,17] It is crucial to empower Black women with knowledge about their bodies to increase their capability to advocate for their needs in unequal power situations, such as those between healthcare professionals and patients, to decrease Black women's negative sexual and reproductive health outcomes. Additionally, as discrimination can lead to increases in sexual risk behaviors that increase women's odds of acquiring an STI,[7,11,17] empowering Black women with sexual health information and resources is integral to allowing them to know when to seek care in the first place.

According to a 2020 grounded theory study, Black girls and women in the United States are disproportionately affected by sexually transmitted infections and HIV despite having fewer sex partners and a lower likelihood of participating in unprotected sex.[17] Among Black women diagnosed with HIV in 2014, 91% of those diagnosed only engaged in heterosexual sexual contact.[17] Relatedly, in 2018 Black women had 5 times as many chlamydia cases compared to white women and Black women between 15 and 29 had 8.8 times the rate of Gonorrhea compared to white women between those ages.[17] These statistics exemplify why empowering Black women with sexual health knowledge and access, as well as addressing stigmatizing ideas about STI's, is an important public health intervention and priority. The disproportionate rates of STI and HIV acquisition in Black women can be mitigated by honest and comprehensive conversations about inclusive safer sex practices, routine STI and HIV screenings, and how to access reproductive health/ family planning resources.

Black women's sexual development and Public Health

There are many direct and simple public health interventions that can be implemented to improve Black women's sexual health outcomes and improve their self-esteem and self-efficacy with consistently engaging in safer sex practices. Addressing stigma through comprehensive sexual health education will be integral to addressing the sexual health disparities that Black women face because stigma and a lack of adequate sexual health education is more likely to lead to behaviors that increase Black women and girls' probability of experiencing negative sexual health outcomes.[5,9,10,18]

As prefaced above, stigma results in the differential treatment and health outcomes of Black women and girls by othering them from other groups through worsening, undermining, or

impeding on processes that affect their relationships, resources, stress and behavioral responses.[10] As a result of this othering, Black women and girls' experience a hyperawareness of judgment they may receive about their sexual health behaviors because of racial and gendered stereotypes, a phenomenon defined as stereotype threat, which has been found to increase the probability that they will experience adverse sexual health outcomes, as well as increasing the probability that they will internalize the negative stigmas they are exposed to.[16] Relatedly, this hyperawareness can cause Black women and girls to believe that they are unable to control the perceptions other have of them, or the treatment they may receive from others, which can further disempower them.[16] A study exploring the effects of gendered racism on the sexual and reproductive health of Black and Latina women found an association between this disempowerment and increased pregnancy-related stress, thus indicating that empowering women is an integral intervention to decrease factors that contribute to negative sexual health outcomes for Black women.[16]

Moreover, sexual health education through different channels, including healthcare professionals, media, and schools, can prove to fill the sexual health education gaps that Black women experience and contribute to their empowerment. The lack of support Black women and girls receive from healthcare professionals and their communities in learning about sexual health creates a barrier to effectively engaging in care.[7,9] Therefore, increasing Black women's access to healthcare professionals by removing knowledge barriers is an important intervention measure that can be implemented while larger issues, such as increasing insurance access, continue to be improved upon since Black women can view healthcare professionals as a resource to fill those knowledge gaps.[7] Similarly, expanding sexual health education curricula in schools through the incorporation of age-appropriate and culturally relevant behavioral goals, teaching methods, and

materials can prove to have a greater impact of student's behavioral outcomes and make more informed sexual health decisions.[18] Several studies have mentioned that young Black people and students are more receptive to receiving sexual health information or instruction from educators or protectors who are trustworthy, nonjudgmental, and empathetic[5,14,17-18]; therefore, emphasizing interventions that educate both Black community leaders, such as women elders, and young Black girls could prove to improve sexual health outcomes in Black women and girls and serve to protect them from further sexual violence.

The usage of media to increase access to sexual health education is another viable intervention method to decrease negative sexual health outcomes in young Black women considering the impact that negative media currently has on the current self-esteem and sexual behaviors of Black women. A study that explored how X-rated movies affected adolescents' sexual and contraceptive-related attitudes and behaviors found that Black girls who watch sexually explicit videos that feature Black actors are less likely to use contraception.[19] Additional studies on the effect of media on adolescent health have found that sexually explicit music increases the likelihood that young Black adolescents will be influenced to engage in similar sexual behaviors, such as having multiple sexual partners and lower probabilities of condom usage during sexual encounters.[20-21] To protect young Black women from engaging in early sexual experiences, some Black parents will prohibit young Black girls from watching or listening to sexually explicit material[5]; However, as this approach can leave young Black women feeling more vulnerable and unprepared in future sexual experiences, the production of sexual education material through media sources such as television and music could prove to improve sexual health behaviors in Black women and girls.

Health education interventions, within communities and medical practices, can be integral to expanding the sexual health knowledge Black women can access and thus can improve their ability to advocate for themselves in different settings. Such interventions should focus on stigma reduction and overall expansion of knowledge around sexual health information and sexual health resources to equip Black women and girls with enough information to make informed choices about their bodies, as well as combatting negative perceptions of their bodies and existence that is prevalent in wider society. Additionally, equipping Black women and girls with this knowledge will empower them to advocate in medical settings where they are likely to encounter professionals with biases that can impede their ability to provide adequate care.

My interest in the Project

As it stands, research exploring Black women's sexual scripts and sexual development, as well as theories and models that address the development of Black women's sexuality are close to non-existent. Many studies that do focus on Black women's sexual health are purely focused on exploring factors that can lead specifically to lower STI acquisition rates, rather than learning about the lived experiences of Black women that can influence their sexual behavior. Additionally, the relationship between Black women's sexual health and their self-esteem has not often been explored. Research questions that address lack of empowerment are the closest examples of attempting to research how self-esteem can affect health behaviors in Black women, or how systemic oppression (racism and sexism) directly impact the self-esteem of young Black women. The interactions of sexism and anti-Black racism, as well as other structural oppressive forces, deny young Black women their humanity and sexual freedom and thus cause young Black women to have a limited self-concept.[9] Moreover, the transition between adolescence and

emerging adulthood is important in understanding the sociocultural context surrounding the development of Black women's self-esteem and sexual development, as they develop most of the initial behaviors from information they gather during these years through self-exploration and socialization.[9]

As a bisexual Black woman who grew up in the American South, in North Carolina, the lack of adequate sexual health education resulted in me losing my power to make informed decisions about my health and my body because the information I received was skewed by formal and informal sources, including the internet and social peer groups. The lasting effects of stigmatizing language and disempowering experiences on my self-esteem could have been prevented if I was given the knowledge on how to take control of my body and advocate for my needs in relationships outside of just not having sex. The empowerment of Black women and girls through sexual health education and radical de-stigmatization of ideas surrounding Black women/girls and their bodies is integral to providing environments where Black women and girls can ensure and advocate for their own safety. Research suggests that early intervention between the adolescent and emerging adulthood life stages could have long-term positive benefits for Black women by providing them with better opportunities to build cultural health capital, improve engagement in care, and help them create a more positive sexual self-concept.[5,9,22]

Thesis Purpose (purpose in response to the problem)

Protecting and empowering young Black women to engage in safe and pleasurable sexual experiences, as well as elevating their sense of self-worth in a world that constantly devalues and dehumanizes them is complex issue that requires researchers to explore a multi-factored approach. Therefore, the purpose of this qualitative study is to explore the multifaceted and

complex relationships between Black women's sexual development, race, sexism, sexual stigma, and sexual health education. Therefore, the research question for this study asks how do racial stigma, sexual stigma, and sexual health in the American South affect the sexual development and self-esteem of Black women between 18 and 30. Through exploring young Black women's sexual experiences and life experiences in their formative years, we hope to gain context into how Black women formed their sexual identities and self-perceptions, as well as provide Black women with a safe space to discuss experiences that they often are not allowed to, or comfortable with sharing because of the lack of community support surrounding sexual health conversations.

Chapter 2: Literature Review

Black Women

Risk

Black women and girls face significant disparities in health because of their experiences with violence, racial and gendered discrimination, racial and gendered stigma from racialized stereotypes about their roles as women and sexual beings.[6] The high prevalence of sexual violence against Black women and girls has resulted in 20% of Black women experiencing rape during their lifetime.[5] Additionally, because of their unique sociocultural experiences, especially when engaging with racialized sexual stereotypes and violence, Black girls are more likely to have early sexual contact by age 13 and 48% of young Black girls will have acquired an STI between the ages of 14 and 19.[5,17] The intersections of race, gender, and sexuality provide Black women with unique experiences of multi-layered stigma.

Young Black women and girls are often overexposed with messages that designate them and their bodies as sexual objects through the media and their communities.[5] Black girls are continually told or shown in society that their existence is less valuable than others and that their bodies are their most valuable asset through music videos that depict them as video vixens, pornography, and a lack of representation in general media as romantic partners in successful love stories. Research shows stereotype messaging that sexualizes young Black women and girls can often result in them emulating provocative behavior they witness from social media and other sources, and thus indirectly contribute to their elevated STI/HIV risk.[14] Furthermore, exposure to sexually explicit videos that feature Black actors increased Black girls' likelihood of engaging with multiple sexual partners more and having sex more frequently, as well as

decreasing their likelihood of utilizing contraception.[14] Correspondingly, the sexual development of Black women has been adversely affected by cycles of intergenerational trauma caused by experiencing violence without protection from elders or other family members, more specifically their own mothers.[5]

The lack of protection young Black women experience from their communities is directly correlated with the lack of sexual health information that they are provided. This deficit in knowledge significantly impacts young Black women's ability to advocate for themselves in interpersonal or medical experiences. The cultural health capital framework, derived from Bourdieu's cultural capital theory, posits that social identities relate to power structures in society that distribute privilege and disadvantage, more specifically, differences in knowledge, beliefs, skills, and identities.[5] Black women of lower socioeconomic status are exposed to more frequent environmental and economic stressors that increase their risk for HIV compared to Black women of higher economic status, however, the typical relationship between educational attainment and better health outcomes does not exist for them, especially regarding sexual and reproductive health.[23] According to The Journal of Blacks in Higher Education, Black women are far more likely to earn degrees than Black men and account for 63.6 percent of African American enrollments in undergraduate institutions.[24] College-educated Black women have been left behind in HIV prevention research and health promotion interventions, despite being at high risk for STI/HIV acquisition.[23] Black women in college are twice as likely to report having had an STI compared to white college women, often due to a lack of comprehensive sexual health education, insufficient access to healthcare services, negative societal stereotypes, and, reconciling with their racial and gender identities within the social context of college campuses that often leaves them at increased risk for violence or engaging with partners practicing sexual

concurrency.[31] Black women's erasure in society perpetuates these disadvantages, contributing to the social and health inequities they experience. The structural forces that increase Black women's vulnerability and reduce their access to social and health services render their life experiences invisible to those with the power to add to their cultural health capital.

Racial and ethnic minority girls continue to experience teen pregnancy and sexually transmitted infections at increased rates despite sustained declines in teen birth rates in the past few decades and despite using family planning services and receiving family planning counseling more than other reproductive-age women in other racial groups as a result of racialized stigma in healthcare[18]; Black women often report poorer encounters with family planning clinic providers which can significantly affect these outcomes as well.[7] In 2015, Black girls aged 15-19 had birth rates that exceeded those of white females, 31.8 to 16.0 per 1000 respectively.[18] Additionally, in 2017, Black women accounted for 60% of newly diagnosed HIV infections among women in the United States as well.[23] Interventions addressing the root causes of these inequalities are necessary to address Black women and girls' increased risk for adverse sexual health outcomes.

Sexual Development

Black women and girls face significant differences in their access to sexual health resources which thus affects their sexual development and STI/HIV risk. Cultures of silence that prevent discussions of sexual health in Black homes and exposure to negative sexual stereotypes about Black women and explicit sexual material lead to deficits in cultural health capital for young Black women.

Gendered societal expectations and sexual stereotypes of Black women that indicate that they should cater to and fulfill the sexual needs of men often limit Black women's self-perceptions and self-esteem, resulting in them feeling devalued and hindering their ability to communicate about sex or negotiate condom usage with their partners.[5] Correspondingly, racist and sexist messages that depict Black women and girls as sexual objects often limit their own perceptions of themselves and the roles they can fill in society.[5]

Childhood is typically considered a protected development period in which children are allowed to safely mature and explore the world however, many Black children often do not get to experience the safety of this period. Early sexualization and stereotyped messages depicted through media of young Black girls often lead those who internalize them to enter the "grown" phase of their development at younger chronological ages.[5] Additionally, young Black girls experiencing accelerated physical maturity are often unequipped to psychologically handle the expectations assigned to people with their body type which makes them more susceptible to sexual predators because they lack the ability or knowledge to understand and take control of their bodies.[5,14] Black women and girls often develop their perceptions through interactions with their parents, specifically their mothers, through the values and social behaviors their parents deem as acceptable or safe, often to protect their children from sexual violence.[5] Armoring is a form of socialization in which a young girl acquires cultural attitudes, preferences, and socially legitimate behaviors as a strategy for self-protection against racism and sexism from their parents.[5]

The protection that Black mothers provide to delay the early sexualization of Black girls can be detrimental, especially when the messaging regarding the protection is religious or restrictive.[5] For example, many older Black women use religious messages to instill moral values

and norms about sex to younger Black women that often stigmatize them and end up evoking feelings of shame or fear in young Black girls and further limiting their ability to have sexual health conversations.[5] Religious ideas that suggest sex is sinful or a taboo discussion topic made participants in Crooks et. al study about protecting young Black female sexuality feel more uncomfortable discussing sex or their own sexual desires.[5] Relatedly, some mothers attempted to protect their daughters' sexuality by controlling their physical environments and limiting their access to sexually explicit media forms, including music and tv programs.[5] This limits young Black girls' ability to safely explore their sexuality and creates cultures of silence in Black homes that constrain choice and access to prevention.[7] Creating environments where young Black women feel confident to discuss sensitive sexual and reproductive health topics is more likely to lead them to engage in fewer risk behaviors.[5] Young Black women draw on their childhood experiences and upbringing to inform decisions they make about their sexual health while simultaneously learning from their own experiences to create their self-concept and self-perceptions.[9] Access to healthcare and sex education creates cultural health capital that Black girls may have not had the opportunity to develop during their formative years.[9] Lacking experiences that allow young Black women and girls to safely discuss sexual health and sexual pleasure limits young Black women's ability to express sexual health concerns with their providers which leads to disparities in care.[7,9]

Racial + Sexual Stigma

Black women not only suffer from disparities due to the intersections of race and gender but also because of the historic stigmatization of Black women's sexuality. Multiple studies have suggested that African American women are more likely than white women to experience discrimination, receive substandard medical care, and undergo unnecessary surgeries such as

hysterectomies.[11] The recollection of sexual stereotypes about Black women in contemporary society significantly affects the experiences, socialization, sexual development, and self-perceptions of Black women.[15]

Black women continue to experience and report mistreatment during their encounters with the health care system, likely due to the intersections between racial and sexual stigma, as well as perceptions of Black women's deficits in cultural health capital.[7] Studies about Black women's experiences with healthcare providers have discussed that Black women have felt pressured to continue birth control methods or experienced provider bias if they indicated they did not want to continue family planning methods.[7] Often, women in these studies stated that they felt that they were not provided enough information to make informed family planning decisions or felt humiliated and diminished when trying to confide in their providers; many women felt that their providers did not believe them when they shared their experiences or made assumptions about them and their sexual behaviors.[7] This poor treatment in healthcare settings contributes to the lack of resources Black women have access to for accurate sexual health information, and thus contributes to depriving them of cultural health capital that could empower them in making decisions about their sexual health.

