SEXUALITY AND STUDENT HEALTH: ACCESS TO SEXUAL AND REPRODUCTIVE HEALTH RESOURCES AND INFORMATION AT AMERICAN UNIVERSITY

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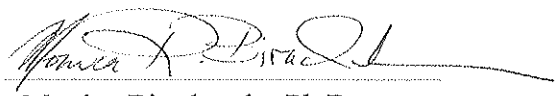
Chair: 

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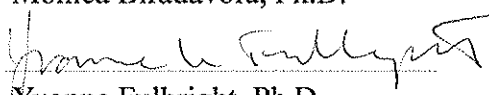

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ABSTRACT

Access to sexual and reproductive health resources is a vital aspect of overall health and wellbeing. College students are in a unique position related to their sexual and reproductive health needs. It is imperative that colleges and universities both provide necessary sexual and reproductive health resources and also that they ensure students are able to readily access those resources. This qualitative research examined access to sexual and reproductive health resources at American University from the perspective of the undergraduate students through interviews. It identifies both facilitators and barriers to access, and makes recommendations for improvements to access. Findings encompass several barriers, including lack of knowledge and information, stigma and certain gender biases, cost and transportation barriers. There were also facilitators, including a number of very strong student-led groups, and a recent program focused on sexual violence prevention. Recommendations include a well-designed education and information program at orientation, increased visibility of programs and services offered on campus, and greater availability of free safer sex supplies and testing, among others.

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Finally, I would like to thank the students who participated in the interviews for taking time out of your busy schedules to talk with me about your experiences and thoughts about making a great school even better.

TABLE OF CONTENTS

LIST OF TABLES

Table

CHAPTER 1

INTRODUCTION

Rising rates of sexually transmitted infections (STIs), unintended pregnancies and sexual assaults among youth in the United States indicate that there is a lack of necessary education and access to resources around issues of sexual and reproductive health for our young people (Centers for Disease Control and Prevention 2009; Lindgren 2009). The Centers for Disease Control and Prevention (CDC) reports that 1 in 4 teenage girls between the ages of 14-19 has an STI (2008) and that even though teens make up only 25% of those who are sexually active, they account for 50% of the new STIs (2009). The purpose of this research was to explore what types of barriers and facilitators to access of sexual and reproductive health resources (SRHRs) exist on the American University campus from the students' perspectives. Specifically, I explored via in-depth interviews whether students encounter barriers and/or facilitators in attempting to access SRHRs on campus, whether the results indicate any gender implications, what those barriers/facilitators consist of, and how students navigate them. Using this analysis, I am making recommendations to improve access.

The information gained from this research can be used directly by stakeholders at American University to improve access to SRHRs on campus, thus facilitating better health outcomes for AU students. It can also be used to guide other colleges and universities in providing better access to resources on their campuses. Additionally, these results can provide insight into how young people perceive themselves as sexual beings, and society's ever-evolving views on sexuality.

CHAPTER 2

REVIEW OF THE LITERATURE

Most studies that have been done on access to sexual and reproductive health education have been performed on younger (high school) adolescents (AVERT 2010; Edwards 2004), in part because there is much controversy about when young people might initiate sexual activity, and how – or how much – they should be taught to protect themselves from potential adverse effects of sexual activity (AVERT 2010; Kirby 2007). There is great debate over whether sexual education should be abstinence-based (i.e., abstinence-only-until-marriage programs) or comprehensive, and whether schools should be involved in the education process or if it should be left entirely up to parents to determine what their children learn and when (AVERT 2010).

The evidence from these studies shows that comprehensive sexuality education programs are the most effective, however, this does not end the debate, which is mired in beliefs surrounding parental and/or religious values and age-appropriateness of the information (AVERT 2010; Guttmacher 2007; Kirby 2007).

However, some of the controversy surrounding this issue ebbs when the subjects are college students, largely because, once students go to college, there is a general acceptance of "emerging adulthood," which includes the likely onset of sexual activity (Browder 2008; Lindgren 2009; Wetherill, Neal, and Fromme 2010). The increased independence of college students and the reduced role of parents in college students' decision-making enables colleges to have greater freedom in instituting sexual and reproductive health care programs (Wetherill, Neal, and Fromme 2010).

Often, greater ability and opportunity to provide these programs and actual implementation on campuses do not necessarily correlate. As some research has pointed out,

there are many colleges and universities that are not providing sufficient education, information and resources for their students (ACHA-NCHA 2005; Butler 2009; Condom Depot 2006; Sperling 2009). Some do a good job, but many do not, and this could explain, at least in part, the extreme jump in the rates of STIs among young people ages 20-24 (CDC - Centers for Disease Control and Prevention 2009). While the rate of 18-24 year olds enrolled in college is 36.2% (National Center for Higher Education Management Systems 2009), and hence it certainly does not explain the increase in rates for the entirety of that population, that percentage does include almost 11 million people in that age range who are impacted by the information and resources their schools provide. As young people gain their independence, and many become sexually active (or more sexually active), logically, the need for effective education increases, but the supply does not necessarily increase at the same rate.

Studies Performed at Colleges

Of the studies that have been done on college campuses, very few of them actually survey the students to determine their experiences with accessibility and availability of resources on campus. Rutter (1986) and Butler (2009) performed surveys of SRHRs on campuses throughout the United States; however, their methods were to survey the health center staff or other administrative staff members, which, while providing a good overview of the staff or administration's beliefs about what they are providing, does not necessarily translate to the students' understandings of availability or utilization of these sexual health resources. This is problematic in that just because a college or university has resources available, if the students are not aware that these resources exist, do not know how to access them, or do not feel comfortable accessing them, they become largely inconsequential in terms of protecting the students from adverse outcomes.

Trapasso (2005), one of the few who used data from surveys of actual college students, found, in her thesis work, that there was a large discrepancy between students' *beliefs* about the availability of condoms on campus and the *actual* availability that existed on campus, wherein almost half of the students in the sample were not aware that condoms were in fact available on campus, or where to find them. She theorized that this was because the sexual health education programs were not reaching enough students, thus potentially limiting the number of students who would use condoms during sexual activity. This further illustrates the importance of not only increasing availability of resources and information, but also of increasing students' awareness of availability of these resources and information.

Another study that used data which included student opinions was performed by Trojan® Brand Condoms, in association with the online rating company, Sperling's BestPlaces. They rated 141 colleges and universities in the United States based on a number of criteria related to sexual health services, including student opinions, and published their fourth Trojan® Sexual Health Report Card. However, this report does not provide full access to the data used for the analysis, and some bias may be assumed since there is a clear conflict of interest when they are likely attempting to pressure colleges and universities to become larger consumers of their products, namely condoms. Colleges and universities that score lower are presumably put in a position to compete over their sexual health services, including access to condoms on campus. That said, this is still an interesting snapshot of sexual health services provided on a variety of campuses, and students' opinions of those services (Sperling 2009).

Barriers

Within the literature on sexual health and access to sexual health resources, there is a widely-accepted understanding that there are many different types of barriers that can affect the

ability of people to access these resources. However, surprisingly, there is not a commonly accepted "list" that identifies these barriers for all people and how they prevent access. There are instead a range of different publications that discuss barriers found within individual communities or groups being studied, specific to the needs and social issues of that group, and addressed in terms of finding ways in which to overcome them for that particular group or population. Most of these are targeted at youth, one of the most vulnerable populations, and one of the best resources found was from the well-respected organization, Advocates for Youth (AFY), which notes, "In most countries, adolescents face significant barriers to using contraception. Service-related barriers include incorrect or inadequate information, difficulty in traveling to and obtaining services, cost, and fear that their confidentiality will be violated." (Advocates for Youth 2003:2). This resource is the foundation of a list I have created, to which I have added information from other sources to create a more complete picture of the universal barriers divided into service-related barriers and other barriers. While those barriers noted in the "other barriers" list are not strictly related to direct patient services, they speak to an important aspect of access to resources, particularly around education, which is a key component.

Service-Related Barriers

1. Lack of accurate information/education (Advocates for Youth 2003:2)
2. Distance/transportation (Advocates for Youth 2003:2; Henshaw & Finer 2003)
3. Cost (AFY 2003:2; Henshaw & Finer 2003; PPFA 2010:4)
4. Stigma/Fear/Embarrassment/Confidentiality (Advocates for Youth 2003:2; Henshaw & Finer 2003; Lindberg 2006:81)
5. Government regulation of contraceptive and abortion services (which can lead to increased cost, distance, lack of information and stigma/fear/harassment) (PPFA 2010:4; Henshaw & Finer 2003)

Other Barriers

6. Lack of condom negotiation skills (this goes along with numbers 1, 4 and 7, but I have given it a place on the list because of the important role condom use plays in prevention of STIs and pregnancy, and because it is important to note that just because someone has access to condoms, and wants to use condoms, does not necessarily mean that they will be able to convince a partner to use them) (Advocates for Youth 2003:2)
7. Partner violence (or fear of partner violence – this can also go with numbers 1 and 4) (Advocates for Youth 2003:2)
8. Side effects of birth control methods (Advocates for Youth 2003:2)

The barriers identified disproportionately negatively affect women, low-income persons and youth, reflecting disparities that exist in multiple arenas throughout our society and which are continually explored by scholars. AFY, in referencing some of the particular barriers faced by young women, states, "Personal barriers that especially deter young women from accessing and using contraception include fear that their parents will find out, difficulty negotiating condom use with male partners, fear of violence from their partner, and concerns about side effects." (AFY 2003:2). This illustrates the link between oppressed populations, in this case female youth, and barriers that limit access to sexual and reproductive health care.

The barriers I anticipated finding for undergraduate students on college campuses were variations of those identified above. First and foremost was education/information; this included education around what risky sexual behaviors consist of and how to prevent/minimize risk, as well as knowledge of how to access services and supplies on campus, such as knowing when and where condoms can be obtained. The rationale for this is that if students don't understand, for example, that all types of sexual intercourse (oral, anal and vaginal) put you at risk for STIs, they may believe it is safe to have unprotected oral or anal sex, as there is not a risk of pregnancy associated with oral or anal sex. Thus, education around risky sexual behaviors and methods of protection is key to preventing or minimizing these types of risk. However, even if students have

received education about the importance of condom use to minimize risks during sexual intercourse, if they are not aware of limitations to access (for example, the place they go to get free condoms is closed on weekends), they may not have the means to find another option for obtaining a condom (this could include financial, distance or other barriers), and thus may have unprotected sex.

Another potential barrier for undergraduate students on college campuses is related to health insurance and financial independence. If students are covered under their parents' health insurance, any bills related to medical visits and explanations of benefits will be sent to their parents. Fear of parental reactions could lead to students either not wanting to use their insurance, (placing a financial burden on the student), or to students not obtaining sexual-health related services (such as pregnancy or STI testing), at least not at their on-campus student health center. At this point, distance and financial barriers come into play, even for students who might not necessarily appear to have these burdens.

Facilitators

Looking at facilitators of sexual and reproductive health resources, it is important to consider what types of efforts or programs might make access to these resources easier and more comfortable. Offering options such as regular, free, anonymous or confidential STI screenings on campus would remove several of the barriers: financial, privacy and transportation. Additionally, offering these services as "events" would increase awareness and conversation about screenings, and may make communication about STIs and sexuality topics more comfortable for students. Frequent and/or mandatory comprehensive sexuality education programs would also be likely to increase this conversation and comfort level among peers, as well as increase the reliable and medically-accurate knowledge base of students regarding

general information and campus-specific resources. Another facilitator is easy, free or inexpensive and constant on-campus access to supplies such as condoms, lubricant, and emergency contraception. Again, this facilitator increases comfort and conversation about these supplies, plus removes the cost and transportation barriers.

Need for (and Purpose of) Additional Research

The argument can therefore be made that there is a lack of research, conducted on university and college students, that primarily focuses on students' experiences with accessibility and availability of sexual and reproductive health services on their campuses. Based on the findings surrounding rising rates of STIs and unintended pregnancies in youth, it can be argued that this access to comprehensive sexuality education and resources is necessary, and it is not only necessary for the schools to provide these services, it is also necessary that the students are aware of them and are able to readily access them when needed. It is also widely recognized that the rights of a person to protect their own sexual and reproductive health and wellbeing are considered to be essential facets of universal human rights (World Health Organization 2004). This study will provide the necessary data on the students' perspectives, and will accordingly be a tool for the improvement of education programs and resource accessibility.

In addition, many of the studies completed have been strictly quantitative, based on surveys. The value of utilizing a qualitative method here is that it provides the opportunity to obtain information from the students that is less controlled by limited questions of a survey, giving them the chance to explain situations and feelings in their own words, and hence much greater freedom to elaborate. This provides the ability to delve deeper, and to potentially get information that was not anticipated, and which could not be obtained through a survey. This

could lead to greater clarity around the issue, or even to refining further questions for future study.

