A GLOBAL SNAPSHOT OF SEXUAL HEALTH EDUCATION:
INSIGHTS FROM INTERNATIONAL STUDENTS AT BGSU

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A Thesis

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ABSTRACT

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Research shows that many international students are coming into the United States from countries with high prevalence rates of sexually transmitted diseases, minimal sexual health knowledge, and pre-conceived notions surrounding sexual health. What results from this at colleges across the country is an unavoidable intersection of international students and sexuality, with many administrators of such institutions feeling uncertain or unwilling to include sexual health in their education model. Through my unequivocal belief that resources related to sexual health education are a crucial need on every college campus, for every population, I decided to focus specifically on international students. The overall purpose of this case study is three-fold: (a) to explore the differences in backgrounds in sexual health education and practices for a diverse cross-section of international students studying at BGSU, (b) to investigate whether there is a need for colleges to implement sexual health education for international students in the United States, and (c) to speculate what strategies/curricula could be implemented.

Through 24 written, qualitative surveys and 13 follow-up interviews, I sought to answer two research questions, with the first being: From international students’ perspectives, how have their social, cultural, familial, and religious backgrounds and practices shaped their home country’s stance on sexual health and, subsequently, their own upbringing? My second research question is: From international students’ perspectives, what is their perception of the influence of American culture, their perception of access to sexual health information and education programs, level of interest in and preferred format of this kind of education? In an effort to answer these questions, I investigate five major themes in my research that serve as the core foundation of this thesis: (a) prior sexual health knowledge and educational accessibility; (b) cultural ideals about virginity, premarital sex, religion; (c) access to and understanding of sexual
health information; (d) influence of American culture; and (e) insight into future sexual health education.

Through the lens of these themes, overarching findings developed about my target population of international students at BGSU. The findings of my study, with correspondence to the original themes, include the following: (a) varying degrees of prior sexual health education; (b) strong beliefs about virginity, premarital sex, contraception, religion; (c) uncertainty towards accessing sexual health guidance; (d) mixed perceptions about the influence of American culture; and (e) conflicting preferences towards future sexual health education.

Though the results of this study are not generalizable, they did achieve to investigate a specific target population, and give a voice to international students at BGSU. This data can and should be analyzed further, expanded on through deeper and different research angles, goals, and data collection methods, and ideally contribute to the development of sexual health education programs for international student populations in the U.S. Through this study, I determined that the sexual health needs of international students represent an inadequately examined field of research and a largely bypassed area of programming. I hope that my research can begin to improve that outlook, especially on the BGSU campus.
This thesis is dedicated to my mother, Betsy Bunner. Without her lifelong dedication to working with people living with HIV/AIDS and educating others about sexual health and sexually transmitted diseases, it is unlikely that I would have the research and career interests that I do.

The opportunities she gave me throughout my adolescence, to participate alongside her in HIV/AIDS outreach and volunteerism, were instrumental in building the necessary skillset to prepare me for the AIDS work I would do post-baccalaureate in the Peace Corps in Namibia.

Without hesitation, I can say that my mother served as my backbone of support while I was abroad for 26 months. She helped me navigate reverse culture shock when I returned, persevere through some tough struggles during readjustment, and unquestionably was the guiding force towards my pursuit of graduate school. If it were not for her encouragement, this thesis would not exist. Thank you, Mom, for always loving me, believing in me, and showing me that with the right motivation and persistent determination, anything is possible.

This thesis is also dedicated to the 24 international students at Bowling Green State University who trusted me enough to share their cultures with me through qualitative surveys and interviews. Their insights form the core of this thesis and the depths of their cultural backgrounds were absolutely fascinating. I am honored to have learned so much from each of you, and I hope I have given due justice to the diverse sexual health climates of your cultures.
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CHAPTER I. INTRODUCTION

The aptly titled book, *Too Hot to Handle: A Global History of Sex Education* (Zimmerman, 2015), begins by stating that the marriage over the years between school and sex has proven to be “both stormy and delicate, spawning heated controversy outside of the schools and surprisingly little instruction inside of them” (p. 3). This stormy yet delicate debate over the level to which sexual health education should be administered in schools has been going on worldwide for years. Certainly a poignant topic, especially with research showing that youth’s degree of sexual experience “varies across regions, but is generally consistent within regions” and most young people throughout the world beginning to have sex between the ages of 16 and 20 (Salgado & Cheetham, 2003, p. 1). “Although approximately 46% of high school students have ever had sexual intercourse (Eaton, Kann, Kinchen, Shanklin, Ross, Hawkins, & Wechsler, 2009), this proportion rises steadily over time, with over 90% of young people reporting sexual intercourse by age 24 (Mosher, Chandra, & Jones, 2005), indicating that approximately half of college students have their first intercourse experience in this context (Eisenberg, Garcia, Frerich, Lechner, & Lust, 2012).

Research by Zimmerman (2015) illustrates how sexual themes that have been taboo in the past have now become commonplace in literature and mass media, as censorship laws and regulations have fallen away. “Many of these trends occurred earlier – and more forcefully – in the developed than in the developing world, where older traditions and restrictions held sway” (Zimmerman, 2015, p. 2). Therefore, these changing trends have not necessarily been well received across the globe. Though a greater number of people are experiencing a greater degree of sexual autonomy than ever before, this has not resulted in widespread changes to sexual health education in school settings (Zimmerman, 2015).
Sexually active adolescents and young adults are at a higher risk than older adults of acquiring sexually transmitted diseases (STDs) for a combination of behavioral, biological, and cultural reasons, with the largest proportion of STDs worldwide believed to occur in people younger than 25 years (Bearinger, Sieving, Ferguson, & Sharma, 2007; Centers for Disease Control and Prevention [CDC], 2012). “The few countries that have successfully decreased national Human Immunodeficiency Virus (HIV) prevalence have achieved these gains mostly by encouraging safer sexual behaviors in adolescents” (Bearinger et al., 2007, p. 1220). Despite statistics such as this, and research that supports that a major component of any comprehensive sexual health curriculum is education about the prevention of STDs, popular unease and disagreement about youth sexuality has limited or even prevented sex education directives around the world for years and continues to this day (Zimmerman, 2015). Interventions that “address underlying aspects of the social and cultural conditions that affect sexual risk-taking behaviors are needed, as are strategies designed to improve the underlying social conditions themselves” (CDC, 2012).

Pushing it under the rug – as we do with so many controversial subjects in society – is not the solution, as research shows that adolescent sexual development is important to the process of identity formation and the establishment of romantic and social relationships among peers (Conklin, 2012). Even countries that have embraced more open sexual philosophies have struggled to provide tangible instruction related to sexual health (Zimmerman, 2015). Aside from schools that have added in some form of sexual health education to their curricula in the twentieth century, sex education still ceases to exist in most cases, globally, after the completion of grade 12.
For those young adults who are fortunate enough to be able to pursue higher education, their college years represent – for many of them – the first time they have been truly on their own and making their own decisions. It is certainly conceivable that this new freedom brings more opportunities for increased sexual exploration. However, most college educators and administrators do not gauge the sexual health background of their incoming students as prior sexual health education is not a prerequisite for admission into any of our institutions of higher education, nor is it a prerequisite for entry into the United States. Furthermore, primarily in the case of international students, they are allowed to enter the U.S. without necessarily even knowing their HIV status (Massachusetts Department of Public Health [MDPH], 2012). Under a change in immigration law five years ago, HIV testing is no longer part of the medical exam required for visa applicants and no one is banned from entering or remaining in the U.S. solely because of positive HIV status (MDPH, 2012). In addition, enrolling in a sexual health education course, whether formally or informally, is generally not a requirement at any point for the majority of college students.

I focus this research particularly on international students coming to the United States for higher education. International students are continuing to encompass more of the overall student population in this country than they have previously. The number of international students attending institutions of higher education in the United States is increasing dramatically, as indicated by a rise from 564,766 foreign students at both public and private institutions in 2005-06 to 886,052 in 2013-14 (Bista & Foster, 2011; U.S. Department of State [DOS], Institute of International Education [IIE] Data Set, 2015). According to IIE (2011), this growth is expected to continue, and “reflects the broader global trend of the increasing number of students who pursue higher education outside their homelands each year” (p. 4).
International students come from many diverse backgrounds and have been raised with particular cultural norms and beliefs, especially in regards to shared values in their group or society (Hall, 1997). Many of them have left home to pursue studies internationally in order to “broaden their cultural and intellectual horizons,” improve their job prospects, and prepare for the next stage of their education or career (Macready & Tucker, 2011, Forewords). Through this experience, not only are international students navigating their new environment and the cultural, linguistic and personal challenges that come with it, but they are also encountering the onset of true adulthood (Bista & Foster, 2011).

Early adulthood, as defined by Luquis, Brelsford, and Rojas-Guyler (2012), “represents a time that individuals engage in extensive identity exploration intensified by new experiences such as living away from home and exposure to different social environments” (p. 602). A term closely related to this is emerging adulthood, which represents a transitional period when “individuals do not feel like adolescents yet do not feel fully adult” and are exploring and developing their adult identities through a state of flux (Lechner, Garcia, Frerich, Lust, and Eisenberg, 2013, p. 28). This life stage is characterized by the acceptance of personal responsibility, including responsibility of one’s own decision-making as it pertains to sexual health (Lechner et al., 2013). Under this rationale, I believe that international college students represent a population that experiences one of the most profound introductions to early and emerging adulthood.

Research shows that many international students are coming into the U.S. from countries with high prevalence rates of HIV, AIDS, other STDs, minimal sexual health knowledge, and pre-conceived notions surrounding sexual health (Kalsi, Do, & Gu, 2007). What results from this at colleges is an unavoidable intersection of international students and sexuality, with many
administrators of such institutions feeling uncertain or unwilling to include sexual health curricula in their education models. Without college students having comfortable access to information on sexual health, “it is less likely that they will enjoy healthy sexual relationships, and they may suffer negative academic outcomes that have long-lasting repercussions” (Lechner et al., 2013, p. 29).

**Research Questions**

My first research question is: From international students’ perspectives, how have their social, cultural, familial, and religious backgrounds and practices shaped their home country’s stance on sexual health and, subsequently, their own upbringing? Through a second question, the participants’ cultural backgrounds were connected to their current status as international students. My second research question is: From international students’ perspectives, what is their perception of the influence of American culture, their perception of access to sexual health information and education programs, level of interest in and preferred format of this kind of education?

**Background and Purpose of the Study**

The foundation for this research was built upon my fascination for the cultural norms and values of international students combined with a deeply rooted interest in sexual health and several years of experience as a sexual health educator both in the United States and abroad. In this study, I seek to address whether or not a cross-section of the international student population at Bowling Green State University (BGSU) fits Kalsi et al.’s (2007) measurement in terms of having minimal sexual health knowledge and pre-conceived notions about sexual health.

The overall purpose of this case study is three-fold:
(a) To explore the differences in backgrounds in sexual health education and practices for a
diverse cross-section of international students studying at BGSU,
(b) To investigate whether there is a need for colleges to implement sexual health education
for international students in the United States, and
(c) To speculate what strategies/curricula could be implemented.

The differences in sexual health education and practices will be generally defined through the
myriad of social, cultural, familial, and religious differences in upbringing in their respective
cultures and countries. These differences include the international students’ backgrounds of
sexual health education prior to coming to the U.S. and their respective culture and country’s
views towards religion and spirituality, virginity and premarital sex, birth control methods,
sexually transmitted diseases, and risk behaviors.

**Definition of Key Terms**

In preparation for exploring this research in greater depth, it is important to review
working definitions of key terms that will be critical to understanding the research being
conducted and its findings. One important term prevalently used throughout my thesis is culture.
Using Hall’s (1997) anthropological definition of culture from the social science context, it is
used to refer to whatever is “distinctive about the ‘way of life’ of a people, community, nation or
social group” as well as “the ‘shared values’ of a group or of society” (p. 2). In this definition,
culture is more of a process or a set of practices than a set of things, and is concerned with the
“giving and taking of meaning” between members of a society or group (Hall, 1997, p. 2).

I define an international student as a currently enrolled student at BGSU who was not
born or raised in the United States. They are also incoming students, which means that they came
to the U.S. to pursue an education. To avoid redundancy, I refer to colleges and universities
generally as one in the same, with preference to the term college. Though my data was collected at a university, it is often common in current society to refer to my target population as college students or college-age, rather than university students or university-age.

Although participants could define sexual health in their own words, through their responses, my own understanding of sexual health was strongly guided by literature by Baek, Akbar, and Baguley (2012). These authors explain that sexual health does not merely mean being safe from STDs or unplanned pregnancies, “but taking responsibility for one’s body, health, partner’s health and decisions about sex” (p. 4). I also use the terms sexual health education, sex education, and sexuality education interchangeably throughout my thesis. Likewise, the terminology of sex (as in sexual behavior) and sexual intercourse are used similarly, as well as birth control and contraception/contraceptive methods, unless specified to the form of a birth control pill.

Per regulations from the Human Subjects Review Board (HSRB), certain key terms were briefly defined in the survey that was provided to students, if there was concern that there may be different interpretations in the global spectrum. The terms that were defined further or provided with supplementary examples included virginity, premarital sex, birth control methods, and STDs. Virginity was defined as “not engaging in sexual intercourse,” whereas premarital sex was defined as “sex before marriage.” Examples provided in the survey of birth control methods included “condoms; contraceptive pills/tablets.” Risk behaviors were defined as “actions that may result in bad consequences for health.” STDs were not defined, but the examples provided were genital warts and gonorrhea.

Though health educators in the U.S. generally tend to use the acronyms STD and sexually transmitted infections (STI) similarly, I preference STD in this study. There were no stated
perimeters – at any point within the data collection process – for the scope of which sexual acts could be categorized under the definitions of sex or virginity. I did not specify types of sexual intercourse (such as oral or penetrative), and I did not ask respondents to differentiate their answers in this manner, either. I left these two terms open-ended for them to interpret in their responses from their own cultural perspectives, and generally no differentiation could be interpreted during my analysis. I did not delve into sexual orientation in my research, and so I make no assumptions as to the heterosexual, homosexual, or elsewise status of my participants and in turn, how this may have impacted their perceptions.

**Organization of the Thesis**

The remainder of this research is divided into four chapters. Chapter II serves as a literature review, providing a context for the research within current and historical scholarship in relevant fields of study. Chapter III explains the full spectrum of methods used to conduct the research. Chapter IV presents the findings of the research. Lastly, Chapter V provides a discussion of the data in relation to the overarching themes that are developed, summarizes the findings, analysis, and conclusions of the study, addresses potential implications for research, suggests areas for further study, and provides final concluding reflections as a researcher.

At the core foundation of this thesis are five major themes, which helped chart the course for my literature review, frame the survey and interview questions I used during data collection, provide a topical outline for the findings of my study, and set the course for the analysis of those findings. Chapter II will highlight the literature behind the development of my five themes, as well as fully introduce them.
CHAPTER II. LITERATURE REVIEW

First is an overview of existing research on the wide spectrum of sexual health education and practices both domestically and abroad, followed by a discussion of my conceptual framework and a concept map to illustrate the framework, and concluding with my research questions.

Overview of Existing Literature

Research suggests that when compared to domestic students, international students have poorer sexual health knowledge, more complex attitudes about premarital sex, more difficulty accessing sexual health information, and a poorer understanding of the role of American health practitioners (Burchard, Laurence, & Stocks, 2011). These four themes were unearthed after Burchard et al. (2011) conducted a qualitative study with focus groups into knowledge, beliefs, and attitudes among Malaysian and Chinese female international students in Australia. The dialogue in the focus groups was modeled around a question guide that was developed by Burchard et al. (2011) and concentrated on issues highlighted by a literature review and through consultation with university healthcare providers and staff of their international student office. The impetus for their research was due to healthcare workers at local public hospitals and at the University of Adelaide in South Australia expressing concerns that the international students they were seeing were terminating unwanted pregnancies and contracting STDs as a result of inadequate prior sexual health education.

After re-framing Burchard et al.’s (2011) emerging themes, I used them as a guiding structure for this literature review. As I am investigating international students at American colleges, I have broadened these themes to include both international and American cultural elements. The existing research that I have analyzed sets the context for the educational and
cultural environments that many international students are raised in prior to coming to the U.S.,
the current status of sexual health among international students in the U.S., how colleges handle
sex education among their diverse student populations, and the literature that supports changes to
these methods. Therefore, this literature review is divided into the following five categories:

(a) prior sexual health knowledge and educational accessibility;

(b) cultural ideals about virginity, premarital sex, religion;

(c) access to and understanding of sexual health information;

(d) influence of American culture; and

(e) insight into future sexual health education

One of the limitations of Burchard et al.’s (2011) study was that they did not collect detailed
information about the ethnic, cultural or religious backgrounds of their participants. Through this
limitation, they acknowledged that such differences could have impacted their respondents’
sexual health knowledge, attitudes, and practices (Burchard et al., 2011), and this served as the
rationale behind why I implemented these aspects into my research.

Prior Sexual Health Knowledge and Educational Accessibility

Zimmerman (2014, 2015) provided a comprehensive and up-to-date account of sexual
health education around the world. His research showed that in most countries, “children and
adolescents receive a smattering of information about their reproductive organs and a set of stern
warnings against putting them to use” (Zimmerman, 2014, p. A19). Abstinence is the only
message about sexual practices allowed in schools in many parts of the world, if broaching the
topic is even permitted (“Sex education in conservative settings,” 2000). Other school programs
often remain limited to basic anatomy and physiology education with no instruction about
contraception or STDs (Burchard et al., 2011).
In Asia and Africa, especially, critics for years have railed against ‘Western’ sex education (Zimmerman, 2014). There continues to be literature related to students educated particularly in Asia and the Middle East, where obstacles remain for research into sexual behaviors (Wellings, Collumbien, Slaymaker, Singh, Hodges, Patel, & Bajos, 2006). In their substantial analysis of sexual behavior data from 59 countries, Wellings et al. (2006) advocate for comprehensive behavioral interventions that take account of social contexts and tackle the structural factors that contribute to risky sexual behavior. They argue that sexuality is an essential part of human nature and its expression needs to be affirmed rather than denied (Wellings et al., 2006).

