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THE SOCIAL ECOLOGY OF MEN'S SEXUAL SELF-EFFICACY IN THE MISSISSIPPI DELTA

A Thesis Presented for the Master of Arts Degree
Department of Sociology and Anthropology
The University of Mississippi

Vanessa Parks
May 2014

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ABSTRACT

Mississippi often has some of the highest rates of teenage pregnancy and sexually transmitted diseases and infections in the country. To combat this, the state uses abstinence-based sexual education in an attempt to discourage young people from having sex. I conducted 27 interviews and one focus group to talk with young men in the Mississippi Delta about their opinions on birth control. Using the social ecological model and self-efficacy framework, this thesis considers the influences on young men that shape their attitudes and behaviors regarding sexual health topics such as birth control. Primary findings include their learning from teachers, parents, and peers, coupled with a general mistrust of their female partners and female birth control methods. Additionally, young men seemed very confident in their perceived sexual self-efficacy, yet they demonstrated limited knowledge, and they expressed a desire to learn more about sexual health.

DEDICATION

This thesis is dedicated to the honor of my grandfather,
Mr. Harold VanBerg Thurman.

ACKNOWLEDGEMENTS

I would first like to thank my thesis committee. Without Dr. John Green's guidance, I would not have believed I could do this project. He taught me what I needed to know but also let me learn along the way. Dr. Kirsten Dellinger inspired me to find the confidence I needed for this project. I would also like to thank Dr. Jeffrey Jackson for all his valuable feedback and positive attitude.

There are many people in Morristown (pseudonym), Mississippi who made this project possible. I extend a special thanks to those people from the community health center who helped me recruit participants. I am also grateful to the owner and employees at the barbershop who made me feel at home in Morristown. To protect confidentiality, I cannot list names, but you know who you are.

Support was provided for this research through the University of Mississippi's Center for Population Studies and the *Right! from the Start* program. *Right! from the Start* is a collaborative program between Women and Children Health Initiatives and the Community Foundation of Northwest Mississippi with partial support from the W.K. Kellogg Foundation. The views expressed in this report do not necessarily reflect those in the partner organizations.

This thesis would not be possible without the men who gave their time to let me ask them very personal questions. I appreciate their candor and conversation. Getting to know them was a privilege and a joy.

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I. INTRODUCTION

Mississippi often makes its way into the news regarding sex education and reproductive rights. Most recently, Mississippi passed a law that requires DNA testing of a child born to a mother under the age of sixteen who does not name the father (Mississippi Child Protection Act 2013; Hess 2013). Mississippi's approach to sexual health and reproductive justice bring the state national attention. The debates surrounding the 2011 Mississippi Life Begins at the Moment of Fertilization Amendment, or Initiative 26, brought to light that until recently, most sex education in schools was centered around abstinence-only curricula with the idea that families would cover any topics left out in schools. This kind of education has yielded the highest teenage pregnancy rate in the country. The United States has the highest rate of teenage pregnancy in the developed world (Centers for Disease Control 2012), and though the teenage pregnancy rates in the United States have declined by 40% over the last 20 years, in 2011, 31.3 out of every 1,000 teenage women had given birth (Centers for Disease Control 2011). Unfortunately, Mississippi continues to have the highest rates of teenage pregnancy in the United States with 55 out of every 1,000 teenage women (ages 15-19) having given birth at least once (Mississippi Department of Human Services 2011).

Additionally, HIV infection rates in adolescents are much higher in Mississippi than the national average. Nationally, 7.9 adolescents per 100,000 (ages 13-19) are infected with HIV every year. In Mississippi, 11.7 per 100,000 adolescents contract HIV every year (Centers for Disease Control 2013). Mississippi currently has the second highest rates of chlamydia and gonorrhea and the fourth highest rate of syphilis in the country (Centers for Disease Control 2011, quoted in Sexuality Information and Education Council of the United States 2014).

In order to address these challenges, we must first understand them better. As part of this, I would like to contribute by focusing on an often-neglected group: young adult males. The setting for this project is Morristown (pseudonym), Mississippi, a small city in the Mississippi Delta region, known for its high rates of poverty (Macartney 2011; Macartney, Bishaw, and Fontenot 2013). Young men from the Mississippi Delta region are an overlooked demographic group, so this thesis will contribute to existing literature on sexual health. There are two major research questions. First, where are young men learning about sexual health? Second, how do young men in the Mississippi Delta feel about birth control, specifically condoms?

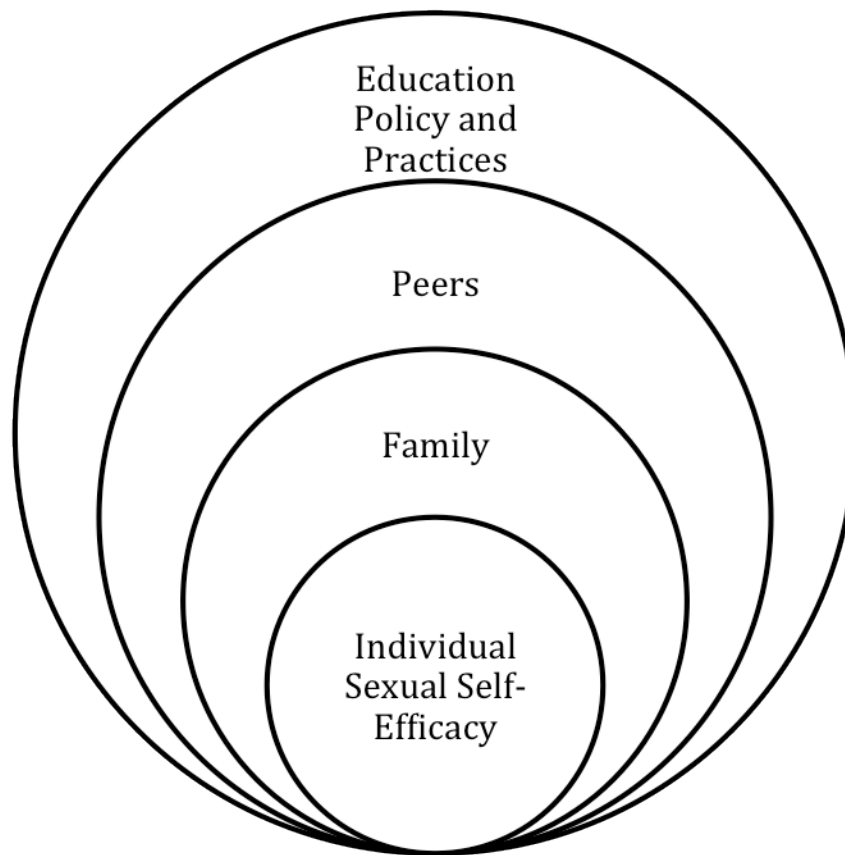
II. LITERATURE REVIEW

In order to explore and understand the sexual activities, contraceptive use, attitudes, and practices of young men in the Mississippi Delta, I use the concept of self-efficacy, which refers to the “beliefs in one’s capabilities to organize and execute the courses of action required to produce given attainments” (Bandura 1997:3). As applied to sexual health, self-efficacy involves the knowledge and preparation to control one’s sexual health. Specifically, I consider the impact of education on sexual self-efficacy, but I also consider other influences like families and peer groups, and how factors such as gender and race relate to sexual self-efficacy. To study these different spheres of social influence on an individual, I utilize the social ecological model.

SOCIAL ECOLOGICAL MODEL

The social ecological model accounts for the many different groups and levels of influence on an individual’s attitudes and behaviors (Lohman and Billings 2008). These levels can be understood as concentric circles, with the individual at the center. The influences acting upon an individual can impact an individual’s self-efficacy, and through their actions, the individual may also influence these spheres (Figure 1).

Figure 1: Sexual Self-Efficacy in the Social Ecology Framework



Some of the literature on sexual self-efficacy has begun to utilize the social ecological model because it provides a useful framework for classifying and understanding the way people learn about sex and sexual health (Baral et al. 2013; Larios et al. 2009).

This project relies on literature from a variety of disciplines and areas. Grounded in sociology, I also draw upon literature from public health, education, political science, and a series of government reports. These different approaches focus on the impacts of education, families, peer groups, or a combination of factors on sexual health and self-efficacy.

Currently, there is much research being done using the social ecological model to understand sexual self-efficacy as it relates to HIV prevention. A 2013 public health article utilizes a social ecological framework for understanding sexual self-efficacy regarding HIV epidemics (Baral et al. 2013). At the center of their model is the individual, with his or her “biological or behavioral factors associated with acquisition or transmission risks” (Baral et al. 2013:3). The first level of influence acting upon the individual is the social and sexual network, “comprised of interpersonal relationships including family, friends, neighbors and others that directly influence health and health behaviors” (Baral et al. 2013:2). The second level of influence is the community. The authors argue, “Environments can either promote health and well-being or be a source of stigma” (Baral et al. 2013:3). The third level of influence encompasses public policies and laws that either promote prevention or decrease the effectiveness to promote prevention, and the fourth level of influence is the HIV epidemic stage, or the actual incidence and prevalence of HIV in a population (Baral et al. 2013:3-4). This model can be extended past HIV and can be applied to the social ecology of sexual self-efficacy in general.

In a 2009 study on female sex workers in Mexico, the authors compared condom use in women who worked in bars and women who worked on the street (Larios et al. 2009). They identified individual, interpersonal, and institutional factors that might impact the women’s sexual self-efficacy, much like Baral and colleagues (2013). They found that if women working in bars have access to condoms, they are more likely to use them. As for women who work on the street, if men offer monetary incentives to have unprotected sex, they are more likely to have unprotected sex (Larios et al. 2009). So, while there may be individual factors at play, such as

drug or alcohol use, the interpersonal (sexual network) level of influence plays a formative role in the decision of whether or not to use condoms.