Qualitative research, grounded in inductive methods and utilizing a critical paradigm, allows for an interactive approach that supports my belief in the value of a collaborative process between researchers and participants. I utilized a variation/combination of Critical Action Research (CAR) and Participatory Action Research (PAR) in which I have empowered students to share not only their experiences, but also their theories about existing issues as well as their ideas for improvements to the current systems. As Daly (2007) notes in her explanation of CAR and PAR, these types of research are clear about their desire to create social change (p. 123-5). My standpoint is one of a feminist, activist and comprehensive sexuality educator. While I certainly acknowledge the value of the postpositivist framework in which researchers attempt to be completely objective, and attempted to remain objective during the interview process, I recognize that the values I bring, as well as my desire to improve on-campus access to sexual health resources, does in some ways shape this research. For that reason, I have striven to be as reflexive as possible throughout.

There is sometimes a perception that qualitative research cannot be generalizable to the population, and is, therefore, less valuable. While it is true that a smaller group of participants who are interviewed will lead to more individualized information being gathered, I argue that the quantitative instruments that are typically used, such as a survey administered to a large group, do not provide a complete picture of the realm of possibilities in an answer to any given question. A frequent complaint of people who respond to surveys is that the possible answers provided did not truly capture their experience, and consequently they had to provide an answer that was not entirely true. Our world, and our society, is very rarely simple and easily

quantifiable. Allowing respondents to provide answers to questions that enable their ability to tell their unique, individual stories and situations provides a much richer wealth of information for a social scientist to study. As Kerry Daly notes,

> Studying human beings is different from the study of physical objects because human beings have the capacity to use language, assign meaning and take themselves and others into account in the way they create relationships and act in the world. Accordingly, human reality is emergent, situational, changeable, and subject to ongoing definition and redefinition (Daly 2007:62)

When these stories are compiled, patterns emerge, and while they may not all be simple and tidy, they provide a much more realistic result that defines the complexities of life as we experience it.

Theories Around Sexuality and Access to Resources

In examining theories behind barriers to access of sexual health resources, we find several major scholars who have done significant work around the broader issues of sexuality and stigma. I have examined significant works from Erving Goffman, Michel Foucault, Gayle Rubin and Janice Irvine to provide a general theoretical understanding for why such barriers exist, and how they have been created and reproduced.

In considering the major force behind the controversies that surround sexuality in our society, the most universally understood is the concept of stigma. Erving Goffman, in his book, *Stigma* (1963), conceptualizes the nature of stigma in society as a means of categorizing others who are different from ourselves, stating:

> Society establishes the means of categorizing persons and the complement of attributes felt to be ordinary and natural for members of each of these categories. … When a stranger comes into our presence, then, first appearances are likely to enable us to anticipate his category and attributes, his *social identity*… We lean on these anticipations we have, transforming them into normative expectations, into righteously presented demands. … While the stranger is present before us, evidence can arise of his possessing an attribute that makes him different from others in the category of persons available for him to be, and of a less desirable

> kind – in the extreme, a person who is quite thoroughly bad, dangerous, or weak. He is thus reduced in our minds from a whole and usual person to a tainted discounted one. Such an attribute is a stigma, especially when its discrediting effect is very extensive; sometimes it is also called a failing, a shortcoming, a handicap. (P. 2-3)

In this brief, but rich, passage, Goffman puts forth some of the key concepts enlightening the phenomenon of stigma. First, categorization occurs as a way to process and understand others, and creates a "norm" against which all can be measured. Second, the concept of differences, which are deemed to be unnatural or "less desirable," and finally, the distinction – or "reduction" as Goffman says – of the person to something "less than" whole or human, "discredited" and "discounted." This conceptualization of stigma lays the foundation for understanding the relationship between what Goffman categorizes as "normals" (1963:5) and the stigmatized in our society; a relationship built on creating a "normal" category against which all others are judged and ranked.

One important aspect he brings up is the dehumanization of those who are stigmatized, stating, "By definition, of course, we believe the person with a stigma is not quite human. On this assumption we exercise varieties of discrimination, through which we effectively, if often unthinkingly, reduce his life chances" (1963:5). In this way the "normals" effectively exercise power through discrimination over those who are stigmatized. The correlation between stigma and dehumanization is a striking one, in that it brings into perspective the depth of the reaction to those who become stigmatized. When a person is not recognized as human, it is simple to justify mistreatment.

When this concept of stigma is applied to sexuality, it is not a difficult leap to see in what ways stigma has affected the controversies that have arisen over sexuality in our society. As noted above, it is considered one of the common barriers for accessing sexual and reproductive

health care, especially among youth, as Lindberg, Lewis-Spruill, and Crownover (2006) illustrate in their work on adolescent males,

> A stigma exists in our society regarding sexually transmitted infections and HIV/AIDS, and while it may not be possible to completely destigmatize the experience of seeking reproductive health care, providers should seek to alter policies, procedures, and physical surroundings to make sites more welcoming and comfortable to male adolescents. (p. 85-6)

While they are describing the stigma associated with STIs, stigma exists even beyond that realm of disease in terms of sexuality, and, as Foucault and Rubin point out, it has a significant impact on marginalizing individuals and groups according to their sexual orientation, preferences, gender and age. Stigma is also present in the ways we consider unwanted pregnancies, rape, date rape and other violence against women.

Gayle Rubin, in her piece, "Thinking Sex: notes for a radical theory of the politics of sexuality" explains stigma in relation to sexuality as a hierarchy, necessarily constructing power-relations in which married heterosexual couples who have procreative sex are the most valued and privileged, while anything outside of that position is looked-down upon, with the disgust increasing the further we move away from that ideal ([1984] 1992). She even created the famous "Charmed Circle" ([1984] 1992, Figure 1:13) that illustrates sexual hierarchies and stigmatization clearly; visually showing us where different sexual behaviors and orientations fall in terms of the "norm" and the "stigmatized," saying,

> As sexual behaviors or occupations fall lower on the scale, individuals who practice them are subjected to a presumption of mental illness, disreputability, criminality, restricted social and physical mobility, loss of institutional support, and economic sanctions. … Extreme and punitive stigma maintains some sexual behaviors as low status and is an effective sanction against those who engage in them (Rubin [1984] 1992:12)

Thus, stigma is fully enmeshed in our social constructs around sexuality, and is today a foundational issue that pervades our political and social discourses around what our values should be and what kinds of sex and sexualities are right, and accordingly, those which are not.

In Michel Foucault's works, *History of Sexuality, An Introduction: Volume 1* ([1978] 1990) and *Discipline and Punish* ([1977] 1995), he brings up several important points that contribute to the understandings of sexuality today. The element I will focus on is the power/knowledge relationship to sexuality, of which Foucault explains the many ways in which it has been constructed and redefined throughout modern history and into today. He notes that one of the important ways of seeing the power relationship as related to sexuality is by exploring the convergence of pleasure and power, stating that we experience, "The pleasure that comes of exercising a power that questions, monitors, watches, spies, searches out, palpates, brings to light; and on the other hand, the pleasure that kindles at having to evade this power, flee from it, fool it or travesty it" ([1978] 1990:45). This is what he identifies as sexuality's "perpetual spirals of power and pleasure" ([1978] 1990:45). An important point he makes at the end of chapter one is, "What is peculiar to modern societies, in fact, is not that they consigned sex to a shadow existence, but that they dedicated themselves to speaking of it *ad infinitum*, while exploiting it as *the* secret" ([1978] 1990:35). Ergo, the crux of his argument revolves around the inter-connections of power and pleasure involved in secrecy and resistance.

Foucault's premise here leads to a simple bridge to one of the reasons that we might create – and keep – barriers in place regarding sexuality and sexual health. If we remove the secrecy, the stigmas, the so-called "forbidden fruit" nature of sexuality, it might result in the diminishing of our excitement and preoccupation with sexuality. If there is no longer a norm,

and dangerous dabblings outside that acceptable norm, where is the pleasure of evading or overcoming that control?

This pleasure/power concept is interesting in considering youth, as we determine whether to provide comprehensive sexuality education or abstinence-only education to increase responsible and healthy sexual-decision making. Some believe that providing the full range of information to youth about sexuality will, in effect, corrupt them and lead to them trying out more sexual behaviors, whereas others believe what seems to be supported by Foucault's concept, that removing the forbidden or secret attachment to sexuality will actually remove the pleasure inherent in disobeying the rigid restrictions placed on sex.

For yet another important concept of Foucault's that impacts his views on how sexuality is constructed and regulated, we turn to *Discipline and Punish* ([1977] 1995). In it, he presents clearly his concepts of power/knowledge and the norm. The norm is important because it provides us with a mode of comparison, a way to categorize and rank people and behaviors. He states, "It is easy to understand how the power of the norm functions within a system of formal equality, since within a homogeneity that is the rule, the norm introduces, as a useful imperative and as a result of measurement, all the shading of individual differences" ([1977] 1995:184). This is reminiscent of Goffman's conceptualization of "the normals" versus those who are stigmatized. Only when we have the construct of the norm, can we judge people to be outside of that standard.

The power/knowledge concept includes many facets, but I will focus on two. The first is that power is multidirectional, meaning that it is not only manifested from the top down, as a form of repression, but it also comes from the bottom up, in the form of resistance. This informs our understanding of his challenge to the repressive hypothesis, wherein one can see that the

proliferation of discourse around sexuality in all its various forms is a form of power unto itself. Second, in describing the control mechanism of surveillance, Foucault says,

> He who is subjected to a field of visibility, and who knows it, assumes responsibility for the constraints of power; he makes them play spontaneously upon himself; he inscribes in himself the power relation in which he simultaneously plays both roles; he becomes the principle of his own subjection. ([1977] 1995:202-3)

This manifestation of power comes through internalization of the norm, a process of control that produces "docile bodies," in which discipline is produced and regulated through the body. As he points out in *History of Sexuality*, this process of regulation through the body as related to sexuality was created when the powerful changed from the simple condemnation of certain sexual behaviors (such as sodomy) to creating them as complete identities of individuals (homosexuals), who could then be condemned. At that point it was no longer enough to simply punish someone for engaging in a certain kind of sexual behavior, instead the person was constructed as a deviant, or a perverse individual, possibly even someone who was mentally ill; a threat to society. "The sodomite had been a temporary aberration; the homosexual was now a species" ([1978] 1990:43). In this manner the individual became an "other," someone outside the norm, who should be studied, examined and, ideally, reformed so that they no longer posed a threat to society. Foucault explains how the supposedly scientific discourse on sex:

> …subordinated in the main to the imperatives of a morality whose divisions it reiterated under the guise of the medical norm … it declared the furtive customs of the timid, and the most solitary of petty manias, dangerous for the whole society; strange pleasures, it warned, would eventually result in nothing short of death: that of individuals, generations, the species itself. ([1978] 1990:53-4)

In this we can see the basis for the fear and stigma that have come to define sexuality over time, at least sexuality that doesn't fall into the category of "the norm." When individuals with

differing sexualities are found to be dangerous and a threat to society, it becomes important to subject them to discipline and discrimination, for the safety of all. The legacy of this body of thought is clear today within the barriers we have constructed to access of sexual health services. For example, in the implementation of abstinence-only-until-marriage sex education, the experiences and realities of those in the LGBTQ community are completely negated. This is also apparent in the common practice of stigmatizing any sexual activity in young, unmarried people, particularly women, of all sexual orientations.

Another fundamental tenet of Foucault's work is the rejection of sexual essentialism. Instead of viewing sexuality as simply a natural force, a desire or animalistic instinct that must be regulated and controlled in people, Foucault conceptualizes sexuality, as we have come to understand it, as socially constructed, rooted in the power/knowledge web. He says,

> Sexuality must not be thought of as a kind of natural given which power tries to hold in check, or as an obscure domain which knowledge tries gradually to uncover. It is the name that can be given to a historical construct: not a furtive reality that is difficult to grasp, but a great surface network in which the stimulation of bodies, the intensification of pleasures, the incitement to discourse, the formation of special knowledges, the strengthening of controls and resistances, are linked to one another, in accordance with a few major strategies of knowledge and power. ([1978] 1990:106-7)

This concept of sexuality as constructed through societies as a means of all the various implementations of power and knowledge, intertwined and working together to produce multiple controls and forms of resistance, is crucial to understanding how sexuality is utilized in modern societies.