Though girls’ education has expanded steadily around the globe over the last two decades, sex education has stalled, Zimmerman (2014) argues. Fine and McClelland (2006) examined the federal promotion of curricula promoting abstinence-only until marriage education in public schools, and how these policies constrict the development of young women. School administrators hesitate to deliver comprehensive sexuality education and contribute to hindering the capacity of their students, especially young women, “to be sexually educated – to engage, negotiate, or resist” (Fine & McClelland, 2006, p. 297). Though condoms, contraceptive pills, injectables, implants, and intrauterine devices are considered “key means of preventing negative reproductive health outcomes,” adolescent women in most countries still face significant barriers to using contraceptive methods, as described below (Bearinger et al., 2007, p. 1221).

Service-related barriers include incorrect or inadequate information, difficulty in traveling to and obtaining services, cost, and fear that their confidentiality will be violated. Personal barriers that especially deter young women from accessing and using contraception include fear that their parents will find out, difficulty negotiating condom
use with male partners, fear of violence from their partner, and concerns about side effects. (Salgado & Cheetham, 2003, p. 2)

The difficulties surrounding negotiating condom use highlights a sexual double standard, where restraint is expected of women and excesses are tolerated for men, which ends up compounding the problems for both men and women (Wellings et al., 2006). Relatively few teenage women in most developing countries report using contraceptives. For instance, only 2% of sexually active young women in Niger, Rwanda, and Senegal; 23% in Cameroon; 1% in the Philippines; 34% in Indonesia; and less than 11% throughout Latin America and the Caribbean report using contraceptives (Salgado & Cheetham, 2003). In countries such as China, concerns perpetuated by gynecologists about the risks and side effects of the oral contraceptive pill results in low support towards and usage of this method for birth control (Burchard et al., 2011).

By not regularly using contraceptive methods, adolescents are at risk for pregnancy and childbirth, which are considered detrimental to their health especially in less developed nations, due to greater risks including complications of pregnancy, illegal or unsafe abortions, and death (Salgado & Cheetham, 2003). “Worldwide, mostly as a result of unintended pregnancy, nearly four and a half million adolescents undergo abortion each year; 40% occur under unsafe conditions” (Salgado & Cheetham, 2003, p. 1).

Parents, with their own background of limited sexual health knowledge, likely contribute to their children having poor knowledge (Burchard et al., 2011). Conklin (2012) addressed trends in adolescent sexual health and behavior in the U.S. and areas that are in need of improvement, and found that many adults are uncomfortable with the idea of teen sexuality, and prefer to remain in ignorance or denial about the subject. This is also evident through Burchard et al.’s (2011) study with unmarried, female international undergraduates in Australia, which showed
that for the majority of them, their parents were unlikely to have spoken to them about sexual health, and overall they had limited knowledge about contraceptive options.

What results from most contemporary sex education models around the world is that they end up admonishing youth against sex itself (Zimmerman, 2014). “Sexual activity is strongly regulated in virtually every society, but its modification to improve sexual health has proved difficult” (Wellings et al., 2006, p. 1706). However, as technology has advanced globally over the years, so has the ability for adolescents and young adults to educate themselves about sex. “Worldwide communications, including the Internet, have had a bearing on social norms, transporting sexual images from more liberal to more conservative societies, especially those in which advances in information technology have been rapid” (Wellings et al., 2006, p. 1707).

Cultural Ideals about Virginity, Premarital Sex, Religion

Cultural ideals are a very tangible issue to consider, especially with the role of cultural meaning in societies around the world. Cultural meanings “organize and regulate social practices, influence our conduct and consequently have real, practical effects” (Hall, 1997, p. 3). This was especially true in regards to the findings of Burchard et al. (2011) about the pivotal role of cultural and sexual taboos in home countries. Their research showed that international students have complex attitudes about premarital sex, and female virginity is still an extremely important concept in many of their home countries (Burchard et al., 2011, p. 818). These complex attitudes can also be related to social norms:

Possibly the most powerful influences on human sexuality are the social norms that govern its expression. Morals, taboos, laws, and religious beliefs used by societies worldwide circumscribe and radically determine the sexual behavior of their citizens. The
scale of the regional diversity in sexual behavior is matched only by the range of cultural constraints on practice. (Wellings et al., 2006, p. 1716)

Furthermore, mass media, materialism, migration, and urbanization “may increase both the desire and opportunity for sexual activity, and many youth feel strong peer group pressure to engage in sexual intercourse” (Salgado & Cheetham, 2003, p. 2).

Nadar and Phiri (2012) challenge the systems of knowledge that exist in the HIV pandemic in the global context in regards to religion and its impact on these systems. “The variable of religion cannot be ignored in the knowledge being generated on HIV as faith plays an important role in individual and community life and has the capacity to control social and health conduct” (Nadar & Phiri, 2012, p. 124). Through a study among nearly 1,000 college students across four colleges in the northeastern U.S., Luquis et al. (2012) further illuminated the links between religion and spirituality to sexual behaviors and sexual attitudes among young people. They found that there seems to be a difference in the way religiosity influences sexual behaviors for males and females, respectfully, but there is certainly evidence of an influence (Luquis et al., 2012). Additionally, “individuals who possess high religiosity and high core spirituality have more conservative sexual attitudes and less sexually permissiveness attitudes than their counterparts, which might lead to fewer sexual experiences” (Luquis et al., 2012, p. 603). This study in particular formed the basis for my implementation of a question about religion/spirituality in my survey.

Zimmerman (2014) notes that some Western European countries do provide “sustained attention” to adolescent sexuality in their schools, “but they have also come under fire from growing Asian and African immigrant communities, which are repulsed by schools’ rhetoric of
sexual autonomy and choice” (p. A19). They do not see sex outside of marriage as a choice, but rather a sin, and “it’s scandalous for schools to suggest otherwise” (Zimmerman, 2014, p. A19).

The female students in Burchard et al.’s (2011) study indicated that although they acknowledged that their peers may be having premarital sex, they could not because of a fear of being judged and due to concern of being regarded by men as “damaged goods” through losing their virginity (p. 819). They also feared judgment if seen going to a doctor or an educational event for the purposes of learning more about sexual health (Burchard et al., 2011). In China, many doctors are in fact unwilling to provide sexual health advice to unmarried young people (Burchard et al., 2011).

**Access to and Understanding of Sexual Health Information**

Baek et al. (2012) aimed to identify the concerns of international students and provide culturally appropriate ideas for the promotion of their sexual health. Their research showed that many international students begin their study abroad experiences with limited knowledge of sexual health matters due to the lack of sexual health education and/or access to health services in their home countries. Compounding this further is the fact that they are entering academic institutions in the U.S. where sexual health knowledge is not necessarily a priority or concern. A study by Lechner et al. (2013) focused on perceptions of individual and institutional responsibility for sexual health, with the goal of determining how institutions can better provide for the needs of their students to increase academic success and healthy relationship outcomes:

As of 2009, only 52.5% of college students reported receiving information from their college on human immunodeficiency virus (HIV) and sexually transmitted infections (STIs), and less than 40% of college students indicated they had received information on unintended pregnancy, despite the fact that sexuality education has been found to
improve health outcomes for young adults, and that a holistic approach is necessary to achieve optimal adolescent well-being. (Lechner et al., 2013, p. 29)

Lesser efforts being made by college personnel on sexual health promotion may lead to college students identifying their friends, magazines and the Internet as sources for information about sexual health, and tending to rely on these sources, without considering their reliability (Burchard et al., 2011).

Health services offered by colleges, if they are comprehensive, are “well-positioned to be a ‘health care home’ for students, but they are often not viewed as such” (Eisenberg et al., 2012). For example, although reproductive health services are one of the primary reasons why the majority of college students seek health care (National Center for College Statistics, 2009), research has shown that over 50% of those who received STD testing or treatment did so off-campus at a community clinic (Eisenberg et al., 2012). Among the participants in Burchard et al.’s (2011) research, they “regarded the decision to become sexually active as emotionally important, but did not see any reason to engage with a professional such as a doctor to discuss sexual health” (p. 819). This idea that doctors did not have a role in advising before sexual intercourse differed from their likelihood towards seeking a doctor for help if needed after sexual intercourse (Burchard et al., 2011).

When it comes to sexual behaviors, domestic students face many of the same challenges as international students do, such as potential exposure to STDs and handling unplanned pregnancies while in college (Burchard et al., 2011). However, due to their foreigner status, potential language barriers, and unfamiliarity/discomfort with the American healthcare system, international students may encounter increased barriers of access related to sexual health services and information unlike their American counterparts. Colleges attempt to provide services for
international students on the surface, but “fail to meet the real needs of the students at a more practical level” and result in international students continuing to have limited knowledge and awareness about sexual and reproductive health (Baek et al., 2012; Bista & Foster, 2011, p. 3). Through videotaped group interviews with six international students from geographically and culturally different countries, Bista and Foster (2011) learned more about the individual needs of international students in the U.S. especially through their first experiences at their new institution and in the community.

It is difficult and challenging for many international students to feel comfortable discussing sexual health needs and concerns (Baek et al., 2012). Research has indicated that embarrassment and stigma are especially significant barriers to international students seeking sexual health education (Burchard et al., 2011). Through conducting workshops and discussion groups with international students, Kalsi et al. (2007) identified them as a high-risk population in relation to sexual health problems due to their lack of sexual health knowledge and the limited amount of sexual health information provided to them at colleges. These barriers cause international students to be considered high risk, because of their tendency to engage in risk behaviors without sufficient knowledge of risks, consequences and protection methods (Kalsi et al., 2007).

“Although international students experience difficulties in adjusting to a new culture, a different educational system and an unfamiliar language environment often preside over concerns for sexual health and relationship matters” (Baek et al., 2012, p. 2). International students are more concerned with safety and security than campus life issues such as athletics, activities, and organizations (Bista & Foster, 2011). Regulations and guidance around campus safety and security often appear unclear at first to many international students, and they may
receive little or no information prior to arrival, on arrival, or through the duration of their stay on sexual safety issues, health, and laws in the United States (Bista & Foster, 2011; Kalsi et al., 2007). If they unknowingly make legally harmful decisions, they would likely be unaware of the consequences they could face.

Influence of American Culture

I found that this theme in particular was the least researched likely because a very limited number of studies have focused on populations where migration was a factor. Most of the studies in this literature review looked at the sexual health of college students overall, and did not differentiate between domestic or international populations. Therefore, the influence of the host country’s culture was not a relevant area to research in the majority of the studies I was able to find related to this topic.

In Burchard et al.’s (2011) study that did make this differentiation, international students “appeared to find themselves buffeted between conflicting cultures, between the conservative attitudes of their upbringing and a more sexualised Australian culture” (p. 819). It would be rational to hypothesize that these students would feel the same way towards American culture in this regard. Especially in the college atmosphere, international students may be introduced for the first time to an American culture of openness about sexual behaviors. Luquis et al. (2012) notes that exposure to these kinds of experiences has the likelihood to influence students’ religious and spiritual beliefs, sexual attitudes, and sexual behaviors. The college atmosphere is ripe to this openness, as found in a study by Oswalt and Wyatt (2013) that examined sexual health outcomes in a national sample of U.S. college students:

For many late adolescents in the United States, the experience of college represents a critical point in life where individuals shift from a role of dependence to one of
independence. This transition requires the reframing and reshaping of many aspects of
the individual, making it ideal and significant for shaping people’s behavior. (Oswalt &
Wyatt, 2013, p. 1562)

The opinions of the female students in Burchard et al.’s (2011) study were divided as to
whether or not international students were more likely to engage in sexual activity while
studying abroad. “While some stated that being away from parents gave them more freedom,
others disagreed, explaining that there is also a trend toward premarital sex in their home
countries” (Burchard et al., 2011, p. 818). In their study, there was an overwhelming sense that
moving abroad was unlikely to produce a radical change in behaviors of sexual activity
(Burchard et al., 2011).

Insight into Future Sexual Health Education

Research supports the rationale that more pragmatic sex education does not increase risky
sexual behavior (“Sex education in conservative settings,” 2000) and there is no literature that
correlates sexual health education to increased sexual activity. Instead, “systematic reviews have
shown school-based sex education to lead to improved awareness of risk and knowledge of risk
reduction strategies, increased self-effectiveness and intention to adopt safer sex behaviours, and
to delay, rather than hasten, the onset of sexual activity” (Wellings et al., 2006, p. 1718).

Prior research has shown that using peers in a storytelling approach has been an effective
method towards promoting awareness and discussing information on sexual health among
international students (Baek et al., 2012). Studies by Borrett and Zysk (2007) and Poljski (2011),
as described below, have supported the incorporation of sexual health and healthy relationship
information into the orientation programs for new international students (Baek et al., 2012).
Poljski (2011) emphasizes that educational institutions should deliver mandatory gender-specific health education; reinforce health messages through social media and international student leaders; distribute multilingual written health information at student services and events and provide information about Overseas Student Health Cover policy to address the concerns for international students in relation to sexual health needs. (as cited in Baek et al., 2012, p. 3)

Almost all of the international students in Burchard et al.’s (2011) study were very interested in having more sexual health education, but were concerned with stigmatization, and had differing opinions about the best way to administer this kind of education in regards to format and timing. Another important consideration suggested throughout the literature was keeping in mind the diverse religious backgrounds of international students. “Lack of consideration of students’ religious views in sexual health programs may prevent students from participating because of feeling alienated from any initiative” (Ulanowsky, 1998; as cited in Baek et al., 2012, p. 9). Complexities such as this paint the picture that “no general approach to sexual-health promotion will work everywhere, and no single-component intervention will work anywhere” (Bearinger et al., 2007, p. 1224-1225). In their article, Berglas, Constantine, and Ozer (2014) sought to reach a consensus regarding the goals, concepts and underlying assumptions of a rights-based approach to sexuality education. In order to engage students in more open dialogue about complex issues related to sexuality, “teachers must have high-level facilitation skills, personal comfort with gender and sexuality, and additional content knowledge” (Berglas et al., 2014, p. 67-68).

Though U.S. foreign policy has become friendlier to sex education and reproductive rights with the election of Barack Obama, the global campaign against providing sexual health
information has prevailed (Zimmerman, 2014). When students are deprived of easy access to
sexual health knowledge and skills, they are “left to their own (and others’) devices in a sea of
pleasures and dangers” (Fine & McClelland, 2006, p. 298). Unless we seek to bear the
consequences of limited sexuality education through increased numbers of unwanted
pregnancies, abortions, HIV/AIDS and other STD rates, then we should increase our efforts to
educate our young adults, especially at-risk college students, about their sexual health (Fine &
McClelland, 2006).

**Conceptual Framework**

Glesne (2010) writes that qualitative research is not typically driven by theory, but is
situated within theoretical perspectives. This helps researchers to “situate their research within a
larger configuration of thought and to form initial questions and working hypotheses during the
beginning stages of data collections” (Glesne, 2010, p. 37). Therefore, I developed a conceptual
framework with the guidance of Glesne (2010) and Maxwell (2013), through which I could
further the research into the factors influencing the sexual health of international students.
Maxwell defines a conceptual framework as “the system of concepts, assumptions, expectations,
beliefs, and theories that supports and informs your research” (p. 39). Maxwell stresses that
conceptual frameworks are created, not found. Thus, the concept map in Figure 1 serves as a tool
to visually present my research framework.
Factors influencing sexual health of international students

Growing up in home countries

Impact of home country/culture's values on sexual health education

Perception of access and level to which sexual health topics are addressed in K-12 curricula

Transition to U.S. as international students

Continued impact of home country/culture's values on culture's sexual health practices

Perception of access and level to which sexual health topics are addressed within college education curricula

Perception of influence of the American culture on sexual health practices of people from their cultures

Future directions: Level of interest in sexual health education, preferred format, and insight into educational needs

Figure 1. Influences on sexual health (conceptual framework). The values being analyzed are social, cultural, familial, and religious. The sexual health topics in question include abstinence, premarital sex, virginity, birth control methods (familiarity, effectiveness, usage), STDs, and risk behaviors.

As seen in Figure 1, my research also looks into perceived access to sexual health information and educational programs at both the home country/culture level and at the U.S. level. Among the international students, perception of influence of the American culture is analyzed as well as related areas such as level of interest in sexual health education, preferred format, and insight into educational needs in this area.

Research Questions

My first research question is: From international students’ perspectives, how have their social, cultural, familial, and religious backgrounds and practices shaped their home country’s stance on sexual health and, subsequently, their own upbringing? My second research question is: From international students’ perspectives, what is their perception of the influence of American culture, their perception of access to sexual health information and education programs, level of interest in and preferred format of this kind of education?
CHAPTER III. METHODOLOGY

Qualitative studies are praised for “contributing to greater understanding of perceptions, attitudes, and processes” (Glesne, 2010, p. 39), which was partly the rationale behind why I pursued the type of methodology that I did. I used an instrumental case study method to guide my research, which is defined as a method that looks at several cases to become a “collective case study,” and allows investigation of “a phenomenon, population, or general condition” (Glesne, 2010, p. 22). The phenomenon in this study is how sexual health and sexual health education is addressed in different parts of the world. The collectiveness aspect is achieved through surveying 24 participants from different countries and cultures. In-depth interviewing, another component of case study research, was also employed. Through these qualitative methods, researchers are able to “focus on the complexity within the case, on its uniqueness, and its linkages to the social context of which it is a part” (Glesne, 2010, p. 22).

Through surveys and follow-up interviews among a small convenience sample of current international students at BGSU, I investigated my research questions. Employing these two types of open-ended, qualitative inquiry methods allowed participants to fully elaborate on subjects that are, at times, taboo to discuss back home in their native cultures (Glesne, 2010; Maxwell, 2013). As an interpretivist researcher, I sought to unravel the complexities of varied and multiple individuals’ experiences by “documenting how structures shape individual experiences, and also how individuals create, change, or penetrate the structures that exist” (Glesne, 2010, p. 39). Also, using Hall (1997), I was able to frame my research within the larger scope of culture, language, and meaning, in that language is central to meaning and culture has “always been regarded as the key repository of cultural values and meanings” (p. 1). These connections helped define my
understanding of culture within the context of analyzing many different cultures at the same time.

**Data Collection Process**

As Figure 2 illustrates, the process that was followed for collecting data during this case study were written, qualitative surveys, followed by in-depth interviews.