Black LGBTQIA+ Women

While Black women face sexual health disparities because of racism and sexism, Black LGBTQIA+ women stand at the intersection between gender and sexuality; The oppressive forces of racism, sexism, and homophobia are compounded and create even wider disparities for Black LGBTQIA+ women.

Sexual and gender minority (SGM) populations face significant disparities in sexual and reproductive health; SGM subgroups are at increased risk for HIV, STD's and unintended pregnancy compared to their heterosexual and cisgender peers.[25] Consequently, young Black women who have sex with women and men (WSWM) are especially vulnerable to these outcomes.[26] Sexual and gender minority youth (SGMY) have been particularly disregarded in adolescent sexual health conversations which have significant effects on the development of their sexual experiences and sexual scripts. Many SGMY lacked context relevant to same-sex sexual behaviors, sexual orientation, or gender identity in their sexual health education.[27] This resulted in feelings of alienation and mental health challenges that could result in skewed perceptions of sex. Results from a previous, unpublished qualitative study discussed similar themes in which sexual health lessons in schools did not include topics about non-heteronormative sex practices, which resulted in the participants seeking out information about sex from friends and online sources.[8]

The inclusion of SGMY health topics and discussions of sexual safety, the ways in which physical boundaries are maintained and respected, can have a positive effect on risky sexual behaviors and sexual perceptions or experiences. However, studies exploring the usage of sexual safety and inclusive sexual health education have yet to be conducted.

Although studies on Black women's sexual experiences have been conducted, currently there is limited data on the influence of sexual health education on the development of sexual scripts and experiences in Black women, especially Black LGBTQIA+ women, women who have sex with women (WSW) or women who have sex with men and women (WSWM). Current qualitative studies have explored the dimensions that define and influence social behaviors and sexual scripts, including theoretical frameworks, intersectionality, and the effects of institutional

racism.[28] Furthermore, previous qualitative studies discuss how race-based sexual stereotypes contribute to less empowerment for Black women and thus lead to risky sexual behaviors that may contribute to adverse sexual health outcomes.[29] They emphasize the importance of sexual liberation in improving sexual health outcomes for Black women. In addition to qualitative studies, previous quantitative studies on sexual identity found that Black women who were also a sexual minority faced worse birth outcomes because of cumulative stress exposure and mismanagement by medical professionals.[30-31] This study could have great public health implications for mitigating early sexual initiation that leads to adverse sexual health outcomes for Black women as well as leading to sexual empowerment interventions that could improve self-efficacy.

Sexual Health Education

Sexual health education is a systematic, evidence-based approach designed to promote sexual health and prevent risk-related behaviors and experiences associated with unintended STI infection and unintended pregnancy.[25] The primary modes of delivery for sexual health education in US school education are abstinence-only programs and comprehensive programs. Comprehensive programs cover a wide range of sexual health topics, including consent and contraceptive use, while abstinence-only programs censor information about contraception and emphasize monogamous, heterosexual sexual relationships with a partner after marriage.[32] Despite evidence that comprehensive programs are associated with decreased risky sexual behavior, many states continue to utilize abstinence-only programs to curb teen sexual behavior and teen pregnancy. However, studies show that state-level abstinence mandates are correlated with higher STI rates and have a minimal effect on birth rates or abortion rates. Although comprehensive sex education decreases sexual health risk behaviors, both abstinence-only and

comprehensive sex education are unlikely to affect the actual knowledge teens have about sex and contraceptives, and thus, further exploration into sexual information influences is necessary.

A study utilized evidence-based sexual health education programs (EBP), which was created to address health disparities, has been implemented and over half of the EBP's included in the program were recommended for school-based implementation and were recommended to be used in school populations similar to their own.[18] In this study, it was found that sexual health curricula that incorporate age-appropriate and culturally relevant behavioral goals, teaching methods, and materials have a greater impact on affecting students' behavioral outcomes than curricula that don't incorporate these characteristics.[18] This study also reported that students prefer to receive sexual health instruction from an educator whom they trust and who is empathetic to their needs and nonjudgmental, similar to sentiments shared by Black women from a non-published qualitative mini study on sexual health education.[8,18]

Results from this unpublished qualitative study on sexual health education found that Black women who were taught abstinence-only sexual health education in the American Southeast felt that they were not adequately equipped by this education and sought outside sources for information about sexual health topics to bridge the gaps in their sexual health knowledge.[8] These alternative sources for information, including the internet and friends, filled in some holes in their knowledge but ultimately still didn't answer many questions regarding sex and the sexual process, led to some instances of misinformation, and led some women to abstain from sex altogether.[8] These results highlight the need for adequate and comprehensive sexual health education programs that will provide the cultural health capital that can empower women to take control of their sexual health and sexual experiences.

Sexual health for Black people, and Black women, in the United States must be considered within the context of institutionalized racism and discrimination. Sexual health literature that has leaned into negative sexual stereotypes of Black women and characterized them as hypersexual or deviant has led to severe misunderstandings of STI acquisition among Black girls and women.[17] Perceptions of STIs resulting from promiscuity, hypersexuality, and recklessness have created barriers to communication about sex and sexual health topics for Black women in fear of being considered less valuable.[17] The hypersexualized Black woman trope is reinforced through the treatment of Black women by Black men as sexual objects.[17]

Black women's sexual partners tend to be Black men because of messaging that their ideal partner should be a Black man because of shared experiences and ideas about the superiority of Black love.[17] The result of this rigid sexual network, i.e., the people connected by sexual contact directly or indirectly, is Black women suffering from a greater risk of acquiring STI/HIV with each new sexual encounter.[17] Black men engage in sexual concurrency, multiple co-occurring sexual partnerships, often without alerting all the partners involved that other partners exist, which allows for the more rapid spread of STI/HIV.[17] The emphasis put on Black women to aspire to Black love and protect Black men also contributes to their increased risk for STI/HIV acquisition because it disempowers Black women from prioritizing their sexual needs or reporting sexual violence at the expense of uplifting and protecting their partners.[9,17] Conversations about condom negotiation, barrier method usage, and body empowerment are necessary to protect young Black women from enduring additional inequity in their sexual health experiences and STI/HIV acquisition rates.

To fill the gaps that Black women have due to a lack of cultural health capital, caused by inequitable access to sexual health resources and cultures of silence around sexual health in the

Black community, many college-aged Black women turn to interpersonal channels for their sexual health information.[33] Cultures of silence about sexual health fostered by a lack of communication about sexual health in Black homes and spaces contributes to disparities in sexual health education and contribute to the perpetuation of sexual violence that Black women experience.[17] The lack of discussions about how sex can lead to STIs has often led Black women, and the Black community in general, to stigmatize STI acquisition or rely on information about STIs described by peers which contribute to continued misinformation and stigmatization.[17]

Narratives about sexual abuse and reproductive injustice at the hands of government and medical systems, like forced sterilization, continue to permeate through Black culture and further perpetrate the silence of Black women by deterring them from discussing their experiences or seeking care for sexual health issues.[7] This deterrence from engagement in care further contributes to gaps in sexual health knowledge that disadvantage Black women and prevent them from being empowered to take control of their bodies and protect themselves. This highlights the need for sexual health education that empowers young Black women to take charge of their sexual health and learn how to be their own sexual health/ medical advocates.

Empowerment

Empowerment, defined by Black feminist theorist Patricia Hill Collins, involves the rejection of personal, cultural, and institutional dimensions of knowledge that perpetuate objectification and dehumanization.[12] Rejecting stereotyped messages of sexualization is a major protection strategy defined by Crooks in her exploration of young Black female sexuality that is utilized by Black women to define themselves outside of the confines of intersectional oppressive systems.[5] The rejection of negative racial and sexual stereotypes about Black women

increased Black women participating in the study's sense of self-worth and allowed them to see themselves as more than just sexual beings.[5]

The instillation of values of self-worth, self-esteem, and confidence in young Black girls is often fostered by elder Black women or the protectors of young Black women.[5] Messages from older Black women that counter the stereotypes they are exposed to often reflected strength, empowerment, and pride in their Black identities.[5] Other messages from protectors emphasized the balance between being a sexual being and being a multi-faceted human outside of the realm of sex and sexuality.[5,17] Black women presented with alternative representations of Black femininity that oppose negative sexual stereotypes will be much more empowered to take control of their sexual health and advocate for themselves in both healthcare spaces and during sexual experiences. Therefore, it is imperative to provide young Black women with trustworthy women and other caring and credible sources of sexual health information who can protect and empower them as they develop.[5]

Theoretical Framework

Intersectionality

To understand the complex ways that race, and gender impact the life experiences of young Black women, it is imperative to utilize intersectionality. Intersectionality is a theoretical framework, and methodological tool, coined by Kimberlé Crenshaw that has notoriously been used to describe how Black women are doubly disadvantaged by race and gender-based discrimination.[7] Intersectionality helps identify how specific populations, i.e., Black women, continue to be disproportionately affected at the hands of ongoing oppressive systems by highlighting how interlocking oppressions function within a larger sociopolitical context, as well

as at the interpersonal level.[7] Existing studies on sexual and reproductive health often use intersectionality to explore the lived experiences of Black women in health management, often because the combination of marginalized identities including race, age, and socioeconomic status often exacerbate racial inequities in care.[7] The intersections of sexism, anti-Black racism, and other structural oppressions often deny young Black women their humanity and sexual freedom and thus limit the development of their own self-concept, the ideas that Black women hold about themselves.[9,34] Impeding the self-development and sexual development of young Black women by progressing ideas that they are inherently sexual beings, or only valued as sexual beings, stunts many young Black women from engaging in safe sexual practices or being empowered to seek out sexual health information.

Critical Race Theory

To understand the sociocultural factors that affect the sexual development of Black women, we must explore the ways that race impacts the circumstances that Black women experience. Critical race theory, and its four distinguishing constructs, work to define the role of racialization, marginalization, and knowledge creation around social inequities and are integral to understanding how Black women's lived experiences are influenced by systems of oppression.[35]

The four distinguishing characteristics of critical race theory include racialization, race consciousness, and social location.[35] Racialization describes how racial and ethnic categories are used to create hierarchies in society. Race consciousness acknowledges interpersonal and societal racial dynamics. Social location explores an individual's or group's position in the social hierarchy and how that informs how people view societal problems. Finally, centering the margins entails the process of understanding how issues, like sexual health disparities, affect

marginalized groups, like Black women, and is integral to our analysis of Black women's lived experiences.

Critical Sexuality Studies

Critical sexuality studies expand on critical race theory and several other fields, including critical health research and critical sociology.[22] This theoretical framework is decisively feminist, self-reflexive, and radical in its considerations of sex and sexuality in social contexts. Critical sexuality studies delves into how the social constructions of gender, race, class, and sexuality inform structures of power and privilege to guide theoretical research.[22] Critical sexuality studies is integral to understanding the factors that affect Black women's sexual development because it is committed to, and invested in, uplifting the voices of those who have been invisibilized by existing literature, which is common in the analysis of issues that affect Black women. It integrates the role of historical and epistemological violence, as well as structures of power, to create new models that will be used to guide empirical research to investigate the issues of marginalized populations.

Socio-ecological model

The socio-ecological model is extremely useful for describing macro and micro-level determinants of health (the impact of racism). This model aids in a better understanding of how racism, stigma, discrimination, and access to comprehensive sexual health education influence the sexual health outcomes of Black women through the exploration of multiple levels of influence and thus can provide a framework to determine how to avert health problems experienced by Black women.[11]

The levels of the socioecological model include the individual, family/ interpersonal, neighborhood/ community, and societal.[11] The individual level encompasses an individual's knowledge, attitudes, behaviors, and history. This level will help explain how internalized beliefs and attitudes adopted by young Black women from their experiences with sexual health in formal and informal spaces have changed their beliefs about sex and their self-esteem. The family/ interpersonal level describes how a person's familial and social networks influence and contribute to a range of experiences.[11] This level will be used to examine how school, familial, and social relationships influence young Black women's sexual health knowledge and self-esteem through the messages they deliver to Black women in their circles. The neighborhood/ community level of influence encompasses how the environments in which people live affect their health.[11] This level will be used to summarize how access to sexual health resources can differentiate between different communities and the effect differential access has on access to cultural health capital and sexual development for young Black women. Finally, the societal level of influence considers factors like institutionalized racism and policy which can help to examine how government policies, such as abortion bans and other reproductive health policies, as well as school dress codes that systemically target Black children affect the self-esteem of young Black women, as well as their belief in their access to sexual health resources.

The relevance of Empowerment and Education to address disparities in Black women's sexual health

Black women suffer from disparities in sexual health outcomes because of the effects of the intersections between race and gender. Black women in the United States disproportionately acquire STIs and HIV compared to their racial counterparts despite engaging in less risky sexual behaviors, such as multiple sexual partners or protected sex (addressing sexual). This increased

susceptibility to STI and HIV acquisition is a result of sociocultural conditions such as sexual and racial stigma, which result in race- and gender-based discrimination, and power dynamics in heterosexual relationships.[17] Black women are 5 times as likely to suffer from chlamydia compared to white women and have 8.8 times the rate of Gonorrhea compared to white women.[17]

It is necessary to understand the factors that lead to poor sexual health outcomes in Black women to understand factors that can facilitate better health outcomes and more positive life and sexual experiences for Black women. Black women will continue to feel disempowered in contexts where they cannot flourish and are not valued.[17] Frameworks that seek to understand the lived experiences of Black women, such as those created by Natasha Crooks, are essential to understand the sociocultural factors that create the circumstances that produce sexual health disparities in Black women.[14,17]

Therefore, the purpose of this study is the explore how racial and sexual stigma, as well as sexual health education provided in the American South, affect the sexual development, sexual perceptions, and self-esteem of Black women and Black non-binary femme presenting people who grew up in the American South between the ages of 18 and 30. The results of this study will provide context for Black feminist thought literature, critical race theory and critical sexuality studies, intersectionality frameworks, and socio-ecological models exploring the root causes of inequity in Black women. Future studies on the effects of systemic oppression on Black women's development can use this literature to build upon their ideas and further explore how to protect Black women as they grow up.

Chapter 3: Methodology

This thesis is the continuation of a previous qualitative methods mini study, as part of a qualitative research course, that explored how sexual health education affects the development of young Black women's sexual scripts and sexual experiences. This prior mini- explored the experiences of five Black women from Georgia, Mississippi, and North Carolina between 22 and 25 and found that young Black women search for sexual health information throughout their formative years to develop their sexual identities. In addition to this, the women in the study emphasized how access to comprehensive sexual health education that explores a wider variety of topics outside of just STI prevention, would have better prepared them for their sexual experiences and helped them advocate for themselves with their sexual partners. Based on the results of the mini study, the principal investigator of this study, decided to delve deeper into the varying factors that affect Black women's sexual development, including sexual health education, racism and sexism, and sexual stigma that they experience during their formative years, through further qualitative research in this study.

This study utilized qualitative in-depth interviews to delve into Black women's experiences with sexual health education, racism, sexism, and sexual stigma. Previous literature, such as grounded theory on Black women's sexual experiences and sexual relationships, was utilized to inform the methods of this study, as well as its formation from the previous qualitative mini study.[9,14,17] The study was approved by the Emory IRB in September 2022. This study was conducted between September 2022 and March 2023.

Recruitment and Sampling

Recruitment for this study occurred through both direct recruitment strategies and snowball recruitment through the interview question ‘Is there anyone you would like to refer to participate in this study.’ The recruitment flyer for this study provided the principal investigator's study description and contact information. The flyer was shared in SisterLove’s email list-serv, the Emory Reproductive Health Associations email newsletter and GroupMe group chat, on the BlackGirlSexualHealth Instagram page, through peer circles and directly by study participants to their social circles, as well as to past participants, from the original mini-study, to share with their social circles. Study participants that indicated they may have recruits for the study either told the recruits to contact the principal director directly or provided the contact information of the recruit to the principal investigator to initiate contact.