Although the particulars of the levels of influence may vary by context, there are similarities between the models. By identifying who or what influences individuals, we can begin to understand decision-making processes. These concepts can be applied to understanding the levels of influence acting on young men in the Mississippi Delta that impact their sexual self-efficacy.

WELFARE REFORM AND SEXUAL EDUCATION POLICY

In 1996, Congress passed a controversial but bipartisan welfare reform act (Personal Responsibility and Work Opportunity Reconciliation Act or PRWORA), which held people in poverty responsible for their own financial situations. Part of the legislation addresses teenage pregnancy and sexual education, requiring that mothers on welfare would have to disclose information about the fathers of their children, so that the fathers could be held financially responsible for the children (Lefkovitz 2011:614). While this policy had good intentions, it capitalizes on the stereotype that black men need to be tracked down and held accountable for their perceived promiscuity. In turn, black men might feel like a third party between black women and the government. Ultimately, this leads to a culture capable of “punishing working-class black male sexuality and eliminating the government’s responsibility to care for black women and children” (Lefkovitz 2011:614).

Across all races, children born into female-headed households are more likely to live in poverty than those with a father present (Sawhill 2006:49). “Unmarried mothers tend to be younger and more disadvantaged than their divorced counterparts. As a result, they and their children are even more likely to be poor” (Sawhill 2006:51). In short, unwed motherhood,

particularly teenage motherhood, is positively correlated with poverty. To many, including members of Congress, a simple solution to reducing poverty was reducing teenage pregnancy. So, as part of a much larger welfare reform act, the PRWORA sought to reduce the rate of teenage pregnancy through promoting traditional family values rather than contraception.

Furthermore, for decades, among developed countries, the United States consistently had the highest rate of teen pregnancy and transmission of sexual diseases and infections. To combat this, federal government leaders decided to support abstinence-based sexual education as a way to reduce both poverty and teenage pregnancy (Stranger-Hall and Hall 2011).

The logic for these programs stemmed from real concerns. After the so-called “sexual revolution,” people became more comfortable talking about sexual issues, which suddenly seemed more and more prevalent in the second half of the twentieth century. For example, teenage pregnancy became a social concern in the 1970s and 1980s, and the AIDS epidemic of the 1980s alerted many to the dangers of sex (Gresle-Favier 2010:414). In addition, Americans started to more openly discuss issues like pedophilia and sexual abuse, especially in the 1980s and 1990s (Gresle-Favier 2010:416). In many ways, sex seemed dangerous. Deviant sexuality, especially sex outside of marriage, was seen as a threat to a healthy and prosperous society.

There is a body of literature arguing that abstinence, or delaying sexual debut, may work to young peoples’ benefit. In a study published in 2009 entitled “The Effect of Religion on Risky Sexual Behavior Among College Students,” the authors found that respondents who identified as religious had a narrower idea of when sex is appropriate (Simons, Burt, and Peterson 2009). They also found that less religious respondents had more sexual partners (Simons et al. 2009:479). Additionally, the longer a person waits to have sex, the more likely they are to have

positive feelings about sex and fewer sexual partners. The authors believe that delaying sexual activity is important because (Simons et al. 2009:480),

[E]arly sexual debut and multiple premarital sexual partners can potentially launch an adolescent on a troublesome life course trajectory of cumulative disadvantage (e.g., acquisition of a sexually transmitted infection, unplanned pregnancy and marital instability).

These findings suggest that teaching young people to delay their sexual debut can contribute to a healthier, more advantageous life. In a related article, “Not Ready for Sex: An Endorsement for Adolescent Sexual Abstinence,” scholars argue that adolescents are not cognitively prepared for the emotional undertaking that is sex (Abbott, White, and Felix 2010). In fact, they see premarital sex as having a negative effect on “self-discipline, personal goals, and safety and health concerns” (Abbott et al. 2010:171). While these authors’ opinions may be unpopular with other scholars, the reality exists that premarital sex can be risky.

Of course, there are advantages to adolescents practicing abstinence. If young people abstain from sex, they are less likely to become pregnant, develop an infection, or contract a disease. However, educating young people about sex will prepare them to reduce risk and plan for the future when they do initiate sexual activity at whatever age.

Though the PRWORA (1996) was passed during Democrat Bill Clinton’s presidency, it takes a very conservative stance on poverty. The law may have been a bipartisan achievement, but it was not without criticism. Arline T. Geronimus, a public health professor at the University of Michigan, published an article in 1997 that challenges the assumptions and morality built into the new law. Her point of view is notable in that she sees poverty related issues as structural

problems rather than personal, moral failings on the part of those in poverty. She suggests that the poverty rates of teenage mothers could be more accurately attributed to their socioeconomic status before pregnancy than the pregnancy itself (Geronimus 1997). In other words, poverty is the problem, not teenage pregnancy. If the United States could reduce poverty, there would likely be a decrease in teenage pregnancy.

One of Geronimus' other major criticisms of PRWORA is the bill's expectation that all Americans will make the same life choices. She reads PRWORA as a vehicle for social control rather than an attempt to improve peoples' lives. She notes that previous attempts to lower the prevalence of teenage pregnancy had focused on the burden teenage mothers place on the taxpayer (Geronimus 1997). PRWORA was unique in its strong moral agenda, taking the position that it is good, right, and patriotic to work, and if a person is not working, they are not trying hard enough. By extension of that, this law asserts that young women who have children alone may not have the time to work, and those children are not living in the best environment to help them succeed, and that is "wrong." Geronimus suggests that to understand issues regarding poverty, policy makers need to be cognizant of the needs of those in poverty, not of the moral expectations of people who are not in poverty.

Another critique of abstinence education is that it does not address the scope of human sexuality. An abstinence-based sexual education upholds gender and sexual stereotypes by often completely ignoring the needs of gay and lesbian youth. Accordingly, "This distribution of errors and misinformation ultimately harms youth because they are unable to make informed sexual choices" (Weiser and Miller 2010:414). Not having access to sexual health information pertaining to lesbian, gay, bisexual, and transgender (LGBT) needs could keep these youth from understanding their sexuality and preparing them to have safe sex.

Others take issue with the ways in which abstinence education pressures young people into having exclusive, monogamous relationships that are intended to lead to marriage, when it is then permissible to have sex. In these cases, an abstinence-based sexual education might not be as effective because the students already feel like such a narrow view of human sexuality does not have room for them, and they may see such a curriculum as not being tailored to them, so they may not feel the need to listen. Sexual education, in order to reach all adolescents, should address a wider range of sexual topics. A more comprehensive sexual education might help young people decide what their boundaries are and what sexual health means to them. Those types of factors contribute to one's sexual self-efficacy.

Evaluation research (United States House of Representatives Committee on Government Reform-Minority Staff Special Investigation Division 2004), has shown that over time, abstinence-based sexual education was not accomplishing what it was meant to. The House of Representatives (2004) released a report on non-comprehensive sexual education programs. For instance, an abstinence-only or abstinence-plus sexual education intimidates young people by showing graphic images of sexually transmitted infections so that students fear sex. When they overcome this fear, they are left unequipped to have safe, responsible sex. Thus, recent data on non-marital births and abortions indicate that the strict welfare reform policies like the PRWORA had “only a weak, and inconsistent, impact on the reproductive behaviors of women” (Kelly and Grant 2007:897).

After the federal funding for abstinence-based sexual education expired in 2009, President Barack Obama made strides in his first term to support schools that provide a comprehensive, medically accurate sexual education (Weiser and Miller 2010:412). A “comprehensive” sex education model still discusses the benefits of abstinence, but it also

instructs students on ways to prevent pregnancy and sexually transmitted diseases and infections. However, these are still just guidelines, and the curricula are relatively new. Perhaps continued efforts and more honest, progressive attempts to teach young people about sexual health, in many forms, will yield lower teenage pregnancy rates and increase sexual health overall.

Many schools have adopted these comprehensive policies, but Mississippi holds fast. Schools in Mississippi were recently given the choice to teach an “abstinence-only” or “abstinence-plus” approach to sexual education. In 2012, of all the 155 school districts in Mississippi, 81 had chosen to teach abstinence-only. Seventy-one were teaching abstinence-plus, and three school districts were teaching a combination of the two, depending on the age of the students (Pettus 2012). These are some of the most conservative policies in the country, and compared to other countries and states in the United States, they are also considered among the most outdated. Abstinence-plus differs from abstinence-only education in that it teaches more about sexuality but never fully addresses intercourse and birth control. A study on the correlation between abstinence-only education and the rate of teenage birth suggests that “The more strongly abstinence is emphasized in state laws and policies, the higher the average teenage pregnancy and birth rate” while states with abstinence-plus education yield a lower teenage pregnancy rate (Stranger-Hall and Hall 2011:6). Moreover, the Mississippi State Department of Health reports that the percentage of high school students who had ever learned about HIV/AIDS in school had significantly decreased over the period from 2001 to 2011 (Office of Health Data and Research 2013:21). This time period coincides with the change in sexual education curricula and demonstrates the effects of abstinence-based education.

The 2011 Mississippi Youth Risk Behavior Survey, part of the Centers for Disease Control and Prevention’s national study, reports that 58% of Mississippi high school students

reported ever having had sexual intercourse. Of those students, 35% did not use a condom the last time they had sexual intercourse, and 85% of sexually active females were not using birth control pills, injections, rings, or implants during the last time having sexual intercourse (Office of Health Data and Research 2013:20). These numbers indicate that sexual activity among Mississippi youth may increase the risk of becoming pregnant, and currently, Mississippi combats this risk with ineffective abstinence education curricula to discourage high school students from having sex.