![Figure 2](image-url)

*Figure 2. Process for conducting case study. This figure illustrates the original recruitment number of participants in parentheses and their retention throughout the entire data collection process.*

**Time Frame**

I was granted HSRB approval at the end of August 2014 and began survey distribution immediately. On each survey, respondents indicated the date on which they completed it, and interviews were scheduled as soon as participants consented. The last interview took place on November 24, 2014, and signified the end of data collection. Factoring in both methods (surveys and interviews), all of my data collection took place between the three-month time span of September, October, and November 2014.

**Measures**

**Open-ended surveys.** I developed a 14-question survey that also included an element of collecting demographic data (see Appendix A). The respondents provided answers to several prompts: gender (male or female), age (participants had to be at least 18 years of age), class
status (undergraduate student or master’s/doctoral student), country of origin, arrival in the United States (month and year), and the date on which they were completing the survey. All of these data were fill-in-the-blank except gender and class status, in which the options to be chosen from were provided.

Following the demographic questions, the first ten main questions on the survey related to the participants’ perceptions of their home country/culture’s background of sexual health education, influence of religion/spirituality on sexual behaviors, views towards virginity/premarital sex and birth control methods, and knowledge of STDs and risk behaviors. The last four questions asked about how their background, influences, and views from their home country/culture impacts their status of sexual health as international students, as well as what their educational needs were in this spectrum.

Ten of the fourteen questions were adapted and expanded on from the seven focus group questions developed by Burchard et al. (2011). I also simplified terminology when possible, being mindful to those international students who have learned English as a second language. My questions were framed considerably differently than those of Burchard et al. (2011) because I felt that it was important to frame them in a way that would avoid potentially embarrassing a respondent or asking them to reveal personal information about their own background of sexual behavior or current sexual health status. For example, Burchard et al. (2011) asked participants how they personally felt about having premarital sex, and I reframed this to ask how members of their cultural group felt about other people from that cultural group having premarital sex.

Burchard et al. (2011) also conducted research among women only, and did not inquire as to the sexual orientation of these women. They did not mention any findings related to participants who identified with non-hetero orientations, nor did they make any differentiation as
to the nature of the sexual act they were intending to learn more about (such as oral or penetrative). Due to the nature of their findings related to the female students’ familiarity with contraception methods, I make an educated guess that they either had an inherent belief that the majority of their participants identified as heterosexual, or they did not receive or analyze responses that led them to the contrary. Since my research questions involved both male and female international students, and their cultural views rather than their personal views, it was unnecessary to ask about their personal choices and views on love, sexuality, and sexual orientation.

Table 1 illustrates my adaptation of the focus group questions developed by Burchard et al. (2011), with respective numbering indicated for reference to the original instruments.

Table 1

<table>
<thead>
<tr>
<th>Question posed in Focus Group (Burchard et al., 2011, p. 818)</th>
<th>Adaptation used in my Survey</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Can you tell us about the sexual health education you received whilst growing up?</td>
<td>1. Describe which kind of sexual health education you received while growing up, if any?</td>
</tr>
<tr>
<td>2. How do you feel about people having premarital sex?</td>
<td>5. How do members of your cultural group feel about people having premarital sex (sex before marriage)?</td>
</tr>
<tr>
<td>3. What types of contraception do you know of that are used by international students?</td>
<td>6. What types of birth control methods (such as condoms; contraceptive pills/tablets) are people in your culture familiar with?</td>
</tr>
<tr>
<td></td>
<td>7. How often and when are birth control methods considered acceptable/appropriate to be used by people in your culture?</td>
</tr>
<tr>
<td></td>
<td>8. How effective are methods of birth control, from your culture’s standpoint?</td>
</tr>
<tr>
<td>4. How do you think that living in Australia impacts on the sexual activity of international students?</td>
<td>11. Do you think that living in the United States can influence the sexual activity of international students from your culture? Why or why not?</td>
</tr>
<tr>
<td>5. How do international students access sexual health information?</td>
<td>12. Where or how can international students from your culture find out about sexual health information and treatment here in the United States?</td>
</tr>
<tr>
<td>6. Do you think that international students would like more sexual health education?</td>
<td>13. Do you believe that international students from your culture would be interested in sexual health education if provided by the university? Why or why not?</td>
</tr>
</tbody>
</table>
Of the remaining four questions I developed, one related to the influence of religion or spirituality on remaining abstinent. This was based on Luquis et al.’s (2012) recommendation that further research could include “qualitative open-ended questions to examine how religiosity, spirituality, and sexual behaviors interact from an individual perspective” (p. 613). The remaining three questions covered topics such as the importance of virginity, knowledge about STDs, and understanding of risk behaviors. I developed these questions to supplement the topics that I felt were lacking in Burchard et al.’s (2011) focus group questions, as they seemingly did not address these three important areas of sexual health.

Follow-up interviews. Follow-up interviews were developed to enrich the survey responses and solicit extra information as needed. The questions for each interview were structured based on the content of the participant’s responses on the survey. Also, on the occasions that there was more than one interviewee from the same country or region (e.g. India), I was able to compare and contrast their survey responses and develop follow-up questions based on multiple participants’ responses. I did not use a pre-established guide for my questioning or a script, as I wanted the conversations to flow as naturally as possible. However, I did inform every participant that they were free to stop the questioning at any point they wished, and were not obligated to answer any question they were uncomfortable with.

Rationale Behind Participant Recruitment Strategy

In determining the parameters of eligible research participants, many factors were considered besides an individual’s status as an international student. I decide to recruit both males and females, undergraduate and graduate students, married and unwed, with no age
A GLOBAL SNAPSHOT OF SEXUAL HEALTH EDUCATION

limitations or countries left out. It was beyond my research goals to focus on other
demographical information such as marital status, religious or spiritual affiliation, sexual
orientation, and attitudes towards or history of sexual behaviors. As long as a student identified
as an international student at BGSU, they were eligible to take part in my research study. I hoped
for a relatively even number of males and females, from a relatively even spectrum of ages and
grade levels, but I did not turn anyone away who expressed interest in participating.

Although the selection of my participants used both convenience and snowball sampling,
I also strove for a cross-section of the international population at BGSU. The rankings for 2013-
14 by the Institute of International Education (U.S. DOS IIE Data Set, 2015), as seen in Figure 3,
list countries in order of enrollment of international students in the United States. The top ten
were China, India, South Korea, Saudi Arabia, Canada, Taiwan, Japan, Vietnam, Mexico, and
Turkey (U.S. DOS IIE Data Set, 2015). All other countries represented 31% of the total
international student enrollment. With these statistics in mind, I purposely attempted to recruit
students from each of the top ten countries (see Figure 3). However, 50% of my sample was
from other countries, so the makeup of international students in my sample does not necessarily
reflect the makeup of international student enrollment across the United States, or at BGSU.
Participant Recruitment Process

To find participants, I organized a main recruitment event, as well as other recruitment events and initiatives, to distribute surveys directly to prospective students and answer their questions about my research. The main event was held in late September 2014, when I spent three hours a day over three consecutive days conducting research recruitment sessions at a table in the lobby of the Bowen-Thompson Student Union, a centralized gathering place for BGSU students. In terms of sheer number of surveys distributed, this tactic proved to be my most successful effort. In context of the 24 surveys that were returned, 11 surveys (46%) came through this recruitment strategy.
Before and after this event, I publicized my study through social media and email forums, and attended many events/meetings held by student organizations and campus offices that served international students. These tactics and venues through which I distributed surveys included:

- Class sessions on campus and student-oriented meetings and events (i.e., Global Village Learning Community, World Student Association, African Peoples’ Association, Graduate Student Senate, Tea Program for International Student Services, Dandiya Night for India Student Association);
- Word of mouth among my international friends (who subsequently would inform their friends of my research, and would, on occasion, distribute some of the surveys to them);
- Email, web-based newsletters and websites (e.g., Facebook, Campus Update email, International Student Services listserv, BGSU Women’s Center newsletter).

Of the above tactics and venues, the most successful recruitment effort in my impression was the Dandiya Night celebration for India Student Association. As a result of this event, and due to other Indian students who had become participants outside of this event, I gained more respondents from India than from any other country.

As a final strategy to recruit respondents, I reserved a room in the Union for three-hour blocks of time over two consecutive days in early November 2014. I marketed this through Campus Update as a final chance for students to either turn in a survey or participate in the research study. This was a drop-in session, which required completing the survey while there, and only one student ended up doing this.

**Results of Data Collection**

In total, I distributed 157 surveys, in paper form, across campus. I received 24 back, indicating a response rate of approximately 15%. I did not need to discard any surveys, as all
participants provided full demographic information and answered most questions. I estimate that half of my respondents (12) were recruited during my efforts in the Union (tables and drop-in sessions), seven were recruited through classes, meetings, and events, and five through word of mouth. Due to the coding on each survey/consent form, consistently distributing the coded order, and keeping track of how many packets were distributed at each event/venue, I was able to determine these estimations, without violating anyone’s confidentiality.

Of the 24 survey respondents, 17 (over 70%) agreed to an optional follow-up interview. I contacted each of these 17 people – rather than selectively choosing respondents – and expressed interest in interviewing them. Thirteen respondents met with me for interviews. The remaining four individuals did not respond to my repeated attempts to schedule a follow-up interview, and so I eventually conceded. Each interview lasted approximately 30 to 35 minutes and was in a one-on-one setting mutually agreed upon. Each participant signed an interview-specific consent form and consented to audio recording of the interview. The discussions were recorded through Voice Memo software on my cell phone. However, one recording did not save, unfortunately. Therefore, I transcribed 12 recorded interviews. See Appendices B and C for survey and interview consent forms, Appendix D for recruitment script, Appendix E for letter of support from International Student Services, and Appendix F for HSRB approval.

**Participant Details**

Table 2 provides full participant details as well as pseudonyms that reflect commonly used names in each of the countries. Ultimately, my sample size of 24 participants was comprised of an almost even number of men (n=13) and women (n=11), ranging in age from 18 to 39, and with twice as many graduate students (n=16) as undergraduate students (n=8).
Table 2

Demographics of Participants

<table>
<thead>
<tr>
<th>Region</th>
<th>Participant Pseudonym</th>
<th>Country of Origin</th>
<th>Sex</th>
<th>Academic Level</th>
<th>Age</th>
<th>Follow-Up Interview</th>
</tr>
</thead>
<tbody>
<tr>
<td>East Africa</td>
<td>Isaac</td>
<td>Kenya</td>
<td>M</td>
<td>G</td>
<td>28</td>
<td>Yes*</td>
</tr>
<tr>
<td></td>
<td>Simon</td>
<td>Kenya</td>
<td>M</td>
<td>UG</td>
<td>25</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Joseph</td>
<td>Tanzania</td>
<td>M</td>
<td>G</td>
<td>37</td>
<td>Yes</td>
</tr>
<tr>
<td>West Africa</td>
<td>Vivian</td>
<td>Ghana</td>
<td>F</td>
<td>G</td>
<td>31</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Joyce</td>
<td>Nigeria</td>
<td>F</td>
<td>UG</td>
<td>18</td>
<td>No</td>
</tr>
<tr>
<td>Central Africa</td>
<td>Deborah</td>
<td>DRC</td>
<td>F</td>
<td>UG</td>
<td>19</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Vidya</td>
<td>India</td>
<td>F</td>
<td>G</td>
<td>20</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Abhishek</td>
<td>India</td>
<td>M</td>
<td>G</td>
<td>22</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Deepak</td>
<td>India</td>
<td>M</td>
<td>G</td>
<td>21</td>
<td>Yes</td>
</tr>
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Note. Under sex, M = male and F = female. Under academic level, G = graduate student, UG = undergraduate student. Under country of origin, DRC = Democratic Republic of the Congo. The asterisk (*) associated with Isaac indicates that he participated in an interview, but it was not transcribed due to the recording failing to save.

The regions represented from the African continent were East Africa (Kenya and Tanzania), West Africa (Ghana and Nigeria), and Central Africa (Democratic Republic of the...
Congo). Three of the six participants, from Kenya, Tanzania, and Ghana, respectively, took part in follow-up interviews. The countries represented from South Asia were India, Pakistan, and Bangladesh, which had the highest representation with seven respondents. India was the country with the most respondents for my research study overall, with five participants. Four of the seven total South Asian participants, three from India and one from Bangladesh, respectively, took part in follow-up interviews. The sole country represented from East Asia was China, and one of these three Chinese participants took part in a follow-up interview.

Providing smaller representations (one or two respondents each) were the regions of Eurasia, Middle East, Western Europe, Oceania, and the Americas. Two countries, Russia and Turkey, represented Eurasia. Both of these participants took part in follow-up interviews. The sole country represented from the Middle East was Saudi Arabia, and one of these two Saudi participants completed a follow-up interview. The sole country represented from Western Europe was England, and this participant took part in a follow-up interview. A participant from New Zealand represented the Oceanic Region, but did not contribute further with a follow-up interview. Participants from Canada and Brazil represented the Americas (North America and South America, respectively). The respondent from Brazil completed a follow-up interview.

**Data Analysis**

My data analysis process was assisted by funneled all of my data into a spreadsheet I made in a single Microsoft Word file, with different categories that could be sorted together depending on the connections I wanted to look at. The categories reflected some of the demographic information that each participant provided at the top of their survey (gender, age, class status, and country of origin. Among these categories, I focused on sorting by respondent code/pseudonym, question, geographic region, country of origin, and gender within regions. I did
not sort responses based on age or class status, and I did not include arrival in the United States as part of this spreadsheet at all. I collected these data on age, class status, and arrival with the intention of perhaps analyzing it standalone, but ultimately decided not to. These pieces of supplementary demographics were more beneficial to verifying that participants were indeed students, and that they were also incoming students as well as of legal age, and did not provide the kind of cultural insight that I was seeking. Plus, the sample size was not large enough to categorize into these sub-components.

Survey data were continually added to the spreadsheet as more surveys were turned in. Each answer to each question (14 total) by each participant (24 total) resulted in 336 distinct rows of responses to analyze. Once I began collecting recorded interviews, I used InqScribe software to transcribe them, which allowed me to slow the pace of the conversation as I typed out the interview in its included interface. Then, I placed sections of transcribed interview into the survey data spreadsheet, with correspondence to each respondent and each of the 14 questions, whenever possible. Survey responses always came first, followed by interview responses in quotations. Seeing the data side-by-side made it easier to analyze the depth of responses and avoid repetitiveness when deciding what to use in my reporting. Literally speaking, my ‘voice’ was not included in the transcriptions. The roughly seven hours of interviews were rich enough in data on their own that adding in my own dialogue to each of the conversations was deemed unnecessary and too time-intensive.

**Ethical Considerations**

I followed Glesne’s (2010) recommendations in that I was as clear and as honest as possible in telling my research participants who I was, how I planned to go about my research, and what I would do with the information I would receive. They were informed that their
responses might be quoted directly in my research, but that they would be associated with their participant codes or pseudonyms, and demographics, rather than their identity. They were also given the option to take the survey home and complete it at another time. Additionally, I noted in the consent form that their participation in the study at any stage was completely optional and they were free to leave the study at any time. I added that respondents might find themselves uncomfortable answering questions about sexuality, and so they could decide to skip questions, avoid discussing certain topics, or end participation at any time without penalty. No incentives were provided to anyone who returned a survey or participated in a follow-up interview, to avoid participants from feeling compelled or pressured to participate for a reward.

Having worked for International Student Services doing orientation over the summer, where some of the students first became aware of my research, I made sure to note that deciding to participate or not in the study would not affect their enrollment or relationship with BGSU or with International Student Services/Orientation. This was also important to mention due to the fact that my main survey drop-off box was at the front desk of the International Student Services office. Occasionally participants who expressed interest in participating, and ultimately did, were students who I met during orientation. There were also participants who I considered to be acquaintances, colleagues, and friends, since I knew them from my graduate program, classes, and student organizations. All of these participants were aware that I was the researcher and still consented to do the survey, and for some, also the interview. Of course, I treated them with the same level of respect and professionalism in the interview setting as I did all other participants.
Limitations

Personal Limitations

Insofar as my role as an American researcher non-native to each and every one of the cultural groups I was studying, I believe that this was a limitation. As an outsider, I could only listen in to their explanations about cultural norms in their countries without my own frame of reference to compare it to. I did find, however, that I could particularly relate to the some of the insights of the African participants, having spent significant time living in southern Africa and working in the field of sex education. Another potential limitation is that we could only converse in English, and students may feel more open and more capable to talk about sensitive subjects in their native dialect. I also began my research with a bias that sexual health education was needed for international students at BGSU, but I remained open to the data shedding new light on that impression of mine, which it did.

Limitations in Data Collection

My data only provided a snapshot of the international student population at BGSU. I did not presume to generalize the statements by my participants, nor did I assume that their impressions represented the majority view in their culture or geographical region. Students hailing from similar geographical regions or even belonging to the same cultures do not always see things the same ways (Hall, 1997), which can be seen by their responses. Also, the makeup of international students in my sample did not reflect the makeup of international student enrollment across the United States (based on 2015 data from U.S. DOS IIE), or at BGSU due to my convenience sample method. Other cultural groups that may be prevalent on BGSU’s campus were not reflective in this study.
It is also possible that some of the participants did not contribute information with full disclosure, due to the sensitive nature of topics being discussed. This was a limitation that was also expressed in Burchard et al.’s (2011) research, and I feel that it similarly applies to my data. It is also possible that the people who chose to participate differed characteristically from those who chose not to participate, as their willingness to talk about issues of sexual health might not have been representative of other students from their cultures. Furthermore, the one-on-one interview format that I developed could also have been a limitation, because although it created a safe space for dialogue to happen without the presence of other students, this could have been intimidating for some of the respondents who were not comfortable discussing sexual issues in a closed space with a relative stranger (at least for most of them). This was partly the rationale behind why Burchard et al. (2011) decided to use focus groups instead of one-on-one interviews, as they believed it could limit open discussion. Glesne (2010) points out that for some respondents, interviewing may resemble a test and can cause anxiety about coming up with the “right answers” (p. 53). Contributing more to that sense of anxiety could also have been the fact that the person interviewing them was unfamiliar to them, which I was to many of the respondents.