Rubin builds upon that foundation in her essay, explaining that, while there is a biological aspect to sexuality,

> …human sexuality is not comprehensible in purely biological terms… It is impossible to think with any clarity about the politics of race or gender as long as these are thought of as biological entities rather than as social constructs. Similarly, sexuality is impervious to political analysis as long as it is primarily conceived as a biological phenomenon or an aspect of individual psychology. ([1984] 1992:10)

Thus, the creation of the discourse surrounding sexuality encompasses not just the biological drives or libido, but also includes the carefully constructed web of morality, stigma, determination of that which is the norm (and that which is deviant), control of the body and other forms of repression within the power/knowledge complex.

This argument is important as we begin to consider in what ways sexuality affects and is affected by politics. As stated above, the stigmas associated with differences in sexualities are designed to regulate what constitutes the norm, and whatever does not fit into that category is threatening. Rubin notes, "Popular culture is permeated with ideas that erotic variety is dangerous, unhealthy, depraved, and a menace to everything from small children to national security." ([1984] 1992:12). Due to this placement of certain sexualities outside the norm, that which is condemned and thought to be a threat is able to be politically regulated, effectively legislating conformity. Attempts to change the norms accordingly become the threats themselves, threats to the hierarchically privileged view of the way life (and society) should be.

Foucault and Rubin also overlap in their examination of how children's sexuality has been constructed over time. Sexual restrictions on children, especially since the 19th century, have taken many forms and still have a significant impact on our modern society. At that time, any vestige of children as sexual beings was looked on as unnatural and dangerous, as Foucault says, "…this sexual activity posed physical and moral, individual and collective dangers" ([1978] 1990:104). This manifested strongly in the masturbation panics in which children were

routinely disciplined and punished for any act of masturbation. In some cases, doctors mutilated children to prevent masturbation, and vast volumes were written on the problems associated with onanism. Rubin describes how, "to protect the young from premature arousal, parents tied children down at night so they would not touch themselves; doctors excised the clitorises of onanistic little girls" ([1984] 1992:4).

While today masturbation is slightly less stigmatized in Western society, or at least it does not result in physical mutilation, the legacy of this concept of children as non-sexual beings continues to impact thought around sexuality. Rubin explains, "the notion that sex per se is harmful to the young has been chiseled into extensive social and legal structures designed to insulate minors from sexual knowledge and experience" ([1984] 1992:4). This can be seen in the positions of the conservative right against comprehensive sexuality education, access for youth to sexual health supplies such as condoms, birth control, and testing, and access to other SRHRs which suggest youth are, in fact, sexual beings. As youth progress to the "emerging adulthood" state, they are continuing to struggle against this construct, and must learn to navigate the barriers that have been put in place, ostensibly, to "protect" children. This legacy leaves a dichotomous grey area in which young people are gaining independence, and yet, faced with barriers such as inadequate knowledge and stigma, they are frequently unable to make healthy decisions around sexuality.

When we view barriers to access of sexual and reproductive health care as forms of oppression, based on those people most profoundly affected by the barriers as stated above, the link between the power/knowledge gap and the stigmatization/privilege relationship is brought to light as a clear method of oppressing certain, marginalized groups such as women, youth, minorities (including those who identify as lesbian, gay, bisexual, transgender, queer or

questioning [LGBTQ]) and low-income persons. Goffman, Foucault and Rubin very clearly elucidate these relationships within their theories.

Another important theorization around issues of sexuality is moral panics and sex panics. Moral panics, and subsequently sex panics, have been identified and elaborated on for over thirty years, since the publication of the book *Folk Devils and Moral Panics* by Stanley Cohen in 1972. The basis of the moral panic is defined by Cohen as when "a condition, episode, person or group of persons emerges to become defined as a threat to societal values and interests" ([1972] 2002:vii). This idea has been applied to sexuality by numerous scholars, creating the spin-off concept of the sex panic, which was introduced by Rubin in *Thinking Sex* ([1984] 1992), and further elucidated by Janice Irvine and Gilbert Herdt (2009) as well as many others. As Rubin ([1984] 1992) states,

> Right-wing ideology linking non-familial sex with communism and political weakness is nothing new. During the McCarthy period, Alfred Kinsey and his Institute for Sex Research were attacked for weakening the moral fiber of Americans and rendering them more vulnerable to communist influence. … Around 1969, the extreme right discovered the Sex Information and Education Council of the United States (SIECUS). In books and pamphlets… the right attacked SIECUS and sex education as communist plots to destroy the family and sap the national will. (P. 8)

These attacks continue today, and the right-wing arguments are strikingly similar. In this we can clearly see the link between political ideology and barriers to one of the main sexual health resources, sex education, in particular comprehensive sexuality education.

Janice Irvine specifically examines sex panics related to sex education, and the political manifestations of morality around sexuality. In her piece, *Emotional Scripts of Sex Panics* (2006), she examines the many ways that barriers to sex education have been rationalized, politicized and legislated through the use of sex panics in the United States. One of her key

concepts is that the Religious Right has constructed specific scripts utilizing sexuality as a danger to society and to the moral fabric of Americans. She states,

> Leaders of the Christian Right recognized early that sexuality would prove to be a crucial vehicle for consolidating political power. They accomplished this through the promotion of national discourses about sexual danger that shaped the ways citizens in localities throughout the United States spoke and felt about sex education. Their formulaic rhetoric became the scripts of sex education panics. (P. 86)

She further ties this in to the acts of politicization through regulation, similar to and informed by Foucault's theory, stating, "Hierarchies regulate sexualities into those that are respectable or disreputable, healthy or unhealthy. Emotions – in particular sexual shame, fear, excitement, disgust, anger – reinforce this regulatory system and are therefore political" (Irvine 2006:86). This politicization of the topic of sex education has led to legislation that prevents comprehensive sexuality education from being taught in many schools, which are instead teaching abstinence-only sex education which reinforces the normative values of abstaining from sex unless and until one is within the confines of a traditional, heterosexual marriage. It also does not teach about issues crucial to sexual health, such as contraception and STI prevention (other than abstinence), or about topics such as masturbation or homosexuality. Consequently, youth who are provided solely abstinence-only education are not given access to medically-accurate, inclusive information about healthy sexuality, which is a significant barrier to their being able to make healthy decisions regarding sexuality, especially if they don't fit within the traditional sexual norms proffered in this type of program.

One frequent argument against comprehensive sexuality education is that providing youth with knowledge about sexual topics will actually increase the likelihood that they will engage in sexual behaviors at younger ages. This reasoning has been disputed by many researchers and

professionals in the field for many years as unsound; however, socially conservative interest groups continue to assert this theory as a fact (Irvine 2006, 2007; Smoak 2006). A recent study completed by Natalie Smoak et al. (2006) involved a meta-analysis of 174 studies of the results of HIV-risk interventions, and looked specifically at this question of whether these programs inadvertently increased sexual activity in adults or adolescents. Their findings indicated that the intervention programs, which included education components among other types of interventions, did not increase frequency or early onset of sexual activity, and, "Moreover, the results indicated that sexual activity was reduced overall" (Smoak et al. 2006). This is a clear indication that providing resources, including comprehensive sexuality education, is beneficial for reducing risky sexual behavior, and that the concept of providing resources in any way encourages risky sexual behavior is based on stigma and socially constructed phenomena.

Sex panics are yet another manifestation of the stigma and fear surrounding sexuality, and have created additional means of regulating marginalized populations through political and legal means. This regulation is the source of many barriers to access, generally, and continually reproduces the stigmas related to sexuality, which are the foundation for many of the barriers, directly and indirectly. These concepts offer a broad base with which to evaluate the responses from the interviews.

In my analysis of the data gleaned from the interviews, I rely heavily on these theories to guide my understanding of the root causes of any barriers or facilitators discovered. For instance, data showing that some of the participants received either no sex education or went through abstinence-only-until-marriage programs, can be related to the concepts of stigma and norms, as well as to the politicization of sexuality, through the legislation of what types of sexuality education can be taught.

In considering how students view the climate on campus, we can see in what ways stigmas and norms come into play in terms of how comfortable (or not) students feel accessing the resources and communicating about sexual health topics with their peers, university staff, and the administration. In what ways do programs or groups (whether university-sponsored or student-run) reproduce or dismantle these stigmas through encouraging or discouraging communication and education? A group such as the Gay, Lesbian, Bisexual, Transgender and Allies (GLBTA) Resource Center (which is supported by the University) might be a facilitator for some students, encouraging communication, offering supplies and resources and reducing stigma. On the other hand, for some students it may reinforce certain stigmas simply because students who do not identify as LGBTQ believe that they cannot access the resources offered without being labeled as such and thus facing stigma.

In employing social constructionism, defined by Kerry Daly as "…accept[ing] the presence of an external reality that is subjectively perceived and understood from the perspective of the observer," (2007:32) the power/knowledge construct is brought into clear focus, and experiences can be understood from the perspectives of the students.

Additionally, analyzing what the University does and does not offer, as well as student perceptions of the reasons for these offerings or lack thereof, can be interpreted using the concepts of stigma and sex panics, looking at the ways in which these existing phenomena have shaped the ways in which institutions regulate sexuality. This is particularly pertinent because we are looking at youth, and as stated above, the sexuality of young people has been oppressed for many years as a facet of the power/knowledge complex surrounding sexuality. If the university mandates comprehensive sexuality education, and increases access to resources, does that imply it is condoning the sexual behavior of its students? How will parents react? If we

consider the theories noted above, this may be dangerous territory due to the constructed societal stigma surrounding young people's sexual activity. However, neglecting the health needs of the students is not an acceptable alternative, and it is important to determine how meeting these needs can be done best, and if it is not happening already, to ask why not? The theories being utilized also inform my recommendations for improvements, as they provide a basis for my analysis of the issues and how we can best address them.

CHAPTER 3

METHODOLOGY

This study utilizes a qualitative approach, employing inductive analysis, and rooted in the critical paradigm. I employ a variation of Critical Action Research and Participatory Action Research, in which I combine aspects of the two approaches. As noted earlier, I carefully designed my interview questions to include obtaining the participants' theories about why certain social issues exist, and how we can work to bring about improvements they identified.

As a feminist, a comprehensive sexuality educator, and a committed activist around issues of social justice, my standpoint is one that distinctly informs my research, both in topic and in style. I fully believe that my values and beliefs impact this study, and see myself as a co-constructor of the findings, along with the research participants. That said, I also strive to employ objectivity to the extent possible, in order to provide a fair and balanced assessment of the situation at American University, along the lines of postpositivism. There are three reasons for this: first, my ultimate goal, as an activist, is to solve a potential problem, anecdotally brought to my attention regarding a possible lack of SRHRs on campus. However, I acknowledge the possibility that this perceived problem is not actually a widespread issue, and if this is the case, I do not wish to create a problem where none exists. Second, with my belief that there are multiple understandings of every situation, I wish to ensure that I don't hinder that or bias responses. Third, because my goal is to make this study useful in a very concrete and applicable way (to improve access on college campuses), I want to ensure that it can be, to some extent, seen as relevant to larger groups and repeated in other places as desired. Therefore I am seeking a pragmatic balance between objectivity in keeping with the postpositivist framework, and my belief in social constructionism.

The critical paradigm becomes apparent when considering how barriers to access of SRHRs are a form of oppression. Sexual oppression comes in many forms, from a feminist standpoint, an LGBTQ standpoint, public health, youth oppression, racism, classism – the list is seemingly endless. Joe Feagin and Hernán Vera note that employing a critical lens is crucial in examining social phenomena related to forms of oppression, stating, "…instrumental positivism must be replaced by research methods and interpretive procedures that provide deeper and more holistic pictures of important social realities, especially the continuing realities of human oppression" (2008:132).

As Rubin articulates so well in her "Charmed Circle" ([1984] 1992, Figure 1:13), the hierarchy of acceptable sexuality leaves anyone outside of heterosexual married couples subject to some type of oppression – even within heterosexual married couples there can be forms of oppression, particularly against women. For young college students, most of whom don't fall into that privileged heterosexual *and* married category, the types of oppression can be numerous and overlapping. For example, consider a hypothetical eighteen-year-old female college student, questioning her sexual orientation, who can only afford medical care under her parents' insurance. Her parents are conservative, and she knows if she goes to student health for birth control or STI testing, any charges will be sent to her parents, thus negating any confidentiality she may have. Additionally, she may not be aware of how to minimize risks in terms of sexuality due to the lack of comprehensive sexuality education programs, and as a result may be engaging in particularly risky behaviors.

While it is necessary to acknowledge that a small-scale qualitative study such as this will not be readily generalizable to the population at large, there is significant value in undertaking such research due to the depth of understanding that can be achieved via these interviews.