Mississippi policy makers seem to hope that parents will play a large role in educating their children about sexual health. However, nationwide, parents would prefer their children receive a more comprehensive sexual education, rather than an abstinence-only education (Weiser and Miller 2010:415-416). Parents may not be sure how to educate their own children about sexual issues.

Whether parents are aware or not, they are considered a major determinant of young peoples' understanding of gender roles (Epstein and Ward 2011), but they are not often the party who teaches children and young adults about sex (Epstein and Ward 2008). In many families, parental communication about sex is limited by gender (Kirkman, Rosenthal, and Feldman 2005). So, fathers talk more to their sons about sex than their daughters, and mothers talk about sex more to their daughters than their sons. If a young man lives in a household headed by a woman, he may be less likely to get a comprehensive education about sex in the home. This is particularly important because Mississippi has the highest rate of female-headed households in the country. Ten percent of households in Mississippi are headed by a female with children under the age of eighteen (Lofquist et al. 2012:10). Accordingly, this would place young men in Mississippi at a disadvantage when it comes to learning about sex in the home.

While policy makers are assuming that parents will be the primary educators of sexuality, it appears that parents are often not providing enough education to adequately prepare young people to make wise choices about their sexual health. Perhaps parents are uncomfortable talking to their children about sex, or maybe parents feel that telling their children too much about sex would lead to their children engaging in more sexual behavior.

Peers also play a large role in an adolescent's sexual development. We must consider the messages young men are receiving from their peers and the media, and the way these messages form their opinions. A recent study found a relationship between objective and perceived knowledge about male condom use (Rock et al. 2005). Objective knowledge includes the hard data and facts about condoms. Perceived knowledge encompasses the experiences and word of mouth that young people encounter. Objective knowledge alone, usually from schools or health care professionals, does not always influence condom usage. Rather, students who report having high levels of both objective and perceived knowledge about birth control are those who are most likely to report using birth control (Rock et al. 2005). Both objective and perceived knowledge are part of sexual self-efficacy.

So, peer influence does play an important role in condom usage. Students do not just need education from schools; they also need a culture of acceptance surrounding sexual health and birth control usage. In a 2001 study, a group of educational psychologists attempted to correlate the source of students' sexual education to their sexual attitudes, behaviors, and knowledge (Somers and Gleason 2001). The sources students learned from were schools, peers, media, parents, and sexual health professionals. Some of the topics the study addressed were menstruation, the reproductive system, the father's role in conception, birth control usage, teen pregnancy, sexual transmitted diseases, and the morality of pre-marital sex. Findings indicate

that increased education does not directly influence young people to participate in more sexual behaviors nor does it lead to more liberal attitudes about sex than peers who receive less education about sex (Somers and Gleason 2001).

Mississippi is arguably a state that provides a very low level of sexual information to its students. As young people start having sexual intercourse, they may not have adequate information to help them prevent pregnancy and to avoid the “troublesome life course trajectory of cumulative disadvantage” (Simons et al. 2009:480). They are not given the tools to decide for themselves what sexual health means to them, or what methods of birth control are the most feasible for their lives.

Providing more comprehensive sexual education could help Mississippians improve their lives, especially in the context of high poverty and racial inequality. In Mississippi, 12.8% of whites lived below the poverty line from the years 2007-2011, whereas 35.7% of black Mississippians lived below the poverty line (Macartney et al. 2013:1-2). Nationally, 11.6% of whites lived below the poverty line, and 25.8% of black Americans lived below the poverty line (Macartney et al. 2013:1-2). Furthermore, as of 2010, 32.5% of children in Mississippi lived below the poverty line (Macartney 2011:9). Notably, 18.6% of white children in Mississippi lived below the poverty line, while 48.6% of black children in Mississippi lived below the poverty line (Macartney 2011:10). These numbers indicate that black Mississippians, particularly black children and young people, are at a particular disadvantage economically.

SEXUAL SELF-EFFICACY

Self-efficacy is a concept operationalized differently across cases. There have been studies that attempt to measure sexual self-efficacy. In one 2003 study, the authors define contraceptive self-efficacy as “the conviction that one can control sexual and contraceptive

situations to achieve contraceptive protection. It refers to motivational barriers or enhancers to contraceptive use among sexually active and potentially sexually active individuals” (Longmore et al. 2003:47). When measuring contraceptive-self efficacy among adolescents, from 7th grade to 12th grade, researchers found that adolescent girls report a slightly higher level of contraceptive self-efficacy than adolescent males. Also, the authors find that more privileged adolescents report a higher level of contraceptive self-efficacy, so adolescent males from low-income families may be at a disadvantage when it comes to feeling comfortable with birth control (Longmore et al. 2003).

However, some researchers argue that male teenagers seem to be more experienced with acquiring and using condoms than females. Although both young men and women report engaging in equally risky sexual behavior, a study from 1993 suggests that young men are more likely to use condoms than young women (Witwer 1993). Perhaps this is due to gendered attitudes about male sexuality. Males may hear about condoms because they are expected to use them. Even before the widespread dissemination of abstinence-based sexual education, the study’s author found that young women felt less comfortable obtaining methods of birth control. Interestingly, young men were more likely to say that using a contraceptive method like a condom would negatively affect the sexual experience, and young men were also more likely to report that their partners were more likely to suggest not using birth control (Witwer 1993). Young women may know about sex and birth control, but their male partners may be the determinants for birth control usage, at least in regard to condom use.

In a study of high school students, males reported a lower sexual self-concept, which is made up of their anxiety and self-esteem, and lower sexual self-efficacy, when asked to rate themselves (Rostosky et al. 2008). Additionally, the authors found that black/African American

males reported higher levels of sexual anxiety and lower levels of sexual self-efficacy than their white or female counterparts, which they were not expecting (Rostosky et al. 2008:281). They argue that having high sexual self-esteem and “feeling positively about oneself as a sexual being may facilitate the development of adaptive sexual self-efficacy beliefs” (Rostosky et al. 2008:284). These findings suggest that positive sexual attitudes may increase sexual self-efficacy, which would encourage adolescents to think carefully about their sexual health. If a young person were to engage in sexual activity but had high sexual self-efficacy, he or she might be more likely to practice safe sex and to seek out routine check-ups for HIV and sexually transmitted diseases and infections, thus further increasing his or her sexual self-efficacy.

A more recent study confirms that being knowledgeable about condoms influences an individual’s success in negotiating condom use (French and Holland 2013). The authors sampled men and women from an Introduction to Psychology course at a southern California university for participants (French and Holland 2013:50). They found that women with high “condom use self-efficacy” were more likely to withhold sex than women with low condom use self-efficacy or men (French and Holland 2013:56). This supports the notion that women are often held responsible for contraception and that men are more likely to engage in risky sexual behaviors. The authors argue that being able to successfully negotiate condom use with a partner is the best indicator of condom usage (French and Holland 2013:57). In order to feel comfortable negotiating condom use, a person needs to be knowledgeable and comfortable enough with the idea of using condoms to make a case to an ambivalent or unwilling partner. By extension (Pearson 2006:622),

Adolescents who felt a sense of control over their lives, both in general and in sexual situations, were more likely to abstain from

sex or to use condoms if they did engage in sexual intercourse ... young people who believe that pregnancy or sexually transmitted infections are not the result of luck or chance but can be prevented by their own actions may make a greater effort to take precautions against them.

When discussing outside influences on a young man's decisions, we must not rule out his agency and/or complacency in matters of contraception use. Many young men are aware of what teenage parenthood entails. Many are born to teenage parents (Davies et al. 2004; Sipsma et al. 2010), which would shape their understanding of parenthood and adulthood, and in turn, their sexual self-efficacy.

Though teenagers are not seen as legal, autonomous individuals, they still have the power to make decisions with serious consequences. The National Research Council and Institution of Medicine released a report in 2000, arguing that children play an active role in their own development and that they want to learn. However, children's environments can influence their decisions (Shonkoff and Phillips 2000). Researchers suggest that the government should be responsible for creating programs that meet the needs of at-risk children based on the obstacles they are likely to encounter.

With this in mind, Mississippi's situation seems even more complicated. Half of children in Mississippi are born out of wedlock, compared to a third, nationwide (Sawhill 2006:51). And again, the rates of teenage pregnancy in the United States surpass those of other developed countries. From this literature, it is clear that cultural and educational variables affect sexual attitudes and sexual behavior. More specifically, education, family, and peer influence may impact sexual self-efficacy.

Seeing all of this, we can determine where important gaps exist in literature about sexual self-efficacy. While there have been a few studies on education's role in teen pregnancy or HIV prevention, nothing seems to be specifically geared towards Mississippi (Denny et al. 2012; Santelli et al. 2007). With teenage pregnancy rates as high as Mississippi's, it is a wonder that more attention has not been given to the matter. In order to better understand and address the issue of sexual self-efficacy in the state of Mississippi, we must take a close and careful look at the different spheres of influence surrounding young men in the Mississippi Delta.

GENDER AND RACE

For this project, gender and race will be understood as the result of societal forces that act upon individuals and impact their behaviors. Birth control, for instance, may commonly be seen as a "women's issue," rather than a general health issue. Since the vast majority of birth control options involve women's bodies, women in relationships are often in charge of making decisions about birth control (Fennell 2011). Because of this, men may feel absolved of the responsibility to know about birth control, so in sexual relationships, female partners are more likely to be the ones prepared to make decisions about birth control methods. However, the female partners may look to their male partners for guidance. Furthermore, males may have strong beliefs about the appropriateness of particular birth control methods as well as their own desires.

Birth control, pregnancy, and parenting are all seen as "women's issues," and therefore gendered. Since the introduction of the contraceptive pill, contraception has become feminized (Fennell 2011; Weber 2012). When an accidental pregnancy occurs, women are seen as the party at fault. By asking the right questions, we can determine where young people learn that women should be solely responsible for these heavy burdens.