Inclusion criteria for this study were that participants must be a Black woman or a Black non-binary person, between the ages of 18 and 30, speak English and either grew up or went to school in the South during their formative years. Exclusion criteria for this study included participants who are cognitively impaired or would not otherwise be able to give informed consent. This criterion was verified through a pre-screening survey that participants took through Google Forms that asked them to self-identify their demographic information and during the demographic questionnaire at the beginning of each interview.

Data Collection

Data were collected for this study, following Emory IRB approval, from September 2022 to January 2023. Interviews for this study were conducted through Zoom by the primary investigator of the study and took approximately 45 minutes to an hour to complete. Prior to each interview, informed consent was read to participants and received prior to continuing onto the interview guide. Each interview was recorded utilizing Zoom software and transcribed verbatim

using the transcription service Otter.AI. Transcripts were checked for accuracy and audio recordings were deleted following the review of transcript accuracy. Interview notes were also completed during each interview by the principal investigator. The interview guide, featured in Appendix A, was originally developed for the foundational mini study and was expanded for this study. Interview questions about the role of racism and sexual stigma were added to the mini-study interview guide to address the research question for this study and create the interview guide for this study. Therefore, the interview guide was separated into seven sections: Demographics, Sexual Health Education, Sexual Scripts, Sex and Intimacy, Racism, Sexual Stigma, and Advice and Critique. Probes were added to some interview guide questions to provide clarity or a deeper understanding of the participant's experiences. The interview guide for this study was reviewed by the thesis chair. All transcripts, audio recordings, and consent forms were de-identified and stored on the principal investigators' private computer. All data for this study was deleted after the data was analyzed in MAXQDA and the results were created.

Data Analysis

The results of this study were analyzed through the lenses of critical race theory, critical sexuality studies, the socio-ecological model and intersectionality to answer the research question. Intersectionality, the socio-ecological model and critical race theory were primarily used to analyze the experiences of discrimination that the participants experienced in different facets of their life. Intersectionality was used to analyze participants' experiences within healthcare, their interpersonal relationships and in their schools. It served as the foundational analysis tool in which each of the participants experiences were set, as their race and gender both played integral roles in how they were treated in their relationships, in their communities and by those in positions of power. Critical race theory is used to analyze instances of discrimination

specific to the racial stereotypes about Black women and their manifestation in institutions that Black women must encounter. This theory is used to analyze how racialization and social location affect Black women's experiences within institutions like schools and healthcare facilities. Critical sexuality studies is used within this study to analyze Black women's sexual embodiment and how their sexual experiences affect how they view themselves and the world. Finally, the socio-ecological model was used in this study to analyze how different socio-ecological factors and levels, including interpersonal, community, and policy level factors, contributed to the sexual development and self-esteem of young Black women in this study.

Codebook Development

The codebook was developed through both deductive and inductive coding procedures. The deductive codes were derived from the interview guide questions and each section title of the interview guide was designated as a parent code. Section titles for the interview guide were demographic information, sexual health education, sexual scripts, sex, sexual pleasure and intimacy, stigma, and racism. Inductive codes were developed from analysis of the transcripts and any themes that were noticed in the interview transcripts. The codebook was independently created by the principal investigator and reviewed by the thesis committee and can be found in Appendix B.

Analysis

Interview transcripts and the study codebook were imported into the qualitative data analysis software, MAXQDA. Transcripts were block coded to identify overarching themes in the data. Code-based analysis was conducted to explore themes found in the data using MAXMAPS within the MAXQDA software. Themes were identified through ideas that multiple

participants shared during their interviews that related to their sexual development and feelings of empowerment.

Sexual Health Education

Sexual health education was measured through questions about formal and informal experiences regarding sexual health education. It included questions about the first experience participants had, influences and sources of information, duration of education, and how they believe their experience affected them.

Sexual Perceptions

Sexual perception was measured through questions about how their experience affected their interactions with sexual partners, their engagement in sexual behaviors, and their perceptions of sex, including their comfort with discussing sex with others.

Sexual Scripts

Sexual scripts were measured through questions about descriptions of their sexual process and the influences and development of their sexual scripts.

Sex, Sexual Pleasure and Intimacy

Measured through questions about their current or past sexual experiences, defining what pleasurable sexual experiences and intimacy are to them, and their feelings about their sexual experiences.

Racial Stigma

Measured through questions about the perceived barriers to care or discriminatory treatment they may have faced because of race in school settings.

Sexual Stigma

Measured through questions about perceived instances of discrimination or poor treatment they may have faced because of negative sexual stereotypes, as well as policies/legislation that is discriminatory against women.

Chapter Four: Results

Sample

Demographics of participants

In this study, ten interviews were conducted with Black women of varying sexual identities and geography between the ages of 18 and 30. The participants in this study all identified as cisgender-women and were between the ages of 22 and 30, however a majority of the participants (6 out of 10) were between 22 and 25. Participants in this study lived in a southern state and received sexual education courses in a southern state; three participants lived in North Carolina, two lived in Texas, two from Georgia and other participants were from Alabama, Louisiana, and Virginia. Six of the participants identified as heterosexual, two identified as queer and two identified as pansexual. Most of the participants were currently enrolled in a graduate program as well. A variety of themes around Black women's experience with sexual health education and stigma were identified and demonstrated linkages between those phenomena and Black women's self-esteem and sexual health outcomes. he eight themes that were identified from this study are participants first introduction to sex, deficits in sexual health education, the role of media and pornography in Black women's sexual development, young Black women's journey to sexual empowerment, the role of elders in Black women's sexual development, negative perceptions of Black women, young Black women's experiences receiving sexual healthcare, and young Black women's recommendations to improve sexual health education.

The Effects of Sexual Health Education on Black women's Sexual Development

First introduction to sex

One of the first major themes present in the data was that Black women's first introduction to sex was often through informal channels in the home, notably through discovering sexually explicit material while trying to engage in other non-sexual activities such as playing games on the computer or watching movies, either on television or on VHS. Participants noted that during these experiences, if adults became aware of their exposure, they would focus more on protecting them from viewing the material than explaining what they viewed and using those experiences as teaching opportunities.

Katia: And I randomly remember just now that I- it was like me my cousins we found this like random VCR tape that my grandparents had. I don't know why they had it or where it came from. But when we played it, it was literally like talking about like sex and like how babies were made. And it was actually kind of graphic even though it was like an animation for children I guess. But I remember I vaguely remember that now. I was about- how old was that? Maybe like five or six I want to say so even after that then like the internet still through like other people. (GA, 23)

Jade: Hm. I feel like it was an unfortunate time I feel like my mom who had a boyfriend had these tapes in my mom's closet because he was also living with us. And one day my brother discovered it and we all like sat and watched it. That was like my first encounter. It's terrible. And it was like my, it was like the summertime so all my cousins, you- we were just like getting into this stuff in our house because we were children in the summertime had nothing to do. So this harmless thing that we were like it's just videotapes. Let's put it in the VHS tape and watch it. We learned more than we should have that summer. I, Oh, I want to say I was probably eight. I was eight years old. Yeah. Eight, nine. (TX, 30)

Sasha: Um, well, I think, so, The first porno I ever saw was, I might have been like, eight. My brother and I are 10 years apart. So he would have been 18 If that timeframe, but at the time it

was back then where you have VHS tapes. And I had a few that were unmarked. And he had a few that were unmarked. And in my pursuit looking for my beloved Barney episode, I stuck in one of his tapes, and I remember my grandma, like, bursting in the room. And he got in like a lot of trouble because it was something he should have kept like, privately, I remember her fussing about, so. (NC, 26)

In addition to leisurely stumbling across material in the home, participants also mentioned encountering pornography or explicit sexual material while they were on the internet, through ads or other means. Participants noted that discovering sexually explicit material through this medium often led to them to continuing to search for more information or other related media.

Tiffany: I think I probably learned it on the internet [affirmative] because I feel like that's where I was exposed the most because I was on my computer all the time. And so naturally, it just kind of like popped up every now and then. And then you start getting curious and you're like, oh, okay, what's that? What's that? (TX, 29)

Solana: I'd say the internet. I guess through like, ads and things um that I didn't necessarily want to see. But like, if I would go on certain game sites. If I went, you know, to an odd site, it will have like certain ads and things. (VA, 25)

Relatedly, a majority of participants mentioned that they were first introduced to concepts about sex and sexuality through their siblings or through their friends and peers at school. Students who were engaging in sexual activity, either because of their own early introductions to sexual information or other experiences, may have been sharing those experiences or knowledge with their peers during school. The concepts they shared may have also contributed to misinformation about sexual health topics or sexual stigma.

Solana: As far as any informal way, I learned about sex, maybe fifth grade, just from other students, uh nudging it, uh notions of having done any type of like intercourse or something like that. (VA,25)

Although many participants had been introduced to sex in some way prior to formal sexual health education classes, many participants noted that they began receiving their first sexual health class in fifth grade. However, participants discussed that this first sexual health education experience focused more on the reproductive health of students rather than comprehensive sex education; it was an introductory course on body changes accompanied by puberty, such as male ejaculation and menstruation, that only focused on teaching the changes associated with the sex of the participants. Participants noted that during these experiences, they were separated from the boys in their class and therefore were not privy to information shared in the boys session, thus further depriving young adolescents of comprehensive sexual health education and community learning opportunities.

Dana: Um, so I would say at least in school, I think it was like in fifth grade, when we started learning about like sexual education. And I remember they like made us so they like split up the boys and the girls. And then they made this watch this like, um like this video, we had to watch both the boy version and the girl version. And we weren't allowed to talk to the boys about it like afterwards. And I remember after that, like that day, because I think all the parents had to like sign consent forms, allowing them to like for us to participate in it. And, like my mom, like, very briefly, like, talked to me about it. But it was more about like, it was more about like, safe sex stuff, like about STDs and like using condoms and stuff like that. (AL, 23)

Tiffany: ...Fifth grade, actually, because that was the first time I remember they separated us in class. They moved all the boys to one side and then kept the girls on one side. And then they

taught us about like tampons and stuff. laughs And then after that, that was I think that was probably the only sex ed I had… But it was around then I would say. Um, yeah. So they would separate us into different classrooms. And then I wouldn't even say they, like taught us about sex. They just taught us about like, essentially, human anatomy, and what the parts were, but they didn't actually teach us about what sex really was. (TX, 29)

Cloe: Yes, so I'd say in terms of formal education, my earliest memory would have to be fifth grade. And so just for context, I attended a PWI private school, um K through 12. So I guess keeping that in mind that my experience was probably a little different. But um, we had sex ed in fifth grade, which was actually Middle School for the school that I went to, the first year middle school. And so I remember, during that time, of course, we went over what periods are body parts, I remember girls and guys being separated. And then when we would come together, we would talk more generally about things. I remember there being kind of like, I guess, kind of more mental health talks around puberty and stuff like that during those times as well. And unfortunately, I don't really remember much more outside of like, talking about vagina and penis and periods during that time. And then quite frankly, after that, I didn't really have any more formal teaching or education around sex throughout, like middle school, high school, I think it was all like, at that point, kind of word of mouth or learning, you know, through friends and family. (NC, 27)

Participants often noted that the informal sexual health education they received from their peers and the internet was inadequate in addressing many of the questions that they had about their body's, sex, relationships and other topics. Participants also discussed that the formal education they experienced also did not fill the gaps in their knowledge regarding sexual or reproductive health topics.

Deficits in Sexual Health Education

Throughout the data, participants repeatedly mentioned that they rarely learned anything outside of STI's, abstinence, basic anatomy and contraception in their sexual health courses, and attribute many of the deficits and adverse outcomes they experienced in their sexual experiences to this lack of knowledge surrounding sexual and reproductive health. Most notably, participants discussed that the lack of discussions surrounding advocacy, empowerment and condom negotiation left them vulnerable in their sexual experiences.

All the participants discussed that their sexual health education experiences, whether formal or informal, was surface level in the knowledge it provided them on sexual health topics. As previously discussed, many of the participants first formal introduction to sexual health education was through a fifth--grade seminar that discussed body changes that occur during puberty. However, other participants did not experience sexual health education until a middle or high school course, paired with their physical education course, whose focus was obvious; preventing teen pregnancy and STI acquisition through abstinence-only education.

Solana: I would say it [sex ed]was not all encompassing. Just because it focused so much on one just abstinence and also just one type of barrier to my- that I can remember. And it was just very, a short lived experience as far as education about sex. So yeah. (VA, 25)

Overwhelmingly, participants noted that this course only occurred for half a semester for less than 60 minutes each session. While several participants mentioned that they learned about condom usage during their class, most participants explained that these lessons primarily discussed anatomy, with extra emphasis placed on male anatomy, basic information about STI's and the importance of abstinence. Discussions about healthy relationships and boundaries were

not included, nor any inclusive conversations about non-heteronormative partnerships. The overarching theme was that sexual health education was to encourage waiting for marriage to engage in sex so that they can create a family.

Katia: I would say that it wasn't very inclusive of all identities. I would also say that it wasn't inclusive of different ways of partnering. It was very much focused on like, heterosexuality, or it was like a heteronormative context, and monogamous context. And yeah, I feel like, yeah, that's pretty much to the extent of how I feel about it. (GA, 23)

Dana: I feel like it was very, like very surface level knowledge. Like, they didn't really go into any depth about anything. And like I said, they didn't even talk about really any, like, the act of sex or anything like that. It was just more of just like STDs and stuff like that. And by them just talking about STDs it kinda made it worse, because you're just like, Oh, if you have sex, you're gonna like get an STD pretty much. So I think that would be one critique is just, like, going like actually talking about like the things and not just like, glossing over them. And then also not like, at least for my experiences, they were really pushing for like abstinence, like, you guys should not be having sex at all at this age. So yeah, even if you were like, participating in sex, they weren't giving you materials or like, any knowledge of what you should be doing. (AL, 23)

Moreover, participants discussed that the images they were shown during their sexual health lessons did not represent them, and therefore were not accurate representations of how STI's manifest on Black skin nor addressed the types of relationships they would encounter. This further added to gaps in their knowledge relating to sexual and reproductive health, and many of them didn't realize how necessary representation in sexual health topics, or in general, were until they discovered them later in life.

Nevra: Why are you teaching me without showing me like, pictures of like, that represent me? Or, like, show representation of me? Because it was like, we were always taught from, like, a white lens. It just wasn't, like realistic, right? Yeah, it just wasn't realistic to our like ethnicity. (GA, 22)

Many participants additionally noted that conversations about consent, boundaries, and healthy sexual relationships did not occur during their formal sexual health education experiences. Often, participants discussed that they only learned about consent and boundaries during Title IX training in college.

Dana: I definitely didn't have any conversations about consent or anything until college, where we would have like, required courses or something we had to take or workshops, we had to take about consent. And then me and my friends would talk about it afterwards. But yeah, before college, I never had any conversations about consent or boundaries. (AL, 23)

Correspondingly, most participants mentioned that they did not have any experiences where healthy relationship boundaries or pleasure for women was discussed with them. While participants mentioned that they would discuss sexual topics, including relationships, with their peers and friends, they also explained that these conversations often did not fill the educational gaps they experienced as a result of their formal sexual health education experiences. Participants friends and peers discussed sexual health from the perspective of their lived experiences, but only shared experiences they felt would not lead to their own stigmatization.