Whereas a survey might be able to capture data from a larger random sample allowing the data to be more readily generalizable, the information that can be captured from a survey is necessarily only scratching the surface of the vast array of experiences students have. As Feagin and Vera point out, "[A]…problem with survey research is that the realities being probed may be far enough below the surface that rather brief (often 10-60 second) answers to brief questions cannot tap respondents' often complex and nuanced views" (2008:119). In the interviews for this study, ample opportunity was provided to follow up on and clarify answers to the questions, and to ensure that complete responses were received, in all their intricacies.

CHAPTER 4

BACKGROUND ON AMERICAN UNIVERSITY

Current Offerings

Student Health Center

I met with the Director of the Student Health Center, Daniel Bruey, to talk about some of the questions that had come up in the interviews with students. I prepared several questions for the meeting, based on the issues that were raised. Before meeting with him, I checked the website for information, and found some very general information including a schedule of fees, an explanation of patient rights and responsibilities, and a list of various services they provide (Appendix B). It is not clear from these documents what STI testing costs, and it does not appear that appointments for STI testing can be scheduled online, although they do offer that for some services (American University Office of Campus Life Student Health Center 2012). I learned during the meeting that the schedule of fees posted on the website was not the most current one, and there were some discrepancies in both what was offered and the fees for various services; both versions are included in Appendix B.

Mr. Bruey was very open to my questions, and we spent almost an hour going over the policies and procedures at the Health Center, as well as background on several issues. In our conversation, my goal was to get information on what their formal policies are, so I did not ask about specific issues that had come up whenever possible, however my questions were designed to elicit the information regarding those specific issues. In some cases, getting a relevant answer without explaining what I had heard was unavoidable. In those cases, I explained that I had heard "_____" from several students, and asked him to explain that or tell me what were they doing to address it.

What They Provide:

The Health Center offers a wide range of services related to sexual and reproductive health, including: an annual women's exam, STI & HIV testing, pregnancy testing, contraception (including free condoms which are available in a large basket in the waiting room), emergency contraception, online appointment scheduling and informational brochures. Additionally, they provide some type of education about their services to incoming students during orientation.

What They Do Not Provide:

They do not offer at this time: *private* access to free condoms, online scheduling specifically for STI or HIV testing, free STI or HIV testing, treatment for some STIs, a well-designed information/education session at orientation, or clear online explanations of their services, costs and policies/procedures.

While there are various areas in which the health center can continue to improve, I was pleasantly surprised by the attention they appear to be paying to several important issues, and the willingness to continue to improve the quality and scope of their services. Some of the issues that were identified in the interviews are apparently related to the difficulties in the bureaucratic system in which they operate, such as not having direct control of their website, and having limited control over what is covered (and in what ways) at orientation. Others seem to be due to outside issues not under their control, such as the DC Government's decision to no longer offer free STI & HIV testing for AU students.

However, I do think that they should take some immediate steps to become accountable for ways in which they can improve communication with students and increase utilization of their services. I outline these suggestions in the conclusion section.

Wellness Center

The wellness center is located near the health center, and is designed to promote healthy choices and reduction of risky behaviors for all students. It is staffed by health educator Alan Duffy, and it is the home of the Love SHACK (Sex, Health & Contraceptive Knowledge) peer education program, as well as other healthy behavior programs such as smoking cessation. Also as part of the wellness center is the Sexual Assault Prevention Coordinator, Daniel Rappaport. Students can drop in to the Wellness Center to talk to someone, pick up safer sex supplies and brochures, or to find out about resources, such as classes and programs that are being offered. The Love SHACK program offers group information/education sessions in which they provide up-to-date, medically accurate sexual and reproductive health information to groups of students, such as dorm floors or clubs.

Sexual Assault Prevention Coordinator

This position is a relatively new addition at AU, staffed by Daniel Rappaport. He was hired in September 2010 on a part-time basis, then became full-time in May of 2011. This position was created by a recommendation of the sexual assault working group, convened by the Dean of Students in the spring of 2009. The coordinator is responsible for raising awareness of resources on campus and he has recently begun a new peer educator program, PEERS (Peer Educators for the Elimination of Relationship and Sexual Violence). According to the AU website, "The mission of PEERS is to increase awareness of sexual assault, dating abuse, and stalking; as well as reduce the incidence of sexual violence in the AU community through outreach and education. PEERS provide workshops and facilitate discussions on dating abuse, stalking, and sexual violence to any university affiliated group." (American University Wellness Center 2012). Mr. Rappaport notes that other than education and Public Safety officers, who will

direct a victim to the off-campus resources, there are not free, on-campus resources through the health center related to sexual assault. The barriers that exist include transportation (although Public Safety will provide a cab voucher if a victim contacts them), and while the off-campus visit to the SANE (sexual assault nurse examiner) program is free, on campus testing for STIs or pregnancy may not be, meaning that students may have financial barriers as well. Some facilitators are the placement of sexual assault information stickers in bathrooms around campus, the Coordinator's work to promote education around prevention of sexual assault and also his work towards ensuring that students are aware of and have access to the off-campus resources.

While sexual assault prevention is an important aspect of SRHRs, an in-depth examination of the multitude of barriers and facilitators as well as a comprehensive history and analysis of the occurrence and statistics of on-campus sexual assault at American University is beyond the scope of this research. I would recommend further research be conducted on this topic.

GLBTA Resource Center

This is a university-funded program offering programming, resources and support to Gay, Lesbian, Bisexual, Transgender and Allied (GLBTA) students at AU. According to the website, their mission is: "to strengthen and sustain an inclusive campus community that welcomes people of all sexual orientations and gender identities by providing support, educational resources, and advocacy" (American University Office of Campus Life GLBTA Resource Center 2012).

The GLBTA Resource Center is one of the best-known groups on campus, and they have a profound effect on many students in terms of connection to safer sex supplies, testing and other resources. However, because of the societal stigma that still exists, there are students who do not

want to – or might not even consider – accessing this resource due to fear that others will think they are gay or lesbian, or due to the belief that they simply are not eligible if they do not identify as such.

Women's Initiative

I was unfortunately unable to interview anyone representing Women's Initiative, however, here is information from their online description:

> Women's Initiative is a non-partisan, inclusive department of the Student Government that helps coordinate and advise campus departments and committees on programming and policy decisions that affect the women students, faculty, and staff of American University. Women's Initiative focuses on making AU a safer, more equitable, and more empowering place for women through AU traditions like the Breastival, AIDS Walk Washington, World AIDS Day, the Vagina Monologues, Women's History Month, and Take Back the Night. Not only do we plan some of AU's most popular annual events, but we also work on policy issues like pushing the administration to create a Women's Resource Center, collaborating with the Student Health Center, and working with Public Safety to keep campus safe for everyone. (Women's Initiative Website 2011)

Free condoms, lube and dental dams are offered at the Health Center, the GLBTA Resource Center and the Wellness Center. Student groups will frequently have tables on the quad or in the Mary Graydon Center, and they will often hand out free supplies. Also, as mentioned above, many of the student groups have events such as workshops on sexual health topics.

What is Missing

Compared to other colleges and universities, American University is missing some key pieces to providing SRHRs. First and foremost, they do not have adequate online resources or a website students could access to get the information they need and to ensure the information they are finding is medically accurate and inclusive. With today's online environment, this is an

integral part of SRHR, and AU has a responsibility to provide this information in a clear and easily accessible way. Many schools provide this service; a quick internet search directed me to sites such as Columbia University (2012) featuring the highly respected Go Ask Alice! resource. The University of Missouri (2012) has a comprehensive online resource maintained by their peer educator program, SHAPE (Sexual Health Advocate Peer Educators) providing information for where and how to access resources on campus (including a map with locations of condoms in residence halls), video condom and dental dam demonstrations, and other relevant information. The University of North Carolina (2010) also provides a clear and accessible site dedicated to sexual and reproductive health. Closer to home, the University of Maryland (2009) also has a fairly comprehensive online resource program.

Another missing piece is a very clear and comprehensive overview of SRHRs on campus for all incoming students, preferably via the orientation program. Also, by not providing free condoms in the dorms (or in any location that can be accessed privately and at any hour of the day or night) as many schools do (Columbia University 2012; University of Missouri 2012), AU is failing to ensure access for all students, thereby increasing the likelihood that students will find themselves in situations in which they cannot practice safer sex. Finally, the lack of free STI and HIV testing on campus, made very visible via marketing and events, makes it significantly less likely that students will get tested regularly, if at all.

CHAPTER 5

METHODS

For this research, I planned to conduct interviews with 20-25 residential undergraduate students at American University. The target population was undergraduate students at least 18 years of age at American University who reside on-campus, later amended to include students who had resided on campus at some point during their time at AU, because I learned that most students move off-campus by their Junior year. While I had planned to utilize a combination of snowball and purposive sampling to choose a "typical" sample of 20-25 students recruited from various groups on campus, including the Women's Initiative, the Wellness Center, the GLBTA Resource Center, the Sexual Assault Coordinator and Resident Assistants in the dorms, I found that recruiting participants was a much more difficult process than anticipated. After encountering significant lack of response and difficulties finding informants through the groups I had contacted, I began requesting interviews from people I attended classes with, and asked professors in the Sociology department who teach undergraduate classes to allow me to come speak to their classes in an attempt to secure additional participants. I also attended a peer educator meeting held by the Sexual Assault Prevention Coordinator. I received a very good response from these in-person recruitments, and was eventually able to perform a total of 19 interviews. The interviews were semi-structured, utilizing an interview guide (Appendix A), and lasted approximately 30-60 minutes each. They were conducted between November 2011 and February 2012.

Unfortunately, due to these difficulties and the ensuing time constraints, I was not able to be as discriminating in choosing the participants, so my final sample was less diverse than I would have hoped in terms of sex, race/ethnicity, age, class year, gender identity and sexual orientation. However, the sample did include representatives of multiple groups and

experiences, and as a result I do think it is still feasible that it can be generalized to some degree to the larger residential undergraduate population. If nothing else, I believe that it indicates an important catalyst for further study of these issues, as well as some immediate improvements as can be seen in the recommendations. The demographic breakdown of participants is as follows:

Table 1 – Demographics of Participants

Age:	**18**	**19**	**20**	**21**	**22**
	4	1	6	3	5
Sexual Orientation:	**Heterosexual/ Straight**	**Gay**	**Bisexual**	**Queer**	**Pansexual/Fluid**
	11	2	2	3	1
Race/Ethnicity:	**White**	**Black**	**Multiracial**	**Puerto Rican**	**Iranian**
	14	1	2	1	1
Class Year:	**Freshman**	**Sophomore**	**Junior**	**Senior**	
	6	2	3	8	
Gender Identity:	**Female**	**Gender-queer**	**Male**		
	14	1	4		

In addition, I collected information about participants' majors. I found that 6 of the 19 students were double-majors, however I am not specifying what the combinations were in order to protect confidentiality. Overall, the majors that were represented consisted of: 11 Sociology Majors, 2 Women's, Gender and Sexuality Studies (WGSS) Majors, 4 Political Science Majors, 1 Psychology Major, 1 Theater Major, 1 Spanish Major, 1 Public Health Major, 1 Audio Tech Major, 1 International Relations Major, 1 Law & Society Major, and 1 Communication, Legal Institutions, Economics and Government (CLEG) Major.

I conducted the interviews in private rooms or offices on campus at American University. As a member of the community, I already had access to these resources with the support of the sociology department faculty and staff. My past experience as a comprehensive sexuality educator and youth program coordinator facilitated my ability to put participants at ease despite the sensitive nature of the interviews. I explained my past experience to the participants in an attempt to increase their comfort before the interview, and during the interviews I was careful to ensure that I did not react verbally or with facial expressions or body language in a way that participants might interpret as judgmental; I consciously kept a very neutral demeanor.

Additionally, as indicated by Participatory Action Research, I am collaborating with participants more than simply studying them. By being open about my reasons for pursuing this research, and my hopes to improve access to SRHR at AU, I actively engaged them in the process as much as possible. One way I am engaging them is by following up with participants after the thesis is published, and encouraging them to utilize it to organize and work for improvements as indicated.

I submitted my proposal to the AU Institutional Review Board (IRB) for approval, and was told that my study did not constitute "human subjects research" as defined by the federal regulations. The chair of my thesis committee followed up with our contact at the IRB, who further explained that it was considered "not leading to generalizable knowledge" (Appendix C). This was a very surprising response from the IRB, which I believe points to some deeper questions regarding how they consider qualitative research, and the value they assign it (or choose not to assign it, as the case may be). After this response, I was able to continue with my research, and had only to modify my informed consent form (Appendix D) to remove the IRB contact information from it.