Another limitation within my data collection was that by allowing respondents to remain anonymous, and opt out of the follow-up interview, I shrunk my pool of possible interviewees. Also, because I did not ask respondents in the demographics section on their survey about how they identified themselves culturally, I was left to assume that their country of origin was also their cultural heritage. Generally this was not an issue, but I questioned whether or not my participant from Canada was actually Canadian based on some of her survey responses. Due to her being one of the four participants to consent to a follow-up interview but not respond to my
attempts to set up this interview, I did not have the opportunity to ask about her background further and had no means of confirming my suspicions.
CHAPTER IV. FINDINGS

The initial written responses provided by participants through the surveys provided a substantial amount of information to analyze. Further elaboration on key points became possible through the follow-up interviews conducted with approximately half of the survey respondents. These interviews also uncovered new themes that had not necessarily come up in the initial survey questions. The layout of Chapter IV is as follows:

1. Background of Sexual Health Education
2. Influence of Religion/Spirituality
3. Virginity/Premarital Sex
4. Birth Control Methods
5. Sexually Transmitted Diseases and Associated Risk Factors
6. Influence of American Culture
7. Access to Sexual Health Information and Programs
8. Interest in Sexual Health Education Programs
9. Format of Sexual Health Information and Education
10. Additional Themes Derived from Follow-Up Interviews

In this chapter, I generally synthesize responses from regional areas, as well as provide supporting quotes from surveys and transcribed interviews. Direct quotes from the surveys and interviews are differentiated with their respective derivation (i.e. survey or interview) in parentheses after the quotation, if not otherwise indicated in some capacity in the text. Occasionally, gender (M or F) as well as country of origin will provide further context after each research participant’s name. It should be noted, also, that Democratic Republic of the Congo has been abbreviated to DRC.
The 12 individuals with transcribed interviews naturally had more data and are mentioned more frequently throughout the findings than the other half, which only completed surveys. Additionally, personal information was often disclosed without solicitation in surveys and follow-up interviews, which furthered my belief that anonymity assisted by pseudonyms was important in the reporting of my findings.

Background of Sexual Health Education

These data derive from Survey Question 1: “Describe what kind of sexual health education you received while growing up, if any?” and Survey Question 2: “If you received sexual health education, who provided it to you? If you didn’t, what do you think are the reasons why you weren’t educated on this topic?” The data from this question is divided into two separate categories based on the responses provided. Participants from Kenya, Tanzania, DRC, India, Russia, Turkey, England, New Zealand, Canada, and Brazil all indicated that they had at least some background of sexual health growing up. Participants from the countries of Ghana, Bangladesh, Pakistan, and Saudi Arabia all indicated they had no background of sexual health growing up. Respondents from China represented both sides of this spectrum and therefore are present in both categories.

Some Background of Sexual Health Education

Seventeen participants (71%) who provided answers to Questions 1 and 2 indicated they received at least some sexual health education growing up, and they hailed from every geographical region except for Bangladesh, Pakistan, and Saudi Arabia. The two Kenyan males, Simon and Isaac, were provided with basic sexual health education, including education about the various types of STDs and methods of prevention. “I was taught about how to interact with members of the opposite sex responsibly,” remarked Isaac (survey). “There was particularly
emphasis on sex after marriage or having protected sex,” wrote Simon. Joseph (M-Tanzania) noted that the sources of his information about sexual health were parents, relatives, teachers, and the church (survey). Although Deborah (F-Nigeria) indicated that older siblings and aunts help provide sex education in her culture, she also said that “sex is considered sacred, so parents don’t really talk about it with children.”

In their surveys, both Narayan (M-India) and Mayank (M-India) said that they had not learned anything formally, with Narayan having only received the scientific explanation of genital organs, and Mayank finding ways to learn about sexual health from friends and the media. Abhishek (M-India) stated that he had received a small amount of sex education while in school, but had learned to use the Internet to educate himself. In most of the schools in India, he wrote, sexual education is not in the curricula. “They think children will get spoiled if they hear the word sex,” noted Vidya (F-India) in her interview, who also had reported to have had some prior education. Papatya (F-Turkey) remembered learning particularly about girls having menstruation and boys having erections, but noted that this was not the norm in her country: “I know that not in all schools do they cover those topics. Especially in the religious schools. My school was a public school; it was a new school.”

Yanmei (F-China) remarked in her interview that although she personally was educated during grade school, “this is a blank page for a lot of families; they will not tell their children the difference between man and woman.” She also alluded to the Chinese government’s practice of Internet censorship, which limited the access to what they would deem “unhealthy” sexually explicit materials and information. Anya (F-Russia) indicated that the sexual health education she received was in high school – mostly through video programs made by the Soviet government at that time. However, she noted that the instruction from her school teachers often
differed from what was portrayed in the video programing and by the government representatives who would back up the film with lectures afterwards (survey/interview).

Cressida (F-England) discussed various points throughout her childhood and adolescence where she received parent-informed sessions about sexuality and through a community nurse that came into her school beginning at the primary level. “We’re pretty much educated; it’s to raise awareness of issues, very much of like where you could go to get help,” she stated in her interview. Oliver (M-New Zealand) wrote that sexual health education was provided to him by his parents and during middle school and high school through health and physical education classes. Pedro (M-Brazil) indicated that he had received a very good sexual health education both from his parents and while in high school: “Mostly in high school, we had sexual health class, and we learned about diseases, and how to protect, how to use condoms, and methods of birth control. Not every week, usually one time a month, or sometimes they had a workshop.” Hayden (F-Canada) noted in her survey that she was taught mostly about the pros and cons of getting involved in a sexual activity in elementary school as well as high school.

No Background of Sexual Health Education

The seven remaining participants (29%) indicated they had not received any sexual health education growing up, and they hailed from the geographical regions of West Africa, South Asia, East Asia, and the Middle East. Vivian (F-Ghana) wrote, “I did not receive any sexual health education in school or at home [...] sexual issues are not discussed publically until marriage; abstinence was what was preached.” In a follow-up interview, Vivian added:

People – even teachers – do not feel comfortable talking about it in class. It’s to discourage them. The more you keep talking about sex, sex, sex; young girls will start thinking about it. So we don't talk about it. We assume it’s not an issue.
Akash (M-Bangladesh) also indicated that he had not received any prior sexual health education. He wrote that people of his country consider it as a hidden topic of discussion, which cannot be shared in front of people, and that everyone tries to be conservative. According to Akash, Bangladeshis try to collect information from the environment, as well as the media, and younger people in society. They never talk to their family members, ever, about sex. In a follow-up interview, Akash elaborated:

It’s not about the school. In the whole country, there is no such kind of education. The country, the school, and the total community are not much worried about having such kind of sexual education. The people are not comfortable to talk about such kind of issues. Being adult, even, we don’t feel comfortable to talk about anything related to sexual relations.

Faiza (F-Pakistan) indicated that she had not received any formal sexual health education, as teachers were also reluctant to talk about sex as society overall discourages this kind of behavior. “Discussing sexual issues with young girls and boys is still a taboo,” she wrote. She also noted a parent-child communication gap in terms of her mother being very shy to discuss sexual matters with her.

Chao (M-China) simply wrote “None” in terms of his background of sexual health education. Jiaying (F-China), provided insight in her survey response as to why that may be a common viewpoint in their country:

Schools tend to avoid any direct information about sexuality [...] my assumption for the lack of education on sexuality is the related institutions’ fear for the stimulation by the education. They would block the channel rather than get it fixed.
The two Saudi Arabian male participants, Shahid and Abdul, had similar responses. “Anything related to sex is a taboo topic,” Shahid wrote, “so, no, sexual health education is not part of the education system in Saudi.” In his follow-up interview, he provided more insight into the Saudi culture:

There are a lot of things you shouldn’t be talking about in Saudi Arabia because the rules think that if we teach people about these things, they would become active in these things. Like, there are three things you shouldn’t be talking about in Saudi Arabia: religion, politics, sex. These are the three things you should avoid everywhere and all the time. [...] They think not teaching students or people about sex would keep people from knowing it’s going on.

Abdul noted similarly in his survey response that culture and religion were the main reasons for this strong sense of taboo.

**Influence of Religion/Spirituality**

These data derive from Survey Question 3: “How does religion or spirituality – however you may define these terms in your culture – influence people from your culture’s decision to remain abstinent or engage in sexual behaviors?” The data from this question will be divided into two separate categories – high and little to no influence on behaviors – based on the responses provided. Fifteen (63%) of the respondents, which included those from Turkey and Canada, the majority from South Asia, and all of the African and Saudi Arabian respondents, reported high influence. Reporting little to no influence were the other nine respondents (37%), which included the Chinese participants, two of the Indian participants, and the participants from Russia, England, New Zealand, and Brazil.
High Influence on Behaviors

The respondents from Africa all indicated that religion influenced sexual behaviors and decisions in their cultures. Joseph (M-Tanzania) remarked in his survey that people in his culture choose to remain abstinent because of fear of being named a sinner in the eyes of God, and the stigma that is associated with that. “People don’t like being called sinners!” stated Joseph (M-interview). “My church discourages sex before marriage since this is considered a sin,” wrote Isaac (M-Kenya), “the most common message that the church uses to discourage people in engaging in sexual activities is that ‘your body is the temple of the Holy Spirit.’” Fellow Kenyan, Simon, had a similar response in his survey, indicating that most people avoid engaging in sex due to their strong religious beliefs. “Religion does play a role,” wrote Vivian (F-Ghana), “and the understanding is that one should not have sex until you’re married.” “Religion and spirituality plays a huge role in the sexual life of Congolese people,” wrote Deborah (F-DRC), “abstinence isn’t just encouraged; it is a requirement that has been recently broken but most people still choose to remain abstinent.”

Vidya (F-India) wrote that people in her culture are really shy to talk about sex, but that they keep producing babies. In her interview, she elaborated:

Overall, yes, religion plays a large role in that they consider in Hindu religion it’s not really sacred if you have kids before you get married. Having kids is related to having sex, so, they think if you’re having kids after getting married then you should be having sex after getting married. This is related to religion but it’s also related to the mentality of people.

Abhishek (M-India) wrote, “If an Indian is religious, then he/she will most probably abstain from sex until marriage. Some people even consider masturbation as a wrong thing to do.”
Akash (M-Bangladesh) and Faiza (F-Pakistan) indicated in their surveys that sexual behavior is strictly discouraged in their cultures because of the teachings of Islam. “If any one is exposed that he/she has a sexual relationship with anyone before marriage, he is socially scolded, convicted,” wrote Akash. He added that married couples are also not allowed to touch each other in front of other people. Papatya (F-Turkey) stated in her interview that in her culture, societal pressure is stronger than religion in terms of maintaining virginity, but religion is still an important factor. “According to the religion (also societal norms influenced by religion and this is valid for different religions in Turkey as well), sex without marriage is not acceptable.”

The Saudi Arabian male respondents (Abdul and Shahid) both indicated in their responses the stance of Islam on sexual behaviors, primarily in regards to its context outside of wedlock. Shahid, who stated in his interview that Saudis link everything to religion, wrote, “any person who’s sexually active before marriage is considered a bad person and a bad Muslim.” Abdul noted in his survey that religion is considered the first priority in his culture.

**Little to No Influence on Behaviors**

Five of the seven respondents from South Asia tended to indicate that religion/spirituality in some capacity had an influence on sexual behaviors, but two of the Indian respondents remarked that religious influence was more on an individual level then across the entire cultural group. Narayan (M-India) remarked in his survey that Hinduism is not against sex or sexual behavior, but that there is a cultural context that sees differently. “There is nothing much related to religion or spirituality, as it seems to me, which makes me remain abstinent, but its more of family values and customs that play a major part in this aspect,” wrote Maynak (M-India).

Chinese female respondents Jiaying and Yanmei provided similar responses, which did not indicate religion necessarily being the driving factor behind sexual decisions. In her survey,
Yanmei discussed how traditional education, conservative parents’ modeling, and Confucian ideologies are the greatest influences towards Chinese people maintaining abstinence. “The traditional thoughts and family education, which might come from the ancient time, serve as the screen for this engagement,” wrote Jiaying. She added in her response, however, that Chinese young adults in present day are not abstinent to this extent any more, which can be seen from the high rate of abortions among young women and the popularity of moving-in together before marriage (survey).

Although most of her schooling took place during post-Soviet Russia, Anya’s comments showed how relevant she felt that this system had been to her own education. She referred to having grown up in a “Communist country with a Communist view on everything,” and noted in her interview that due to this, religion was not something you would even talk about, it did not impact society, and it did not influence the school curricula. Cressida (F-England) wrote, “Religion is not as openly discussed in England. It is a personal matter and rarely discussed. Usually beliefs or the decision of abstinence is passed down and encouraged by parents.” Similarly, Oliver (M-New Zealand) noted in his survey that religion has a small influence in his culture, but does not serve as common reason used to either abstain or engage in sexual behavior. Pedro (M-Brazil) stated in his interview that many people in his culture do not adhere to abstinence “even if their religion requires them to remain abstinent.” He added that they do not really care, and they do not wait.

**Virginity/ Premarital Sex**

These data derive from Survey Question 4: “How important is virginity (not engaging in sexual intercourse) in your culture? Please explain.” It also includes data from Survey Question 5: “How do members of your cultural group feel about people having premarital sex (sex before
marriage)?” The responses have been divided into three categories: High importance of virginity/low acceptance of premarital sex, shifting importance of virginity/acceptance of premarital sex, and low importance of virginity/high acceptance of premarital sex. The majority (75%) of the participants were categorized into the first category based on the content of their responses. The shifting importance/acceptance category was added to account for the responses that could not definitively be placed in one of the other two.

There was a pattern among respondents especially in the first category to highlight the importance of female virginity, even if male virginity was also assumed to be important (if there was no differentiation made between sexes). For example, several participants mentioned that virginity among women is important, but it was never mentioned by any of the participants that virginity among men in particular is important.

**High Importance of Virginity/Low Acceptance of Premarital Sex**

Just as all of the African respondents and almost all of the South Asian respondents had indicated the importance of religion in sexual decisions, all responded similarly when asked about the importance of virginity. According to Deborah and Simon, virginity represents purity in DRC and Kenya; it is seen as a virtue in Tanzania, according to Joseph; and it defines dignity in Nigerian culture, according to Joyce (surveys). Simon added that it reflects good parenting practices (“parents will in most cases be blamed for not teaching their children better”), and that virgins are highly respected, “mainly because they are getting fewer and fewer each day,” he wrote.

Vivian (F-Ghana) lamented that virginity is what is expected of people who are not married, but that realistically, not everyone maintains this. “I think guys have this notion that they feel like they have the upper hand when it comes to sex; they can sleep around with multiple
girls and break up with them and move on. And it hurts the girls” (survey). She further elaborated in her interview that many men will have girlfriends before marriage, but that they would prefer to marry a virgin than marry someone who has been sexually active before. Alluding to this double standard, Joseph explained in his interview:

People try to be secretive, especially girls. The girls are more secretive for other reasons too, because if your parents or your brothers found out you were doing something like that, it’s a disgrace to them, and they may punish you. For boys, it’s a little different, because it’s seen as an expression of masculinity. So for boys, it’s not considered a very, very bad thing. But for girls it’s considered a very shameful thing. It’s strange, because boys want girls . . .

There was a similar consensus among the respondents from South Asia in regards to the importance of virginity. Faiza (F-Pakistan) noted in her survey that both religion and culture reinforce this. Abhishek wrote that the majority of Indian parents expect their child/children to maintain virginity until their marriage. “That is actually considered the norm,” Vidya (F-India) noted in her interview, “it is expected from the children that they won’t have it [sex] until they’re married to someone.” She added that for those couples who have chosen not to abstain, they do not disclose this information, especially to their families (survey). Deepak, Mayank, and Narayan all had similar responses to the prevailing Indian cultural view on this matter, that premarital sex is considered as wrong, it is frowned upon, and members of society may be looked down upon for such behaviors (surveys and interviews).

In addition to noting that virginity is considered mandatory in Bangladesh, Akash wrote that an individual would have to keep any deviation from that hidden until marriage as well as the rest of his/her conjugal life. “It is taken for granted in my country that [if] you are going to
marry a girl, she has to be a virgin. And it is considered that all the girls in the country are virgins, none of them are having sexual relations” (survey). This notion that it is almost unfathomable for a woman to deviate from virginity was echoed in an interview with Deepak (M-India), “In our society, it’s like, she is a virgin. For sure. There is no ‘she should be.’ She is one.”

In her interview, Papatya (F-Turkey) said that it is important for a woman to maintain her virginity, and referred back to the long-standing cultural practice of a groom’s mother and sisters checking for menstrual blood on bed sheets after a wedding night as affirmation of the bride’s premarital virginal status. But Papatya noted that “what everyone says in Turkey is that it totally depends on the guy” in reference to whether or not a man will take issue with a woman losing her virginity before marriage (interview). Hayden (F-Canada) wrote that it is important in her culture to remain a virgin before marriage. “If by chance you don’t,” she wrote, “then it falls bad on your family and their teachings.”

Abdul and Shahid from Saudi Arabia had similar responses on this topic and nearly echoed what the respondents from South Asia stated. Abdul wrote: “Virginity is really important especially for woman. In my culture if the woman is not married and she is not a virgin, that is really forbidden. That woman would never get married easily, because she lost her virginity before marriage.” Shahid also noted the importance of virginity, but indicated that more young people these days are open to being sexually active without being married. In his interview he mentioned that if you were sexually active, you would be more likely to talk about that with people close to you, such as your friends or siblings, but not your parents, as they would not approve of premarital sex. “If the society or the people around you learned about this,” he added, “they would look at you as if you’re not a good Muslim” (interview).
Shifting Importance of Virginity/Acceptance of Premarital Sex

Anya (F-Russia) referenced the multicultural diversity of Russia that results in virginity holding varying degrees of importance depending on the region in question. She noted in her survey that “each state has its own rules,” and in the northwest part of Russia, virginity is not very important. “I mean, 80% of young men and women who get engaged have had sex before. But in Muslim states, it is all the [other] way around,” she wrote, “only 20% of couples have had sex before the wedding day.” All three respondents from China had similar responses that the passing of time has changed their culture’s stance on virginity. Yanmei noted in her survey that premarital sex used to be considered a “serious blunder” in a female’s life. “Sometimes, it may ruin her whole life” (survey). “Recent decades have seen a different trend that nobody cares much about virginity any more,” Jiaying wrote. “They don’t think it’s possible.” Chao wrote in his survey that premarital sex was considered immoral 20 years ago, but people are now accepting it as normal. “It is not a good or bad thing for others to comment on anymore,” Yanmei added, “it’s more like a private/personal choice” (survey).