Cloe: And even like with friends, right, like, as much as they're your friends are like, they're kind of going through the same waves as you are. It didn't always feel comfortable talking about certain things. (NC, 27)

Dana: Um, I think it was mainly like from my friends and stuff. Because like, when I got into college, I think most of my friends that I had were, like, sexually active or had been sexually active before. And like, had had relationships and stuff in the past, which I did not have. And I think just being in an environment with, like, a bunch of people that were, like, sexually active or were like, trying to be it like I think a lot of the stuff I learned about it was from just like friends talking about it. (AL, 23)

Yasmin: Mmm, older peers, um, I learned from them. And honestly, with that, too, i was just very vague at times, because the thing is, they didn't want to tell their business, and then their business then becomes someone else's business. So it's just just be careful. Okay, exactly what does that mean? Like, I need you to be a little more specific with that. (NC, 24)

Similarly, many participants' parents did not assist in filling these educational gaps either. Participants explained that their parents mostly provided discouragement from engaging in sexual activity and parents that did talk about sexual health topics with their children didn't go into depth about the topics. The denial of information about sexual and reproductive health topics often deterred participants from relying on their parents for information and resulted in them no longer seeking out information from them or other elders in their immediate family.

Yasmin: So it's like, okay, I wish … my parents had the backbone to you know, learn from their generational trauma and curses, and then change their behavior to then make my sister and I's life a little bit easier and better on ourselves. I wish they were a little more open as far as like sex and like, you know, and this is what's gonna happen, this is what your body's gonna do and this is what you need to do to make sure you're okay. (NC, 24)

Cleo: And then my mom, she never like openly shared anything about her sexual experiences so I never felt comfortable coming to her with questions. (LA, 25)

The culmination of these experiences left these young Black women unprepared in the realm of sexual and reproductive health and resulted in many of them discovering their sexuality through experimentation in their sexual experiences, often in a passive way. Participants discussed that they either lacked the agency or language to advocate for themselves in their sexual relationships but cited those experiences as integral to how they learned about themselves as sexual beings. The lack of empowerment participants felt in their sexual relationships often manifested as the prioritization of the pleasure of their sexual partners, while not realizing they were also entitled to pleasurable sexual experiences. Many participants described the lengths they went to in order to maintain their desirability with their sexual partners. Many of these actions were informed by images and representations of sexuality that the participants learned from media and the internet, most notably movies and pornography, because participants decided to fill the gaps in their sexual health knowledge through their own independent research, which often opened them up to embodying and internalizing inaccurate and stigmatizing representations of Black women.

The role of media and pornography in Black women's sexual development

The deficits in sexual health knowledge that young Black women experienced as a result of their formal sexual health education experiences was often supplemented by information they acquired through a variety of sources. The most notable sources that informed young Black women's sexual perceptions of themselves and their roles in their sexual interactions were media, including social media, and pornography.

When discussing how they believed their sexual experiences should look or feel, many participants cited that their perceptions of ideal sexual experiences came from representations from media sources such as pornography, music and movies. Many of the descriptions of their ideal sexual experiences were romantic and prioritized intimacy and pleasure for both participating partners. However, when participants discussed their perception of their role in sex or the actions they should take to be good and pleasurable partners, the descriptions shifted to be more male centered.

Many of the participants discussed that when thinking about their sexual scripts and how they cultivated the roles they embody when they are engaging in their sexual experiences, specifically engaging with male partners in their sexual experiences, they developed their actions from how they saw women in movies or porn act in similar situations. One participant discussed how in her attempts to be the perfect sexual partner, she often studied how women in pornography engaged in sex, as well as internalizing the stigmatizing messages about women, their bodies and how ideal sexual partners acted that she heard from her peers and saw on social media.

Cloe: I definitely watched a lot of pornography in high school, I do you remember that, and so of course, that was quote unquote, a teacher, to me, right? Even though it wasn't the best teacher. So me showing up in ways sexually, Like, actually, sexually, I think I was taught from porn. And also like, what other people talked about, or like, what was kind of like, the thing that you hear about from other people. (NC, 27)

Relatedly, as participants shared the perceptions of women's bodies they heard from their peers and others in their communities, they often discussed that they had internalized some of those descriptions and tried to apply them to their sexual experiences. Many of the participants heard ideas such as 'Black women should be good at sex" or "squirting means that the man is

providing a good sexual experience" from peers, social media posts or songs and used those ideas as guidelines of how to be pleasurable sexual partners. In each of these discussions, participants emphasized that all the guidelines they heard about sex were focused on ensuring the pleasure of their male partners and ensuring that men desired them sexually.

The effect of this is that these participants often took a passive or submissive role in their sexual relationships because they were prioritizing the needs of their sexual partners over their own pleasure. Several participants even labeled themselves as givers in their sexual relationships, meaning that they derive pleasure from pleasuring others. However, those participants also discovered that being a giver didn't mean that their pleasure isn't equally important in their sexual relationships after having unfulfilling sexual experiences with their partners. Relatedly, this lack of agency often resulted in participants engaging in sexual experiences because of coercion or that did not include the use of barrier methods.

Yasmin: But like, I felt like since I already, in a way entertained him, I then had to move forward with it, or I would be considered like, I don't even know what the term is, but like someone who just doesn't pull through, like, what is it a blue baller? I don't know, like, given guys, blue balls like just somebody who's just, I don't know, playing games, where it's really I just don't know if I want to do it or not. (NC, 24)

As this participant shared, the pressure of maintaining her desirability to her sexual came at the cost of her maintaining her own autonomy over her body. Other participants also shared instances where they denied their own boundaries to still be considered desirable by their partners, which often came at the cost of sexual safety with those partners. The emphasis on submissiveness within their sexual relationships often shared a direct correlation with the perceptions of good sexual partners that came from pornography or descriptions from their peers

and thus placed an extra emphasis on the participants to perform well for their partners. One participant discussed that unlearning this performative nature was a part of her journey to discovering her own sexual pleasure as she embarked on her journey to sexual empowerment.

Young Black women's journey to sexual empowerment

As the women in this study discussed the effects the deficits in their sexual health education had on their sexual experiences and self-esteem, they repeatedly mentioned that the experiential learning they acquired through their sexual experiences were the catalysts to their own sexual empowerment. The journey of the participants sexual empowerment can be described through a series of phases: 1) A passive role in their sexual relationships as a result of a lack of information about sex, 2) a period of reflection and 3) sexual empowerment. The model accompanying this journey is featured in Appendix B.

Passive in sexual relationships

All participants in this study expressed that they did not feel that they had safe spaces to explore their sexual identity when they were growing up. Whether this was because their parents explicitly discouraged those conversations or if sex was never discussed in the home, participants did not believe they had a place where they could ask questions about sex, relationships or their reproductive health in the home.

Yasmin: And it just, I don't know, it just really impacted me in a way where I just didn't feel comfortable talking to them, or my parents, because the thing is, when I was growing up, my parents were like, You know what, just don't do it. Just don't do it. And it's like, okay, don't do what because my body, I'm feeling different. Obviously, I'm developing, my hormones are

changing. I feel aroused when I'm around guys. Like, that's normal. But it's like okay, What do we do now to protect myself from pregnancy STD, there's so many other things. (NC, 24)

As prefaced, the result of the lack of preparation Black women experienced, both formally and informally, left them feeling unprepared for their sexual experiences. Because of this, participants shared that when they were beginning their sexual journey~~'s~~ they often let their male partners take the lead and prioritized satisfying their male partners, often at the expense of their own sexual pleasure. This often lead to experiences where the participants didn't feel like their sexual pleasure was a priority, or shifted their perceptions to believe that they had to engage sexually with their partners in order to remain desirable to them or other future partners. As the participants became more dissatisfied with their sexual relationships, they shifted from just accepting their roles in their experiences to reflecting on them and what they wanted for themselves.

Yasmin: I couldn't really blame it on the education because I knew like they told me that you need to use a condom. But for some reason, during that time, I just didn't. And then that led to me taking a Plan B and it was just like, Okay, you're doing a lot. But if I just talked to my parents, right, had that, I don't know, safe space with them, maybe I wouldn't feel so uncomfortable. So I feel like my education did play a role in that. because if I felt comfortable enough to do it, I should at least feel comfortable enough to ask for birth control. (NC, 24)

Period of reflection

During the period of reflection, participants began thinking about whether their sexual experiences were pleasurable or ideal to them. Participants weighed how they felt after their sexual encounters, any experiences of sexual violence, their experiences trying to perform during

sex and whether they felt that their current sexual experiences and relationships were emotionally or physically pleasurable. When reflecting on a past relationship with one of her first partners, one participant described her reflection process that helped her discover her agency in her sexual relationships.

Yasmin: That's why he you know, was attracted to me because I was younger, I had no idea what I was doing. But in my mind, given what he said to me, I thought that I was not old enough in a way to make those decisions, because I didn't know. I didn't know was my first time but really, I just didn't have that backbone. I didn't have the education or the knowledge to realize okay, no, [name], you do it when it's, you know, right for you. You do it when you feel comfortable, and you're able to say no at any time. So I was timid when I was first engaging in sex, but then as I've gotten older, I realized, you know what, I can do what I want. I could say what I want, if I don't want to do it, I don't have to. (NC, 24)

Two participants shared that the catalyst to their period of reflection was acquiring an STI from a partner or partners. These participants explained that these experiences were life-changing for them and not only affected them physically but affected them mentally. One participant shared that their STI acquisition affected their self-perception and made them feel less worthy of love because it was a consequence of what they believed was poor decision-making. Another participant who acquired an STI shared that they experienced shame when discussing their results with their health provider. As a result of these experiences, they became advocates for others in their social circles and reflected on the importance agency and advocacy is in their sexual journey's. Participants discussed how they would encourage their siblings and friends to engage in safer sex practices, including routine STI testing, and through sharing their sexual experiences amongst friends. These stories are significant not only because these

participants recognized the importance of self-advocacy but also because it emphasizes the need to de-stigmatize and educate women about STI's.

Cloe: I remember, I got a pap smear one year. And I had a call back about results. Because I was positive for an STD. And I remember at that time, I was very confused because like I said, I'd never overlap partners. So like, I never was sleeping with more than one person at once, because I was a very faithful and like I said, I thought the person that I was with or having sex with was someone that I wanted to be with. And of course, they weren't reciprocating. And I remember, I had to go back into the office and they told me I had chlamydia and I lost my mind. And I think I was like, 16 at this time. And I lost my mind. I was like, What do you mean? And I think this was like, my first time like, reality settled in like again about like, the, the kind of scarier or like not scary, but the kind of more uncomfortable parts about sex right? Or like being sexually active and more harsh realities, right of being able to get sick from from sex, right? And so that like, blew my mind and long story short, that guy cheated on me and that was very traumatizing. (NC, 27)

Additionally, as some participants went through their reflection period, they began to create new boundaries for their sexual relationships. These boundaries ensured that they made meaningful connections with their sexual partners and thus defining what would make ideal sexual partners and creating pleasurable experiences for themselves.

Katia: When it comes to like, partnered relationships, like, sexual relationships, I'm extremely picky. So like, I don't really like people like that in terms of just in terms of like, relational, like, sex relationships, and just romantic. So I have to really like the person. And this is just me, like, realizing it, as I have, like, had the hoe phase and even like, being in relationships, like realizing that I have to really, really like a person to even, you know, want to consider anything. (GA, 23)

Some participants mentioned that during this reflection, they began to redefine what their sexuality meant to them and began viewing their value outside of their sexual capabilities. As participants reflected on the quality of their romantic and sexual relationships, many of them began to reassess what created pleasurable sexual experiences for them and began the work to unlearn the lessons they were taught from media, peers, and pornography about how to be desirable sexual partners. Participants shifted the emphasis to determining whether they were enjoying sex with their partners and what defined a healthy and desirable sexual partner to them. Many participants referred to this process as an opportunity to learn more about themselves since they did not previously prioritize themselves in this space.

Cloe: Um, so I always, always enjoyed sex, I think it's, of course, it's very pleasurable. But I also am personally, a person that loves connecting with others. And that is, like, one of the, of course, most intimate and closest you can get with someone is through sex. But also, I enjoy the conversation. I enjoy everything that goes into it, not just the act itself. But yeah, I just, I think it's a beautiful thing and a beautiful part of life. And also a way we can connect with ourselves too, right? Like I I've also had to redefine my own self pleasure and like, what masturbation looks like to me and even having those sexual moments with myself and so I really enjoy that exploration and also figuring myself out and learning more about myself through that too. So yeah, I yeah, I definitely. I definitely consider myself a sexual person.(NC, 27)

As the participants moved through their periods of reflection, they continued to realize that their satisfaction and pleasure during their sexual experiences should be at the forefront when engaging with their partners. Consequently, as the participants felt more empowered, they began to improve the way they saw themselves, not only as sexual beings but also as women.

<u>Sexual Empowerment</u>

Throughout the study, the participants described their experiences with sexual empowerment in subtle ways. Each of them were in different stages of their sexual empowerment journey, however each of them recognized reached the stage of empowerment where they realized that their needs were as important as the needs of their partners. They had begun to question the messages they were taught about sex and healthy sexual and romantic relationships.

One of the most profound findings during this study was that the women in partnered relationships felt that their partners assisted in their sexual empowerment. The affirmations and support these participants received from their romantic partners helped them feel safe to explore their sexuality and redefine their sexuality. Many of the participants discussed that the support of their partners changed the ways they engaged in their sexual relationships and made them feel more natural, i.e. they began to explore sex outside of the lessons they learned from porn and other informal sources.

Dana: I feel like it just happened organically. Like, I had never really done that previously. But that was something that they would do. And then I think we just got into the habit of like, they would ask, and so then I would ask, and so now that's like, just something we do. But before like, that was definitely not something that I really had experience with. So I think it just was just organically something me and my current partner would do. (AL, 23)

Jade: That's back to my husband a lot. Like he likes just seeing me and understanding. He was like, hey, I can see that you're uncomfortable. And if you're uncomfortable, we can stop. And that had never been said, like, before him I had never had anybody experienced with being like, even noticing how discomfort I was feeling during sex. So it was kind of, I was taken aback and being one embarrassed too.. (TX, 30)

The Role of Elders in Black women's Sexual Development

Elders serve a crucial role in shaping the lives of their children, and throughout this study participants continually discussed how the actions of their elders impacted their sexual development and self-esteem. Often, the elders in the participants lives perpetuated negative sexual stereotypes in an effort to protect their children from engaging in sexual behavior, which often had the opposite effect, and thus created a barrier to sexual health information or safe spaces to explore sexual health topics with a trusted source. Participants often noted that having more support from their elders during their formative years would have assisted in their journey of discovering their sexuality and self-esteem.

Being "fast", the act of being noticeably interested in the opposite sex or engaging in romantic relationships at a young age, was the most recognized stigmatizing term described by participants. All of the participants in the study had heard someone in their immediate family utilize the term, and it often resulted in the participants doing whatever they could to hide any behaviors that may have had them labeled as such. This negative stigmatization of sexual behavior caused participants in the study to feel less comfortable discussing their curiosities about sex with their family members and often resulted in them engaging in sexual behaviors in secret, which put some participants at higher risk for adverse sexual experiences. This also resulted in some participants stigmatizing others in their peer or family circles because of the negative connotation sexual behavior had been labeled with by their elders.