I used audiorecording and occasional note-taking for each interview. Initially, I considered videotaping to have a more complete record of the interviews, but determined that informants would become too self-conscious and would not be able to relax, especially due to the sensitive nature of the topic. Audiorecording is much less obtrusive, and provides the complete record I desire, while also allowing me to devote myself fully to listening and responding during the interview.

I informed participants before I began that I planned to audiorecord the interviews through the informed consent form that each participant signed. If they had questions or concerns, I explained my reasons for audiorecording and steps being taken to keep their personal information confidential, and then checked to see if this alleviated their concerns. Only one participant expressed any concern over the audiorecording, but after I responded to the questions, that person determined that it was acceptable to move forward with the audiorecording.

I measured the informants' responses in terms of the types of barriers and/or facilitators they reveal, and also their suggestions for improving access to resources. I defined main concepts at the beginning of the interview, and also as we progressed throughout the conversation, as needed. Main concepts that required definition were:

1. Sexual and reproductive health resources, including
    a. Factual information on topics including safer sex, proper condom use, emergency contraception, and transmission of STIs, which students may receive in the form of takeaways (such as brochures), web site posts or articles, or questions they might ask another person such as a health provider or educator
    b. Education programs, such as workshops or classes on sexual health topics provided in the dorms or health centers, or at another location on campus
    c. Supplies related to sexual health, such as contraception, safer sex supplies, or testing
2. Sexually Transmitted Infections or STIs/STDs
3. Campus Climate

4. Barriers to access, as per my list above
    a. Stigma was the one that required definition most often
5. Risky Sexual Behaviors

After completing the interviews and collecting the data, I transcribed the interviews using a method in which I listened to the recording of the interview on headphones, and with the assistance of a voice recognition software, I repeated the entire interview into a microphone while the software transcribed my speech. Though it was not perfect, I was able to then go through relatively quickly afterwards to make any necessary corrections. This process saved me significant time in the transcription process, allowing me to collect data in a way that was useful and fairly inexpensive. After the transcribing was done, I employed coding to facilitate the finding of emerging patterns and theories, as outlined earlier.

Limitations

The limitations of this research are that it is a small sample specific to the undergraduate population of American University, and thus this study would need to be reproduced in other locations and with larger, more representative samples to become more comprehensive and to allow for generalization to undergraduate students at large. However, this study can be easily reproduced at other colleges and universities, so it is beneficial as a guide for additional study.

CHAPTER 6

FINDINGS

Facilitators

Of the nineteen students I interviewed, the vast majority felt that AU does a fairly good job providing or supporting certain resources, but all thought that some improvements could be made. They all identified at least one facilitator to access, as well as barriers. Generally, students who had attended AU for a longer period of time were more likely to have encountered or have an awareness of more barriers than those students who were newer to the school.

In terms of facilitators, almost everyone I interviewed mentioned that AU is very affirming of the LGBTQ population. A great support for this community is the GLBTA Resource Center, which is supported by the University. A couple of students identified some issues they have encountered around stigma towards the LGBTQ population within the student body, as well as some heteronormative attitudes that can affect access to SRHR, however, overall most feel that this is a very welcoming and supportive environment for people who identify as LGBTQ, especially in comparison to other schools.

Another facilitator that came up in every interview was the sexual assault resource stickers in every bathroom stall on campus. This is something that every student I spoke to was aware of and appreciated, and something they recalled readily when they were asked to talk about the SRHRs they knew about. Many also mentioned the addition of the sexual assault prevention coordinator as a very positive step for AU in terms of working to eliminate sexual violence on campus.

Additionally, several student groups were mentioned in almost every interview as providers of resources and information regarding SRHR. These included the Women's Initiative,

Queers and Allies, and AU Students for Choice among others. These groups have succeeded in making students aware of them through outreach, events and programming. They are a strong presence on campus and a very visible and accessible part of student life.

Barriers

In terms of issues and barriers, there were several key elements repeated frequently by many of the students. Several of the participants had negative experiences with the Student Health Center, with fifteen of the nineteen recounting situations in which they had encountered significant barriers in accessing resources there. These barriers ranged from prohibitive costs to scheduling issues to lack of respectful demeanor to misinformation and confusion. Thirteen of the nineteen specifically mentioned that the health center does not have a good reputation amongst students, and only two described it as a trusted resource. Almost all of the women I interviewed mentioned that they were always asked about pregnancy, some described it as being "accused" of being pregnant, even when they went in for something completely unrelated, like a sore throat or a cold. Many students stated that they preferred to go off campus for testing or other sexual or reproductive health services, rather than go to the Health Center, with several expressing a profound lack of trust.

Many participants had attempted to get STI testing through the health center, but only a couple succeeded in getting tested there. Several expressed that testing was too expensive, and that there were conflicting accounts of the fees for STI and HIV testing. It is not clear from materials accessed on the Student Health Center's website, including on their published schedule of fees, how much STI testing costs, although it does show fees for two different types of HIV tests. It is also unclear from their schedule of fees whether the costs are completely out-of-pocket or if there are insurance co-pays, in which case it could vary based on the individual's

insurance plan. After my conversation with the Director of the Student Health Center, I did learn that they have revised their fee schedule to include STI testing, however it is not yet posted on the website, nor does it clarify *which* STIs are screened for on the updated schedule.

Some were able to pay for it or get their parents to pay for it, and three of these attempts led to the students finding an off-campus resource for testing, but at least one expressed that it was too difficult to find an alternative site for affordable testing, and thus did not pursue getting tested. One student who accessed off-campus testing after learning of the fees at the Student Health Center confirmed hearing similar stories from friends, saying, "I mean a lot of other people, like I said, have problems with the STI testing and most of the people I know don't end up going to Planned Parenthood. They just end up not getting tested." This is one of the greatest barriers to sexual and reproductive health, as many people who contract STIs can have no symptoms for a long period of time, and the effects of STIs going untreated for a long time can be devastating, including increased transmission, sterility and even death.

Another issue that several participants mentioned regarding the Student Health Center was significant confusion around access to prescription birth control. There were conflicting reports of what kind of testing or exams were required before they could receive a prescription for birth control. Some had a very easy experience, where they were only required to answer a couple of questions and have their blood pressure checked, while others were required to undergo a full exam, including a Pap-smear. While this may be attributable to individual health differences, at least one student was sure that it was not medically necessary, stating,

> I've had [Pap-smears] before, but it wasn't in the amount of time the health center wanted. My father's a pediatrician, and it was in a time-frame he was comfortable with, so I take his medical advice, and I didn't want to pay for a Pap-smear, and so the health center declined my request for birth control.

Luckily, this student was able to employ other means to get her birth control, however, not all students would be capable of doing that. Even among those who were told they did not need to undergo a full exam, there was a lack of trust for the health center, because the students weren't clear on why this process might be different for individuals, and there was speculation that different health care providers might be unclear as to what is required. One student said,

> …I had made an appointment for like the full women's health exam and someone told me, 'you don't have to do that,' and just scheduled me with the nurse to do the blood pressure, but I don't really know…why. It seems, like, really arbitrary as to who has to do it and who doesn't.

The lack of trust in the proficiency of the health center was pervasive, particularly among the women I interviewed. Between the issues with accessing birth control and STI testing, the common belief that they will ask women if they are pregnant – or even "accuse" women of being pregnant – regardless of their reason for their visit, as well as a couple of references to a heteronormative mentality and not being very LGBTQ-friendly, the overall reputation of the Student Health Center among students appears to be wanting. In my conversation with Director Daniel Bruey, he described a marked improvement in the level of trust and a much lower number of complaints in the past few years; nevertheless, many of the students I interviewed still appeared to have serious concerns that warrant being addressed.

Sexuality Education and Knowledge of Sexual Health Topics

Most participants stated that they had received some type of formal sexuality education, and most described it as comprehensive, however, of the fourteen who said this, only four said they had received any information about communication or condom negotiation, and several said things throughout the course of the interview that revealed significant gaps in *their* actual level of knowledge on sexual and reproductive health topics. Also, many of these students said they

had supplemented their education through informal means, such as searching online or talking with parents or friends. Additionally, the fact that five out of nineteen students had not received any formal comprehensive sexuality education means that twenty-six percent of the sample had either received no sex education or abstinence-only sex education.

While I acknowledge that this is a small sample and this cannot be generalized to the entire undergraduate student population at AU, I believe it is a significant indicator that the University should take steps to assess incoming students' knowledge base on sexual health topics. Also, several participants shared stories of friends who didn't know basic information such as proper condom use. While this does not seem to be the case for the majority of students, twenty-six percent is significant, and this lack of knowledge could lead to negative outcomes in a large number of students, especially if further assessment finds that the number in my sample is similar to the proportion of the general population at AU that is lacking in this basic knowledge.

Many participants believe that their peers' level of knowledge of sexual health topics is fairly good, however, when asked about which topics they were least knowledgeable about, there were several interesting examples illustrating a significant lack of understanding. One student discussed attending a class on anatomy and physiology, "…and during our entire … fertility and sexual and reproductive health unit, like, the questions that some people had… I was like, whoa… a lot of the guys had no idea what a menstrual cycle was. I mean, really, really… I was shocked…". The same student, and this was a student who had a very strong level of knowledge of sexual and reproductive health topics, mentioned hearing statements frequently that indicate students have a low understanding of how STIs are transmitted, particularly HIV, which lead to spreading myths among peers.

Other students talked about encounters they have had with friends who do not understand either how to use condoms properly to prevent pregnancy or STIs, or who do not understand the importance of condom use in preventing transmission of STIs and will therefore not use condoms if they are also using a hormonal method of birth control. One student was talking about how "alarming" it is that many friends were not aware that taking antibiotics lessens the effectiveness of hormonal birth control. When I asked if she thought that her friends were not using condoms as well, she said, "Yes, that's something I've found… almost all of my friends who are on birth control don't use condoms."

Another student spoke of learning that a friend, "…was sleeping with this guy and she was only putting the condom on like halfway through sex, and she like told some of her girlfriends about it and we were all like, no, that's not how that works." Yet another student mentioned that in speaking with friends about testing, they would often respond, "…well, I don't have any symptoms;" very few understood that STIs can frequently manifest no symptoms. And another mentioned the frequently cited issue in which even when people understand the importance of regular testing, and even those who will profess the importance to others, they often will not get follow through in getting tested themselves, saying, "I personally have never, like, sought out to be like tested for STDs or HIV, or anything, so I'm probably in the same boat. But it's kind of interesting how we all spread this information, but then none of us will go get tested." When I questioned why the student thought that was, the reply was, "I feel like we are young. And, you know… immortal. So I don't know why we don't get tested… it's such a serious thing."

It was difficult to determine what kind of information is disseminated at orientation regarding SRHRs. The group was almost evenly split with ten participants saying they did

receive information at orientation, and nine saying they did not receive any. Of the ten who stated they did receive sufficient information at orientation, several were unaware of significant on-campus resources, such as the ability to get birth control at the health center or where to get free condoms and supplies. One explanation for this may be what Daniel Bruey described as changes to what is presented and how it is presented each year, in part based on student leaders' involvement, and in part based on reactions from the administration to complaints they have received from parents and the occasional student regarding discomfort around either the sexual nature of the information or the way in which it was disseminated.

Stigma, Norms and Fear

Seventeen students described encountering various forms of stigma on campus, mostly from attitudes within the student population. Sixteen of these students suggested that gender played a large role, with most of those believing that females continue to be stigmatized far more than males for being sexually active, with both males and other females participating in the stigmatization through the use of derogatory terms such as "slut" or "skank." A couple of the participants mentioned that they believe sometimes males are stigmatized as well, mostly around issues of sexual orientation. As one student put it,

> I think there is a general pervasive… an attitude that pervades the students about, like, being promiscuous… like whore, slut, skank, manwhore, etc… things like that. People who are of a greater sexuality might be a little… might be a little nervous to access things for fear of getting labeled as someone like that.

Another student discussed how the double-standard still exists for college students, noting, "...the frat guys can go and have as much sex as they want and it's fine, but girls will be labeled as sluts if they have the same amount of sex." Many noted that fraternities and "Greek life" seem to be

the worst offenders on this campus in terms of creating and reinforcing these stigmas and social norms, with one student explaining,

> My boyfriend's in a fraternity, and there's definitely the double-standard there… we're in a long-term, monogamous relationship, and I still get made fun of… we'll go upstairs to his room, and everyone, like, teases me, and that's extremely inappropriate. But they'll be like, 'Yeah, you're getting some' to him, so there's absolutely still that double-standard, especially in the Greek system.