Low Importance of Virginity/High Acceptance of Premarital Sex

Cressida noted in her survey that in British culture, young people feel encouraged by the media to engage in sexual activities, and that they are never told specifically by society to maintain virginity. She felt as though sex is not openly discussed in many families, and that “it is not until people are older [that] they see virginity as something to hold onto” (survey). “People are free to make their own choices,” she wrote, “however, in retrospect, many people can see why waiting would be a better option because of the ‘sacred’ idea.” Oliver had a similar response in regards to the cultural views surrounding virginity in New Zealand. He wrote that virginity is not seen as extremely important, but that some people are looked down upon because they
engage in sexual behaviors so young. Pedro also indicated that virginity is not seen as very important in Brazil, and most people do not care about one’s virginal status (survey).

**Birth Control Methods**

These data derive from Survey Question 6: “What types of birth control methods (such as condoms; contraceptive pills/tablets) are people in your culture familiar with?” as well as Survey Question 7: “How often and when are birth control methods considered acceptable/appropriate to be used by people in your culture?” and Survey Question 8: “How effective are methods of birth control, from your culture’s standpoint?” Overall, these questions garnered content-heavy responses across the board and were more descriptive than what could be as easily categorized as the five prior questions. Therefore, I combined the responses to these three questions into four content areas: Familiarity and accessibility of birth control, high use and high acceptability of birth control, affect of stigma on acceptability of birth control, and varied effectiveness of birth control. Respondents may appear repeatedly in more than one of the content areas.

**Familiarity and Accessibility of Birth Control**

The resounding responses from every participant from Africa in terms of what method of birth control were members of their culture most familiar with was condoms. This was followed by birth control pills. But familiarity does not always result in easy access. “There are plenty of birth control pills; they are available in small dispensaries, health centers, big hospitals,” Joseph (M-Tanzania) stated in his interview. “The thing is, if you go to rural areas, in some villages, there are no dispensaries, no health centers. You have to travel, in some places, up to 10-70 miles to get to a health center.”

Similarly to the African respondents, the majority of the international students from South Asia also pointed to condoms and birth control pills as the most familiar methods of
contraception in Indian, Bangladeshi, and Pakistani cultures. In his response, Abhishek wrote that people in Indian culture know what condoms are for, but are scared to get and use them. He believed that they are not easy to access and that there is uncertainty about the quality of condoms sometimes. “Even I don’t know where to get them,” he added in his interview, “Maybe you get it [birth control] in the department store, but maybe the shopkeeper won’t sell it to you” (interview). In her interview, Vidya elaborated on her perception of this issue in India:

A lot of government efforts in rural places are distributing free condoms. There are a lot of programs spreading family planning, and a lot of NGOs are working on it, too. So most places are giving them for free or at a very, very low cost. Now, there are a lot of campaigns about using condoms, so using condoms is encouraged higher than other methods. But a lot of people don’t even want to use condoms just because of the pleasure being less.

Vidya added that Indians are familiar with all methods of birth control, but are not necessarily choosing to use them – at least those outside of the urban crowd (survey).

Akash had a similar response in regards to Bangladeshis: “When someone is living in the urban area or in the capital city Dhaka, they are more educated, civilized,” he stated in his interview. “They are having a smarter life than the rural people. They have the means of getting lessons about sexual health and protection methods.” In her survey, Faiza wrote that familiarity in Pakistani culture depends on the socio-demographic and economic characteristics of the individuals, such as their place of residence and education. She noted, however, that the majority of people in her culture are familiar with birth control pills.

The three respondents from China all noted condoms as the most popular method of birth control, followed by contraceptive pills. Both Jiaying and Yanmei alluded to perceived health
risks associated with using certain methods. Jiaying wrote that she had heard about “lots of sickness and infections” that were caused by using intrauterine devices (IUDs). “I've heard that birth control pills are not good for women’s bodies/health,” Yanmei stated in her interview. “So I think if you use that often, your period will be postponed or you cannot control it.” She also mentioned that Chinese governmental institutions would ask married couples to have sterilization surgery to comply with the country’s one-child policy.

Both Anya (F-Russia) and Papatya (F-Turkey) wrote in their surveys that people in their culture are most familiar with condoms. Anya wrote that vaginal rings as well as the “pull-out” method are most popular in Russia among couples that live together. She added that education about birth control methods is more advanced in bigger cities such as St. Petersburg and Moscow as opposed to smaller villages (interview). In her survey, Papatya wrote that her culture is very conscious about pregnancy prevention and that the Turkish government provides free birth control methods (especially IUDs) to people financially in need.

Though both Abdul and Shahid mentioned that there is familiarity in Saudi Arabian culture with condoms and birth control pills, Shahid added the “pull-out” method as another common practice, but that birth control pills are viewed as something that shouldn’t be prescribed to people who are not married (surveys). In his interview, he stated that condoms are not free, but that they can be purchased from pharmacies and supermarkets. Cressida (F-England) listed nearly every common contraceptive method as familiar to people from her culture, including condoms, birth control pills, implants, injections, and patches (survey). In his survey, Oliver mentioned condoms and birth control pills in particular as familiar to New Zealanders. Hayden (F-Canada) and Pedro (M-Brazil) both wrote that all contraceptive methods are familiar to people in each of their cultures. “Getting birth control usually is pretty easy,”
Pedro said in his interview. “I think it’s good, because if condoms are not around, they’re gonna have sex anyways. So it’s good to have it,” he added.

**High Use and High Acceptability of Birth Control**

Isaac remarked in his survey that Kenyans use birth control methods all the time, and Joyce noted that in Nigeria, condoms are often used to prevent disease, and also to control childbirth. “As long as one is not ready to become a parent or is without the economical means of supporting a child, then birth control should be put into play” Simon (M-Kenya) wrote. “Birth control is always acceptable in China,” wrote Chao. Yanmei seemed to follow his viewpoint, as she remarked in her survey that single people use birth control methods when they think it is necessary to avoid pregnancy and disease, and that married couples use birth control methods to avoiding unexpected pregnancy. She added that for a married couple with a child already, they use birth control for avoiding further pregnancies.

Yanmei went on to comment on China’s one-child policy, and how that puts a lot of pressure on couples to be consistent in their use of contraception:

I don’t think most young couples would like to have a second child. Even if they get accidently pregnant, they would not choose to give birth to the second child. Because there are a lot of pressures, especially in China. We have a very large population and fierce competition. You don’t have any more time or energy, and more importantly, economic problems. Women are not forced to have an abortion . . . you are just wanting to do that, willingly.

Cressida noted that in her survey that in England, birth control methods are free and encouraged by medical centers if you are sexually active. She added that many people use contraception for
prolonged periods of time, especially in the case of implants, and that it is common to seek guidance from medical professionals.

**Affect of Stigma on Acceptability of Birth Control**

Acceptability often times related back to how one would be viewed in society if known to be using birth control. Vivian noted that sex is perceived to be in the married context in Ghana, so it would be expected that married couples, and not unmarried, young people, would request birth control. In her interview, Vivian expanded on this further:

There is this stigma that if you are a young person going to the store to buy a condom, people will look at you. You would be shy. People are shy to go and get them; so most people do not. Because it’s a community, right? So, the person who is the pharmacist knows you, knows your parents. So you’ll be thinking, oh, what will he be thinking of me? Going in there to buy a condom; what for?”

Joseph provided a similar reaction when he noted in his interview that condoms are everywhere in Tanzania, but that most people don’t feel comfortable using them. “In most places, condoms are free, but you don’t want people to know you are going to have sex,” he added. “People wouldn’t just walk into a dispensary, because there’s stigma. People try to get birth control stuff secretly.”

Similar responses were garnered from the international students from South Asia. The majority of responses alluded to the social standard that birth control methods are meant for use by married couples. Abhishek (M-India) noted in his interview that there is a stigma associated with buying condoms, “the whole culture is such that people expect young people not to have sex.” Furthermore, a shopkeeper may refuse to sell condoms to teenage kids because he/she
believes they are too young. “And they are too afraid to go,” Abhishek added. “The adults don't educate them that it’s okay to get contraception to protect yourself” (interview).

Deepak (M-India) wrote that birth control, in theory, shouldn’t even be needed, “because sex is ‘supposed’ to be had after marriage.” In his interview, he elaborated further:

You're not supposed to buy it. People don’t even have the guts to go buy birth control. It’s funny, like, I know friends who have actually told me they’ve gone to a chemist to buy pills and those guys working there, they have, like, laughed at them and ridiculed them and all that, so, basically it’s a bad thing. It’s a stigma. And the worst part is that if you want to buy them . . . people talk a lot, so, you can’t.

Akash and Faiza noted that in their Bangladeshi and Pakistani cultures, those who are married do not face stigma when accessing birth control. “The people who are married do not feel any discomfort or stigma to buy condoms,” Akash stated in his interview. “It again depends on individual circumstances, wrote Faiza. “As premarital sex is out of question so people usually use after marriage and especially to space the births” (survey).

In her interview, Anya remarked that birth control methods are not free in her country, and particularly within the Muslim regions, social opinion would prevent a woman from feeling comfortable accessing birth control. “If a girl is taking birth control pills, she’s having [an] active sex life [...] if the family knows about it, they would know she’s sexually active; that would be a bad thing for her” (interview). Papatya said that birth control methods are considered important in Turkey, but it depends on which city and what part of the country you live in as to what the reaction will be if you try to purchase contraception. “As a woman, if you buy it, it is more difficult” (interview).
Shahid (M-Saudi Arabia) had a similar answer to Papatya’s for this question. “If there’s a female using this type of birth control, she wouldn’t talk about it with anyone other than her partner” (interview). As for birth control pills, Shahid explained in his interview that it would not be appropriate for unmarried women to try to access them:

You should have your husband to get those pills; they’re not just given to anyone. If a woman is married, she is married, and so she can get them. She would go to a doctor so they can prescribe. If not, I’m not aware of a way that she can. I would think she would have a hard time doing it.

He added that no one in his culture really talks about these things, so it is not easy to determine when contraceptive methods are considered acceptable (survey). For his stance on the matter, Abdul (M-Saudi Arabia) wrote that if a couple agreed on using a method, then it was seen as acceptable.

In her interview, Cressida (F-England) mentioned that stigma, awkwardness, and potential gossip that could result from being spotted at a sexual health clinic by someone you know leads people to prefer to make private doctor’s appointments for these issues. In his survey, Oliver also indicated that birth control methods are encouraged in New Zealand culture for those who are sexually active and for medical reasons. Pedro noted that birth control methods are considered acceptable for most people in Brazilian culture, but that it depends on the family (survey and interview). “Some girls are ashamed; they don’t tell their parents they are going to take the pills,” he said. “But they can go and have their pills. Sometimes at school they even give condoms for free, if you want.” Hayden (F-Canada), on the other hand, wrote that contraceptive methods are not considered acceptable at all in her culture because it is assumed that people would refrain from sexual activities before marriage.
Varied Effectiveness of Birth Control

With the African respondents, the perceived level of effectiveness of birth control methods among members of their cultures ranged from uncertainty to “very effective.” Overall, this question garnered very minimal responses from six African international students. “I’m not sure how effective it is, probably effective among the educated,” wrote Vivian (F-Ghana). “Somewhat effective,” lamented Joseph (M-Tanzania) in his response, “most people don’t use them consistently, and some people don’t use them at all.” Deborah (F-DRC) wrote that since her culture highly encourages abstinence, they do not give much consideration to birth control methods.

The international students from South Asia had similar responses to the African students, without much elaboration. The common thread was that birth control methods were more effective among the urban population, as they would be more likely to have access to them unlike the rural populations. Faiza noted that in Pakistan, it varies from person-to-person, but she really was not sure (survey). “I am not sure if birth control is effective at all in India,” wrote Abhishek, “as many young people probably don’t use it.” Deepak (M-India) remarked in his interview that with those people who actually can access birth control, they have no idea how to use it, especially without easy access to a computer. “The educated ones, they can like, Google it, ask friends or something, people living in cities and all, but there are those who have no idea” (interview).

The three Chinese respondents all similarly responded that birth control is viewed in their culture as either very effective if used properly, or ineffective if it fails. Yanmei added that because abortion is legal in China, many young couples are having abortions when methods of birth control fail (survey). “All methods are good if they work,” remarked Anya (F-Russia) in
her survey. “Some are more effective than others, some are cheaper, some are more expensive, some are easy to use, some are not very convenient,” she added. Shahid wrote that the perceived effectiveness of birth control in Saudi Arabian culture is hard to gauge because nobody would talk about such a thing, and that it is a very private matter. Cressida noted in her survey that birth control methods in England are seen as very effective with exceptions being rare. Oliver similarly stated “very effective” with regard to the cultural perception of contraception in New Zealand, and Pedro (M-Brazil) responded with “very good” in his survey.

**Sexually Transmitted Diseases and Associated Risk Behaviors**

These data derive from Survey Question 9: “What do most people in your culture learn about HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) and other sexually transmitted diseases/infections (For example: Genital warts or gonorrhea)?” and Survey Question 10: “What risk behaviors (actions that may result in bad consequences for health) do you think people in your culture believe could lead to someone contracting HIV/AIDS or another sexually transmitted disease/infection?” Though these questions aimed to develop two separate sets of data, many of the participants gave answers to Question 10 (risk behaviors) in their answer to Question 9 (what is taught about STDs), and so the answers overlapped to the point that it necessitated combining the responses. As a result, the responses could not reasonably be categorized.

All of the respondents from Africa indicated that people from their respective cultures are aware of the prevalence of HIV and how it is transmitted through sexual behavior. Risk behaviors that were stated included unprotected sex, having multiple partners, sharing needles, blood transfusions in unsafe clinics, and sharing sharp objects such as razor blades or knives (surveys). Deborah (F-DRC) wrote that this is why people in her culture are encouraged to stay
abstinent until marriage, and that there is mandated disease testing by ministers before weddings are officiated. “We learn that these diseases are embarrassing and can cause sterility and/or death,” wrote Joseph (M-Tanzania). In his interview, he elaborated further:

Most people who suffer from HIV look so weak. So people look at those who have HIV as dirty people, they wouldn’t want to shake hands with you. Not because they believe they would catch the disease, but they think you are dirty. They look down on people who have those kinds of diseases. People wouldn’t come up and be like, ‘oh, I have this disease.’ It would be very shameful to have such a disease; you wouldn’t even tell your parents, you would probably only tell your closest friend.

In her interview, Vivian stated that there have been a lot of educational campaigns in Ghana surrounding sexually transmitted diseases, but that there are also misperceptions that mirror Joseph’s impressions of Tanzania culture. “It’s promiscuity,” Vivian added. “You are a bad person; you were a bad person; that’s why you got it [...] people know you have been sleeping around” (interview). But ultimately she believed that the main issue in Ghanaian culture at the moment is the lack of education about pregnancy prevention rather than disease prevention:

You have young girls that get pregnant even before high school, and are unable to continue their education because they were not taught how to protect themselves. And some people only have sex once and they get pregnant and that’s the end of their education; they can’t go back to school. So that’s the biggest impact of us not having sexual education.

Isaac noted that in Kenyan culture, people learn that they can get help from hospitals, and are encouraged to get tested and take medication if found to be HIV-positive. Simon (M-Kenya)
wrote that people in his culture are taught to have protected sex if they can’t abstain until marriage.

A handful of the respondents from the South Asian countries referenced the media as a source of information about sexually transmitted diseases. “Media is playing [an] important role in educating people about HIV/AIDS and also creating awareness about safe-sex methods,” wrote Faiza (F-Pakistan). Mayank similarly stated that Indians are aware of these diseases, especially through television, where they learn the causes and effects (survey). Some of the respondents, however, mentioned the inability of the government/media to reach more rural populations. Abhishek noted in his interview that the government in India has done a big campaign on HIV, but not everyone can be reached:

People in the cities might know, but people in the rural areas, I’m not sure, because the level of education there is really, really quite bad. There is a possibility of people having them and not knowing that they have it, and they don’t go to a doctor.

In her survey, Faiza had a similar stance about Pakistani culture; that because sexual health information is limited, many uneducated, rural people have misunderstandings about STDs. “Even I come across people who are educated and living in urban centers [that] have misconceptions,” she added (survey). Akash gave a comparable observation about Bangladeshi culture. “In the countryside, people are not very careful or concerned about diseases,” he stated in his interview. He added that people don’t tend to take HIV tests unless suggested to do so by a doctor.

Overall, the risk behaviors that respondents from the South Asian region mentioned as being familiar for people in their cultures included unprotected sex, shaving rods, blood transfusions, illegal (out of marriage) sex, having sex with prostitutes and multiple partners, and
the behavioral activities that could result from drinking and drugs (surveys). Narayan (M-India) also mentioned kissing, shaking hands, hugging, touching and using the same chairs/toilets/latrines as still-common misperceptions in Indian culture. “There’s a ‘Devil’ inside you,” wrote Deepak (M-India). “You’re cursed.” When asked in his interview what he meant by this, Deepak explained that in his culture, having an STD indicated that you must have done something wrong in your past life. Similarly, Narayan wrote that it symbolizes poor choices and a loose lifestyle. Abhishek mentioned discrimination and stereotyping in Indian culture against people with STDs, especially in the suburbs as opposed to the cities, where there tends not be as high of a level of education (interview).