Sasha: Oh my God. I wasn't called fast because I did everything in my power to make sure I wasn't. Apparently reading the book can make you not fast. (NC, 26)

Cloe:…I remember, I was never called fast, I don't think at least not to my face. But I remember my like, aunts talking about a cousin, who like she was fast. And I remember that being just having such a negative connotation. And so I was like, Oh, I don't ever want to be called that. Like, I don't want to be fast. Like, it didn't have a positive connotation to it. And so I remember that word just being heavy and like, not really the best word to be like adjective to use be used to call like, describe somebody. So yeah, I remember that being in my the back of my head, like not wanting to be fast. So it definitely shaped some things in my mind. (NC, 27)

Relatedly, one participant discussed how an elder in her family would regularly remind her that her worth was supported by her sexual purity. This stigmatizing idea frustrated the participant but also made her more conscious of how her sexual partners perceived her.

Sasha: Oh, my God, I wish I had earlier conversations because I feel like it may be would have given me more agency when I got in college. Because again, like I I had a very fleeting relationship with my grandfather. But one of the things I like always remember him telling me is if you let a man like milk the cow for free, he'll never buy it. And that that was my understanding of like, my my role in a relationship, and what I should expect from men, but then on the opposite side media, like music and everything else made it clear that it was very difficult to keep a man interested without also offering that up. And so you offer it up, it doesn't work out, you try it again, was most of my college experience. But if someone had actually had a conversation with me when I was younger, and was like, ''Hey, this is something that you can enjoy. It's not taboo, like you are meant to enjoy it. You like definitely should be using condoms when you do so.'' As opposed to like, if more conversations had been on training me for like relationship and the human so like, the human interaction part of sex…like that would have better prepared me for what I experienced in college. (NC, 26)

The stigmatizing messages that participants' family members perpetuated contributed to the misinformation about sexual health topics that many participants believed reinforced their lack of preparation for their sexual experiences. However, participants discussed that their family members were not only just perpetuating harmful stereotypes in attempts to deter them from sexual activity, at times they also served as literal barriers to sexual health information by refusing to discuss sexual health topics with the participant or prevent them from accessing resources that would aid them in acquiring that information as well. One participant discussed that their mother wouldn't let them access a book that would educate her about male and female anatomy because she was too young, without supplementing that material with information that she may have deemed more age appropriate for the topic, thus leaving the participant frustrated.

Yasmin: There were some book that my mom bought, like when I was super young. And she like, hid it away. And I was like, Mom, can I read the book? She like No, not yet. You're not ready to read that book. When it's like, okay, this book obviously has pictures of like, male and female parts on it. Why can't I read the books by know more about it? She's like you can't read it yet. It's like, Well, why not? (NC, 24)

Because of these experiences, participants often responded that they wished their parents or elder family members took a more active role in guiding on their sexual health journey's so that they could have engaged with sexual health in a safer and more informed way. They wished their parents would have been more transparent about their own experiences in the realms of sexual and reproductive health, or at least been more willing to provide them access to resources or safe spaces so that they could safely explore and learn about their sexuality without having to engage in experiential learning.

Cleo: If I was like in a family unit that, I'm not gonna say we're talking about sex all the time, but like, if I were to ask them, I could get a response that's not based on me being a child or anything like that. They just try to help me understand the subject. I feel like That would have been, that would have been better.

Participant 5: but I feel like if I had, like family members, or somebody who like actually talked to me about it, like people that I trusted that, like, went into detail about it, and their experiences, like I feel like if I had known about other people of colors experiences with these things, then that wouldn't have, it would have relieved me of a lot of pain. (LA, 25)

Racial and Sexual Stigma (Intersectionality, CRT)

Throughout the data, the intersections between racialized and gendered stigma were apparent and had a demonstrable effect on the self-esteem of the participants during their formative years. Through interactions with authority figures in school, the home, and peers in both realms, young Black women in this study had stigmatizing experiences in all the places they frequented, thus providing them with consistent exposure to negative and stigmatizing perceptions about Black women that they internalized. Because of this, participants developed a hypervigilance over how they were perceived by others and some participants actively worked to avoid being perceived according to stigma.

In addition to experiences with their parents and other elders, participants discussed that they heard other family members and community members utilize the word *fast* to describe women who were perceived to be sexually promiscuous. The widespread usage of this word throughout the Black community lead to many participants actively working to prevent themselves from being viewed as sexually promiscuous, even if they weren't actively engaging in sex. In addition

to this, participants also battled against oversexualization as their peers and authority figures made comments about the way they dressed or how their body looked when wearing certain clothes or performing certain activities, such as sports.

Dana: And I, I would say actually, most of my body like image problems stemmed from tennis and comments I would get from, like coaches or like other players, or like my family about my body, in relation to tennis. But like, also, I think that also kind of bled over into school where I- and even now like, I feel like I'm very, like, I kind of always like joke about this, but I feel like I try to dress like more, like, conservatively or like, like, kind of like a bum, I always say, because I'm just afraid, Like, I don't like attention. I don't want unwanted attention. And so I kind of wear stuff to not get attention, whether it's positive or negative. I just don't want it. (AL, 23)

School dress code policies were disproportionately applied to young Black students who may have been more developed than their white counterparts and emphasized the perception that Black women were defined by the way their bodies looked. Relatedly, for participants who went to school at predominantly white schools, they noticed the difference in treatment they received based on both their body and their desirability by men in their school.

Tiffany: So I feel like, again, like the the white girls at our school were like, the popular ones. Like, and this was this was high school. And even though like they were fewer white people at our high school, it was like they were, you know, they were the athletic ones, or whatever. They were like, the high scorers and everything. And so people or rather for teachers and like administration or whatever, they basically said nothing to them. Whereas if we tried to say something, we would come off as like, Oh, there they go again, you know how they are. [affirmative] And it's like, what the hell like, you're not gonna tell her to go change? (TX, 29)

Nevra: But like, I feel like anything with length or like a shorter length, It gets like sexualized or like, Oh, well that's too short. You don't want that type of attention. Or even like certain types of shirts, but like, I never had any, like bad experience with, um, I guess like dress code. I personally didn't feel comfortable to wear, like certain type of like, revealing clothes until I probably got a little older. Because I just… I don't want to be sexualized and I have a fear of being like, overly sexualized. But like, I don't want to be sexualized by like, a creep, if that makes sense. (GA, 22)

Cloe: So, trying to live up to be beautiful and like what was, especially with like, I had a huge thing about about wanting a white guy, but I was just very much wanted a white guy. And so I knew like straight hair, like white girls always had straight here, I had that straight hair. Anyway, so that was another thing too. That like, made me more pretty or like, more attractive or more desired if I had straight hair. So I remember like a lot of black girls at my school, like we always had our hair straight. And we we wanted to have our hair straight. We wore like the cute preppy things and like, tried to be that way. (NC, 27)

Jade: Oh, Oh like I would say it's like the black girl has always got it because we would always try to wear what our white friends and our Latino friends would try to wear and they wouldn't get in trouble like we would. So, we were kind of like the sore thumb we had assets that were very much like I don't know trying to trying to fit into a limited too stuff was unfortunate for me because limited too did not make curvaceous anything- (laughs) I'm trying to be like disney channel but everybody else sees P Valley… I thought I was the latest twitches too bad for me. I just want to dress like a Brat. I don't know, Bratz had it all. They had all, they was the Fashionistas. Everybody just sees some totally different. Cool. (TX, 30)

In addition to being aware of the hyper sexualization of their bodies by their peers, teachers, and family, participants were also aware of the negative sexual stereotypes ascribed to Black women. A majority of participants described stereotypes that designated Black women as hypersexual, aggressive, and curvaceous and mentioned how those perceptions of Black women affected the way they maneuvered through the world and thought about themselves.

Katia: Oh, also that we're like, permissive, so that's like the Sapphire one. I've heard that one before. Oh, and then we're fast. Like, I've heard that from like, adults. I remember that. That like black girls are like fast. (GA, 23)

Solana: I guess like, our attitudes and things like that. As far as intimacy, people it's hard to be intimate with us because of that. I guess because we're not a very timid or we just don't let shit fly. (VA, 25)

Jade: I tended to like, stay to myself, I really tried to, like, be invisible, as much as possible. Because I did see it though, I did see that that there was a group of kids like if the black girls was doing something and the white girls didn't get in trouble for it, or if the white girls were doing something, and then you see like one of they black friends or one of their other just bipoc friends doing it, they would get more harsher punishment to and it was kind of just like that's really fucked up. And you couldn't, we were kids so we were just like, you know, we'd say something but to no avail. (TX, 30)

Participants mentioned that the differential treatment they received as a result of stereotypes about Black women were noticeable in their school interactions as well; participants described experiences where they were unfairly targeted for dress code, when they were advocating for themselves or for simply being children, unlike their white counterparts. Many

participants mentioned that they did not personally experience this targeting because they made a purposeful effort to not be labelled according to those stereotypes.

The differential treatment that the participants experienced was not only limited to unfair targeting for behavior or dress code; participants also perceived differences in the access their schools and communities had regarding sexual health information and resources, compared to their white counterparts. Structural racism embedded in their communities limited the resources dedicated to education in certain schools, and predominantly Black schools were more likely to suffer from limited resources and apathy toward educating students.

Jade: Like I mean, it's not even equal down to if men between men and women let alone race. if your school can't afford it, which is both basically the schools in BIPOC areas and or more populous areas they don't get it or to like a private school like and I don't even know what their education system is but I know their parents can pay for them not to have it if they didn't want to. So no, definitely not equal. (TX, 30)

Participants also mentioned how the religious context of communities and organizations could affect the access people have to sexual health resources. Religious parents can prevent their children from learning about sexual health information in schools if they do not consent to their child receiving that information and can also bar them from any knowledge of organizations or other places where their children can receive information about sexual health topics. Similarly, communities with a large religious population often will impede knowledge or access to community organizations that support sexual and reproductive health, such as planned parenthood or other sexual health clinics.

Dana: I lived in Alabama, which a lot of people were very religious and whatever. I definitely did not have any knowledge of anywhere I could get, like abortions, or I didn't even really know, places to get birth control or anything until I got older and my, like, I had older, like friends of family and stuff that would recommend me to places that they go to, but that was not something that I really had any knowledge of growing up. And unfortunately, like, especially when it was just my dad, it was like, even more of a struggle, because then it's like, I don't even have somebody in my house that's like accessing those things. So and I'm the oldest. So yeah, it was all very new to me. And I didn't really know of where to go outside just like going to school services. (AL, 23)

Additionally, participants noted that stigma affected which community organizations were considered valuable or safe institutions to receive sexual health resources while also mentioning that communities with more financial and material resources were more likely to provide or make community members aware of the services available for sexual and reproductive health.

Cloe: Yeah. I feel like in Durham there just there just wasn't a lot of resources to be honest. Like there was planned parenthood or health department. I don't remember schools ever giving out condoms ever. Like I said, the education was very limited. I don't really can't really speak upon like public health or public school system and how they taught sex ed and things. But I'm pretty sure they didn't provide condoms or things like that. So I remember God, where did I get my condoms from, I think, either got them from the store. But I remember also having free ones from somewhere, and I can't remember where I got them from. But to access it was it was hard where I grew up to it just felt like everything was either far away, or like, it wasn't easy to get to or like you really had to dig to like, even just look for to get a condom and like you like,

went to the store. But even then that was kind of weird, because you weren't sure if like someone you were there was gonna see you get a condom or like.(NC, 27)

Healthcare and Health Policy (SEM, Intersectionality, Racially Concordant Care)

Young Black women's experiences receiving Sexual Healthcare

Disparities in accessing sexual health resources, such as gynecological care and barrier methods, resulting from stigma, discrimination and community resources were observed throughout the data but in varying levels and with nuances previous data has not documented. Participants in this study often had more positive experiences during their healthcare visits overall, but most participants also noted that they often had racially concordant providers, or providers they had been seeing since they were children.

For those who did have stigmatizing experiences within healthcare, it didn't act as a deterrent to accessing future healthcare, however it did make accessing care more distressing for participants. The racialized and gendered stigma that participants experienced from healthcare workers came from systemic stigma within healthcare that labeled Black women as more promiscuous and thus at higher likelihood to be experiencing systems of STI's or pregnancy.

Sasha: And we're all like master students. So again, this is very interesting, dynamic. We go to the hospital, we're experiencing something." Could you be pregnant?" "No." "Are you sure?" "Yes." Especially for my friends who are virgins. Being able to like have a conversation and like be no, like, I haven't had sex so you can exclude everything that has to do with that. Like we said it once and that should be the end of it. Because I remember I passed out in high school being dramatic from a breakup. And I went to the hospital and one of the nurses came back and threw

the, threw the like curtains back and she was like, are you pregnant? And I was like no and she was like, Are you sure? I was like yes, I haven't been eating. And she said, Oh, okay. (NC, 26)

Cloe: Yeah, so I remember feeling a little judged with my very first like chlamydia. And since because I was young, right? I remember just my doctor. I mean, I was pretty close with that doctor, because she was my mom's doctor, which is also like weird, laughs now that I think about it. Oh, it was just like, yeah, and my aunt's doctor, so it was just like, she's kind of like family to a certain degree. And she's a black woman. And so I remember feeling a little judge not like very much, but I remember just being very, of course, I was already like, embarrassed and confused. (NC, 27)

In the aftermath of the repeal of Roe v Wade, many participants discussed that their perception of their access to sexual health care had shifted. Participants shared that they began to fear more for their ability to access healthcare if they were to become pregnant or need birth control methods because of information circulating about criminal prosecution for receiving abortions or having miscarriages. For participants who weren't worried about their access to sexual health care or resources, they feared for the safety of other women in their families or communities because they may have different barriers to care compared to the participant.

Sasha: Oh, yeah, the overturning of Roe v. Wade, was like, mind blowing for me. But I am now in a position where if I needed an abortion, and I had to go to another state to get one, I could get one. So I am now one of those women less impacted by it which is a whole interesting, dynamic. And still felt like I had been stripped of some type of like agency to decide over my life. So there was a whole conversation between me and my partner, like, vasectomy, which he was like, oh, what? And I'm like, okay, so thinking about changing my birth control, so I have the nexplanon but I'm like, should I get an IUD? Then you get on tik tok, and you see all those videos

about how painful it is, and like it's like nevermind. So I think that was the most recent one that impacted the way I approach health. Also, anytime I feel like that's impacted in time, I felt like I have a pregnancy symptom, I'll take a test. Even though there was a 0.01% chance I'll still take a test because I don't have time to be late on information like the especially as a woman who doesn't want children. (NC, 26)

Relatedly, participants who were not currently enrolled in a degree program had a different experience seeking sexual health care compared to current degree-seeking participants or their own experiences when they were enrolled in a degree program. Their current location determined the ease of their access to sexual health resources, with college towns being perceived as affording easier access to care versus participants in other areas who had to do more searching for their specific needs.

Jade: Because I think after that, or trying to just get anything after college was a little more difficult, because I think people just like, oh, well, you need to, you should be taking care of yourself, and you should be doing these things. And you know, and they kind of, like, chastise you a little bit more outside of the collegiate health clinic and it's kind of weird. I was like, okay, even going to I've been to Planned Parenthood and it can be a little, I mean, as much as the education as it is and they deliver what you need, It can be a little chastising, and you're like, Alright, calm down. (TX, 30)

Tiffany: Well, right now, so I live in like a college town. And so the college kind of has its influence everywhere. But because this college is typically a little bit more liberal in a conservative state, I feel like there's sometimes outside influences that try to like kind of seep in, and the university tries to fight back… Whereas now I do have to dig a little bit more and consider what needs I have, you know being older now. I'm not like old old, But like, I'm

definitely not like 20 anymore, you know? And so I have to think about like, other long term things, I would say, and so it requires me to, I guess dig a little deeper and then question things a lot more because just because I found- find something I'm you know, WebMD or whatever and uh I- it starts a path, I would say, so like, I can get started here's some, you know, stories good or bad. Consider it myself for a little bit and then kind of reach out to different, you know, faculty like different doctors or different websites or different organizations or websites or whatever it may be to kind of form my own research database, in my head. (TX, 29)

Young Black women's recommendations to improve sexual health education

Overall, young Black women have shared that to encourage and support them on their journey to sexual empowerment, they need to be supplied with education, resources, and trusted community members, more specifically parents and Black educators, who can provide them with information and safe spaces to safely discuss sexual health topics as they come up. Participants discussed that the most important factor to changing the trajectory of their sexual health journey's and sexual development. Participants had specific critiques and advice for improving the sexual health education that they received during their formative years. Most notably, participants shared that they wished sexual health education started earlier, was more inclusive, that topics covered are more expansive than STI and pregnancy prevention, and that the education came from trusted and credible sources who looked like them.