The students stated that of the stigma they have encountered, much of it has come from both external and internal sources; meaning that they have heard or been part of conversations or events on campus in which stigmatizing things were overtly said, as well as acknowledging that internalized stigma, in the form of embarrassment, discomfort or self-policing is a societal norm. Several students expressed what I would consider "sex-negative" attitudes, in which gender stereotypes were espoused, and they were concerned about being judged, in addition to participating in judgment of others' sexual behaviors. One student stated, "One of my new friends… we had a party and she didn't know him and… she just ended up having sex with him that night, and I just, I could never do it, but, like, it's not just, like, me being judgmental. I just really don't think she like understands that that's kind of dangerous to do." This student expressed being sexually conservative in responses to several of the questions, and seemed to have a very fear-based attitude towards the risks of being sexually active, including the risk of being perceived as being promiscuous. This same student mentioned not feeling comfortable accessing free condoms at the health center for fear of being recognized and judged. Another noted that the message he received at orientation was, "…it's very common for people to become promiscuous when they're in college. We don't recommend casual sex, but if you are going to have sex, have it safe." The use of the term "promiscuous" indicates some sex-negative attitudes, although it is difficult to discern whether the attitude came from the University

representatives or through the student's interpretation of the information. For me these examples indicate that a crucial facet of any sexuality education program is sex positivity, by which I mean a very values-neutral program, including discussion of value ranges and of sexuality being a natural, essential aspect of human beings (that is not to say sexuality is not also socially constructed, as per Foucault, but only that each individual is innately sexual, and there is a spectrum of "normal" and "natural" human sexual behaviors).

Additionally, several students noted that gender norms continue to be prevalent around responsibility for birth control, specifically that women typically take on the burden for hormonal forms of birth control with no financial support from their sexual partners, and that males typically provide condoms, and are expected to provide condoms. This was also reflected in some females stating they were personally uncomfortable getting condoms, particularly on campus where people they know might see them, as evidenced by several female students who stated as much directly, and one who stated, "I guess this would go back to being labeled a slut or something like that and also to the idea that I think exists that like men should have condoms and women shouldn't…. So I don't know how comfortable girls would be walking in to get condoms."

Improvements

Most participants were extremely supportive of requiring some type of mandatory basic comprehensive sex education and "how to access resources on-campus" class or workshop. Fourteen of the nineteen students interviewed felt this was an important and necessary improvement they would advocate for. One student replied to my question asking whether there should be mandatory classes or workshops,

> Yes. Definitely. Absolutely. If they make us take like an alcohol test about the dangers of alcohol, I mean, sex can be just as dangerous. You know, if it's not done safely or consensually. I mean, yeah, I mean the focus on alcohol over sex bothers me. There should definitely be mandatory sex ed.

The same participant suggested,

> Start with… having some kind of workshop for all freshmen where they know more about all of their options, not just – the condoms are over there. Go over all the stuff on the back of the bathroom doors, only not when you're in the bathroom, like in a workshop setting. Like how, if this happens to you or your friends, here's how you can deal with it. If you think you have an STI, this is what you should do…. explain to people that they should get checked [for STIs] and make it more affordable, like that's the biggest thing… instead of spending so much money on the WONK campaign, maybe spend a little on students.

This student indicated a clear frustration with AU over a perceived lack of information and access around SRHRs. This was something that several students echoed, and their suggestions included statements indicating that it would be meaningful to them in terms of how the administration respects students. As one stated, "Then the students would think that AU takes it more seriously, and it's more of a public issue then, and they want us to be safe and not diseased." Another student mentioned a belief that any increase in programming would "realistically" come from student groups, saying, "I think it would mean a lot if it came from the administration, but I don't think it will, because I think the administration is rather conservative. Not politically; socially… It would send a bigger message about the school and the administration if it came from the administration." Another student thought that classes or workshops should be tailored to her perceptions of the bigger issues at colleges, stating that a sex ed class or workshop should "…focus a lot more on things, like, issues on college campuses… like consent, or like, what exactly is sexual assault? Like what happens if you get sexually assaulted? Things like that."

Most thought it should be included in the orientation programming, and a few mentioned that it might be effective as an online requirement, similar to the existing "alcohol.edu" program. Of the remaining five, four students were opposed to making it mandatory (although they all stated that there should be something additional offered), and the other student was unsure whether or not it could or should be mandatory. When asked whether they would attend (or would have attended) a class or workshop if it was not mandatory, seven participants said yes, six said maybe, and five said no. However, most students I spoke with did *not* think that other students would attend if it was not required. Their reasons for students not attending ranged from stigma about being perceived as promiscuous to stigma about being perceived as ignorant about sexual and reproductive health topics, as well as simply issues such as time constraints and a belief that they already had all the knowledge that was necessary for them.

Thirteen of the nineteen students believe that free condoms should be offered in the dormitories, with one students stating, "…giving out condoms in the dorms would be a really, really good idea, because then… I mean they could potentially be totally uninformed and still have… access to protection, and I don't know why the administration wouldn't provide that. It's a good idea." Some participants suggested having condom and emergency contraception vending machines in the dorms, or potentially in bathrooms. Many students related this issue to stigma that exists, reasoning that it would remove the discomfort barrier of getting condoms from a very public space such as the health center waiting room, and for emergency contraception in particular, one student mentioned that it would greatly reduce feelings of shame and fear of judgment if students could access that more privately. Nine students noted that the University might have concerns with parental reactions if condoms are widely and visibly available in the dorms, suggesting that there is still a condition of stigma and fear around youth

sexuality being immoral and undesirable. A couple of students mentioned that the University might be concerned about liability if a condom was tampered with or failed, however, this could also be viewed as a possible liability if students do not have access to these supplies and suffer an adverse health outcome. One participant who is also a Resident Assistant (RA) mentioned that the administration strongly discourages RAs from providing condoms, saying,

> We don't do much sexual health programming in the residence halls or provision of resources … it requires active participation on behalf of the individual students to seek out education and resources, rather than it being integrated or offered in a more direct fashion.

A few of the students believed that the University may also be concerned that providing more resources could be construed as encouraging student sexuality or promiscuity. Of these five participants, most thought it was parental concern over this that would make it a factor, however, one student did mention it as a personal belief as well.

Some students had innovative ideas about ways to improve access, such as adding another sticker to the bathroom stalls that gave an overview of on-campus SRHRs. Several mentioned more visibility online, in the form of drastic improvements to the websites of both the Health Center and the University, and specific emails, perhaps even targeted to various populations. One participant noted,

> We were talking about the fact that the website didn't have a lot of information, and I think, like, that's a source that students would often use if they didn't feel comfortable necessarily talking to someone in person, and they wanted to kind of scope out and see what's available. And if there's not anything on the web, they might think that there's not anything available to them.

One student suggested that an online workshop be offered through Blackboard to alleviate potential discomfort of having to interact while dealing with a sensitive topic. Several others

mentioned increasing visibility and marketing of available resources around campus, through posters and flyers to be posted in dormitories and other buildings such as the dining hall. Additional marketing to RAs was also raised, so that they would be more likely to inform students in the dorms. Another idea that was raised a few times was to offer free STD testing events around campus with some frequency, such as on the quad or in the Mary Graydon Center. Because STD testing was one of the most common complaints about the health center due to cost, information or scheduling barriers, this might be an improvement with a strong impact.

Generally, the students who were most involved in student groups around campus were the ones who were most knowledgeable of the various SRHRs available at AU, and I had several of those students' in my study, perhaps because of my sampling method. Again, further study will need to be done to determine if this is proportionate, however, it is a concern for those who are not as actively involved in these various groups. If the University administration is not working to ensure that all students are reached, chances are good that the lack of not only awareness of resource availability, but also of medically accurate information will have a strong impact on students.

CHAPTER 7

CONCLUSIONS

While the students I interviewed generally believed that American University is fairly progressive in the SRHRs it offers, there are several areas in which improvement is necessary in order to protect students' health and well being, and to promote healthy, responsible sexuality. A few steps could be implemented very quickly, such as providing free safer sex supplies in the dormitories, or at the very least installing very low cost vending machines in the dorm bathrooms for condoms and lube. This would remove several barriers to access by way of reducing stigma and increasing comfort for students in need of these supplies, as well as the barriers related to timing in which students can't currently access these supplies after business hours. Also, Daniel Bruey mentioned that they previously had a basket of free condoms in the bathroom at the Student Health Center, but they removed it to the current location near the front desk in the waiting room when it appeared that some students were taking large quantities at one time. I would argue that while that issue is understandably concerning, it is better for one student to take a large quantity of condoms at one time, than for students to be without condoms when they need them. In all likelihood, these students are distributing the condoms to other students on campus, however my interviews showed that not having them available in a private location decreases accessibility for students who are concerned about being seen getting condoms. Increasing availability and creating very convenient access strongly increases the likelihood that students will use these resources.

Another improvement that could be quickly implemented would be the addition of some type of class or workshop for all incoming undergraduate students. Orientation is the most logical choice for providing this, as students are already required to attend these sessions to

receive a wide variety of information to make their transition to life at AU smoother. As many of the participants noted, coming to college is a brand new environment for young people, especially as it relates to sexuality, and they will be exposed to many forms of potential risk. Ensuring that they have the knowledge and skills to negotiate this new environment in ways that will mitigate risk is a logical step to take, and is in the University's best interest. These workshops or programs could be easily implemented through existing on-campus resources, such as the Wellness Center educators or representatives from student health, or they could be brought in from an outside source, such as educators from local organizations such as Planned Parenthood. The key piece in this is a well-designed program that is not too long, but covers basic topics in sexual health, such as how to use condoms properly, various contraceptive methods, why regular testing for STIs is important for anyone who is sexually active, condom negotiation and issues around consent. I do not believe this piece should be based entirely upon the preferences of student leaders. While they may have some important insights and ideas, and I fully support student participation in these initiatives, there should be a carefully designed standard to ensure the information does not vary widely from year-to-year based on their level of knowledge or comfort. The other important piece is determining how to *effectively* provide all the needed information about where and how to access SRHRs on campus. It is unclear from the responses whether there have been times when this information was simply not provided, or if many students simply aren't retaining the information they receive. Either way, best practices should be employed to ensure that students actually retain the information, even if the only piece they actually retain is how to access that information, potentially online, whenever they may need it. While it is a distinct possibility that there will be some complaints from the occasional student or parent, I believe that the value of this information far outweighs the risk of potential

complaints. In addition, I believe a strong argument can be made (as is shown throughout this paper) that while not all students are sexually active, AU is committed to ensuring that those who are sexually active have the knowledge and access to resources that will help them to ensure they are healthy, and that the vast body of research available on comprehensive sexuality education has shown it to be effective at improving health outcomes, and not to be a factor in earlier onset of sexual activity.

Increasing and clarifying the information on the website regarding SRHRs at AU would be another logical and relatively easy way to greatly facilitate that access. I believe this should be a priority, as many students expect to be able to - and frequently do - access a majority of information online. If AU were to have a stronger online presence regarding SRHRs, it would facilitate access to information for many students, particularly those who may not be able to access facilities such as the Student Health Center and the Wellness Center, that are typically open only during business hours.

As for improvements that will require more time for implementation, I recommend that the University begin a thorough assessment of the Student Health Center, with an eye toward improving services so that the reputation among students can also improve. Trainings for staff to increase their cultural competency, particularly around becoming more LGBTQ-inclusive, and potentially also to improve the manner in which they interact with students around sexual health-related topics like pregnancy, birth control and STIs to increase comfort and trust, would go a long way to improving students' perception of the health center, which would in turn increase students' access to one of the main SRHRs on campus. While I believe the Student Health Center has made great strides over the past few years, the frequency of certain complaints that arose in the interviews suggests that there is still room for improvement – even if that means

simply taking additional time to explain procedures to students, such as why an inquiry regarding possible pregnancy is being made.

The issue that came up most frequently I would categorize as a lack of communication or miscommunications with students, which is a significant barrier to accessing these resources. Many students complained, for instance, that they could not schedule an appointment for STI testing online, although other appointments can be scheduled online. Students were then concerned that they would have to explain what they wanted at the front desk, in front of anyone in the waiting room. According to Mr. Bruey, this is not the case, and they have made efforts to ensure that students don't have to disclose confidential information in the waiting room at all. He states that their plan is that students can schedule a routine health exam, and tell the health care practitioner what they want in private during the visit. Additionally, students mentioned that there were only certain practitioners who could provide this service, but Mr. Bruey stated that any of the practitioners would be able to perform the STI testing, so there was no specific scheduling requirement. I recommend that they fix this issue immediately by having the information on the website changed so that students who are trying to schedule an appointment for STI or HIV testing are made aware that they can simply schedule a routine office visit, and ensure the front desk staff are trained in how to clarify to students that they do not need to disclose confidential information about the reason for their visit until they are meeting privately with their provider.