In a study on young African-American fathers in Alabama, the authors argued: "...very little attention has been given to the role of...male sexual partners...Males are believed to be a critical behavioral mediator for young women" (Davies et al. 2004:418). In a sexual relationship, men may make many decisions about sexual activity. So, if we can ensure that both young men and women are familiar and comfortable with birth control, we may find an increase in condom usage over time.

Race is also a crucial part of this study. I use the term race to describe the "sociocultural phenomenon conceptually separated from human biological variations" (Smedley and Smedley 2011:19). Race is used in a cultural context, not biological. Negative, racist opinions about teenage pregnancy and government assistance are prevalent, especially in the South. Dating back to slavery, there exists a long history of regulating black male sexuality (Nagel 2003). These attitudes create a barrier to addressing the real needs of minority populations, in this case, of black Mississippians.

In a study on black fathers, Julia Jordan-Zachery argues that the termination of welfare support will not yield happy married couples raising a child together (2009:200). To try to best understand the needs of black and Latino fathers, she performs evaluation research on the fatherhood and marriage promotion programs aimed at these at risk populations and interviewed participants of the programs to see if their lived experiences are accounted for in the program curriculum. By interviewing the men in the programs, she was hoping to "give voice to those who are often silenced and are rendered invisible in the policy making process" (Jordan-Zachery 2009:201).

Jordan-Zachery points out that fatherhood initiative programs are written by and for "Euro-American middle class families" (2009:201). Policy makers might assume that low-

income black males lack the knowledge of how to be a father because these new fathers were statistically more likely to have been children without a father-figure present (Jordan-Zachery 2009:214). To try to reach as wide an audience as possible, the curricula focus on basic strategies for parents, addressing issues like patience and problem-solving with both children and co-parents.

Her findings are important. She found that involvement in the programs may have improved the fathers' self esteem and helped them feel more prepared to parents; "The men argued that they are better dads because they are now better men" (Jordan-Zachery 2009:212). However, because the programs are not specifically built around the lives of low-income black fathers, the fathers are still discouraged with the child support system. She finds that the child support is a major hindrance in a father's relationship with his children and the co-parent. Once becoming fathers, men may be driven away from their children because of the demanding nature of the child support system (Jordan-Zachery 2009:208-209). This system consistently assumes that mothers are the fitter parents and that a father's major role in his children's lives should be economic support. Because of this, fathers may begin to see their children as a burden rather than trying to forge relationships with their children, or restore relationships with the co-parents.

Gender and race are integral perspectives for this thesis. The consequences of the socially constructed realities of gender and race shape the way men and women interact with each other, and the way we conceptualize sexuality.

CONCLUSION

When exploring issues of sexual health in the Mississippi Delta region, I utilize the social ecological model to understand young men's sexual self-efficacy. In particular, I consider the

overall health outcomes in the Mississippi Delta, the education policies that impact how young people learn about sex in school, and the socially constructed intersections of race and gender.

III. METHODS

To address the questions of where and how young men learn about sexual health and how they feel about birth control, I used an exploratory qualitative research approach. My sample was focused on young men living in the Mississippi Delta region of northwest Mississippi, a rural area with high incidences of teenage pregnancy and other poor health indicators. My research consisted of qualitative interviews and a focus group, combined with a short demographic questionnaire.

I interviewed 27 men from the ages of 18 to 30. I also conducted one focus group with seven participants in the same age range. This age range was ideal because the participants were young enough to remember their high schools' sexual education programs but old enough to have had time to reflect on what they learned and were able to discuss their own experiences. All 33 participants completed a sociodemographic questionnaire that asked questions about their age, racial identity, educational attainment, religious involvement, and occupation.

The setting for this study was Morrystown (pseudonym), Mississippi, the county seat of a Mississippi Delta county. Bordering the Mississippi River, Morrystown is part of the larger Mississippi Delta region. According to the Decennial Census, the population was around 26,000

in 2010, and it is experiencing a steady rate of population loss (United States Census Bureau 2010). In terms of racial composition, the county is approximately three-quarters black, and close to one-quarter white (United States Census Bureau 2012).

The focus group and interviews all took place in Morristown between July and October of 2013. The first two interviews and the focus group were conducted at a community health center. For the focus group, I was assisted by a co-facilitator, a black male in his twenties, living in Morristown and working at the health center. He was instrumental in the early stages of recruitment.

After the initial focus group, my co-facilitator suggested a few locations for interviewee recruitment: two barbershops, a fire station, local parks and basketball courts, and the student union at the local community college. All of my subsequent interviews occurred at these places. I found that participants were much more willing to open up to me about their experiences and opinions when they were in familiar settings. Some would even offer to recruit their friends and family members for me. Overall, I used a combination of purposive and convenience sampling.

The focus group was particularly valuable because I was able to see how young men in the Delta talk about sex in front of and with each other and what kinds of issues were fresh on their minds. In a way, it set the tone for the interviews I conducted afterwards because being in a group setting relieved some of the tension that people might feel about talking about sex with strangers.

Interviews provided the majority of my data. I found that participants were largely forthcoming and willing to talk to me about what some might consider sensitive topics. The interviews allowed participants an opportunity to tell me stories and to tell me personal details that they may not have felt comfortable sharing in groups. I did not find that having a black male

co-facilitator for the focus group changed the conversation very much, though I am sure as a white woman, who is not originally from the Delta, my presence may have been somewhat unsettling to some participants. To others, I think I was a more welcoming presence that encouraged them to share some of their personal opinions and stories with me.

For both the focus group and interviews, I used a list of questions, which had been reviewed and approved by the University of Mississippi's Institutional Review Board. I asked questions about where the respondents received sexual education and what kinds of things they learned. Then I asked questions about their condom usage and their opinions about birth control. By asking participants broadly about sexual education, I gave them time to warm up to me before answering very personal questions about their own personal sex lives. These questions helped me make connections between attitudes about sex and birth control with the high teenage pregnancy rate in the region. The participants' knowledge and experience were shaped by school curriculum, parental involvement, communication with peers and partners, and first hand experience (see attached Appendix D).

With participants' consent, I took audio recordings of the focus group and 24 of the 27 interviews. I also took detailed notes with pen and paper. I later transcribed the interviews and provided pseudonyms to all the participants that will be used henceforth in this document. While reading through my transcripts, I identified recurring themes and coded content with special attention to particular issues, such as what respondents learned in sexual education, their reported condom usage, and any feelings of mistrust that they communicated. My major findings, presented in the following chapter, are grouped together under the headings sexual education, self-efficacy, gender, and race.

IV. FINDINGS

The interviews, focus group, and sociodemographic questionnaires provide the basis for my findings. In this chapter, I report issues relating to sexual education, self-efficacy, gender, and race. These findings complement existing literature on sexual self-efficacy and can be used to understand and improve sexual health in the Mississippi Delta region.

SOCIODEMOGRAPHIC CHARACTERISTICS

The average age of the 33 participants was approximately 22 years. Nearly 88 percent (n=29) of participants identify as black or African-American. Six percent (n=2) identify as white or Caucasian, and another 6 percent (n=2) identify as mixed race. In terms of religious affiliation, slightly more than 60 percent (n=20) of the participants identify as Christian. Of those Christians, 5 percent (n=1) identify as a member of the Church of God in Christ denomination, 5 percent (n=1) identify as nondenominational, and 45 percent (n=9) listed that they are Baptist. The other 45 percent (n=9) of religious respondents simply wrote “Christian.” Another 40 percent (n=13) of respondents said that they had no religious affiliation or chose not to answer. Only one participant reported being married, and 30 percent (n=10) of the participants reported they were fathers on the demographic questionnaire.

In regard to educational attainment, approximately 6 percent (n=2) reported having not finished high school. Slightly more than 39 percent (n=13) responded that a high school degree was their highest educational attainment. Just over 45 percent (n=15) said that they had completed some level of college coursework. Approximately 6 percent (n=2) hold an associate's degree, and 3 percent (n=1) hold a bachelor's degree. There were a variety of occupations listed. Some of their occupations, as listed, are fire fighter, carpentry, construction, barber, car washer, military, manager at a fast food chain, dietary aid, irrigation, student, welding, truck driver, brick mason (See Appendix A). Please note that their age, number of children, religious affiliations and occupations were fill-in-the blank answers. Their race, marital status, and educational attainment responses were selected from a list.

SEXUAL EDUCATION

Research participants did discuss learning some information about sex at school through engagement with teachers and peers. This was followed in prevalence by information provided by family members. Although the social ecological model notes these dimensions of influence, I was not expecting the variation in sexual education experiences among participants. The wide age range (18-30) represented the policies both before and after the start of abstinence-plus education in Mississippi, but it seems as if their experiences were largely dependent upon their teachers. Lavon¹, for instance, relayed a positive experience, saying that his teacher was a “fun” person. When I asked him what kinds of information his teacher would provide on birth control, he responded “...abstinence, don't have sex. That's the best birth control...if you're gonna do it, take it on birth control. Make sure you keep yourself healthy.” His teacher also told them, “no one should be ashamed to buy protection if you're not ashamed to have sex,” and he said that

¹ All given names are pseudonyms

this kind of sexual education, teaching abstinence first and then safe sex, might discourage about a third of high school students from having sex. Lavon discussed his sexual education in a positive way, and I believe this had to do with his teacher whom he trusted and admired.