Although some participants experienced sexual health education lessons about puberty during the fifth grade, other participants didn't receive any sexual health education experiences until middle school or high school. Therefore, to enhance current sexual health education, participants suggested that sexual health education should begin earlier and introduce more topics outside of anatomy and menstruation. Starting sexual health education courses earlier and

equipping children with knowledge of consent and boundaries in tandem with anatomy and body changes can help children have more agency regarding their bodies and help protect them from sexual violence.

Cleo: I would start the preparation a little earlier in high school so that once people went to high school they already were aware that of their own anatomy and how they interact with other people. I would give resources at the school like condoms and how to get access to birth control and not and not not discuss those things. Because then that's how people get into different situations that they can't get out of because they don't know anything regarding the subject. (LA, 25)

Relatedly, participants also largely wanted the inclusion of more topics in sexual health education in general so that they are learning about more than preventing STI's and pregnancy. Participants wanted to learn about more reproductive health, different types of relationships, how to have healthy sexual and romantic relationships, consent and boundaries, and learning about different gender and sexual identities, among other topics. Participants want sexual health to cover all topics that they may experience in their lives and therefore want there to be more inclusivity overall.

Katia: Maybe for it to be more inclusive of all identities, and I guess ways to engage in like sexual pleasure. And I may not have thought about that back then. But I would say moving forward, I think that's how it should look. (GA, 23)

Solana: I feel like I would like to know more about different reproductive health services or things that I can use. Also, the barrier methods I will try to learn about that more. And I guess,

as far as STIs I feel like we should have learned about that more just because most people think it always has to be symptomatic, but it can definitely lie dormant in people so. (VA, 25)

Generally, participants mentioned that they believed that receiving their sexual health education from a trusted source who looked like them would have helped them retain the information they were taught in their sexual health education courses more. They believe that having someone who identified with them would have changed the way the courses were taught and would have made the information feel more relevant to them.

Yasmin: So I wish I had a teacher who could relate to me a little bit more. And she was older too at that she was older. So somebody who can relate to the students, but also put it down for them, where they understand what is being said so they know what to say or do. So they're putting themselves you know, in the safest situation. (NC, 24)

Limitations

There are several limitations for this study. The first limitation of this study is my positionality as a Black, bi-sexual woman who received my sexual health education in the American South. Because of my own experiences and the experiences of those I know, my positionality introduces the possibility of bias to the study since I am the sole researcher on the study, however I argue that my positionality is a strength to this study. Additionally, the small sample size of the study; because only ten participants were utilized for the results of this study, the results may not be generalizable to all young Black women who received their sexual health education in the American South, even with the strong patterns shown in the data. More studies would be needed to establish causality or a deeper pattern within the results of this data. Another

limitation of this study is that there were limited questions that specifically explored how sexual health education and sexual development was different for people who were LGBTQIA+. Although there were participants who identified as either bi-sexual, pan-sexual or queer and shared their experiences surrounding their sexual development in general, there were not enough questions that delved deeper into how their queer identity may have changed their access to sexual health information or how their self-esteem was affected by the increased lack of representation they experienced. Future studies should explore this facet of identity more clearly to establish patterns around sexual health education, stigma, self esteem and sexual identity. Furthermore, this study didn't delve deeply into how experiences of racial or sexual violence affected the sexual development and self-esteem of participants although two participants mentioned experiences of sexual violence. Future studies should explore how sexual violence impact young Black women's self-esteem and sexual development as well. The final limitation of this study is that participants were the study criteria did not specify ethnicity and therefore comparisons between African American versus Black immigrant or Black immigrant descendants cannot be drawn. Future studies should be conducted to determine whether sexual health education and sexual development outcomes are different between Black participants of different ethnicities.

Chapter 5: Conclusions, Implications and Recommendations

Discussion

The purpose of this qualitative study was to determine how sexual health education, racial stigma, and sexual stigma affected the sexual development and self-esteem of Black women between the ages of 18 and 30. The study of this topic spans multiple theoretical frameworks including intersectional, critical race theory, critical sexuality studies, and the socio-ecological model. The data from this study support previous research studies that describe the process of young Black women's sexual development and add additional nuance to the topic to explain young Black women's lived experiences during their formative years. Moreover, the results of this study are consistent with the findings of the unpublished qualitative mini-study that preceded this research especially in consideration of the recommendations young Black women provided to improve sexual health education (Joseph, 2022). Analysis of ten qualitative interviews resulted in the identification of eight themes across the four overarching topic areas: sexual health education, sexual development, stigma, and healthcare. The eight themes that were identified from this study are first introduction to sex, deficits in sexual health education, the role of media and pornography in Black women's sexual development, young Black women's journey to sexual empowerment, the role of elders in Black women's sexual development, negative perceptions of Black women, young Black women's experiences receiving sexual healthcare, and young Black women's recommendations to improve sexual health education.

The results of this study have emphasized that the sexual health education Black women receive in the south during their formative years is not adequate in preparing them for their sexual experiences or protecting them from adverse sexual experiences, such as sexual violence or STI acquisition. Many of the young Black women in this study were exposed to sexual material early on in their lives but were not supported within their homes or communities to

appropriately learn about sexual health topics and thus learned most of their information through their peers, pornography, social media, or their own research, which supports previous research that shared that Black women are keen to learn about sexual health but don't have many opportunities to do so because of the lack of adequate sexual education in formal settings.[5,9,14] The participants in this study wish that their families would have been more open in discussing sex with them or that they had safe spaces within their communities to learn about sex and reproductive health from trusted and credible sources who represented them, which was similarly needed by Black women in a study about protecting their sexuality.[5] Because creating this openness within the Black women's communities will take time, bolstering sexual health education to encompass a wide range of inclusive and relevant topics will be integral to preparing young Black women for entering sexual and romantic relationships. A plethora of factors influence people's access to sexual health information including religious factors, community resources, and credible sources, therefore standardizing comprehensive sexual and reproductive health education will minimize these differences and ensure equal access to sexual health information for young Black women.[14,17]

Equally important, racialized, and gendered stigma significantly affect the self-esteem of young Black women during their formative years.[11,16-17] Systemic oppressive systems that have designated Black women as hyper-sexual, aggressive and less valuable sexual partners is perpetuated through every facet of young Black girls' lives and results in hypervigilance over how others in their community perceive them.[14,16] A study on gendered racism acknowledged that stereotype-related gendered racism results in Black women feeling as though they have less power in controlling how they are perceived by others and thus increases their sexual risk as well.[14,16] To avoid being designated as "fast" for their curiosity about sex, and thus reclaim some

of this power, participants would use education, clothes, and timid behavior to distance themselves from negative racial and sexual stereotypes, and thus prevents a reduction in their "value". This negative stigmatization was present in previous grounded theory studies about protecting young Black women, in which the use of the term fast by older Black women to encourage young women to savor their innocence although it only served to make younger Black women internalize its negative connotation and act on it.[5] Relatedly, to avoid unfair racial targeting by school authorities, the participants often dimmed their voices because participants who advocated for themselves were dismissed or punished for it. The constant hypervigilance and distancing from stigma the participants engaged in resulted in the internalization of stigma related to sexual activity, sexual stereotypes and racial stereotypes about Black women for some of the participants.

The rigid definitions of sexual desirability based on racial and sexual stereotypes derived from media and social media also significantly affected young Black girls perception of themselves and their value. Because of this intersectional stigma (REF), many young Black women internalized that their value is embedded in their sexual desirability and sexual skill, which is supported by previous studies studying young Black female sexuality.[5,9,14,16,22] Young Black women are influenced by both images of celebrity Black women in media they want to emulate to be considered desirable as well as from the pornographic imagery of ideal sexual partners.[5] Therefore, those who believed they did not embody the sexual siren or video vixen stereotype believed they were less desirable partners and therefore less desirable women. Additionally, the lack of representation young Black girls? Women? have in media in general emphasizes and assists in the internalization that they are less valuable and desirable to society. Because of the large role that media and internet sources played in influencing these perceptions,

more effort should be invested in creating media representation that shows healthy self-image for young Black girls, healthy romantic and sexual relationships, and provide information about sexual and reproductive health topics to disparage misinformation that young Black girls may learn from their peers. Previous digital story-telling interventions created safe spaces to facilitate healthy conversations about sexual health, more specifically endometriosis and condom usage, among women, and thus there is promise to use social media and other media sources to promote health sexual behaviors and conversations.[36-37]

The gendered stigma that young Black women in this study experienced was not limited to school and their communities; Young Black women also faced stigmatizing experiences with healthcare providers who perpetuated ideas around Black women's promiscuity and accompanying sexual health outcomes.[7] Participants in the study who had racially concordant care or providers who cared for them since they were young shared less negative experiences in the healthcare space compared to those without those experiences.[7] This supports research that emphasizes racially concordant care to increase positive health outcomes for Black women, as well as the frustration felt by Black women during their family planning care visits.[7] More specifically, the emphasis on culturally relevant care, such as an experience of one participant who described an empathetic and stern provider, are important in ensuring adequate health care access for young Black women.

Finally, sexual empowerment in this study is related to increases in participants self-acceptance and self-esteem. Sexual empowerment not only improves women's sexual experiences, it also makes them more comfortable advocating for themselves in their sexual experiences and increases their likelihood of practicing safer sex behaviors.[5] A previous grounded theory study about the process of becoming a sexual Black woman described a

phenomenon similar to sexual empowerment called the protection phase: in this phase participants began protecting themselves by taking care of their bodies, rejecting stereotypes messages and sharing sexual health information.[5] This phase shares stark similarities to the experiences noted on journey to sexual empowerment that participants shared during this study. As participants embarked on their sexual empowerment journey, they began unlearning prior lessons from their communities, media and society that prioritized their male sexual partner's pleasure at their expense. Once they began to internalize that their pleasure is just as important as that of their sexual partners, participants became more comfortable engaging in condom negotiation and advocating for their needs during their sexual experiences. Moreover, participants who had supportive romantic partners felt as though their partners support made them more comfortable in continuing on their sexual empowerment journey and as they redefined the meaning of their sexuality. Therefore, we should prioritize support for young Black women through their sexual empowerment journeys, whether it be through partners or community support.[38] At the center of sexual empowerment for many participants is being equipped with information to assist them in their decision making.[38] Previous interventions focused on empowerment in Black women found that social support enhanced the ability for women to learn in these programs and thus improved their mental health outcomes during the study. Increased education has also been associated with Black women having greater intentions and ability to disseminate information to others, thus contributing to community knowledge and facilitating social support amongst Black women.[38-39] Participants who mentioned experiencing sexual violence believe that having more information or agency could have helped them prevent their adverse sexual experiences, which is supported by a study exploring critical sexuality studies but differs from a previous study that explored Black women's socialization, as they

described moving on from sexually violent situations by forgetting they occurred.[9,22] To protect young Black girls and reduce their negative sexual health outcomes, we must prioritize equipping them with as much information and support as possible to help them navigate their sexual and romantic experiences.

Recommendations- based on guidance from interviewees and literature

Several recommendations to improve young Black women's experiences with sexual health education, and thus improve their sexual health outcomes, were proposed during the study. Overall, young Black women in the study expressed that they want more education from people who look like them and that they can trust, with special emphasis on lessons and support coming from their parents, as well as a more inclusive and robust sexual health education curriculum. From these recommendations, I have envisioned a few interventions that can help bridge the gaps in young Black women's sexual health caused by cultures of silence and inadequate sexual health education.

To support young Black women in learning about sexual health education outside of the school setting, based on the interview data, I propose the creation of community sexual education spaces, supported by local sex educators, mental health counselors, OBGYN's and health educators, that will be used to provide information, resources, and answer any questions young Black girls have about sexual and reproductive health. In these community spaces, which can be held at current community centers such as the YMCA, churches, or even places like SisterLove (a woman centered sexual and reproductive justice organization in Atlanta), the curriculum will emphasize empowerment through affirmations and other mindfulness-based strategies alongside the sexual health curriculum that will span the topics of healthy boundaries, consent and

relationships, STI's and safer sex methods, women's anatomy and reproductive health, staying safe on the internet and any other topics that the young girls are interested in. Previous interventions have explored the facilitators and barriers to implementing sexual health conversations in churches and future interventions can utilize these findings to increase their success in church settings and other community settings.[40] Additionally, an intervention utilizing text messages to disseminate sexual health information addresses the need to increase the accessibility of sexual health information for young Black women and can also be utilized in future interventions as a supplement to community based interventions.[41] This intervention will also provide young women with resources that they can find in their own schools or on social media to help supplement their learning while they are away from the healing space. Young girls who have experiences with sexual violence or are interested in beginning sexual relationships with their partners may also receive mental health services from on-site mental health counselors as well.

Relatedly, a similar community space to educate the elders of young Black women can also help to bridge the gaps created by cultures of silence by providing them with the knowledge needed to share sexual health information with young Black girls without feeling as though they are empowering them to have sex. A previous study mentioned that other women in young Black women's community who were considered trustworthy, caring, and credible sources of information can serve as protectors for young Black girls, thus empowering them with information can help facilitate this role.[5] In this intervention, community health educators and sex educators will structure the curriculum around providing sexual health education to Black elders and de-stigmatizing sex, including how to have sexual health conversations with the young Black girls in their lives while emphasizing that education does not encourage sexual

behavior. Additionally, for elders who are completely uncomfortable with having sexual health conversations with the young people in their lives, educators can provide them with options of where to steer their young girls so that they can still receive information from a trusted and reliable source. Following each session, elders will be provided with prompts and homework that can be used to encourage sexual health conversations in the home alongside tips on how to handle certain conversations when they arise so that young Black women can learn to rely on their elders for sexual health information. Moreover, a session dedicated to Black women elders sharing their sexual health experiences with the young Black women in their lives may be included as a "heart-to-heart" session that can break down the walls older Black women may have with having sexual health conversations.[5] The session can be structured to include prompting questions about different sexual health experiences that the women elders can answer to, such as experiences with healthcare providers, adverse sexual health experiences, stigmatizing experiences, positive sexual health, and sexual experiences, and many more topics.