Another issue pertaining to lack of communication is that the most current schedule of fees is not posted online (as of March 22, 2012), and the one that is posted does not specifically list any STI testing, and has two different prices for HIV tests without a clear explanation of the differences. It also has significant cost differences from the current one of which Mr. Bruey

provided me a copy, for example Plan B emergency contraception costs $40, as opposed to the $15 on the fee schedule that is online. Additionally, while the STI testing listed on the updated fee schedule costs $90 (and states that it is not billed to insurance), this testing does not cover tests for Gonorrhea or Chlamydia, two common STIs, and if those are included, it's an extra $30, bringing the total cost of the tests to $120. This is not clear on either fee schedule, and is something that I recommend should be addressed immediately. Also, I believe that overall, the information on availability of services needs to be significantly more visible/accessible and clarified, so that students can quickly understand their options.

The second issue identified is the cost barrier. Mr. Bruey notes that the costs for the STI tests were previously over $300, so they have negotiated a significant discount for the students, however this may still be cost-prohibitive to some students. They are aware of this, and explained that in previous years they were able to obtain free testing through the DC government, however, according to Mr. Bruey, that has been taken away by the DC government, supposedly because of a low proportion of positive results as compared to the number of tests performed. I recommend that the Student Health Center look into working with local non-profit groups by bringing them onto campus for free or low-cost STI testing events as a way to bridge the gap the loss of the DC Government program has left and to ensure that the students have means and incentive to get tested regularly.

In addition, on the schedule these tests show that they are not billed to insurance, but I believe this is something that should be determined on an individual basis, and using insurance to offset the costs should be an option that is offered to the students. As evidenced by my interviews, there are students who either have their health insurance in their name or who have no concerns related to their parents receiving information from the insurance company regarding

the testing, but they were never provided that information as an option, and thus they either attempted to find a lower cost-option, or they simply did not get tested.

Another piece that could be implemented fairly quickly, but would also benefit from a long term strategic plan, is marketing of the various resources and facilities on campus, such as the Wellness Center and the Student Health Center. Right now very few people know about the Wellness Center, and those who have heard about it do not have a clear understanding of its role or what it offers. Creating more visibility and clear messaging on campus could begin with flyers and innovative use of the peer educators. Additionally, these resources need to be strategically marketed to the RAs, as they are key players in terms of disseminating information to and having meaningful conversations with incoming students. However, they cannot be expected to provide this information if they do not have a thorough understanding of the resources themselves.

Increasing publicity and marketing around SRHRs is also a way to reduce the stigma that students are perceiving on campus, by increasing awareness and a sense that American University does not participate in sex-negativity, but instead supports students' sexuality and sexual health as one part of their holistic identities. College campuses are ideally supposed to be places that provide leadership in progressive thinking, and AU has the opportunity to continue the tradition they have begun in their affirmations of LGBTQ populations by expanding it to the entire student body through increasing access to SRHRs on campus.

APPENDIX A

INTERVIEW GUIDE

Before beginning, be sure to clearly define "sexual & reproductive health resources" for the participant. This should include sexuality education classes/programs, supplies such as condoms and birth control, medical services such as testing for HIV, STIs and pregnancy, and counseling/services around sexual assault. Also define Campus Climate, and STIs/STDs.

Larger topic	**Main question**	**Potential Probes**
Access to resources		
	Tell me about the last time you accessed (or attempted to access) SRHR at AU?	Was that a typical experience? Why or why not?
	How do you know about the SRHR available at AU?	Do you hear about them from friends, or on the website? Some other way(s)? Please tell me all the ones you are aware of…
	Are there any resources you are aware of that you would **not** use at AU?	Which ones? Why or why not? Would you go somewhere else for these resources if needed?
	How often do you access SRHR on campus at AU?	Which ones? Is there a reason you utilize certain ones over others? If there are resources you don't access frequently, why not?

Larger topic	Main question	Potential Probes
	Have you had any sexual/reproductive health education either here or before you came to AU?	If yes, where, when and what was covered? Do you think this education was comprehensive and provided the information you needed to make healthy decisions related to sexuality?
	Tell me about a time when you wanted or needed to access a sexual health resource, but weren't able to do so.	Be specific…
	Have you ever heard from friends about problems they have encountered in attempting to access resources on campus?	Please give me a specific example
	Have you noticed any differences in how easy or difficult it might be to access these resources for different groups?	For example, is it easier or more difficult for men to access resources than women? Why? Straight vs. gay? Trans? People of color?
Campus climate		
	In your opinion and experience, how knowledgeable about sexual health topics are your peers (i.e., undergraduate students at AU)?	Which topics are they most knowledgeable about and why? -Condoms, testing? Which topics are they least knowledgeable about and why?
	Overall, in your opinion, what is the climate on campus around sexuality and sexual health?	Do you feel that there are enough resources and/or support? Why or why not?
Stigma/norms		
	Do you think any stigma exists that might prevent students from accessing sexual health resources?	If so, does it come from external sources (i.e., the university, or peers) or is it more internal? Give me some examples…

Larger topic	Main question	Potential Probes
	Why do you think there might be societal barriers to certain resources?	
	What are the reasons, in your opinion, you think that the administration at AU is not comfortable offering certain resources?	For example, why don't they provide condoms in dormitories? Or why don't they require certain classes or workshops on sexual health?
How they would improve access to SRHR on campus		
	How could access to on-campus resources be improved?	Build off this if response is something like – make condoms more readily available - ask where, how, etc Are some groups more difficult to reach than others (sexually conservative perhaps) and why? How do you ensure that everyone is reached?
	Do you think there should be mandatory sex ed & "how to access resources on campus" classes or workshops for incoming undergraduate students? Why or why not?	Have you ever talked with your peers about this? Have you ever talked about this with university staff or administration? What were their responses?
	If these classes or workshops were offered, but not mandatory, would you attend?	Why or why not?
Demographics & basic information		
	What is your class year (freshman, sophomore, junior, senior)?	
	How old are you?	
	What is your major?	

Larger topic	Main question	Potential Probes
	How do you identify in terms of gender identity?	
	How do you identify in terms of sexual orientation?	
	How do you identify in terms of race/ethnicity?	

APPENDIX B

STUDENT HEALTH CENTER DOCUMENTS

AMERICAN UNIVERSITY
WASHINGTON, DC

Office of
Campus Life

About Us

STUDENT HEALTH CENTER GENERAL INFORMATION

Hours of Operation:
Services at the Student Health Center are available by appointment. To make an appointment, simply call 202-885-3380 or stop by the SHC on the 1st Floor of McCabe Hall. The SHC is open from 9 AM – 6:00PM Monday through Friday. During semester breaks and the Summer the Student Health Center is open from 9 AM - 5:00 PM.

Who is eligible to be seen at the Student Health Center?
All student enrolled in credit bearing courses at American University, regardless of the type of insurance they carry, are eligible for care in the Student Health Center.

Medical Emergencies and After Hours Care:
Students who live on campus and experience a medical emergency, or become ill after the SHC is closed, should immediately notify the Resident Assistant on duty or the Resident Director on duty. If you are off campus and have a medical emergency, call 911 to activate the DC Emergency Medical Services system.

Immunizations:
District of Columbia law requires that all students under age 26, enrolled in schools within the district, provide proof of having had the following immunizations: Two vaccinations against Measles, Mumps, and Rubella, given after 1 year of age and at least 30 days apart; one Diphtheria/Tetanus booster given within the past ten years; two doses of Varicella (Chicken Pox) vaccine 60 days apart, and a series of three Hepatitis B immunizations administered over a 6-month period. First year, resident students are also required to have the Meningococcal vaccine. The mandatory immunization should be completed with your physician present so s/he can consolidate your records and update any immunizations you may be missing. If you submit an immunization form that is incomplete, has invalid dates, or lacks a validating stamp, it will not be processed and will delay your registration for classes.

Health Education Programs:
The SHC is also home to the Wellness Center, located behind the Student Health Center on the first floor of McCabe Hall. Students are invited to stop by and talk to a health educator, ask some questions of the peer educators, or pick up literature. For more information, call the Wellness Center at x3276.

Student Insurance:
If you are contemplating the purchase of student medical insurance or re-evaluating your current insurance plan, it would be prudent to participate in a plan which provides broad coverage at school and can also be utilized at home.

At American University, medical insurance is mandatory for all full-time degree, resident and international students (except those on A, G, and H visas). Students who do not specifically waive medical insurance are automatically billed for the university sponsored insurance plan. Policy information and Insurance ID cards will be mailed to the permanent residence address.

To confirm acceptance of the university sponsored medical insurance plan, complete the Insurance Registration on-line form at my.american.edu. To waive the university plan, an Insurance Registration/Waiver form must be submitted prior to the waiver deadline, with proof of comparable, alternate insurance coverage. The Insurance Registration/Waiver form can be submitted electronically at my.american.edu. Please note: Medical insurance coverage is available at an additional cost to part-time students carrying at least six credit hours, spouses, domestic partners, and children of students enrolled in the university sponsored plan. For information call the Student Insurance Office at (202) 885-3298.

Referral Policy:
If you are covered by the AU Student Health Insurance Plan, the Student Health Center is your primary care provider and should be your first stop for your health care needs. The SHC can take care of most routine internal medicine and GYN problems (including annual GYN exams and physicals), and will refer you as needed for specialty care, diagnostic testing, or therapeutic services.

- Referrals are valid for 60 days from the date it is written and covers services provided by the consulting provider. The insurance company requires a separate referral from the SHC for additional services (such as MRI or physical therapy) that the consultant may order. Your provider at the SHC must

have the consultant's report before issuing these referrals, or before issuing a new consult after the initial 60 days.

- If you are referred to a specialist directly from an emergency room, it is important that the specialist be a participating provider with the Student Health Insurance Plan in order to maximize your benefit. In an emergency situation, one initial visit with the specialist can occur without a referral, but subsequent visits must have a referral from the SHC. Your provider at the SHC must have the consultant's report before issuing these referrals.

AMERICAN UNIVERSITY
WASHINGTON, DC

Office of
Campus Life

Patient Visit Information

PATIENT RIGHTS AND RESPONSIBILITIES

Patient Rights

The Student Health Center provides quality health care to eligible students regardless of race, color, religion, national origin, sex, age, marital status, personal appearance, sexual orientation, gender identity and expression, disability, or political affiliation.

Our patients have the right:

- to be treated in a civil manner with consideration, respect, and courtesy in all interactions
- to have discussions, examinations, and treatments conducted in a private, safe environment
- to expect that protected health information (PHI) will be kept confidential per American University, state, and federal regulations and released to a third party only with the patient's written consent or if required by law
- to be informed of the identity and credentials of the health care professional providing services
- to actively participate in decisions concerning their health and the care they receive
- to a clear explanation of diagnosis, prognosis, methods of treatment, and alternatives to treatment
- to a clear explanation of tests ordered, the reason(s) for ordering them, and the benefits /risks of medications dispensed or prescribed
- to ask questions of their health care provider
- to be informed of personal responsibilities for medical treatment, and managing health and well being after treatment
- to choose or change providers (depending on availability) within the Student Health Center (SHC)
- to receive information on patient rights, patient responsibilities, services, hours of operation, and provisions for after-hours care and emergency coverage
- to receive information about and explanation of fees for services and payment policies
- to express concerns directly to the Director of the SHC or any staff member of the health center

Patient Responsibilities

The Student Health Center at American University is committed to providing quality health care to students. We believe that quality health care is a result of collaboration between medical provider and patient. Active participation in your own health care is a responsibility that will assure the best outcomes.

Responsible actions on behalf of our patients include:

- Seeking medical care soon after feeling ill so you do not put others at risk of becoming ill.
- Allowing a reasonable amount of time when accessing services and arriving 15 minutes before your scheduled appointment to complete paperwork or pre-exam procedures.

  * For example, do not schedule an appointment 15 minutes before a class or work.
- Keeping your appointments, or cancelling / rescheduling as far in advance as possible, so that your appointment time may be given to another patient.
- Familiarizing yourself with visit fees, associated laboratory and medication fees, and paying for services rendered at the time of service.
- Presenting an ID card (or other form of photo identification) to SHC staff at check-in.
- Having a basic understanding of the benefits of your insurance plan and contacting the member services department of that plan if you have questions.
  *Students on the AU insurance plan should remember that they must be seen at the health center to obtain referrals for

specialty care. Additional information can be found at www.myaustudentinsurance.com or the health center Web site at www.american.edu/healthcenter

- Acting in a courteous manner, showing respect to health care personnel and other patients by refraining from eating, drinking, and using cell phones while in the health center.
- Providing complete information about a health problem or illness to the medical provider, including accurate information about your medical history, allergies, or medications you are taking.
- Asking questions to ensure that you understand your illness or problem and the recommended treatment.
  *If you find the care or course of treatment unacceptable for any reason, please discuss it with a member of the staff, the Patient Services Manager, or the Director.
- Securing prescription medications (in your possession), taking them as directed, and not sharing them with others.
- Communicating with your health care provider if a condition worsens or does not follow the expected course.
- Taking responsibility for actions and outcomes if you refuse treatment, care, or services or if you do not follow the health care professional's instructions.
- Completing satisfaction surveys that may be provided.
- Contacting the Director with any concerns about the Student Health Center

AMERICAN UNIVERSITY
WASHINGTON, DC

Student Health Center

2011-2012 Fee Schedule

Fees as of August 1, 2011 and subject to change.