Two of the three Chinese respondents provided similar commentary about misperceptions in their culture surrounding STDs. “Stay away from it and people with it,” wrote Chao. Jiaying commented that people in her culture see HIV as a “dirty disease” but may not even know the consequences of it (survey). She added that they believe that other STDs are either the result of sexual behavior outside of the marriage or that they need to pay better attention to their sexual hygiene (survey). Jiaying also wrote, “many migrant village workers in the cities have to buy sex from prostitutes due to their unmarried status or absence of their wife’s companionship.” Items that the Chinese participants listed as commonly believed risk behaviors in their culture included “any sexual contact,” infidelity and disloyalty to the spouse, a one-night stand, meeting online dates, and going to certain nightclubs. Even having listed some of these misperceptions, Yanmei also stated that those who have finished compulsory education (both those in the cities as well as those in the countryside) actually do know about HIV/AIDS, and that the media functions well to spread information and knowledge about STDs.
Anya noted in her survey that awareness of STDs is very prevalent in Russian culture, and all children in schools are educated primarily through video programs and lectures. Blood tests for diseases are as common in school settings as they are prior to the start of new employment. However, misperceptions still exist, and Anya referenced drug use, prostitution, and homosexuality as the prevalent risk factors believed by her culture to contribute to sexually transmitted diseases (survey). “If you have HIV, you either are a whore or a prostitute,” Anya said in her interview. “They think it’s something evil [...] if you have it, you’re evil from that Western culture” (interview). Papatya painted a similarly grim picture of her culture’s level of sexual health knowledge. In her interview, she spoke to how HIV/AIDS is seen as a fatal disease: In Turkey, maybe the doctors know about it [that it’s not fatal], but we don’t! AIDS is known as a bad thing, it’s a death sentence. I still don’t know exactly what’s going on right now, what they’re teaching in the schools, but it’s my assumption that they’re still teaching that it’s fatal, to scare people of it. Governments do these kinds of things.

The Saudi Arabian participants, Abdul and Shahid, both indicated that people in their culture are aware of STDs. Shahid added that they learn that these kinds of diseases are more likely to be transmitted when being intimate with more than one person. He defined risk behaviors in his culture as “any behavior that is not really humane or what normal people would accept or do,” and by that, he meant foreplay (survey and interview). He also noted in his interview that the accessibility of the Internet has made it possible for people to learn about sexual health, in a way that they had not been able to in the past.

Cressida (F-England) wrote in her survey that in her culture, people learn about the physical effects of STDs, and what happens to the body as a result, in both the short and long-term scenarios. Commonly believed risk behaviors in her culture included the lack of condom
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use and oral sex. Oliver (M-New Zealand) mentioned unprotected sex as the most well known risk behavior, and that people in his culture are taught about condom use and the importance of testing (survey). Pedro attributed disease awareness in Brazilian culture to the media as well as family provided and school administered education on HIV (survey and interview). He added in his interview, however, that the level of sexual health education one could access depended on their location within the country (i.e. north, south, or central region), due to varying backgrounds and school systems. Hayden (F-Canada) lamented in her survey that in her culture, they are not very educated about risk behaviors.

Influence of American Culture

These data derive from Survey Question 11: “Do you think that living in the United States can influence the sexual activity of international students from your culture? Why or why not?” The answers varied across the board for this question, and were categorized as such: Some potential for influence, uncertain potential for influence, and low potential for influence. Just over half (54%) of the participants were categorized as believing that there was some potential for influence. Four were categorized as uncertain, six were categorized as low influence, and one participant gave an unrelated response, and so his answer was not categorized.

Some Potential for Influence

Vivian (F-Ghana) referenced the liberal nature of the United States when it comes to sexual health, which could lead to international students also developing a liberal mindset about sexual activity (survey). “But of course you need to have a sexual partner to engage in sexual activities,” she pointed out. “Living in the United States definitely influence[s] the sexual activity, because of the difference in sexual practices,” wrote Deborah (F-DRC). Simon (M-Kenya) mentioned in his survey that the realization that people in the United States engage in
sexual behaviors at a much earlier age than in African culture could influence the way that international students perceive sexual activity.

Akash referenced the differences in societal rules perhaps influencing someone from Bangladeshi culture to deviate from the rules held at home (survey). Giving insight in his interview to this possible mindset, “my thinking is changing; maybe I’m a little receptive, because I have experienced this thing in the U.S. So, maybe my behavior is slightly changed.” Narayan (M-India) wrote that behaviors could be influenced due to the absence of family and relatives watching over and easy access to privacy. Vidya (F-India) also agreed that sexual activity could be influenced due to more freedom. “They would have a lot of sexual choice here, rather than back home,” she added in her interview.

Yanmei remarked in her interview that some concepts Chinese international students have familiarity with, such as having free mind and free will, and not having to “compress” your desires come from the western countries. “America is called the melting pot because people just want to have more freedom, so they come to the United States,” she added in her interview. “This influences Chinese young people a lot.” Papatya (F-Turkey) also alluded to this concept of freedom expressed by Yanmei. “There seems to be ‘freedom of sex’ here just like freedom of other things,” she added (survey). In her interview, Papatya remarked, “the guys get very excited about that [...] they are like, we are going to have sex, and afterwards we’re not going to feel guilty about it.”

The Saudi Arabian male participants, Abdul and Shahid both gave reference to sexual behavioral changes being more likely caused by a change in mindset or partner rather than the location of where they were living at that time (surveys). However, as Shahid remarked in his interview, younger Saudi students might be more open to having sexual relationships knowing
that their parents were not with them in the U.S. and they were free to do what they wanted to do. Using the change in mindset angle, “if I am with someone who is more open to these things, probably I would be inspired,” he added. “I would be curious to try these things. So probably that would result in changing my behavior” (interview). Pedro (M-Brazil), like Shahid, noted that for students from his culture who lived with their parents before coming to the United States for school, this new freedom could impact their behaviors (survey). Oliver, also, believed there could be an influence among those from New Zealand culture due to the exposure of different viewpoints in the U.S. (survey).

**Uncertain Potential for Influence**

Some students were hesitant to make a firm determination in their impressions of American influence on the behaviors of international students from their cultures. Abhishek (M-India) believed that behavioral changes really depend on the student’s family background. “Some people will probably change, some people will be the same. It totally depends on how they are brought up by their families,” he said. Deepak (M-India) said that it depends from person to person, but students are coming to the U.S. having already been through a similar college life (survey, interview). Jiaying gave rationale that a Chinese student’s viewpoint on sexuality might be broadened because of the diverse cultures they’re exposed to while in the United States, but that this new knowledge doesn’t necessarily result in action (survey).

**Low Potential for Influence**

Joyce alluded that African culture is so important to people from Nigerian culture that they do not let American culture influence them (survey). Joseph (M-Tanzania) also did not necessarily believe that the sexual activity of international students from his culture would be affected (survey). “Some international students don’t interact with Americans enough to get
influenced by the American culture in any way other than the education they get here,” he wrote. Anya and Cressida both noted in their surveys that they did not believe there to be much behavioral influence, because they do not see many differences between the sexual behaviors of people in the United States and in their home countries of Russia and England. In her interview, Cressida added that she felt like people from her culture grow up a lot quicker than some Americans do, anyways. Additionally, Hayden (F-Canada) reasoned in her survey, “if one has a firm morale and set of values, no change should influence sexual activity.”

**Access to Sexual Health Information and Programs**

These data derive from Survey Question 12: “Where and how could international students from your culture find out about sexual health information and treatment here in the United States?” The sources that the participants listed included the university, health centers, hospitals, the Internet, media, counselor’s office, the library, and the International Student Services office. Generally respondents mentioned more than one idea, or reflected inclusion of both on and off-campus resources, so I have categorized rather than quantified the responses. They have been divided into on-campus, off-campus, and unsure about resources, with occasional overlap of participants in both categories if they listed multiple options. Despite the wording of this question, it resulted in particularly more answers of personal preference as opposed to overall preference of the cultural group.

**On-Campus Resources**

In his interview, Joseph (M-Tanzania) stated, “I think everybody knows the health center, and that the university does a good job of communicating the availability of health services on campus,” After stating “I don’t know anything about this at all,” Jiaying (F-China) wrote, “if for me, I would go to our school health center or the hospital for advice.” Both Anya (Russia) and
Papatya (Turkey) listed the student health center as a source of information that students from their cultures would likely refer to (surveys). Anya added that the student health center has many brochures about risks, diseases, and treatments.

Oliver (M-New Zealand) listed the health center in his survey in addition to RecWell (the university’s Department of Recreation and Wellness, which is the main provider of free, confidential HIV testing on campus). Oliver was the only respondent of the 24 to mention RecWell. In her survey, Hayden (F-Canada) listed the university itself as a source for sexual health information, and Pedro (M-Brazil) suggested that students from his culture could seek guidance on sexual health from the health center as well as their health insurance provider.

Off-Campus/Online Resources

Outside of a few suggestions towards community health centers and hospitals, 10 of the 24 respondents (42%) indicated that international students from their cultures could find out about sexual health information and treatment online through the Internet (surveys). In his interview, Joseph (M-Tanzania) mentioned being aware of free HIV testing on campus through the daily “Campus Update” digest email, and felt that through this avenue, quite a bit of information is disseminated about health services available on campus. Jiaying (F-China) indicated that online resources “seem to be more convenient and comfortable” for people from her culture (survey). Chao (M-China) similarly responded by stating that students from his culture would go online for this kind of information. Yanmei (F-China) mentioned that videos she had to watch to make up for not attending Graduate Student Orientation may have “implied something about sexual health information,” but she was unsure (survey).
Unsure About Resources

A few respondents were unsure about where international students from their cultures could access sexual health information or where they, themselves, would be able to. “I don’t know where and how I can find sexual health information and treatment while here in the U.S.A.,” wrote Abhishek (M-India). “Healthcare is very different in India. Insurance is not a mandate there. When people get sick, they just go to a doctor and it’s not really as expensive as here. People can afford it” (interview). Abhishek added that this kind of information wasn’t covered during orientation, and that he was unclear as to whether or not his health insurance here would cover HIV testing (interview). Mayank (M-India) and Akash (M-Bangladesh) were also unsure of where to go for this kind of information (surveys).

Akash remarked in his interview that friends of his who have been living here for at least two years would know; insinuating, perhaps, that it might take a year or two before incoming international students would be conscious of this kind of information. He noted, however, that this kind of information would not be very significant or important to them if they did not have a need to know. Cressida (F-England) stated that she wasn’t sure of where to go for sexual health concerns, because the campus health center may be meant for only general health problems. “We should be told where to go for advice and stuff,” she added in her interview, “It might not be an important factor for a lot of international students, but I still think it’s good to know.”

Interest in Sexual Health Education Programs

These data derive from Survey Question 13: “Do you believe that international students from your culture would be interested in sexual health education if provided by the university? Why or why not?” The answers varied for this question, and were categorized as such: Some
level of interest, uncertain level of interest, and low level of interest. The responses were nearly even for level of some interest as compared to level of low interest.

**Some Level of Interest**

Half of the students from Africa answered that they did believe other international students from their cultures would be interested in or would have a need for this kind of education. “They would be interested because they need to know where they can get help whenever the need arises,” wrote Isaac (M-Kenya). Joyce (F-Nigeria) similarly said yes with the rationale that sexual health education is an important issue (survey). Vivian (F-Ghana) felt as though “they would feel they know enough at this point,” but went on to say in her interview that although she doesn’t know how many graduate students from her culture have the need for sexual health information, the younger undergraduates “will need such education to guide them.” She added that, in general, it doesn’t hurt to know your HIV status, and that it could be helpful to have some sort of sexual health education available for free without restrictions (interview).

Mayank (M-India) thought that other Indian students would be interested because their nature back home is to generally try to stay away from this topic (survey). In regards to other international students from Pakistan, “I am pretty confident that people are willing to get this education, which will provide us the opportunity to discuss myths and clear our misconceptions,” wrote Faiza. The two female respondents from China also fit into this category. Jiaying cited one’s responsibility to care about their own health as well as the health of others (survey). Yanmei stated in her interview that she believed that this kind of education would be helpful, even necessary, for all international students, and not just those from China. She viewed it as part of how they adapt themselves to a new, multicultural context (interview). However, she did note that Chinese people are very conservative, and would generally want to avoid such a topic. “It’s
very touchy and very sensitive,” Yanmei stated. “They just think that these are private things; they don’t want to share [...] they don’t think this is science. They think this is private stuff.”

Papatya felt that students from Turkey would be interested in sexual health education (interview). Abdul and Shahid, from Saudi Arabia, also saw the importance in students from their culture receiving this kind of information. “We need this major[ly] back home and we want people to be educated about sexual health,” Abdul stated in his interview. Shahid also thought there was a need among other Saudi Arabian students for this kind of education. “It would benefit them,” he explained, “it would be something that you should learn before it’s too late” (interview). He wrote that whether or not students from his culture learned about sexual health depended mostly on how serious they were about getting such information. Also, he added that if a sexual health program were available when he first came to the United States, he would have gone. “This is something that I would have wanted to learn” (interview).

Uncertain Level of Interest

Some of the participants were unsure of what the interest level in sexual health education would be for international students from their countries. Abhishek (M-India) stated that it depends from person to person. “People are so different, and it’s hard to generalize and stereotype,” he remarked in his interview. Hayden (F-Canada) and Pedro (M-Brazil) were both also unsure. Pedro noted that although he personally had a good knowledge base on sexual health, not all students would. In reference to other Brazilian students, he said that most of them live with their parents until they come to the United States, whereas they are now living by themselves (interview). “So, they feel free to have more sexual relations, and maybe most of them don’t have a good background on these things,” he stated in his interview.
Low Level of Interest

The other respondents whose answers varied from “maybe not” to “no” tended to reason that this was because international students from their cultures already receive a lot of (at least basic) information about sexual health before coming to the United States. Joseph (M-Tanzania) elaborated in his interview:

If you went to school in Africa, I don't know of any African country that does not teach people about sexual health, at least at the secondary school level. Because we’ve had this disease for many years, and the government is trying, actually, to infuse sexual health education into their curriculums. So, most people who make it to America, chances are they have heard something about sexual health. And when they come here, there’s a good chance they will just dismiss the idea of going through another sexual health education program, thinking that it’s the same stuff they have learned before. I may be wrong, but I’m pretty sure most people would be like; I don’t really think I need that.

Deborah (F-DRC) stated no as she felt that it would make people from her culture feel uncomfortable to talk about sex in an open space (survey).

Akash noted in his survey that although this kind of education could be useful, and other students from Bangladeshi culture may be interested, they might just not be willing to spend the time on it. “If I had free time, I would, otherwise I wouldn’t,” Deepak (M-India) stated in his interview. Deepak also felt as though most students from his culture probably wouldn’t be interested because they would have already had this kind of education back in India (survey).

Vidya had a similar perception, in regards to time constraints and workload. She commented in her interview that Indian students are more concerned with what they’re studying and getting paid, and how they can make incentives, so unless there was some kind of incentive, it might be
hard to draw them in. She added that those who have had some prior background in sex education might be more open to a program of this nature as opposed to those who have not, but because they think they are adults, they are quite certain they already “know what’s good for them” (interview). Chao (M-China) also cited that international students from his culture are mostly adults already, and that they are too busy to add this into their schedules (survey).

Anya (F-Russia) didn’t think other international students from her culture would be interested in sexual health education because they generally come to the United States with prior knowledge about sexual health (survey). “I think a lot of people from England would be like, ‘no, I don’t need,’ because we’ve already had the education and had readily available services, where we know we can go back home,” remarked Cressida in her interview. Like other respondents, however, she expressed a common interest in knowing where international students could go for sexual health advice, and what sexual health related services are covered by their health insurance plan (interview). Oliver (M-New Zealand), like Anya, did not think other international students from his culture would be interested in sexual health education, due to their prior knowledge of this subject through schooling while growing up (survey).

Format of Sexual Health Information and Education

These data derive from Survey Question 14: “In what format do you think international students from your culture would prefer to have sexual health education provided to them (i.e. reading materials, informal group setting, or classroom instruction)?” The responses developed from this question varied greatly across the board, with all three categories being equally advocated for among the different regional groups with not much deviation from the provided examples, except for the addition of online trainings and orientation sessions. The preferences towards informal group settings and classroom instruction were seen as one in the same for some
participants, and so I did not attempt to categorize them separately. Also, some participants liked more than one format, and so they may appear multiple times throughout this section.

**Reading Materials, Online Trainings**

Deborah (F-DRC), Vivian (F-Ghana), and Joseph (Tanzania) gave preference to reading materials for international students from their cultures. Deborah viewed reading as more personal and private, and Vivian believed that reading would be the best option because students would be too shy to discuss these matters within group settings (surveys). Joseph stated that it depended on individual preferences on how to learn, but that an online training setting would give students the chance to start reading about sexual health information related to living in the United States before they would arrive (interview). He elaborated further:

> In my opinion, international students should probably start going through that training even before they come here. Because, you know, sometimes people arrive early [...] and by the time the university opens, they have already been to the clubs. The damage may have already happened.

Anya thought that reading materials would be best for students from Russia, as she noted that most of them are not aware of how to access HIV testing here. In their surveys, Oliver (M-New Zealand), Cressida (F-England), and Pedro (M-Brazil) all suggested reading materials as the ideal method for international students from their cultures. Pedro also thought reading materials that students could take home would be a good avenue to try. “So people can read alone in their homes, and they don’t have to talk to someone about it,” he explained (interview).

Though their preferences varied slightly, it was clear that all three respondents from China did not find classroom or group settings to be ideal. Chao and Yanmei thought reading materials would be best for fellow Chinese international students, and Yanmei specifically
recommended an online format for this reading or a video lecture (surveys). She also thought this kind of program should be mandatory because if it were optional, people would not choose to do it (interview). Jiaying did not prefer one method to another, but noted that informational videos in particular should contain valuable information as well as be interesting (survey).

**Informal Group Settings, Classroom Instruction**

Isaac (M-Kenya) thought that teaching in an informal group setting would work best for international students from his culture (survey). “This is because there would be free exchange of information,” he wrote. Joyce (F-Nigeria) and Simon (M-Kenya) both gave preference to classroom instruction. Akash (M-Bangladesh) thought that other students from his culture might find an informal group setting to be appropriate, but he cautioned that people are very conservative about these issues in Bangladesh. “Sitting and listening would be fine,” he elaborated in his interview. “But if I had to talk about these things in front of a group, I might be uncomfortable.” Faiza also gave preference to this kind of instruction for other Pakistani international students. “I think informal group setting/classroom instruction is [a] better way of communication, because sometimes reading yourself doesn’t help in understanding matters,” she wrote.