Xavier, on the other hand, had a health teacher responsible for providing the sexual education, who was religiously motivated in her approach. He said, “She would be like, ‘Y’all are too young to be doing that anyway. Y’all supposed to wait til y’all married. That’s what they say in the Bible.’” When I asked him what he thought of abstinence education, he responded, “Abstinence? I don’t understand that. I can’t be abstinent. I cannot. I absolutely can’t...I won’t be the same person.” However, he felt that abstinence-based education could discourage young people from having sex, “because sometimes they get scared and they be like, ‘Oh I don’t want this to happen to me,’ especially at an early age.”

Xavier’s experience is much different from Lavon’s in that Xavier’s sexual education had a religious bias. Though his teacher said that the Bible would not approve of premarital sex, he thought it was the fear of pregnancy and disease that might be the primary motivator for young people to abstain from sex. While Lavon and his classmates might also fear unplanned pregnancy and disease, they might feel more comfortable talking about sexual health topics or asking adults or professionals for advice because their teacher made them feel comfortable in class.

Terrell, Kendrick, and Vince separately told me that their sexual education teachers would ask the class directly who was sexually active. Terrell explained, “They would like see if you were having sex or not...They’d ask if you use protection, had you ever caught a disease or something.” When I asked the three participants about this, none of them seemed particularly

uncomfortable with this kind of discussion in a classroom in front of their peers. In fact, it seemed like they had a fairly open dialogue with their teachers about their sex lives.

A few participants told me that teachers would talk to females and males separately. Both females and males were told to wait to have sex if they could, but females were specifically told to talk to their doctors about birth control if they were going to have sex, and males were told to wear condoms. As Moses talked to me about his experiences in sexual education, he reported that his teachers placed a lot of the responsibility on the girls. He said, “They just always told us that it’s always best for the girls, especially the girls, to be taking birth control.” While it is not a bad idea for young women to find a suitable birth control method for themselves if they are sexually active, this kind of message might absolve the responsibility of young men to use condoms if they are not told more in-depth about the benefits of wearing condoms.

While many participants said that their teachers provided information about sex, birth control, and condoms, some thought that parents, specifically, should be the ones responsible for telling young people about sex. As Jay put it,

I believe you have a better understanding of it if your parents taught you because mainly schools are so fast-paced now that they don’t take no time to really teach the kids about it. That’s why we got so many drop-outs because kids are getting pregnant so early.

I asked a question specifically about whether or not participants think abstinence education discourages young people from having sex. Some participants said that young people are going to do whatever they want, so abstinence education probably would not dissuade the majority of students from having sex. Cole brought up a few interesting points as he was telling me that he does not believe abstinence education discourages young people from having sex;

“They gonna do what they wanna do regardless. They’re doing it before sex education, so what makes them gonna stop afterwards when they ain’t brought up in the home like that?”

What Cole may not realize is that many young men *are* being taught about sex in the home. Since most of the participants expressed that their families did talk to them about sex, there seems to be a disconnect between knowledge and preparedness. Participants reported that they talked to their mothers, fathers, uncles, brothers, and sisters about sex, many times before they learned about it in school. Young men have been given condoms by their family members or at the health department and been told how to use them, but it is clear from the data on the rates of teenage pregnancy and sexually transmitted infections that young people in the Mississippi Delta region are having unprotected sex. Among participants, there is a general understanding that condom usage is an issue in the community, though they do not see themselves as a problem. Winston told me, “I see a lot of people now, young people, that...got diseases and stuff from not using a condom.”

Cole went on to say that high school is often too late to begin formal sexual education in schools; “Ten, eleven. There’s girls getting pregnant at twelve...They saying you gotta wait to have sexual education until you get to high school, but by the time that happens, you pregnant, got a disease that you didn’t know nothing about until you got it.”

In contrast to the other participants, Wilson had been home-schooled with a very religious upbringing, and his parents had always told him to wait until he was married to have sex, but when I asked him if he thought abstinence education discourages young people from having sex, he replied,

I’m starting to lean more toward the safe-sex side because...a lot of teenagers now are really rebellious... and if they’re not taught

safe-sex and just taught not to have sex...they're going to go out and do it, and they don't know what kind of protection or what to use or anything.

By not knowing what protection to use, or how, these young people are at a disadvantage, and Wilson realizes this. In this case, he is arguing that knowing more about condoms and other forms of contraception can increase the likelihood that a person will have safe sex.

Other participants were more optimistic about abstinence education and believe that some students may listen to lessons about abstinence and may think twice before engaging in sexual behavior. Xavier told me that while abstinence education may not have dissuaded many, like himself, from having sex, he mentioned there were students who actively practiced abstinence, and he thought it was mostly practiced by girls.

SELF-EFFICACY

This project uses sexual or contraceptive self-efficacy as a framework for understanding young men's attitudes about birth control. I define contraceptive self-efficacy as young men's knowledge, comfort, preparedness, and confidence regarding condoms and sexual health. This is not so much an external, quantitative measure of their objective knowledge as it is a consideration of their viewpoints and the way they would describe their contraceptive self-efficacy. So, I was not only concerned with what or how much the participants knew objectively about sex and contraception, but also how they approached what they already knew and their perceptions about sex.

When asked if they feel comfortable using condoms, most participants said that they do. Comfort and a partner's perceived birth control status are the main reasons participants choose not to wear condoms. Many say that they have been told by their teachers and family members to

always wear protection. It is clear that this idea has been ingrained in all of them. Condoms, in this case, are synonymous with “protection,” and there is a good deal of fear from what having unprotected sex might bring. Wearing condoms allows these young men to control their sex lives, and essentially, protect themselves from others because, as Andre put it, “you don’t know what they got.” There is a sense of individualism about these young men’s sex lives. When talking about their partners, they were more likely to discuss fears rather than trust or intimacy.

None of the participants said that they would *not* feel confident using a condom. Only two participants told me they were virgins, and one of them even said that he would feel comfortable with condoms, although he received no formal sexual education. However, participants only had a vague idea of what other forms of birth control are and how they work. Perhaps this is due to the way teachers talk about birth control to students, when they talked about it at all.

In terms of sexual self-efficacy, these young men exude confidence, but they may not have the necessary objective knowledge or preparedness to be in complete control of their sexual health. Though none of them outright said that they felt ill-equipped, respondents did sometimes indicate an interest in learning more. Malcolm told me, “I wish that I could have learned more about birth control in general because they have patches now that females wear, and I wish I could learn a little more about condoms.”

Some participants choose not to use condoms with long-term partners, maintaining that there is no need. Jay was expecting his second child when I interviewed him. He and his wife were not using condoms during her pregnancy because there was “no need.” When I asked him if they were considering birth control options after their child is born, he responded, “Nothing but her tubes tied.”

Another participant, Andre, used similar logic. When I asked him how he felt about condoms, he responded, “If you’re in a relationship, I don’t see no need to use them... You know, for a one night stand, or something like that, you should use them.” Here, Andre is demonstrating that he knows the advantages and disadvantages of wearing condoms, and he feels confident in his ability to distinguish when it is appropriate to wear a condom and when he might feel like he could go without wearing one.

Moses said, “When you talk to someone for a certain amount of time, they may feel like it’s uncomfortable. I mean, it’s comfortable to not have protected sex.” Again, Moses feels comfortable and confident in his decisions to wear condoms or to not wear condoms. Andre and Moses are displaying confidence in their sexual health, which is a very important part of sexual self-efficacy.

It seems that in committed relationships, men may be less likely to wear condoms or consider using birth control at all. If they feel like they trust their partner, they might take the chance of having unprotected sex in order to be more comfortable. Participants seemed like they would rather have children inside a committed relationship than outside one because of their fear of women using them for child support.

A few participants choose not to use condoms even if their partners are on birth control, but most express mistrust of other forms of birth control, that nothing is foolproof. Though 30 percent of participants are fathers, they never talked about fatherhood in great detail. Cedric, however, felt comfortable enough to tell me that he wishes he “had learned more about that people can still get pregnant off it [birth control] because I have a little daughter. She [his partner] was on the depo shot.” Similarly, Lewis said, “After I made my first mistake, getting my

girlfriend pregnant in high school, made me think...use a condom...instead of just unprotected sex.”

Cedric and Lewis both casually mentioned fatherhood, and both times, they mentioned it to point out how they wished they had known more about birth control. Perhaps part of participants’ fears and mistrust surrounding female birth control methods stem from their lack of objective knowledge about these practices and methods.

Participants said that they wear condoms when they are actually concerned about pregnancy and sexually transmitted diseases and infections, and this fear is exacerbated by the fear-based sexual education that some participants reported to having experienced. Winston said he wears condoms “to prevent AIDS, STDs, all that, pregnancy.” Some suggest that women lie about whether or not they use birth control, in order to get pregnant. These fears seem to encourage these young men to wear condoms, not concern about the child per se, but rather in response to what the potential mother is doing. This will be discussed later in greater detail.

Overall, participants talked like they were in complete control of their sex lives. No one ever admitted to contracting a sexually transmitted disease or experiencing serious negative consequences because of their sexual activity, and I think this is one of my most compelling findings. They were not willing to discuss anything that would admit weakness, fear, or shame on their parts.

Some participants did ask me questions, particularly about diseases. Malik asked several questions. As we were discussing sexually transmitted diseases and HIV in the area, he asked, “Can you still have sex with them [women] and not catch it?...You can treat it, but you still can have it forever, right?” From there, he started talking about other diseases, like herpes. He asked, “So if you have a sore on your lip from when you was a young baby? They said it’s herpes but is

that forever?...So if a woman got herpes on her lip, can you still talk to that woman? Can you catch it like she has it?”

Malik demonstrated a high level of confidence in his sexuality and never seemed nervous talking to me, yet I was surprised by how many questions about sexually transmitted diseases and infections that he asked. Again, this is a case of a young man presenting himself as sexually confident, but he lacked adequate sexual knowledge to make informed decisions to control his sexual health. In these instances, I would try to answer a few questions to keep the interview moving in a direction that would not distress him, but there were other times participants shared information with me that was not altogether factual, and in those instances, I chose not to say anything. Correcting them, I felt, might disrupt the interview process, and they might be more likely to censor themselves afterwards.