VISIT FEES (PER VISIT)

	CHARGE
Routine Visit	20
Physical Exam	30

GYNECOLOGICAL CARE	CHARGE
Annual Women's Exam	30

PSYCHIATRIC CARE	CHARGE		CHARGE
Initial Visit with Psychiatrist	75	Follow Up visit with Psychiatrist (AU Plan)	35

MEDICATIONS

ALLERGY/ASTHMA	CHARGE		CHARGE
Methylprednisolone 4mg (#21)	15	Prednisone 10mg (#30)	15

ANTIBIOTICS	CHARGE		CHARGE
Amoxicillin 500mg (#30)	15	Azithromycin	20
Cephalexin 500mg (#28)	15	Ciprofloxacin 250 mg (#6)	15
Ciprofloxacin 3% ophthalmic solution	15	Doxycycline 100mg (#14 tablets)	15
Fluconazole 150mg (#1)	15	Metronidazole 500mg (#14)	15
Neo-Poly HC Otic Suspension	20	Penicillin VK 500mg (#20)	15
Polymyxin-Trimeth ophthalmic solution	15	Trimeth Sulfa DS (#6)	15

COLD/FLU	CHARGE		CHARGE
Benzonatate 100mg (#20)	15	Mucinex	15
Zofran	15		

CONTRACEPTION	CHARGE		CHARGE
Cesia (Cyclessa Generic)	15	Ella Emergency Contraception	25
Microgestin	15	Mononessa	15
Plan B Emergency Contraception	15	Solia (Desogen Generic)	15
Sronyx	15	TriNessa	15

DERMATOLOGY	CHARGE		CHARGE
Clindamycin 1% Topical Gel	15	Fluocinonide 0.05% Cream	15

PAIN RELIEF	CHARGE		CHARGE
Omeprazole 20mg (#30)	15	Phenazopyridine 200mg (#6)	15
Mobic	15		

PROCEDURES	CHARGE		CHARGE
Dressing Change	10	Ear Irrigation	15
EKG	35	Nebulization	20
Suture Removal	15	Wart Removal (per treatment)	15

LABORATORY/BLOODWORK

	CHARGE		CHARGE
Blood Draw (for students not on the AU plan)	10	Glucose	20
HIV Test - Blood (not billed to insurance)	40	HIV Test - Ora Quick	20
PAP Smear (not billed to insurance)	50	Pregnancy Test	20
Pregnancy Test Blood (not billed to insurance)	20	Rapid Influenza	30
Rapid H. pylori	20	Rapid Mono	15
Rapid Strep Test	15	RPS Adeno	20
T spot TB Testing	80	UA- Dipstick	10

TITERS

	CHARGE		CHARGE
Hepatitis B titer	25	MMR titer	50
Varicella antibody titer	20		

IMMUNIZATIONS

	CHARGE		CHARGE
Flu vaccine	20	Hepatitis A per injection	95
Hepatitis B per injection	65	Hepatitis A and B per injection	120
HPV Vaccine per injection	155	Meningitis vaccine	125
MMR per injection	60	Tetanus / Diphtheria/Pertussis	50
TB Testing (Placement and Reading)	10	Typhoid Oral	60
Varicella per injection	110	Polio	70

INJECTIONS

	CHARGE		CHARGE
Allergy Injections per semester	60	Benadryl	10
Ceftriaxone 250mg	15	Ceftriaxone 1gram	20
Depo Provera Administration	15	Epinephrine	10
Ketorolac	15	Penicillin G	30
Promethazine	15		

SUPPLIES

	CHARGE		CHARGE
Ace Bandage	5	Air Stirrup Kit	35
Crutches	40		

MEDICAL RECORDS

	CHARGE		CHARGE
Under 10 pages	$1 per page	Over 10 pages	15

AMERICAN UNIVERSITY
WASHINGTON, DC

Student Health Center

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Initial Visit with Psychiatrist	75

PSYCHIATRIC CARE	CHARGE
Follow Up visit with Psychiatrist (AU Plan)	35

MEDICATIONS

ALLERGY/ASTHMA	CHARGE		CHARGE
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ANTIBIOTICS	CHARGE		CHARGE
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Fluconazole 150mg (#1)	15	Metronidazole 500mg (#14)	15
Neo-Poly HC Otic Suspension	20	Penicillin VK 500mg (#20)	15
Polymyxin-Trimeth ophthalmic solution	15	Trimeth Sulfa DS (#6)	15

COLD/FLU	CHARGE		CHARGE
Benzonatate 100mg (#20)	15	Mucinex	20
Zofran	15		

CONTRACEPTION	CHARGE		CHARGE
Cesia (Cyclessa Generic)	15	Ella	15
Microgestin	15	Mononessa	15
Plan B Emergency Contraception	40	Solia (Desogen Generic)	15
Sronyx	15	TriNessa	15

DERMATOLOGY	CHARGE		CHARGE
Clindamycin 1% Topical Gel	15	Fluocinonide 0.05% Cream	15

PAIN RELIEF	CHARGE		CHARGE
Omeprazole 20mg (#30)	15	Phenazopyridine 200mg (#6)	15
Mobic	15		

PROCEDURES	CHARGE		CHARGE
Dressing Change	10	Ear Irrigation	15
EKG	35	Nebulization	20
Suture Removal	15	Wart Removal (per treatment)	15

LABORATORY/BLOODWORK	CHARGE		CHARGE
Blood Draw (for students not on the AU plan)	10	Glucose	20
HIV Test - Blood (not billed to insurance)	40	HIV Test - Ora Quick	20
PAP Smear (not billed to insurance)	50	Pregnancy Test	20
Pregnancy Test Blood (not billed to insurance)	20	Rapid Influenza	30
Rapid H. pylori	20	Rapid Mono	15
Rapid Strep Test	15	STI Testing (not billed to insurance)	90
UA- Dipstick	10		

TITERS	CHARGE		CHARGE
Hepatitis B titer	25	MMR titer	50
Varicella antibody titer	20		

IMMUNIZATIONS	CHARGE		CHARGE
Flu vaccine	20	Hepatitis A per injection	95
Hepatitis B per injection	65	Hepatitis A and B per injection	120
HPV Vaccine per injection	155	Meningitis vaccine	125
MMR per injection	60	Tetanus / Diphtheria/Pertussis	50
TB Testing (Placement and Reading)	10	Typhoid Oral	60
Varicella per injection	110	Polio	70

INJECTIONS	CHARGE		CHARGE
Allergy Injections per semester	60	Benadryl	10
Ceftriaxone 250mg	15	Ceftriaxone 1gram	20
Depo Provera Administration	15	Epinephrine	10
Ketorolac	15	Penicillin G	30
Promethazine	15		

SUPPLIES	CHARGE		CHARGE
Ace Bandage	5	Air Stirrup	35
Crutches	40		

MEDICAL RECORDS	CHARGE		CHARGE
Under 10 pages	$1 per page	Over 10 pages	15

APPENDIX C

IRB DECISION EMAIL

Christine Gordon <cgo618@gmail.com>

IRB Review not needed - Access to On-Campus Sexual and Reproductive Health Resources at American University

Research Compliance <researchcompliance@american.edu> Tue, Oct 25, 2011 at 2:55 PM
To: cg3422a@american.edu
Cc: monica.biradavolu@american.edu

Dear Christine Gordon,

Based on the information provided in your application and correspondence, it was determined that the project does not constitute "human subjects research" as defined by the federal regulations:

§46.102 Definitions.

(d) ***Research*** *means a systematic investigation, including research development, testing and evaluation, designed to develop or contribute to generalizable knowledge. Activities which meet this definition constitute research for purposes of this policy, whether or not they are conducted or supported under a program which is considered research for other purposes. For example, some demonstration and service programs may include research activities.*

(f) ***Human subject*** *means a living individual about whom an investigator (whether professional or student) conducting research obtains*

(1) Data through intervention or interaction with the individual, or
(2) Identifiable private information.

No further action with the IRB is needed, and you are free to proceed with your study.

It is the responsibility of the investigator to ensure that no human subjects research is conducted prior to IRB review and approval.

If you have any questions regarding this notice, please contact the IRB office at 202-885-3447.

Sincerely,

Matt Zembrzuski
Research Compliance Manager
American University
http://www.american.edu
tel: (202) 885-3447, zembrzus@american.edu

Christine Gordon <cgo618@gmail.com>

IRB Review not needed - Access to On-Campus Sexual and Reproductive Health Resources at American University

Monica Biradavolu <monica.biradavolu@american.edu> Tue, Oct 25, 2011 at 3:09 PM
To: Christine Gordon <cgo618@gmail.com>
Cc: Yvonne Fulbright <fulbrigh@american.edu>, Gay Young <gyoung@american.edu>, Salvador Vidal-ortiz <vidalort@american.edu>

Hi Christine,

I was unsure when I received this email as to why your research was deemed to NOT constitute human subjects research so I called and spoke with Matt Zembrzuski of the IRB. He said that the Chair of the IRB had reviewed it and determined that your research was "not leading to generalizable knowledge". I'm not entirely convinced by this rationale but I did check with Matt and asked if you could present your findings at a conference and/or later publish it and he said you could.

I'm cc'ing Gay and Salvador as well to see if they have different thoughts on this. If not, this means you are good to go!

Best,

Monica
[Quoted text hidden]
--
Monica Biradavolu, PhD
Assistant Research Professor
Assistant Director, Center on Health, Risk & Society
Department of Sociology
American University
4400 Massachusetts Avenue
Washington DC NW 20016
Phone: 202-895-4971

APPENDIX D

INFORMED CONSENT

Access to On-Campus Sexual and Reproductive Health Resources at American University

Consent to Participate in Research

Identification of Investigators & Purpose of Study

You are being asked to participate in a research study conducted by Christine Gordon from American University. The purpose of this study is to identify barriers and/or facilitators to access of sexual health resources on campus at American University for undergraduate, residential students. This study will contribute to the student's completion of her master's thesis.

Research Procedures

Should you decide to participate in this research study, you will be asked to sign this consent form once all your questions have been answered to your satisfaction. This study consists of an interview that will be administered to individual participants in a mutually agreed upon, private space. You will be asked to provide answers to a series of questions related to access of sexual health resources on campus. This interview will be audiorecorded.

Time Required

Participation in this study will require approximately one to two hours of your time.

Risks

The investigator does not perceive more than minimal risks from your involvement in this study.

Benefits

Potential benefits from participation in this study include a greater awareness of sexual health resources on campus, and an opportunity to be a part of improving access to sexual health resources for all students.

Confidentiality

The results of this research may be presented at conferences. The results of this project will be coded in such a way that the respondent's identity will not be attached to the final form of this study. The researcher retains the right to use and publish non-identifiable data. While individual responses are confidential, aggregate data will be presented representing averages or generalizations about the responses as a whole. All data will be stored in a secure location accessible only to the researcher. Within three years, all information that matches up individual respondents with their answers including audiorecordings will be destroyed.

Participation & Withdrawal

Your participation is entirely voluntary. You are free to choose not to participate. Should you choose to participate, you can withdraw at any time without consequences of any kind. You may also refuse to answer any individual question without consequences.

Questions about the Study

If you have questions or concerns during the time of your participation in this study, or after its completion or you would like to receive a copy of the final aggregate results of this study, please contact:

Christine Gordon
Sociology Department
American University
Cg3422a@american.edu

Monica Biradovolu
Sociology Department
American University
Telephone: (202) 895-4971
monica.biradavolu@american.edu

Giving of Consent

I have read this consent form and I understand what is being requested of me as a participant in this study. I freely consent to participate. I have been given satisfactory answers to my questions. The investigator provided me with a copy of this form. I certify that I am at least 18 years of age.

☐ I give consent to be audiorecorded during my interview. _____ (initials)

_____
Name of Participant (Printed)

_____ _____
Name of Participant (Signed) Date

_____ _____
Name of Researcher (Signed) Date

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