Abdul and Shahid both mentioned classroom instruction as the method that they thought other Saudi Arabian students would prefer for this kind of education (surveys). Shahid elaborated further in his interview:

I think the only way to teach Saudis about sexual health education is to make it a required course to be admitted at BGSU. Because otherwise, they would feel like, no, I can’t do that, because other people would know I’m taking this class and they would feel embarrassed. As far as reading something, I don’t there’s a lot of people who are really
into reading. And even sometimes when you read something, you would have questions, and you would want someone who would be able to answer these questions.

“With the reading materials, nobody is going to read those,” Papatya (F-Turkey) commented in her interview. She gave preference to informal group settings and mentioned that she wished, as international students, they were more informed about their insurance, in terms of what it covers within female and sexual health (interview). This was a common thread with many of the female respondents.

**Orientation Sessions**

Vidya (F-India) questioned how effective reading materials such as a pamphlet or flyer would be, mentioning in her interview that they would not garner much response or attention from students. She as well as Akash (M-Bangladesh) mentioned orientation as a possible venue for such session, because the students already have to be there (interviews). However, they both stressed that sexual health shouldn’t be too lengthy of a session during orientation, as students are overwhelmed with many other things at that same time, such as registering for courses and learning how to avoid plagiarism in their coursework (interviews).

In their interviews, Cressida and Pedro both specifically mentioned orientation as a good venue for a sexual health education program. Cressida echoed Papatya by stating the need for further information about what their student health insurance covers, “especially coming from a country where you don’t have a private health system, and you don’t need to have insurance” (interview). Pedro suggested that there be a small presentation during orientation, followed by an invitation for students to come to another event if they wanted more information (interview).
Additional Themes Derived from Follow-Up Interviews

Various other themes came up during my follow-up interviews, that either ended up taking the conversation in an interesting new direction, or off-track from the kinds of data I was aiming to collect. These themes included sexual consent, abortion laws/one child per family policies, childbirth out of wedlock, stigma in home country settings surrounding HIV status, access to antiretroviral therapy (ARV treatment) in home countries, government censorship in home countries, comparisons of healthcare systems, navigating the U.S. healthcare system as international students, and impressions of and suggestions towards International Student Services/Orientation. I decided to leave this supplementary data out, as these topics were not brought up in every survey or interview, and in many cases, only one or two each.
CHAPTER V. DISCUSSION AND CONCLUSION

Summary of Findings

Through the questions I asked in my surveys and follow-up interviews, I aimed to answer my two research questions:

(a) From international students’ perspectives, how have their social, cultural, familial, and religious backgrounds and practices shaped their home country’s stance on sexual health and, subsequently, their own upbringing?

(b) From international students’ perspectives, what is their perception of the influence of American culture, their perception of access to sexual health information and education programs, level of interest in and preferred format of this kind of education?

As can be found from the Findings chapter, an overwhelming amount of data was collected on topics of contraception, which necessitated its own section. Adjusted as needed to reflect the findings of this study, the following corresponding and overarching themes developed:

(a) varying degrees of prior sexual health education;
(b) strong beliefs about virginity, premarital sex, contraception, religion;
(c) uncertainty towards accessing sexual health guidance;
(d) mixed perceptions about the influence of American culture; and
(e) conflicting preferences towards future sexual health education

The key descriptive words used above such as ‘uncertainty’ and ‘conflicting’ illustrate the diversity in participants’ responses. Most interesting were times in which two individuals from the same country/culture had different viewpoints on the same issue. This was evident throughout Chapter IV, but will be revisited in this chapter. Also, when analyzing the data, I noticed that there were sometimes inconsistencies between what respondents wrote on their
survey and what they stated during their interview. For example, Akash (M-Bangladesh) wrote that birth control use is considered acceptable by around 70% of people in his country, but he then stated in his interview that as long as two people were married, they wouldn’t feel discomfort or stigma in buying condoms. I considered this to be a discrepancy because his initial survey response did not make this distinction between the acceptable uses of birth control among married couples as opposed to unwed people.

When asked in her survey if she thought living in the U.S. could influence the sexual activity of other international students from her culture, Vivian (F-Ghana) wrote “yes, to some extent,” and then explained why. In her follow-up interview, she said she didn’t think so, and then also explained why. With this same question, Pedro (M-Brazil) simply wrote, “I don’t think so” about whether living in the U.S. could influence the sexual activity of other Brazilian students, but then explained in his interview why “probably, yes” this was case. Respondents also provided different answers between their surveys and interviews about their preferred format(s) of sexual health education.

Discrepancies such as this could have been caused by numerous factors such as participants not being given their survey to review prior to the interview (although they could have, if someone had asked), the span of time between the two forms of data collection, or either more or less openness in the interview situation. Glesne (2010) points out that inconsistencies can help to reveal the complexity of a topic (p. 47). Most of these inconsistencies, however, were not noticed during the interview as it was happening, as my focus was not to compare and contrast the two data collection methods at that time. It was rather to build upon answers, on whichever path the respondent decided to go. I also did not want a respondent to feel that their credibility was in question or feel compelled to change their answer on my behalf. I dealt with
these discrepancies by including both viewpoints if possible, if I could do so in a way that made sense, or if the results were categorized. Alternatively, I analyzed the data further and made a judgment call as to the prevailing thought that should be extracted from the excerpt in question.

**Analysis and Discussion**

In this section, I will touch briefly on each of the five themes as listed in the last section, and through content analysis, highlight particular literature as well as my own data that supports them. The five themes are reflective of the data found through all 14 of the survey questions.

**Varying Degrees of Prior Sexual Health Education**

The 17 participants (71%) who indicated that they had at least some background of sexual health growing up hailed from every geographic region except for Bangladesh, Pakistan, and Saudi Arabia. Those who had received some type of education mentioned that it included topics such as types of sexually transmitted diseases, methods of prevention, birth control methods, hormonal changes (such as menstruation/erections), where one could go for help and advice, and the pros and cons of getting involved in sexual activities. Sources of sexual health information included parents, relatives, teachers, community nurses, government video programs, health and physical education classes, churches, and the Internet.

The remaining seven participants (29%) came from Ghana, Bangladesh, Pakistan, China, and Saudi Arabia (representing Asia, Africa, and the Middle East) and indicated they had no background of sexual health growing up. In Asia and Africa, critics for years have railed against ‘Western’ sex education, and obstacles remain towards the support of research into sexual behaviors particularly in Asia and the Middle East (Wellings et al., 2006; Zimmerman, 2014). In China, many doctors are in fact unwilling to provide sexual health advice to unmarried young people (Burchard et al., 2011). Research shows that “morals, taboos, laws, and religious beliefs
used by societies worldwide circumscribe and radically determine the sexual behavior of their citizens” (Wellings et al., 2006, p. 1716).

Those who had not received some type of education gave various reasons as to why, and they included: culture and religion, sex being seen as a hidden and taboo of discussion, sexual issues not discussed publicly until marriage, avoiding the topic was seen as a way to discourage the behavior, reluctance by teachers due to society overall discouraging sexual behavior, low comfort level on the part of teachers and other adults, shy parents creating parent-child communication gap, and low level of societal concern on the subject. Burchard et al. (2011) found that parents, with their own background of limited sexual health knowledge, likely contribute to their children having poor knowledge.

Some of the respondents who had indicated that they had no background of sexual health growing up also mentioned that they came up with their own ways to educate themselves about sexual health matters, such as collecting information from the media, friends, and younger people in society. The participants from China represented both ends of the spectrum, and I attribute this to the nature of different schools in different areas utilizing different curricula. Case in point, only one of the three Chinese participants, Yanmei, indicated that she had received prior sexual health education. In her interview, Yanmei described how she had gone to a famous middle school for her area in that time that had very advanced classes, and was unlike most other schools in China.

Research shows that many international students are coming into the U.S. from countries with high prevalence rates of HIV/AIDS and other STDs, pre-conceived notions surrounding sexual health, and poorer sexual health knowledge when compared to domestic students (Burchard et al., 2011; Kalsi et al., 2007). The level of access to sex education among the
participants seemed to impact the accuracy of the information that they reported as common teachings in their cultures. Media was highlighted as playing an important role in educating people about HIV/AIDS and creating awareness about safer-sex methods, but so was the inability of the government/media to reach more rural populations. Those that had basic STD knowledge indicated that people from their respective cultures are aware of the prevalence of HIV, how it is transmitted through sexual behavior, the physical effects of STDs, why they should seek help from hospitals, and why they should get tested and take medication if found to be HIV-positive.

There was mention that even those who are educated and living in urban centers have misconceptions along with those in more rural areas who are not very concerned about diseases nor tend to take HIV tests unless suggested to by a doctor. Some respondents stated that people in their culture are taught that STDs are the result of sexual behavior outside of the marriage, socially abnormal sexual behaviors or foreplay, and poor sexual hygiene. Some are taught to look down on people or discriminate against those who have these kinds of diseases because it symbolizes promiscuity, poor choices, a loose lifestyle, and being cursed. Other respondents mentioned that people in their cultures are taught that HIV symbolizes a “dirty disease” and a sign of evil from Western culture, and that you must either be a whore or a prostitute if you are infected. STDs are seen as embarrassing and are widely known within the different cultures to cause sterility and/or death.

The participants discussed the various different risk factors that other students from their cultures would likely be familiar. Still-common misconceptions of risk behaviors in Indian culture included kissing, shaking hands, hugging, touching and using the same chairs, toilets, and latrines. Others mentioned meeting online dates and going to certain nightclubs as risk factors.
Some participants reported that people in their cultures are encouraged to stay abstinent until marriage due to these risks, or to have protected sex if they cannot abstain until marriage. There is mandated disease testing in some cultures before weddings are officiated, as well as in some school settings and prior to the start of new employment.

**Strong Beliefs about Virginity, Premarital Sex, Contraception, Religion**

**Virginity, premarital sex.** Research suggests that when compared to domestic students, international students have more complex attitudes about premarital sex, and female virginity is an extremely important concept in many of their home countries (Burchard et al., 2011). This is supported through my own research with the majority of my participants (75%) that could be categorized as having cultural beliefs related to high importance of virginity/low acceptance of premarital sex. The remaining participants could be categorized as having cultural beliefs related to shifting importance of virginity/acceptance of premarital sex, and low importance of virginity/high acceptance of premarital sex. For those who considered virginity being of high importance in their cultures, they cited reasons such as: religion, it represents purity, it is seen as a virtue, defines dignity, reflects good parenting practices, leads one to be highly respected, is expected of people who are not married, and that an individual and their family may be looked down upon for premarital behaviors. What came up repeatedly is that there is a double standard between men and women about whose virginal status is more important. For men, it is seen as an expression of masculinity, but for women, it is considered a very shameful thing. Men prefer to marry virgins, which may lead to women having difficulty getting married due to losing virginity before marriage. In prior research related to this, the female students in Burchard et al.’s (2011) study indicated that although they acknowledged that their peers may be having premarital sex,
they could not because of a fear of being judged and due to concern of being regarded by men as “damaged goods” through losing their virginity (p. 819).

The remaining 25% participants could be categorized as having cultural beliefs related to either shifting/low importance of virginity and shifting/high acceptance of premarital sex. Cited reasons included: regional differences in religious views, passing time has changed trends, virginity not being seen as possible anymore, view towards premarital sex switching from immoral to normal, sexual behaviors being seen as more of a private and personal choice and not for comment, encouragement from the media to engage in sexual activities, lack of open discussion in families, freedom of choice, and virginal status not being a factor in relationships.

**Contraceptive methods.** These data were divided into four content areas: Familiarity and accessibility of birth control, high use and high acceptability of birth control, affect of stigma on acceptability of birth control, and varied effectiveness of birth control. In regards to familiarity, the resounding method from the majority of respondents was condoms, followed by birth control pills. Other less commonly mentioned methods included IUDs, hormonal/vaginal rings, implants, injections, patches, sterilization surgery, and the “pull-out” method.

Though condoms, contraceptive pills, injectables, implants, and IUDs are considered “key means of preventing negative reproductive health outcomes,” adolescent women in most countries still face significant barriers to using contraceptive methods (Bearinger et al., 2007, p. 1221). In my research, I found this to be true among some participants, in that familiarity with contraceptive methods did not always result in easy accessibility of these methods. There was a common thread that easier access to contraceptives was correlated with health centers and hospitals in bigger cities, where the more educated and civilized people were living, as compared to rural areas which were less likely to have dispensaries, and therefore whose residents were
less likely to access sexual health education and protection methods such as condoms. Similarly, Salgado & Cheetham (2003) found that service-related barriers included cost as well as difficulty in traveling to and obtaining services. Socio-demographic and economic characteristics of the individuals, such as their place of residence and level of education, came up repeatedly as barriers to access by my respondents, and is supported by research that shows that relatively few teenage women in most developing countries report using contraceptives (Salgado & Cheetham, 2003).

Other issues included low level of comfort in accessing condoms, lower interest in usage due to the belief that condoms lessen the pleasure of sexual acts, fear of health risks/menstruation issues and infections associated with contraceptive methods, fear of a shopkeeper denying their sale, denial of sale of birth control pills to unmarried couples, and uncertainty of their quality. In countries such as China, concerns perpetuated by gynecologists about the risks and side effects of the oral contraceptive pill results in low support towards and usage of this method for birth control (Burchard et al., 2011).

Some participants noted that contraceptive methods are considered acceptable in their cultures and used frequently as a result for a variety of reasons, such as when seeking to prevent disease, control or space childbirths, if someone was not ready to become a parent or was without the economical means of supporting a child, or was living in a country with a one-child policy (such as China) or under another strict policy where abortion could be forced. In some countries, participants talked about how birth control methods are encouraged by medical centers for those who are sexually active, and are generally used for prolonged periods of time.

High acceptability was not the norm, however, as the majority of participants mentioned the affect of stigma on the acceptability of contraception in their cultures. Acceptability often
times related back to how one would be viewed in society if known to be using birth control. For many of the cultures, sex was perceived to be in the married context, so it was expected that married couples would request birth control, and not unmarried, young people. Stigma was a major concern, which was evident through the varied examples:

- fear of community members passing judgment or gossiping after seeing you in a public place or sexual health clinic accessing contraception;
- likelihood of familiarity with community pharmacist and their familiarity with your parents, and being laughed at and ridiculed by the pharmacist;
- shopkeeper may find you to be too young,
- purchasing contraceptives may lead others to believe you are having sex;
- lack of guidance from adults that it is okay to get contraception to protect yourself;
- tendency to feel ashamed, or social opinion preventing women from feeling comfortable or being able to access birth control; and
- fear of family finding out you are sexually active

Related to these points, Salgado and Cheetham (2003) found in their research that there was less acceptability of contraceptive use among adolescents due to the fear of parents finding out, difficulty in negotiating condom use with male partners, and fear of violence from partners. Conklin (2012) determined that many adults are uncomfortable with the idea of teen sexuality, and prefer to remain in ignorance or denial about the subject. This is also evident through Burchard et al.’s (2011) study with unmarried, female international undergraduates in Australia, which showed that for the majority of them, their parents were unlikely to have spoken to them about sexual health, and overall they had limited knowledge about contraceptive options.
Perceived level of effectiveness of contraceptive methods among the respondents’ cultures ranged from uncertainty about effectiveness to high levels of effectiveness. Overall, this inquiry did not produce very rich data. Participants mentioned that effectiveness depended on factors such as frequency of use, level of education, urban or rural environment, proper and consistent use, cost, ease and convenience of use, and ability to access sex education or the Internet to learn how to use contraceptive methods.

Role of religion. In their research, Nadar and Phiri (2012) stated, “the variable of religion cannot be ignored in the knowledge being generated on HIV as faith plays an important role in individual and community life and has the capacity to control social and health conduct” (p. 124). This became evident in my own research as fifteen (63%) of the respondents, which included those from Turkey and Canada, the majority from South Asia, and all of the African and Saudi Arabian respondents, reported high religious influence on people from their culture’s decisions to remain abstinent or engage in sexual behaviors. Reporting little to no religious influence were the other nine respondents (37%), which included the Chinese participants, two of the Indian participants, and the participants from Russia, England, New Zealand, and Brazil.

Research supports that “individuals who possess high religiosity and high core spirituality have more conservative sexual attitudes and less sexually permissiveness attitudes than their counterparts” (Luquis et al., 2012, p. 603). Based on the responses from some of my participants, I believed that they would fit under this description by Luquis et al. (2012). Those who reported high influence on people from their culture’s decisions to remain abstinent or engage in sexual behaviors mentioned factors such as:

- strong religious beliefs,
- societal pressure to uphold religious teachings,
church institutions discouraging sex before marriage,

- abstinence being required by religion rather than just encouraged,

- fear of being named a sinner in the eyes of God for not remaining abstinent and the stigma that is associated with being seen as a sinner,

- church teachings about the body being a temple of the Holy Spirit,

- having kids before marriage is not seen as sacred,

- threat of being socially scolded and convicted if exposed to be having a sexual relationship before marriage, and

- threat of being seen as a bad person if having sex out of wedlock.

Those who reported little to no religious influence on behaviors mentioned reasons such as there being more focus on family values and customs rather than religion and spirituality, and religious viewpoints impacting more on an individual level than across an entire cultural group. Other factors driving this low influence included: Low impact of religion on society or school curricula, religion being seen as a personal matter and not openly discussed, parents’ input more substantial than religion’s input, conservative parents’ modeling, traditional education models, and Confucius ideologies.

Uncertainty Towards Accessing Sexual Health Guidance

The respondents who had ideas about where they could learn about sexual health information while in the U.S. listed resources such as health centers, a counselor’s office, online through the Internet, the library, the International Student Services office, and health insurance provider. Only one respondent of the 24 mentioned RecWell as a resource, which is the university’s Department of Recreation and Wellness, and the main provider of free, confidential HIV testing on campus.
However, when compared to domestic students, research suggests that international students have more difficulty accessing sexual health information and have a poorer understanding of the role of health practitioners (Burchard et al., 2011). This is evident through the responses of some of my participants, who were unsure about where international students from their cultures could access sexual health information, indicating that they did not know where and how they could find this kind of information, and that the campus health center may be meant only for general health problems and not sexual health concerns. A few participants had uncertainty especially about what their mandated health insurance covered in terms of sexual health needs and advice.