For instance, Ray told me that he does not always use condoms because he tries to be aware of his partners' cycles. He told me, “You gotta look at the fact that periods come at certain times of the month. You gotta. Sperm lasts three days, seventy-two hours, so three days before and three days after, I'm free to shoot.” While this strategy of avoiding pregnancy might work for some couples, many women do not have regular enough menstrual cycles to accurately predict when they are or not fertile.

These young men want to know more about sex. However, they do not seem particularly interested in birth control, and perhaps this is because they are not even aware of what to ask in regard to birth control since they have not received enough education on the topic.

GENDER

In the focus group and interviews, I found a considerable amount of gendered expectation and performativity. In the focus group, I asked participants how their families talked to them

about sex growing up. Darius responded saying, “There’s a difference between guys and girls,” to which Rodney responded, “My sister couldn’t even come out of the house. She got off the bus and went straight into the house.” Families are policing gender roles and sexuality, and these ideas are being reified in schools.

When the participants talked about female sexuality, they used language that indicates mistrust and even disgust for women in their community. A few men were very open with me about their attitudes about women and sexuality. As a female interviewer, I imagine that I impact the way they talk about women in front of me, possibly censoring themselves, but they also seemed to voice their opinions about women as if I would agree with them. This could be due to their perceptions of me as a white woman.

There is a general mistrust among the participants: mistrust of women, mistrust of condoms, mistrust of other forms of birth control. These young men felt strongly that there is much from which to protect themselves. However, this mistrust did not extend to teachers and healthcare professionals. None of the participants ever expressed questions about the validity of what they had been taught by teachers, nurses, or doctors.

Of the participants I explicitly asked if they would wear condoms even if their partners were on other forms of birth control, about 56% (n=13) said that they would. However, 35% (n=8) said that it would depend on the situation and the partner in question, and 9% (n=2) said that they would not wear condoms. One participant said he would not use them because of discomfort, and the other is married. Of those who said that they would always wear condoms, many said that this was in order to protect themselves and that you can never be too careful. Part of this was due to the mistrust they felt in regard to women and birth control.

Those participants who said that condom usage would depend on the situation were largely talking about their partners, how well they know them and how much they trust them. Cole was among those who said that his decision to wear a condom would be based on the partner. When I asked him what made two women different in that regard, and he responded,

Some girls that you come across, they want a baby. They want money. It's a whole bunch of things that would keep me from doing it [having unprotected sex]. Some girls try to get pregnant, so they can get child support, get money, things like that. Only time I have unprotected sex is if it's with a girl I know for a long time...If she comes onto you too quick, then you know that she's fast. Then you wanna make sure you wrap it up.

It is important to note that Cole was practicing abstinence at the time of the interview. He reported to having had many experiences with sexual intercourse but changed his mind. He believes that sex should be reserved for married couples for the purpose of procreation. Perhaps because of this, he has strict attitudes about who should be having sex and who should not. Among those who should not include unmarried women, so in his mind, an unmarried woman wanting to have sex must have some sort of ulterior motive.

Paul used the word "nasty" to describe why he would wear condoms every time. I asked him about the high rates of STIs and HIV in the Morristown region, and he responded, "...it's just nasty. You don't want to put your body in a harmful way like that." He uses condoms every time, even when his partners are on other birth control methods, because he seemed very afraid of infections, diseases, and HIV. He also voiced that schools should teach more about sex, particularly about condoms, to help young people protect themselves. He is slightly less

concerned about pregnancy, but he still said that he would not trust a woman who said she was taking birth control.

Cedric told me that he learned in sexual education that you should “always buy your own [condoms]. Don’t give them to some girl...cause some girls pop holes in them...Some be desperate, and you look at the fact that some just want babies.” Cedric heard in school that young women are actively trying to get pregnant, and he continues to believe it in adulthood.

When I was talking to Elliot, a recent high school graduate, he told me that his experience with sexual education was limited to learning about the reproductive system and diseases. I asked him how this form of sexual education made him feel about sex, and he told me, “...doing the early fornicating...you shouldn’t do it...don’t no one wanna be with somebody that’s been with everybody.”

Here, Elliot is placing the value judgment on the female partners, rather than saying that he, or people in general, should be discerning about their sexual activity. He argues that women who have had multiple sexual partners are undesirable; “That just nasty, I mean, that’s nasty. You know, just go out and just do it with no care in the world. Nasty.” Interestingly, another participant, Paul, also used the term “nasty” to describe sexually transmitted diseases. “Real bad about the situation [AIDS and STDs in Morristown] because it’s just nasty.”

Using strong language like this emphasizes Elliot’s mistrust for women, but also the ideas he has about female sexuality in general. It may be practical to avoid sexual partners who have had multiple partners themselves, but his language goes beyond that, making the case that these women’s characters might be at fault as well. These attitudes may stem from experiences in abstinence-based sexual education.

When I asked him if abstinence education discourages high school students from having sex, he said, “Not really...she gonna do whatever she gonna do, but I mean, it’s good to inform them, you know that, you shouldn’t be doing that until you get married or until you get with somebody you feel that, you know, that’s special.” Here, he even goes so far as to use a female pronoun when talking about not heeding the advice of abstinence education. Elliot may not have done this intentionally, but it gives some insight into how he thinks about sexually transmitted diseases and pregnancy, and where to place blame when these occur.

Xavier told me about one of his sexual education teachers who shared these attitudes about young women in the community with his entire class;

She usually be like, “We shouldn’t believe that what every girl say because majority of the girls will be like they on birth control just for you to go in them without the condom and get pregnant by you just to put you on child support and stuff like that.”

Xavier said that the girls in his class were not offended by the teacher saying this because “they knew what it was.” Having a female teacher say these kinds of things solidifies pre-existing stereotypes these young men, like Cole or Xavier, might already have about women in their community, and it likely affects young women’s ideas about themselves.

The participants never discussed promiscuity in males, and male sexuality was never questioned. Malik can say, “I liked to learn about sex because I love sex,” and Xavier can say, “Oh I love it. I just could talk about it all the time.” We can contrast this to Elliot’s attitudes about women being “nasty” because they have multiple sex partners. Some participants said that they enjoy having sex, but they never addressed other males who are sexually active and potentially spreading diseases or infections in the community. None of the participants identified

themselves as anything other than heterosexual, so they would only need to be concerned with the sexual health of their potential female partners, but it was notable that none of them discussed the sexual health of other men specifically.

RACE

Though most participants were very open and forthcoming when discussing their ideas about gender and sexuality, only one participant spoke directly about race. In this project, race has served largely as a context rather than a conceptual focus. As a researcher, I was cognizant of racial issues in Mississippi, but I found that respondents were not openly concerned with race. For instance, the two white participants never discussed race, which I found a little surprising. The one time race was addressed, Ray was talking to me about the dangers of sex. He explicitly said that AIDS and STDs are manmade diseases;

They make diseases to stop other diseases to stop other diseases like you take chemotherapy. Chemotherapy kills your hair cells, make you sick, it do all types of stuff to you, but then once you get off it, you go back to normal. See, that's how I feel about AIDS and other diseases. They made these diseases, certain diseases, just to do what they do...to destroy a certain category of people. Because you might introduce it to just one race and just then everybody be like, "Oh it's coming from this race," but it doesn't come from this race if everybody else getting it too, but they always blame it on black people and homosexuals.

Ray's quote epitomizes mistrust. He wears condoms because he does not always trust women to be honest about their birth control status, but he is also hesitant of birth control

because of the adverse effects it can have on women's bodies. In addition to this, he distrusts scientists and the government for their supposed role in disseminating HIV and sexually transmitted diseases and infection.

With all this mistrust, Ray exhibited high confidence in his sexual knowledge, saying that he taught himself about sex and birth control, perhaps because he did not trust what others had told him. He said, "You gotta watch yourself at all times...knowing what's going on around me keeps me alert and on my feet. Ten toes down at all times." He is confident in himself and his ability to make decisions about his sexual health, but this confidence is fear-driven. While he may enjoy having sex and feel prepared and confident, he still feels like his sexual health is indirectly out of his control, decreasing his sexual self-efficacy.

It may be possible that the other participants never brought up race because Morristown is a predominately black space, as seen in the majority black Census numbers (United States Census Bureau 2012), and the distinction may not be necessary. They also may have felt uncomfortable talking about race in front of me. While race was not explicitly discussed by the other participants, many of them talked about their communities or classmates in a somewhat derogatory way that may have been alluding to a racialized context.

Cole, a white participant, used a lot of language that specifically distanced himself from the community. I asked Cole what his opinion on abstinence education was, and he told me that, "everybody should have their own choice and way of thinking. That's why we live in America, is to do what we please and whatever we want to do," but then as I asked him if he thought abstinence education was working, and he said no because "they ain't paying no attention."

While he may not realize it, Cole has acknowledged that he, a white male, should have sexual freedom because he lives in America. When it comes to other people, he thinks they should pay attention to abstinence education.

SUMMARY

In conclusion, I found that sexual education varied widely across social domains among participants, including teachers, peers, and parents. Some received no sexual education whatsoever, some were taught an abstinence-only approach to sexual education. Interestingly, others had very open conversations about sexual activity in the classroom. When asked if they planned on educating their children on sexual health issues, they said they would want their children to know as much as possible. Xavier put it this way, “I would want them to know everything. The ins and the outs. I won’t leave out any details because they need to know everything about it.” Clearly, he felt like comprehensive knowledge is an important aspect to controlling one’s sexual health.