While gaps in sexual health knowledge are being bridged in young Black girls' communities, policy to enact change in the current sexual health education curriculum is integral to ensuring that they are being taught these lessons from a variety of sources. Therefore, inclusive and comprehensive sexual health education has been noted as an integral part of the sexual health journeys of young Black women and thus should be prioritized. Moreover, sexual health education that is taught throughout students' entire school careers should also be included in the new policy as well.[42] Many of the participants noted that they only received sexual health education for a maximum of one semester for less than 60 minutes each session, which is not enough time to engage in all of the topics that may be relevant to their lives. Therefore, sexual health education should be taught during at least one quarter/semester/trimester per year starting

in elementary school and should continue throughout the entirety of students' school careers, including in higher education institutions.[43] A systematic review of school-based sexual health education programs in the United States and a plethora of non-US countries found that found that introducing sexual health topics at earlier ages resulted in a multitude of positive outcomes such as the development of self-protective knowledge, decreasing homophobia and hostile school environments and improving academic outcomes.[43] The samples of these interventions varied from pre-school students to 12th grade, which demonstrates that inclusive sexual health education produces positive health outcomes amongst all age groups.[43] The curriculum should be relevant to the grade level of each student as well. For example, age-relevant and development adjusted curriculum could look like this, as referenced from the National Sex Education Standards created by the Future of Sex Education Initiative[44];

> Elementary-age students should have the following topics included in their sexual health curriculum:
>
> - Consent, boundaries, menstruation/ changes during puberty, identifying good touch versus bad touch, and bodily autonomy. School educators should work alongside health education and sex educators to develop relevant curricula across age groups and development stages.
>
> Middle school-aged students should have the following topics included in their sexual health curriculum:
>
> - Pregnancy, including how it happens and the stages of pregnancy development, STI's/ HIV, Self-pleasure, birth control methods for people with vulvas, barrier methods and how to use them in different

types of relationships, types of relationships/ partnerships, consent and boundaries, condom negotiation, social media literacy for sexual health information, healthy relationships and both male and female anatomy.

High-school aged student should have the following topics included in their sexual health curriculum:

- Pregnancy, including how it happens and the stages of pregnancy development, STI's/ HIV, Self-pleasure, birth control methods for people with vulvas, barrier methods and how to use them in different types of relationships, types of relationships/ partnerships, consent and boundaries, condom negotiation, social media literacy for sexual health information, healthy relationships, class-guided lessons based on questions students have, and both male and female anatomy. Consent, healthy relationships, and safer sex practices should have a greater emphasis, especially in the higher grades as preparation for their college experiences.

College- aged students should have required courses, as a part of general education requirements, on pleasure and intimacy, consent and boundaries, pregnancy and contraceptive methods. These courses can be housed within the sociology or gender studies departments in universities.

Moreover, within these lessons, video demonstrations should be provided for each of the topics covered, especially for lessons on barrier methods, healthy relationships, and consent and

boundaries, so that students have a visualization of how certain processes should look.[45-47] When discussing STI's and anatomy, students should be shown representations of all STIs or anatomical figures on diverse models, so that young Black students know what to look for on themselves.[48] A study examining the decolonization of anatomy discusses that diversifying the representation of anatomy is a part of a wider effort to decolonize anatomy curricula and addressing health inequity as it allows all members of the education community to find their place which widens the scope for discussing pathology.[48] In the context of healthcare, addressing the implicit biases of healthcare providers also includes including images that are race and gender inclusive so as to change the attitudes of healthcare professionals that leads to discriminatory behavior.[49] Additionally, when conducting the lessons for students in higher grades, such as those in high school, and college, teachers should provide them with resources for clinics or organizations that provide low-cost sexual healthcare and provide educational or sexual health resources.

Schools should also emphasize offering sexual health resources at their own schools' nursing offices so that students don't have to rely on transportation or permission from their parents to access sexual health resources. Resources should include barrier methods, such as condoms and dental dams, pamphlets or informational booklets about different contraceptives and STI's, and information about how to deal with instances of sexual violence. Relatedly, OB-GYNs and other health care offices should offer similar information, as well as include pamphlets about the side effects and process for choosing a birth control method while providing culturally concordant or compassionate care that doesn't make patients feel rushed or unheard.

Need	Recommendation
Sexual health education outside of formal classroom settings by trusted individuals	Community sexual health education spaces supported by qualified Black sex educators, mental health counselors, OBGYN's and health educators.
Bridge the gaps in knowledge created by cultures of silence in Black families and communities	Create sexual health education curriculum designed for adults that shares accurate sexual and reproductive health information and teaches adults how to have sexual health conversations with young women or femme-presenting people. Educate Black elders, especially women or femme identifying elders, on sexual and reproductive health and how to share that information with the young Black women and girls in their lives.
Mandated comprehensive and inclusive sexual health education	Create and pass policy that mandates comprehensive and inclusive sexual health education that occurs for at least one semester per year beginning in pre-school and includes topics included in the Future of Sex Education Initiative and includes diverse

	representations of anatomy plus digital tools to enhance learning.
Lack of access to sexual health resources	Provide sexual health resources, including barrier methods and information, in schools, healthcare offices and other spaces that young people frequent.

Public Health Implications

Many of the public health implications for this study go hand in hand with the recommendations provided by participants regarding empowering them on their sexual health journeys. Creating and passing policy to mandate inclusive and comprehensive sexual health education across the country, as well as the creation and implementation of community-based healing and education spaces for young Black women to learn about sexual and reproductive health topics will both serve to reduce the sexual health disparities that Black women experience because they will be empowered to advocate for themselves in sexual situations, as well as be more likely to abstain from sex for a longer period of time because they know about their own ability to choose in sexual situations, understanding their worth outside of their sexuality, and knowing the consequences of sex at earlier ages.[5,9,17]

Furthermore, increasing the amount of culturally competent and compassionate healthcare providers through training during and after medical school will help to curb the sexual health disparities in healthcare that Black women experience as well. Several participants in the study noted that their adverse experiences in healthcare made them feel unheard and left them with more questions than answers. Those who had culturally competent and compassionate

healthcare providers often felt more confident in their sexual and reproductive health choices and felt comfortable sharing any concerns they had with their providers as well. Previous studies discussing the effects that personally mediated racism has on the interactions between healthcare providers and their patients discuss that physicians' unconscious attitudes about Black women, including that they are more likely to have higher pain tolerances or attempt to access prescription drugs, leads to disparities in treatment.[11] In a country where Black women are three times as likely to die from maternal causes compared to white women,[50] trusting that your provider will care for you without having to constantly advocate for yourself, which contributes to the stress Black women experience, is integral to preserving the lives of Black mothers. Healthcare providers provide care and are sources of knowledge for young Black girls and women. Therefore, providers who are equipped to disregard biases that result in a higher likelihood of adverse experiences or death for Black women are integral to addressing the Black maternal health crisis in addition to the adverse sexual health outcomes Black women experience.

Equally important, as media and pornography had a wide-ranging effect on the behaviors and self-perceptions of the participants in this study, public health must begin to utilize media to mitigate misinformation and begin assisting young people with learning about sexual health in safer ways.[5] Participants in this study discussed that media, especially social media, was an influential source of information for them in learning how to have sex and interact in sexual situations, results from a previous study about Black female sexuality.[5] Current sexual images define women who enjoy sex and openly discuss sex as nymphos and Black women as sexual sirens.[15] These characterizations reduce women's ability to negotiate sex and condom usage because they don't want to be overly sexualized.[15] Additionally, imagery in current pornographic

media does not depict condom negotiation experiences and portrays many women as submissive partners who are supposed to receive sex.[15] A few participants mentioned utilizing the information they gained from social media sex educators to inform their more positive views of sex and how to embody their sexuality. While planned parenthood does provide web resources through its internet pages,[51] that information is not broadcasted to the audience that would benefit from it the most from it, as evidenced by the experiences of the participants in this study. Therefore, creating more representative and educational sources for young people wanting to learn about sex and reproductive health should be widely available and advertised in schools and on social media to replace the plethora of sexual health information that exists online. Relatedly, education about pornography and healthy sexual relationships must be provided with similar accessibility to pornography. Pornography should include disclaimers and warnings, similar to movies, that explain that the dynamics shown in pornography are not realistic as well.

Future Directions

As described by the limitations, this study has opened a wide variety of avenues for future research to explore. Future studies can continue to explore the different facets of young Black women's sexual health experiences and journeys and the relationships between those experiences and their self-esteem and development, as well as begin exploring how different aspects of Black women's identities affects these relationships as well. Therefore, future directions based on the results of this study include the relationship between young Black women's self-esteem and safer sex practices, the sexual development of young queer Black women and their sexual health outcomes, the relationship between experiences of sexual violence and Black women's self-esteem and the exploration of the sexual development, self-

esteem, and experiences of Black women across the Diaspora compared to Black American women.

Future studies should focus on both exploring the experiences of Black women as well as allowing the participants to identify what would assist in better health outcomes for them and other Black women in their communities. Legitimizing the experiences of Black women is integral to expanding research so that other researchers will continue to work toward changing the sexual health outcomes for Black women, however, Black women are also the best sources to receive information from regarding how to address the needs that directly affect their health outcomes. Combining health behavior theory with qualitative interviewing can help ensure that the issues that are identified are relevant to Black women's health outcomes and also that inspire the interventions that are created to address those outcomes as they will be directly informed by the population whose they are addressing. Changing the sexual health outcomes of Black women will require a multi-level approach informed by compassion and intersectional theories to truly address their needs as their issues are affected by a myriad of factors.

Conclusion

The instances of sexual and emotional violence that Black women experience have a significant effect on their sexual health outcomes. Misinformation perpetuated by peers, elders, and different media forms causes Black women to struggle to find information about sex that could empower them in their sexual decision-making and their ability to advocate for their own sexual needs. The lack of adequate and comprehensive sexual health education provided by schools in the south assists in the continuation of this misinformation because it fails to fully address the concerns that are most pertinent to young Black women who are curious about sex and fails to provide imagery that is representative or relevant to them. Cultures of silence in

Black communities combined with stigmatizing experiences informed by stigmatizing language within and outside of the Black community, such as being called fast or emphasizing women's worth in their sexual desirability, further limit the informational sources and sources of protection that Black women have access to as they begin their sexual health journey's.

Moreover, experiences within the healthcare system can be stress-inducing when providers perpetuate biases against Black women informed by racism and sexism. As young Black women move on their sexual health journeys, they seek out information to inform how they behave during their sexual experiences and thus can fall into cycles of perpetuating the stereotypes they learned about Black women during their formative years. As young Black women continue to experience sex and grow older, they move closer to their sexual empowerment as they continue to seek out more information about ensuring their pleasure and how to advocate for themselves and their needs. Through this process, young Black women begin to redefine their identities as sexual beings and become more comfortable making safer sex decisions. Therefore, empowering young Black women during their formative years, through resources, education, and support, is integral to addressing the adverse sexual health outcomes that they experience, which include disproportionate STI/HIV acquisition and sexual violence. Ensuring that safer sex materials and resources, like barrier methods and qualified healthcare professionals, are easily accessible and that the communities' Black women are situated within are dedicated to assisting them in learning about themselves and their bodies will be essential to reducing the disproportionate sexual health outcomes that young Black women experience.

References

1. National Profile | Volume 33 | HIV Surveillance | Reports | Resource Library | HIV/AIDS | CDC. Published May 23, 2022. Accessed April 17, 2023. https://www.cdc.gov/hiv/library/reports/hiv-surveillance/vol-33/content/national-profile.html
2. Table 2. Chlamydia — Reported Cases and Rates of Reported Cases by State, Ranked by Rates, United States, 2021. Published April 11, 2023. Accessed April 17, 2023. https://www.cdc.gov/std/statistics/2021/tables/2.htm
3. Table 7. Gonorrhea — Reported Cases and Rates of Reported Cases by State, Ranked by Rates, United States, 2021. Published April 11, 2023. Accessed April 17, 2023. https://www.cdc.gov/std/statistics/2021/tables/7.htm
4. Abstinence-Only Education States 2023. Accessed April 17, 2023. https://worldpopulationreview.com/state-rankings/abstinence-only-education-states
5. Crooks N, King B, Tluczek A. Protecting young Black female sexuality. *Culture, Health & Sexuality*. 2020;22(8):871-886. doi:10.1080/13691058.2019.1632488
6. Green S. Violence Against Black Women – Many Types, Far-reaching Effects. IWPR. Published July 13, 2017. Accessed April 17, 2023. https://iwpr.org/iwpr-issues/race-ethnicity-gender-and-economy/violence-against-black-women-many-types-far-reaching-effects/
7. "When Is Health Care Actually Going to Be Care?" The Lived Experience of Family Planning Care Among Young Black Women. doi:10.1177/1049732321993094
8. Joseph Veronica. Education and Empowerment: The Effect of Sexual Health Education on the Sexual Identities and Experiences of Black Women in the American Southeast. Qualitative Methods, Emory University, Qualitative Mini Study.

9. Logan RG, Vamos CA, Daley EM, Louis-Jacques A, Marhefka SL. Understanding young Black women's socialisation and perceptions of sexual and reproductive health. *Culture, Health & Sexuality*. 2022;24(12):1760-1774. doi:10.1080/13691058.2021.2014976
10. Stangl AL, Earnshaw VA, Logie CH, et al. The Health Stigma and Discrimination Framework: a global, crosscutting framework to inform research, intervention development, and policy on health-related stigmas. *BMC Medicine*. 2019;17(1):31. doi:10.1186/s12916-019-1271-3
11. Prather C, Fuller TR, Marshall KJ, Jeffries WL. The Impact of Racism on the Sexual and Reproductive Health of African American Women. *Journal of Women's Health*. 2016;25(7):664-671. doi:10.1089/jwh.2015.5637
12. Patricia Hill Collins, Black Feminist Thought in the Matrix of Domination. Accessed November 17, 2022. http://www.hartford-hwp.com/archives/45a/252.html
13. Jones CP. Levels of racism: a theoretic framework and a gardener's tale. *Am J Public Health*. 2000;90(8):1212-1215.
14. Crooks N, King B, Tluczek A, Sales JM. The Process of Becoming a Sexual Black Woman: A Grounded Theory Study. *Perspect Sex Reprod Health*. 2019;51(1):17-25. doi:10.1363/psrh.12085
15. The politics of sex research and constructions of female sexuality: what relevance to sexual health work with young women? - Few - 1997 - Journal of Advanced Nursing - Wiley Online Library. Accessed April 17, 2023. https://onlinelibrary.wiley.com/doi/abs/10.1046/j.1365-2648.1997.t01-1-1997025615.x?sid=nlm%3Apubmed

16. Rosenthal L, Lobel M. Gendered racism and the sexual and reproductive health of Black and Latina Women. *Ethnicity & Health*. 2020;25(3):367-392. doi:10.1080/13557858.2018.1439896
17. Crooks N, Wise A, Frazier T. Addressing sexually transmitted infections in the sociocultural context of black heterosexual relationships in the United States. *Social Science & Medicine*. 2020;263:113303. doi:10.1016/j.socscimed.2020.113303
18. Socio-Ecological Factors Associated With Students' Perceived Impact of an Evidence-Based Sexual Health Education Curriculum - Markham - 2020 - Journal of School Health - Wiley Online Library. Accessed April 17, 2023. https://onlinelibrary.wiley.com/doi/10.1111/josh.12908
19. Wingood GM, DiClemente RJ, Harrington K, Davies S, Hook EW III, Oh MK. Exposure to X-Rated Movies and Adolescents' Sexual and Contraceptive-Related Attitudes and Behaviors. *Pediatrics*. 2001;107(5):1116-1119. doi:10.1542/peds.107.5.1116
20. Travis R, Bowman SW. Ethnic identity, self-esteem and variability in perceptions of rap music's empowering and risky influences. *Journal of Youth Studies*. 2012;15(4):455-478. doi:10.1080/13676261.2012.663898
21. Wright, Chrysalis & Craske, Michelle. Music's Influence on Risky Sexual Behaviors: Examining the Cultivation Theory. Media Psychology Review. Accessed April 17, 2023. https://mprcenter.org/review/musics-influence-on-risky-sexual-behaviors-examining-the-cultivation-theory/

22. Fahs B, McClelland SI. When Sex and Power Collide: An Argument for Critical Sexuality Studies. *The Journal of Sex Research*. 2016;53(4-5):392-416. doi:10.1080/00224499.2016.1152454