Also, participants expressed confidence in their ability to control their sexual health, though they often voiced concerns about HIV and other sexually transmitted diseases and infections. Part of their willingness to wear condoms stems from a common fear of being exploited by a woman. They discussed women like they are manipulative and exploitative. This fear and mistrust drives their insistence on wearing condoms. In all, the respondents’ sense of sexual self-efficacy is based on fear.

V. DISCUSSION

Much of the literature on health in Mississippi is based on quantitative studies. When formulating my research questions, I used data from the Centers for Disease Control and Prevention and the Mississippi State Department of Health. It is important to understand the population health statistics in a region. However, the primary qualitative data I collected help put the quantitative data in perspective and provide a basis for understanding the factors associated with these complex demographic and health characteristics.

Having the highest teenage pregnancy rate in the country (Centers for Disease Control 2011), Mississippi receives national attention for its approach to sexual education. In an attempt to reduce teenage pregnancy, as well as other sexual health concerns like HIV transmission, policy makers made a decision to provide less education on sexuality and health, i.e. abstinence-based education. This type of curriculum did not prepare young people for the real concerns that sexual activity creates, such as the risk of pregnancy, infection, or disease. By asking young people directly about their experiences related to sexual education and their attitudes about sex, birth control, and condoms, we can better understand the alarmingly high statistics for issues like teenage pregnancy and HIV infection rates in Mississippi. In other words, this research helps us

to better understand the relationships between policies, practices, lived experiences, and health outcomes.

Too often, blame is placed on young people for making choices that might disadvantage them later in life (Simons et al. 2009). Qualitative data can help researchers understand why young people make the decisions they do about sexual activity. This way, in conjunction with the statistical demographic and epidemiological data, research can be used to inform steps to make institutional changes that would affect sexual education and sexual health in Mississippi.

SOCIAL ECOLOGICAL MODEL

To understand how young men learn about sexual health, this project used the social ecological model as a guiding framework. I found that individual opinions, attitudes, and behaviors were heavily influenced by teachers in the educational system and family members, as well as peers. While it may seem simplest to try to change individual behaviors, to see a real difference in the community regarding sexually transmitted diseases and infections as well as teenage pregnancy, the larger social forces like education and public policy will need to change to affect these more micro levels of influence.

I was not anticipating the large role family played in participants' understanding of sexual health. While I think this is an important finding, I do not think education in the home replaces the formal, scientific presentation of sexual education in school, partially because many of these family members likely received similar abstinence-based sexual education. Objective knowledge is a critical aspect to self-efficacy, and if a young man from Mississippi is having sex and hopes to prevent pregnancy and protect himself from sexually transmitted diseases, he should be knowledgeable and equipped to use a condom. Families can impact this behavior, and it sounds like in many cases, they have, but it should not be the sole responsibility of the families

to teach sexual health information to their children. This is especially notable given the seemingly low levels of objective sexual knowledge.

Peers played an important role in informal sexual education, but the influence of family was most compelling. Additionally, only two participants discussed the role of television in their sexual education, and none of them mentioned pornography. This is important because it highlights the critical role that families and schools play when teaching young people about sex and sexual health. Still, these other areas of influence should be researched in greater detail.

By simply changing the sexual education curricula to include more information about safe sex, Mississippi would be taking the first steps to improve sexual self-efficacy in the state. A learning environment plays an integral role in a young person's behavior (Shonkoff and Phillips 2000). Providing more information to students about how to protect themselves against diseases and infections, as well as how to prevent pregnancy, would give them the tools to make informed decisions about their sexual health (Somers and Gleason 2001). This empowerment could positively reinforce other behaviors to improve young peoples' health and wellbeing (Rostosky et al. 2008).

The data from this project emphasizes the role of sexual education in a young person's understanding of sexual health and their sexual self-efficacy. Their experiences in abstinence-only classes, abstinence-plus classes, or classes made up of a combination of the two directly influence their knowledge and preparedness related to sex.

SEXUAL SELF-EFFICACY

This project contributes to the wide range of literature on self-efficacy. My sample included young men who received very little formal sexual education, and therefore arguably might have low objective knowledge about sexual health topics. However, they presented

themselves as very confident and capable of controlling their sexual health, sometimes by deciding not to wear a condom. In some ways, this could be seen as being sexually self-efficacious because they have made a confident choice about their sexual health, but it is clear from the focus group and interviews that these young men were actively trying to avoid pregnancy and sexually transmitted diseases, so they should be able to discuss sexual health topics with more objective knowledge at their disposal. They need to know more about contraception to achieve their goals of preventing pregnancy and disease.

Longmore and colleagues (2003) found that adolescent females tend to self report higher rates of sexual self-efficacy than their male counterparts, more privileged adolescents report higher sexual self-efficacy than their less privileged peers, and adolescent males from low income families are at a great disadvantage regarding their sexual self-efficacy. The sample for my project would fall on the lower end of the sexual self-efficacious scale as determined by Longmore and colleagues. I think the participants in my project might report their sexual self-efficacy higher than Longmore and colleagues might expect because I found, as Witwer suggested (1993), that these men were very comfortable using condoms, or reported to being comfortable using condoms. However, this does not mean that they necessarily have the objective knowledge that Longmore and colleagues might use to classify a sexually self-efficacious person.

French and Holland (2013) found that people were successfully able to negotiate condom usage if they felt comfortable with and knowledgeable about condoms. Although I did not quantify sexual self-efficacy for this project, I did ask questions about their comfort level with condoms, if they would wear a condom if their partners were on other forms of birth control, and how sexual education made them feel about sex, among other sexual self-efficacy related

questions (see Appendix B). I found that many participants insist that condoms be used, and they seemed very comfortable discussing condom usage. However, I think this needs to be extended past condom usage and maybe include knowledge about birth control methods for women so that if young people choose to have sex, they can protect themselves in more than one way.

This project also complements existing literature because of its setting. Mississippi is an important place to study sexual health and health behaviors because of its conservative approach to healthcare, education, and sexuality, coupled with high rates of teenage pregnancy and poor health outcomes. There is a wealth of literature about teenage pregnancy and HIV prevention that takes places in urban settings, which is very important, but less attention is given to young people in rural settings, and their health is impacted by this, given incomplete information for evidence-based programming.

GENDER

From this project, I found that males seem to treat birth control, other than condoms, as a “women’s issue.” Recent literature on gender and birth control has found that women are charged with the responsibility of using birth control (Fennell 2011; Weber 2012). When I asked participants what types of birth control their partners used, they usually seemed hesitant to answer. None of them seemed particularly comfortable discussing their partners’ birth control methods. So, young women who have not received much instruction on sexual health or birth control might look to their male partners for advice (Davies et al. 2004), and if a young man prefers not to wear condoms, his female partner might be inclined to engage in unprotected sex because he asked her to do so.

I was very surprised by the level of mistrust for women that respondents communicated to me. Their reticence to discuss female birth control methods may be tied to their lack of

knowledge about female birth control, but I think it also stems from the mistrust they feel of women in general. Some respondents, like Xavier and Cole, felt that women were actively seeking to get pregnant so that they could receive child support. This fear drives some of them to wear condoms every time they have sex, but that fear has not yielded low levels of teenage pregnancy. Clearly, believing in stereotypes about exploitative “welfare mothers” does not keep young men from having unprotected sex.

It would be most beneficial for both partners to take some kind of contraceptive precaution (men wearing condoms, women using birth control), yet this does not appear to be a common practice in Morristown. While female methods of birth control may be reliable in preventing pregnancy, they do not protect against the threat of sexually transmitted diseases and infections. For this reason, schools should promote condom usage in sexual education. Both young men and women should learn about the benefits of condoms, and the responsibility should lie on both partners to be adequately prepared to have safe sex.

From the interactions I had with participants, I think they may have appreciate a more comprehensive sexual education. No one expressed that sexual education was a waste of time or was not applicable to them. A few thought it was a little graphic and fear-driven, particularly when learning about childbirth or sexually transmitted infections, but they mostly found it somewhat useful. They are active knowledge-seekers, and they actively want to learn more about sexual health. This is important because it indicates that the participants are aware that they could learn more and seem very willing to learn, which contradicts the stereotypes of arrogant young, black men.

LIMITATIONS

This research was exploratory, and I was not sure what to expect to hear from my participants. Because of this, I asked open-ended questions and had to revise my question list over the course of my interviews because issues arose that I had not anticipated. Now that I am more familiar with young men's attitudes about birth control and sexual health in the Mississippi Delta, I feel that I could craft a more pointed question list that might ask more direct questions about frequency of condom usage and ask about their experiences with sexually transmitted diseases and infections. I was anticipating that pregnancy would be a major motivator to wear condoms, but disease seemed to be a much more pressing fear.

Methodologically, I feel that this project would have benefitted from another researcher being involved. A male interviewer conducting a second set of interviews might be able to elicit a much different set of responses than what I received in that some participants seemed very comfortable with me and others did not. Perhaps a male interviewer, particularly a black male interviewer, might elicit some discomfort for respondents not wanting to discuss personal sexual issues in front of their peers, but the responses could serve as a control or comparison.

The setting of this project also presents some limitations. By nature of the sites I chose for recruitment, I limited myself to a sample consisting primarily of black males. Had I frequented more white spaces in Morristown, my sample may have changed to include young men from more diverse circumstances and who had attended private schools in the region. Those factors may have resulted different experiences with sexual education in schools and at home. Since this involves a convenience sample, it is not generalizable and must be interpreted as a case study.

RECOMMENDATIONS FOR FUTURE RESEARCH

There are several directions future research could take building off this project. This could be replicated in other geographic regions or with different demographic groups of participants. Also, a similar type of project could be designed to ask slightly different questions about sexual health.

Of course, Morristown is a unique setting with very specific demographic characteristics and health issues, but I chose it as a research site because I felt it is representative of the demographic and health profile of the Mississippi Delta. This same study could be replicated in other Mississippi Delta towns or another setting in need of exploratory research on sexual health or health behaviors and attitudes.

This project interviewed young males because I felt that young males are often the major determinants of birth control decisions. However, I found that many of the decisions young men made about condoms and birth control were related to their attitudes about women. Interviewing young women could give them a chance to provide their own opinions about birth control and condoms, and it could also give them the chance to respond to the assertions that young women are poking holes in condoms or lying about their birth control status to receive child support or other money from their male partners. Future research could explore these gendered stereotypes about relationships.

Since the project was focused on community and sexual education, future studies on sexual self-efficacy, particularly concerning young people, could consider the role of peer pressure and influence, as well as the mass media. These are also powerful social forces in the lives of adolescents.

Because this was exploratory research, I was unaware of how the participants would talk about their sexual health and sex lives. I did not think it prudent to create a scale to statistically measure sexual self-efficacy. Now that there are data representing how young men do feel about condoms, birth control, and sexual education, future research could perhaps create such a scale or measure, like the self-report surveys from Longmore and colleagues (2003), Rostosky and colleagues (2008), or French and Holland (2013).

Future studies could explore the roots and social ecology of young peoples' fears about sexually transmitted diseases and infections by asking about their memories of sexual education and their lived experiences regarding sexually transmitted diseases and infections. This way, researchers could find a way to reduce the amount of fear-driven sexual education and increase the strategies to empower young people to improve their sexual and contraceptive self-efficacy.

CONCLUSION

In all, this type of exploratory study can be useful to the existing literature on sexual self-efficacy. It gives a voice to a largely marginalized and demonized demographic group, and it considers the influences that act upon them. This kind of information can help inform school districts, healthcare facilities, and policy makers to better address the needs of young people. Abstinence-plus education might have the potential to better prepare young men and women to have healthy, safe sex lives as compared to what they are learning from abstinence-only sexual education. The young men I interviewed are eager and willing to learn, so as more school districts start using abstinence-plus education, Mississippi may see a decrease in teenage pregnancy rates. An increase in their knowledge and preparedness to have safe sex, and thus their sexual self-efficacy, will increase.

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LIST OF APPENDICES

APPENDIX A: SAMPLE CHARACTERISTICS

SAMPLE CHARACTERISTICS

| Name (Pseudonym) | Age | Race | Marital Status | Number of Children | Religion | Highest Level of Education | Occupation |
|------------------|-----|------------------------|-----------------------|--------------------|------------------|----------------------------|--|
| Andre | 22 | Black/African American | Single, never married | 0 | Baptist | Some college | Dietary aid |
| Anthony | 28 | Black/African American | Single, never married | 2 | N/A | Some college | Carpentry, construction, steel work, self-employed |
| Calvin | 20 | Black/African American | Single, never married | 0 | Did not report | Some high school | Did not report |
| Cedric | 21 | Mixed Race | Single, never married | 0 | No | Some college | Brick mason |
| CJ | 28 | Black/African American | Single, never married | 0 | Baptist | Some college | Barber stylist |
| Cole | 19 | White | Single, never married | 0 | Baptist | High school | Welding |
| Corey | 21 | Black/African American | Single, never married | 1 | Christian | Some college | Business administration |
| Darius | 19 | Black/African American | Single, never married | 0 | Christian | Some college | N/A |
| Denzel | 21 | Black/African American | Single, never married | Did not report | Christian | Associate degree | Truck driver |
| Derek | 28 | Black/African American | Single, never married | 2 | No | High school | Teller |
| Elliot | 18 | Black/African American | Single, never married | 0 | No | High school | N/A |
| Isaac | 19 | Black/African American | Did not report | Did not report | Did not report | High school | Did not report |
| Jarvis | 20 | Black/African American | Single, never married | 0 | Baptist | Some college | N/A |
| Jay | 26 | Black/African American | Married | 1 | Baptist | Bachelor's degree | Military |
| Jaylen | 26 | Black/African American | Single, never married | 1 | Did not report | Associate degree | Fire fighter |
| Kelsey | 26 | Black/African American | Single, never married | 0 | Non-denomination | Some college | Barbering and collision repair |
| Kenan | 22 | Black/African American | Single, never | 0 | Christian | Some college | Barber |

| | | | | | | | |
|----------|----|------------------------|-----------------------|---|------------------|------------------|------------------------------|
| | | | married | | | | |
| Kendrick | 19 | Black/African American | Single, never married | 0 | No | High school | Fast food |
| Lavon | 29 | Black/African American | Single, never married | 2 | Baptist | Some college | Barber |
| Lewis | 20 | Black/African American | Single, never married | 1 | Christian | High school | N/A |
| Malcolm | 20 | Black/African American | Single, never married | 0 | No | Some college | None |
| Malik | 28 | Black/African American | Single, never married | 0 | No | Some high school | Wash cars |
| Moses | 22 | Black/African American | Single, never married | 0 | No | High school | Manager at a fast food chain |
| Nelson | 19 | Black/African American | Single, never married | 0 | COGIC, Christian | Some college | Not employed |
| Paul | 19 | Black/African American | Single, never married | 0 | No | High school | Fast food |
| Quincy | 19 | Black/African American | Single, never married | 0 | Baptist | High school | Did not report |
| Ray | 20 | Black/African American | Single, never married | 0 | Baptist | Some college | Did not report |
| Rodney | 30 | Black/African American | Single, never married | 3 | Christian | High school | Car washer |
| Terrell | 23 | Black/African American | Single, never married | 1 | Christian | Some college | Irrigation |
| Vince | 20 | Black/African American | Single, never married | 0 | Baptist | High school | School |
| Wilson | 19 | White | Single, never married | 0 | Christian | High school | Student |
| Xavier | 20 | Black/African American | Single, never married | 1 | Christianity | Some college | Criminal justice |

APPENDIX B: QUESTIONNAIRE

Questionnaire

1. What is your age? _____
2. What is your race and/or ethnicity?
 - a. White, Not Hispanic
 - b. Black, Not Hispanic
 - c. Hispanic
 - d. Asian
 - e. Native Hawaiian or Pacific Islander
 - f. Other
 - g. Mixed race
3. What high school did you attend? _____
4. What year did you graduate from high school? _____
5. What is your marital status?
 - a. Single, never married
 - b. Married
 - c. Divorced
 - d. Widowed
 - e. Other _____
6. Do you have children? If so, how many? What are their ages?

7. Do you have a religious affiliation? If so, what is it?

8. What is the highest level of education you have completed?
 - a. Less than high school
 - b. Some high school
 - c. High school
 - d. Some college
 - e. Associate's Degree
 - f. Bachelor's Degree
 - g. Master's Degree or Higher
9. What is your occupation?

10. Please feel free to add anything else to our discussion that was not addressed or that you did not get a chance to say.

APPENDIX C: FOCUS GROUP QUESTIONS

Focus Group Questions

1. How did your family talk to you about sex as you were growing up?
2. When did you first start receiving sexual education in school?
3. What kinds of things did your teachers talk about during sexual education?
4. How did your high school teachers talk about sex during sexual education?
5. In high school sexual education, what do you remember learning about the relationship between sex and pregnancy?
6. What were you told in high school sexual education about birth control? Where did you go, if anywhere else, for additional information?
7. What kinds of education about sex did you receive from anywhere else (doctors, partners, etc.)? What else did you learn about sex and birth control outside school and family?
8. Who do you think should be responsible for teaching young people about sex? Why?
9. What do you think are the advantages and disadvantages of teaching abstinence to high school students? And, what do you think are the advantages and disadvantages of teaching students about birth control?
10. Is there anything about birth control that you wish you had known in high school that you know now?
11. Do you feel that it is the man or woman's job to provide the birth control? Why?
12. Which methods of birth control do you feel would be most reliable? Why?
13. What are your experiences with teenage parenthood?

APPENDIX D: INTERVIEW QUESTIONS

Interview Questions

1. Tell me a little bit about the community where you went to high school.
2. Do you remember the first time anyone ever had a discussion with you about sex? What was going on in your life at the time?
3. Where did you learn more about sex, in school or outside of school? What did you learn? From whom?
4. Did anyone ever teach you how to use birth control? Did anyone ever provide you with birth control, like condoms?
5. What are some of your memories about sex education in school?
6. Who was the person at school who talked to you about sex? Was it part of a class?
7. Do you recall how these instructors talked about pregnancy and birth control? Can you give a specific example?
8. What kinds of information did they provide on birth control?
9. How did sexual education in school make you feel about sex?
10. What are some of your fears about sex?
11. What is your opinion of abstinence education?
12. Do you feel like abstinence education discourages high school students from having sex? Why or why not?
13. When you started having sex, what were your thoughts about birth control and pregnancy?
14. If you were having intercourse in high school and using birth control, what methods were you using?

15. How do you feel about condoms? Are you comfortable using them? Do your partners ever ask you to wear condoms?
16. Do you and your partner(s) talk about birth control?
17. If your partner was taking birth control, would you still wear a condom? Why or why not?
18. How does teenage pregnancy impact your community?
19. What is your opinion about the issue of AIDS and STDs?
20. Looking back on your own upbringing, is there anything on the subject of birth control or sex education that you wish you had learned about more?
21. If you have children someday, what do you want them to know about sex? What do you want them to know about birth control?
22. Are you planning to educate them about these matters? At what age do you think they should receive this information?
23. Who else do you think should be responsible for teaching young people about sex? What kinds of roles should schools, health care professionals, or churches play in sex education?
24. Are there any other concerns about sex education or birth control that you can think of?
Any questions you might have?

VITA

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