23. Chandler R, Guillaume D, Tesema N, Paul S, Ross H, Hernandez ND. Social and Environmental Influences on Sexual Behaviors of College Black Women: Within Group Diversity Between HBCU vs. PWI Experiences. *J Racial Ethn Health Disparities*. 2021;8(4):852-862. doi:10.1007/s40615-020-00843-2

24. Black Women Students Far Outnumber Black Men at the Nation's Highest-Ranked Universities. Accessed April 19, 2023. https://www.jbhe.com/news_views/51_gendergap_universities.html

25. Pampati S, Johns MM, Szucs LE, et al. Sexual and Gender Minority Youth and Sexual Health Education: A Systematic Mapping Review of the Literature. *Journal of Adolescent Health*. 2021;68(6):1040-1052. doi:10.1016/j.jadohealth.2020.09.032

26. Alexander KA, Fannin EF. Sexual Safety and Sexual Security among Young Black Women Who Have Sex with Women and Men. *Journal of Obstetric, Gynecologic & Neonatal Nursing*. 2014;43(4):509-519. doi:10.1111/1552-6909.12461

27. Keuroghlian AS, Ard KL, Makadon HJ. Advancing health equity for lesbian, gay, bisexual and transgender (LGBT) people through sexual health education and LGBT-affirming health care environments. *Sexual Health (Online)*. 2017;14(1):119-122. doi:http://dx.doi.org/10.1071/SH16145

28. Opara I, Abrams JA, Cross K, Amutah-Onukagha N. Reframing Sexual Health for Black Girls and Women in HIV/STI Prevention Work: Highlighting the Role of Identity

and Interpersonal Relationships. *International Journal of Environmental Research and Public Health*. 2021;18(22):12088. doi:10.3390/ijerph182212088

29. Bond KT, Leblanc NM, Williams P, Gabriel CA, Amutah-Onukagha NN. Race-Based Sexual Stereotypes, Gendered Racism, and Sexual Decision Making Among Young Black Cisgender Women. *Health Educ Behav*. 2021;48(3):295-305. doi:10.1177/10901981211010086
30. Geronimus AT, Hicken M, Keene D, Bound J. "Weathering" and Age Patterns of Allostatic Load Scores Among Blacks and Whites in the United States. *Am J Public Health*. 2006;96(5):826-833. doi:10.2105/AJPH.2004.060749
31. Everett BG, Limburg A, Charlton BM, Downing JM, Matthews PA. Sexual Identity and Birth Outcomes: A Focus on the Moderating Role of Race-ethnicity. *J Health Soc Behav*. 2021;62(2):183-201. doi:10.1177/0022146521997811
32. The Effects of State-Mandated Abstinence-Based Sex Education on Teen Health Outcomes - Carr - 2017 - Health Economics - Wiley Online Library. Accessed February 2, 2022. https://onlinelibrary-wiley-com.proxy.library.emory.edu/doi/full/10.1002/hec.3315
33. Jenkins Hall W, Tanner AE. US Black college women's sexual health in hookup culture: intersections of race and gender. *Culture, Health & Sexuality*. 2016;18(11):1265-1278. doi:10.1080/13691058.2016.1183046
34. What Is Self-Concept and How Does It Form? Verywell Mind. Accessed April 17, 2023. https://www.verywellmind.com/what-is-self-concept-2795865

35. Ford CL, Airhihenbuwa CO. The public health critical race methodology: Praxis for antiracism research. *Social Science & Medicine*. 2010;71(8):1390-1398. doi:10.1016/j.socscimed.2010.07.030

36. Howard AF, Noga H, Parmar G, et al. Web-Based Digital Storytelling for Endometriosis and Pain: Qualitative Pilot Study. *JMIR Formative Research*. 2023;7(1):e37549. doi:10.2196/37549

37. Xu MA, Griffin M, Jaiswal J. An Examination of Condom Brand's Social Media Influence on Sexual Health Messages. *Health Communication*. 2022;0(0):1-10. doi:10.1080/10410236.2022.2042144

38. Bassett SM, Link to external site this link will open in a new window, Brody LR, et al. Feasibility and Acceptability of a Program to Promote Positive Affect, Well-Being and Gender Empowerment in Black Women Living with HIV. *AIDS and Behavior*. 2021;25(6):1737-1750. doi:10.1007/s10461-020-03103-w

39. Hempstead B, Green C, Briant KJ, Thompson B, Molina Y. Community Empowerment Partners (CEPs): A Breast Health Education Program for African-American Women. *Journal of Community Health*. 2018;43(5):833-841. doi:10.1007/s10900-018-0490-4

40. Powell TW, Weeks FH, Illangasekare S, et al. Facilitators and Barriers to Implementing Church-Based Adolescent Sexual Health Programs in Baltimore City. *Journal of Adolescent Health*. 2017;60(2):169-175. doi:10.1016/j.jadohealth.2016.09.017

41. Montgomery TM, Mays VM, Heilemann MV, Nyamathi A, Bauermeister JA, Koniak-Griffin D. Acceptability and Feasibility of a Sexual Health Intervention for Young Adult Black Women. *Journal of Obstetric, Gynecologic & Neonatal Nursing*. 2018;47(6):862-873. doi:10.1016/j.jogn.2018.04.136

42. Gaines L, Miller E. The case for starting sex ed in kindergarten (hula hoops recommended). *NPR*. https://www.npr.org/2022/09/12/1121999705/sex-education-school-kindergarten. Published September 12, 2022. Accessed April 17, 2023.
43. Goldfarb ES, Lieberman LD. Three Decades of Research: The Case for Comprehensive Sex Education. *Journal of Adolescent Health*. 2021;68(1):13-27. doi:10.1016/j.jadohealth.2020.07.036
44. NATIONAL SEX EDUCATION STANDARDS CORE CONTENT AND SKILLS, K-12 SECOND EDITION. Accessed April 17, 2023. https://siecus.org/wp-content/uploads/2020/03/NSES-2020-web-updated-1.pdf
45. HIV Basics | HIV/AIDS | CDC. Accessed April 17, 2023. https://www.cdc.gov/hiv/basics/index.html
46. CDC - STD Videos. Published November 28, 2022. Accessed April 17, 2023. https://www.cdc.gov/std/products/videos.htm
47. Human Sexual Anatomy and Physiology. Noba. Accessed April 17, 2023. https://nobaproject.com/modules/human-sexual-anatomy-and-physiology
48. Finn GM, Danquah A, Matthan J. Colonization, cadavers, and color: Considering decolonization of anatomy curricula. *Anat Rec (Hoboken)*. 2022;305(4):938-951. doi:10.1002/ar.24855
49. Parker RB, Larkin T, Cockburn J. Gender Bias in Medical Images Affects Students' Implicit but not Explicit Gender Attitudes. *AERA Open*. 2018;4(3):2332858418798832. doi:10.1177/2332858418798832

50. Green EL. ‘I Don’t Want to Die’: Fighting Maternal Mortality Among Black Women. *The New York Times*. https://www.nytimes.com/2023/01/18/us/doula-black-women.html. Published January 18, 2023. Accessed April 17, 2023.
51. Planned Parenthood | Official Site. Accessed April 17, 2023. https://www.plannedparenthood.org

Appendix A: Interview Guide

The Effect of Internalized Racism and Sexual Education on the Development of Black Women's Sexual Identities and Experiences in the American South

Research Question

How do racism, stigma, and sexual health experiences in the American South affect the self-esteem, sexual development, sexual scripts, sexual pleasure and sexual identity of Black women between the ages of 18 to 25?

Purpose

The purpose of this qualitative study is to understand how racism, sexual/ racial stigma and sexual health education in the American South affects the sexual development, self-esteem, sexual pleasure, sexual scripts and sexual experiences for Black women ages 18-30. The aims of this study are to understand the individual and collective effects racism, stigma and sexual health education have on shaping how Black women perceive sex, their sexual behavior, their sexual experiences, and their self-perception and sexual development. This study will utilize the social ecological model, as well as Critical Race Theory, to interpret how external factors (community, institutional, interpersonal and policy) impact the way Black women maneuver through the world as women and sexual beings based on the information they receive in their formative years. A further objective of this study is to understand if there are differences in the development of Black LGBTQ+ women and non-binary people compared to cis-women with raised in a similar environment.

At this stage in the research, sexual health education will be generally defined as "the lifelong process of acquiring information and forming attitudes, beliefs, and values about such important topics such as identity, relationships, and intimacy (*Components of Sexual Health Education*, n.d.)." Sexual scripts are defined as guidelines for appropriate sexual behavior and sexual encounters ("Sexual Script Theory," 2021). Sexual experiences are defined as the culmination of experiences that include sexual behaviors and include the phases of sexual intercourse. Racism is defined as both "an ideology that prescribes statuses to racial groups based on perceived differences (*What Is Racism*, 2021)" and "Discrimination or prejudice based on race. (*What Is Racism*, 2021)." Stigma is the situation of the individual who is disqualified from full social acceptance (Fitzpatrick, 2008), as well as, negative attitudes against someone based on a distinguishing characteristic (*How to Cope With Stigma When You Have a Mental Illness*, 2022).

Questions:

Introduction Questions:

1. Demographics
    a. Age
    b. Gender

c. Where did you grow up?
d. What year are you?
e. What is your concentration?
f. What would you describe your gender as?
g. What is your sexual identity?

Thank you so much for sharing your background with me. We'll now be moving onto the main questions for this interview regarding your sexual health education experiences and overall sexual experiences. Let me know when you're ready to begin.

Sexual Health Education Questions:

1. Tell me about yourself and your history with sexual health education:
    a. Tell me about when you first learned about sex?
        i. Probe
            1. Age
            2. Parents
            3. Family
            4. In school?
            5. Internet?
            6. Friends
            7. What other sources have you received information about sex from?
                a. Conferences?
                b. Community based events?
    b. What, if any, type of sexual health education in school growing up?
        i. Probe
            1. If so, what did it consist of? (Topics, examples, etc.)
                a. positive or negative messages?
                b. Anatomy?
                c. Abstinence?
                d. consent or boundaries?
                e. STI's and contraception?
            2. How long were the lessons?
            3. If not in school, where?
2. How do you believe your experience with sexual health education informed how you perceive sex?
    a. Is sex an uncomfortable topic for you?
    b. Where you seek out more information about sex?
    c. Did you continue to engage with sexual health or sexual health topics after you had sex ed? I.e. were you still curious about sex?
    d. What do you wish you could have changed about your sexual health education?
3. How do you believe your experience with sexual health education informed how you approach sex with your partners?
    a. Probe

i. Positively? Negatively?
ii. What did you learn about having protected sex?
    1. Could you give me an example?
        a. Condoms?
        b. Dental dams?
        c. PrEP?
    2. How did this influence your sexual behavior?
        a. Deterrence?
            i. Protective behavior?
        b. Risky behavior?
            i. When was it difficult to have protected sex?
                1. Condoms unavailable?
                2. Secret sexual encounters
                3. Shame or embarrassment?

4. Did you ever feel like you had a safe space for sexual exploration growing up?
    a. Why or why not?
    b. Do you feel that you have one now?
5. Describe any experiences where you were taught about healthy sexual boundaries or healthy sexual relationships, if any.

Sexual Scripts

6. Can you describe what your typical sexual script is? Do you feel as though you have a sexual script that you follow?
    a. If not, why not?
7. What is your process of cultivating your sexual scripts?
    a. Where did you get your information to create your scripts?
8. What other experiences influenced how you developed your perceptions of sex or sexual scripts?

Sex, Sexual Pleasure and Intimacy

- Do you consider yourself a sexual being or sexual person?
    - Why or why not?
- What does the end of your sexual experiences look or feel like?
    - Is there aftercare involved, I.e., making each other food, cleaning each other up, etc.?
    - Intimacy?
    - Leaving?
- What have you learned about aftercare or anything outside of the penetrative experience of sex?
    - Where?
- How would you describe your sexual experiences?
    - Intimate?

    - Just sex?
    - How does that affect how you perceive sex?
- Please define what pleasurable sex looks, feels or sounds like to you.
- Growing up, were there any experiences you had that emphasized the importance of pleasure for women or yourself?
    - Can you describe the experience or messaging? Where did it come from? Who delivered it?
- Do you believe that your current sexual experiences are pleasurable? Do they measure up to your expectations of sex?
    - How do you think that the way you learned about sex contributed to this?
    - Have your sexual experiences impacted how you feel about yourself?
- What barriers do you feel like you face with becoming fully intimate with partners, if any?
    - This could be emotionally intimate, physically intimate, etc.

Stigma

- Did you ever have any negative experiences with dress code or perceptions of your body in school?
    - Can you describe the experience?
    - How do you think it may have been different for other groups, if at all?
- What negative sexual stereotypes have you heard about Black women?
    - Where did you first hear it or learn about it?
    - How did/ does it make you feel?
    - Has it affected your sexual behavior in any way?
    - Has it affected how you perceive yourself or think about yourself as a sexual being?
- In what ways or instances do you feel like you've been unfairly sexualized, if at all?
    - Could be by family, teachers, partners/ people of the sex you're attracted to
    - Have you ever been called or heard anyone be called fast? How did that affect you or your behavior?
- Can you describe an experience where someone mentioned their preference for how female genitalia should look or what women should look like?
    - How did that impact you?
    - How did that change your behavior? Sexual or non-sexual.
- What has been your experience receiving sexual health care in a clinic or OBGYN?
    - Have you ever felt unheard when expressing your concerns?
- What policies/ legislation/ or laws regarding sexual health have you heard about?
    - If names them; How have these laws/ policies/ legislation affected your perception about the availability or accessibility of sexual health resources?
    - Did this ever affect how you attempted to access sexual health resources?

Racism

- Going back to how you received your sexual health information. Do you believe access to sexual health is equal?
    - Are there any groups of people that you believe have differential access to sexual health information?
- Can you describe any experiences or any instances where you believed you were unfairly targeted for something, like dress code or behavior, compared to white or other race women/ girls while you were in school?
    - Can you describe that experience?
    - How did that make you feel?
    - Did it change how you felt about yourself?
- During your sexual education courses, did you ever see images that represent people with your skin complexion?
    - If yes, how did that impact you?
    - If no, how did that impact you?
- What barriers have you faced in trying to access sexual health resources including but not limited to
- How do you think other races or genders access sexual health information?
    - Do you think it's different for other races? Genders?
- How do you think your access to sexual health resources, (clinics, teachers, condoms, abortion etc.) was affected by the place that you lived/ live?

Closing Questions:

1. Looking back, how would critique how you learned about sex growing up?
2. What support do you feel like would have changed the trajectory of your journey with sexual health and self-esteem?
3. What advice you would give your younger self or younger women now about development of sexual perception or sexual health?
4. What else would you like to share with me?
5. Is there anyone that you would like to refer to participate in this study?

- **Experiences of Sexual Assault (can listen, if it comes up acknowledge it (thank you for sharing this information with me, who supported you through that experience? What other areas of support do you have currently around this subject?)**

Resources:

- Sexual assault resources
    - https://www.rainn.org/national-resources-sexual-assault-survivors-and-their-loved-ones
- Sexual health resources
    - https://www.plannedparenthood.org/learn
- Sexual functioning
    - https://www.aafp.org/afp/2011/0915/p705.html
- Intimate partner violence

    - https://www.futureswithoutviolence.org/userfiles/file/HealthCare/reproguidelines_low_res_FINAL.pdf
- Pleasure
    - https://www.gab-shw.org/resources/sexual-pleasure-an-assessment-tool/
    - https://www.plannedparenthood.org/planned-parenthood-st-louis-region-southwest-missouri/blog/that-8-letter-word-including-pleasure-in-sex-education
- Aftercare
    - https://kimatwood.com/aftercare-an-important-though-often-overlooked-step/

Appendix B: Journey to Sexual Empowerment Diagram