It is difficult and challenging for many international students to feel comfortable discussing sexual health needs and concerns, and embarrassment and stigma are considered to be especially significant barriers to them seeking sexual health education (Baek et al, 2012; Burchard et al., 2011). For those participants in my study who were unsure about where they could learn about sexual health information, online resources seemed to be a more convenient and comfortable solution to them, at least for information gathering. Research shows that college students tend to identify their friends, magazines and the Internet as sources for information about sexual health, and tend to rely on these sources, without necessarily considering their reliability (Burchard et al., 2011).

**Mixed Perceptions About the Influence of American Culture**

The responses varied across the board on this area of data, and ranged between some potential, uncertain potential, and low potential for influence of American culture. Just over half (54%) of the participants could be categorized as believing that there was some potential. These respondents referenced such things as the liberal nature of the United States when it comes to
sexual health, which could lead to international students also developing a liberal mindset about sexual activity. Supported through research by Luquis et al. (2012), international students may be introduced for the first time in the college atmosphere to an American culture of openness about sexual behaviors, and exposure to these kinds of experiences has the likelihood to influence students’ religious and spiritual beliefs, sexual attitudes, and sexual behaviors.

Other responses by the participants as to why other students from their cultures could be more likely to engage in sexual activity, due to the influence of American culture, cited reasons such as: Differences in sexual practices, earlier engagement age-wise in sexual behaviors in the U.S., differences in societal rules influencing deviation, absence of family and relatives watching over, easy access to privacy and more freedom of sexual choice, western ideal of free will, less feelings of guilt towards behaviors while in the U.S., and exposure to different viewpoints.

Some students were hesitant to make a firm determination in their impressions of American influence on the behaviors of international students from their cultures. Their remarks included that behavioral changes really depended on the student’s family background, and that it depended from person to person, but that many students who come to the U.S. have already been through a similar college life, and that new viewpoints do not necessarily result in different behaviors. One respondent who believed that American culture would have a low influence on other students from his countries cited that they do not interact with Americans enough to be influenced by their culture. Also mentioned by participants was the importance of their own culture trumping any influence by American culture, low levels of differences between the sexual behaviors of Americans and those in their home countries, a higher level of maturity than Americans, and firmer morals and values of certain cultures. Reasoning such as this was also evident in the study by Burchard et al. (2011) with some of his participants indicating that there
was similarly a trend toward premarital sex in their home countries and the belief that moving abroad was unlikely to produce a radical change in behaviors of sexual activity.

**Conflicting Preferences Towards Future Sexual Health Education**

The findings of my study, similar to those of Baek et al. (2012) and Burchard et al. (2011), demonstrate that the majority of my respondents are interested in learning more about sexual health, but have varied opinions towards what would be the best way to access information regarding sexual health. As with Eisenberg et al.’s (2012) study, several of my participants tended to become aware of sexual health information only when they felt a need for it, and had no reason to investigate this kind of resource on the BGSU campus. Increased communication about available resources was the impetus of most respondents’ suggestions, rather than actual sexual health instruction.

**Interest level.** For the participants who expressed that other students from their cultures would have some level of interest in sexual health education programs, reasons included a desire to know where they could get help if needed, and an impression that younger students need this kind of education. Other reasons behind interest level were that it provides access to a topic that is avoided in some cultures, provides opportunity to discuss myths and clear misconceptions, connects to one’s responsibility to care about their own health as well as the health of others, is an important part of how international students adapt to their new and multicultural context, and provides a way to learn more about what services are covered by the student health insurance plan, especially when coming from countries without health insurance systems.

Not all of the participants were sure what the interest level would be like for other international students from their countries, and cited that it depends from person to person, which makes it difficult to generalize. The other respondents whose answers varied from “maybe not”
to “no” tended to reason that this was because international students from their culture already receive a lot of (at least basic) information about sexual health before coming to the United States. Other reasons included that international students would be uncomfortable to talk about sex in an open space, would desire to avoid such a private and sensitive topic, they are too busy and might not be willing to spend their time in this way, are more concerned towards schoolwork and engaging in programs with incentives, and may feel as though they are adults and already know what is best for them. Research data from a 2011 U.S. DOS IIE report correlates this impression of Indian students in particular as focused on their academics while in the U.S., as IIE found that over three-fourths of the international students from India in their research study cited that the reason for studying abroad was the quality or type of academic program, as opposed to another motivation such as cultural experience (p. 12).

**Preferred format.** The responses varied greatly across the board, with considerably equal numbers of participants advocating for reading materials, informal group settings, classroom instruction, online trainings, and orientation sessions. Reading materials were seen as more personal and private, a way to read alone at home and not have to talk to someone about sex, and a good option for students who would be too shy to discuss these matters within group settings. However, other participants believed that students from their cultures would not take the time to actually read the reading materials, and they would not garner much response or attention from students. Online training settings were seen as a chance to start learning about sexual health information related to living in the United States before arriving. Informational videos and video lectures were also suggested, as long as they were interesting and contained valuable information.
Informal group settings were advocated by some respondents because they would provide a space for free exchange of information, the answering of questions, and help in understanding matters, but other feedback noted that some students may only be comfortable with sitting in and listening. Some participants suggested orientation as a possible venue for a sexual health session, because students already have to be there, but it was noted that it should not be too lengthy of a session, as students are overwhelmed with many other things at the same time. It was recommended in the feedback that there be a small presentation during orientation, followed by an invitation to come to another event for more information. Other studies have also supported the incorporation of sexual health and healthy relationship information into the orientation programs for new international students (Borrett & Zysk, 2007; Poljski, 2011; as cited in Baek et al., 2012).

Conclusions and Research Implications

Though my findings showed that the majority of my participants indicated that they had at least some background of sexual health growing up, I believe that there is still opportunity to educate them further, and to take advantage of this opportunity while these international students are still in the United States. Of particular concern for me was how drastic the differences in backgrounds were between those who were educated and those who were not. Additionally, the barriers to accessing sexual health education, the fear of shame that threatens those who pursue this kind of information, and the stigma surrounding sexual behavior risks (e.g. loss of virginity, unwanted pregnancies, STD transmission) are seemingly more striking in several of the respondents’ cultures than what most other college students experience within American culture in this day and age. I believe that without trying to identify these kinds of differences among our
students’ cultural backgrounds, there is an inherent assumption that these differences are not important or relevant to their lives here.

My findings demonstrated that the majority of my respondents are interested in learning more about sexual health, but varied on how they thought was the best way to access this kind of information. However, with just over half of them categorized as believing that there was some potential for the influence of American culture on other international students’ sexual behaviors, this showed me that even strong cultural norms and beliefs could shift depending on the environment. I think this points back to one of my introductory points that international students in particular face one of the most profound introductions to early adulthood. Having followed the footsteps of prior research in this field, especially the studies conducted in Australia, it was upon raised concerns for the sexual health wellbeing of their students that their research came to fruition in the first place. I do not advocate that programs should be implemented only in the aftermath of presented problems, or when statistics become worrisome among college health professionals. I stand by my belief that there is a need for this kind of education, despite if my standalone study in particular does not make waves for programmatic change.

Based upon my research questions, I showed that there is indeed a prime opportunity for colleges to implement sexual health education for international students at their respective institutions in the United States. To my knowledge, my study is the first of its kind to focus specifically on the sexual health education of college-level international students at a mid-western institution in the United States. I found there to be a gap in sexual health literature in regards to varying cultural perspectives on the topic, which need to be addressed in order to build relevant programming that supports and encourages student learning about the importance of maintaining their sexual health while in college.
The implications for this research relate back to the overall three-fold purpose of my case study, which I introduced in Chapter I:

(a) To explore the differences in backgrounds in sexual health education and practices for a diverse cross-section of international students studying at BGSU,
(b) To investigate whether there is a need for colleges to implement sexual health education for international students in the United States, and
(c) To speculate what strategies/curricula could be implemented.

I achieved these three goals throughout my study through the surveys and follow-up interviews. Though the results were not generalizable per se, they explored, investigated, and most importantly, gave voice to international students at BGSU. This study also provided a chance for them to be open and honest about the sexual health practices of their culture/home countries, and subsequently their own and their peers’ backgrounds of sexual health education. These data can certainly be analyzed further, expanded on through deeper and different research angles, goals, and data collection methods, and contribute to the development of a sexual health education program for international student populations in the U.S.

Areas for Further Study

This section highlights other data collection methods that were considered but not implemented in this study, new angles of research that can be analyzed as related to this field, and future curricula ideas that might be worth implementing, keeping in mind the cultural sensitivities of this topic.

Deeper, Different Data Collection

In conducting my literature review, I analyzed many possible data collection methods that I ultimately decided to not pursue, for various reasons. In the research study conducted by
Burchard et al. (2011), researchers asked their participants various questions in a focus-group setting. I felt that utilizing focus groups would limit how explicit my inquiry could be, and could make my participants uncomfortable, but it has proved to be a successful method for other researchers and could benefit from further consideration. Looking deeper at Bista and Foster’s (2011) suggestion that colleges should offer ongoing online forums, as they allow international students to openly express their needs without fear of identification by school professionals and future retribution, I thought this idea could also work within my own data collection. “An online forum for students to speak out gives them a voice and allows the university to address the needs of international students which may lead to retention,” stated Bista and Foster (2011, p. 5). However, I did not find this method to be conducive to my time limitations, but felt that in the right setting, it could possibly contribute to meaningful change.

Kalsi et al.’s (2007) research suggests engaging in discussions with healthcare providers and faculty/staff at the university’s international student office, as these are fruitful methods for information gathering about the current health issues being raised by international students and the types of testing and treatment they might have a need to seek out. Through my summer internship with International Student Services at BGSU, it became evident that sexual health issues were not generally a topic of discussion or an area that was focused on, and so this approach of information gathering could be vital to changing that trend.

In a further study, it would benefit to track numbers among international students in terms of pregnancies, abortion rates, sexual assaults, rapes, and reports of students from high risk countries found to be HIV-positive, as Kalsi et al. (2007) suggested in their research. Not all of these figures are currently being tracked by college health centers, and a researcher would likely face an uphill battle trying to get this kind of personal health data on students, but the
information could be very helpful to pinpointing problem areas. Future research should also involve college health educators and researchers “continuing exploration into the complex aspects of sexual risk taking behaviors among young adults” (Luquis et al., 2012, p. 612). It also would have been beneficial to analyze data from BGSU on how international students, historically, have actually used college health resources towards sexual health needs (Eisenberg et al., 2012).

**Impact on International Student Retention**

Determining the sexual health status of international students would be irrelevant without an international population to analyze, and so the retention of this population at colleges in the United States is an important point to consider. If international students felt like their college was making a solid effort to educate them about important issues they may encounter, such as sexual health, then they may feel more welcomed and that their well-being is important to the institution.

Research by Bista and Foster (2011) shows that institutions are committing increased amounts of financial resources to overseeing recruitment, but are neglecting to recognize the importance of retaining these students. A report by Noel Levitz in 2009 indicated that only 33.9% percent of four-year public education institutions had programs explicitly intended for retention of international students, and that only 6.8% of the individuals in these programs felt that they were effective (Bista & Foster, 2011). This is not to say that many institutions do not already provide a variety of services to international students, as evident in the frequency of departments dedicated solely to assisting international students, but their effectiveness is sometimes debated (Bista & Foster, 2011). As an example relevant to this research, many schools do provide sexual health education to international students upon arrival, but it is often
too brief, in large group settings to students coming from varied backgrounds, and far from culturally conscious; hence the need for the more thoughtful and structured approach. Therefore, I believe that further study of the connections between the sexual health of international students and their retention at colleges in the U.S. could be an interesting research area to consider.

Developing Sexual Health Curricula

“Because college is a transitional time when many students begin to examine their own health behaviors and possibly develop life-long health habits, this is a critical time to reinforce low risk sexual behaviors and prevention practices” (Oswalt & Wyatt, 2013, p. 1568). With this in mind and based on the survey responses and interviews I conducted, I believe it is worth considering implementing a sexual health education program at BGSU that could be developed and tailored to the needs and issues of our international student population. Keeping the beliefs and practices of countries/cultures in mind, this would be a good start in terms of developing tailored curricula to diverse audiences. These curricula would certainly need to be reevaluated and adjusted over time, however, as “even programs that have been created to be culturally competent will need modifications occasionally, because culture itself is constantly changing, with new vocabulary, cultural norms, and situations” (Davis & Rankin, 2006, p. 251). Findings from previous similar studies conducted among international student populations have stressed the notion that there is no “one size fits all” approach to college sexual health education or resources, and that colleges must constantly adapt their resources in ways that will best meet the needs of their students (Eisenberg et al., 2012).

In order to remain sensitive to cultural differences, I would recommend that a culturally specific sexual health education program be tailored to each different cultural/ethnic group, if possible, avoiding “pre-packaged” health education (Davis & Rankin, 2006). Burchard et al.
(2011) notes that it is important to avoid Westernized sexual health education programs as they may be inappropriate for more traditional groups. Westernized programs typically do not factor in such aspects as linguistic and ethnic differences, as well as subcultures, and sex and gender roles within different cultures, which all need to be taken into consideration (Davis & Rankin, 2006). “A program that is not culturally competent is one that lacks sensitivities needed to reach a specific culture and does not directly address certain issues that are relevant for the culture for which it is intended” (Davis & Rankin, 2006, p. 250). Therefore culturally incompetent sexual health education programs must be avoided.

Tying in the use of vocabulary, proper translation is fundamental when working with international students. Davis and Rankin (2006) suggest conducting ethnographic interviews to help determine proper terminology of sexual health vocabulary, and that key terms and phrases are administered in the target language to help make the material more culturally appropriate. “This may or may not include changing the text to another language or changing or inserting words that conform more closely to the sociolect of the target population” (Davis & Rankin, 2006, p. 251). A key point to remember is that representation through language is central to the processes by which meaning is produced (Hall, 1997). Another important aspect of sexual health education curricula is to display contraceptive devices to students and describe specific scenarios on how and when they are used. This could lead to an open conversation (depending on the setting) about differences in cultural beliefs/norms surrounding sexual practices. It will be crucial, also, to determine if group sessions should be gender-specific in an effort to keep all participants feeling safe and comfortable to share openly. Evidence also shows that interventions encouraging adoption of risk reduction practices “need to go beyond mere provision of information to be effective” (Wellings et al., 2006, p. 1717).
Researcher Reflections

In this study, I analyzed an educational issue that I find relevant to my background as a prior sexual health educator both in the United States and in Namibia and in following my interest in working with international students, especially at the collegiate level. As I come to the conclusion of my current degree program in cross-cultural and international education, I envision myself working in an international student services office/department at a college or university. Based upon my past experiences, an ideal role for me would be exactly what I have laid out in this paper, helping to implement a culturally relevant sexual health education program catered towards international students. I have personally seen the need for a program like this here at Bowling Green State University, and this need was evident throughout the years as I began my studies at BGSU nearly ten years ago.

I felt compelled to pursue this research, as it has been my inherent goal to improve the services available to international students at BGSU, through unequivocally believing sexual health education to be an important service on any college campus. Bista and Foster (2011) raised an excellent question that every institute of higher education should be asking themselves when seeking to improve retention: “How often are we requesting input from international students on improving services?” (p. 7). Tweaking that question for my angle would be: How often are we addressing the sexual health needs of international students and improving services as a result of these needs? I believe it’s not happening often enough, if ever, unfortunately. The sexual health needs of international students represent an underutilized programmatic area and infrequently analyzed area of research. I hope that my research begins to change that, especially on the BGSU campus. I know I am not alone in thinking that comprehensive sexual health
education is important, for all students, but acknowledging its importance is clearly not enough. It’s time to take action.
REFERENCES


Research Survey for Incoming International Students

Gender:  □ Male  □ Female  Age: _____________  Date: __________________

Class Status:  □ Undergraduate Student  □ Master’s/Doctoral Student

Country of Origin: __________________________________________

Arrival in the United States (Indicate Month and Year): _________________________________

1. Describe what kind of sexual health education you received while growing up, if any?

2. If you received sexual health education, who provided it to you? If you didn’t, what do you think are the reasons why you weren’t educated on this topic?

3. How does religion or spirituality – however you may define these terms in your culture – influence people from your culture’s decision to remain abstinent or engage in sexual behaviors?
4. How important is virginity (not engaging in sexual intercourse) in your culture? Please explain.

5. How do members of your cultural group feel about people having premarital sex (sex before marriage)?

6. What types of birth control methods (such as condoms; contraceptive pills/tablets) are people in your culture familiar with?

7. How often and when are birth control methods considered acceptable/appropriate to be used by people in your culture?
8. How effective are methods of birth control, from your culture’s standpoint?

9. What do most people in your culture learn about HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) and other sexually transmitted diseases/infections (For example: Genital warts or gonorrhea)?

10. What risk behaviors (actions that may result in bad consequences for health) do you think people in your culture believe could lead to someone contracting HIV/AIDS or another sexually transmitted disease/infection?

11. Do you think that living in the United States can influence the sexual activity of international students from your culture? Why or why not?
12. Where or how can international students from your culture find out about sexual health information and treatment here in the United States?

13. Do you believe that international students from your culture would be interested in sexual health education if provided by the university? Why or why not?

14. In what format do you think international students from your culture would prefer to have sexual health education provided to them (i.e. reading materials, informal group setting, or classroom instruction)?

THANK YOU FOR YOUR PARTICIPATION. PLEASE KEEP ONE OF THE TWO COPIES OF THE CONSENT FORM FOR YOURSELF. RETURN A COMPLETED CONSENT FORM AND THIS COMPLETED SURVEY IN THE PROVIDED ENVELOPE (OR A SEPARATE BLANK ENVELOPE) TO ONE OF THESE THREE LOCATIONS:

At a survey drop-off box (if completed at the same time you receive it)

Placed into the survey drop-off box located in the International Student Services Office (219 University Hall) between the hours of 8am-5pm, Monday-Friday

Through the free BGSU Campus Mail service, marked to Kristen Bunner, 108 Hanna Hall
Informed Consent for Incoming International Students

Introduction:
My name is Kristen Bunner, and I am a Master of Arts student in the Cross-Cultural and International Education Program as well as a current Intern for International Student Services at BGSU. With the help of my advisor Sherri Horner, Ph.D., I am now doing research for my thesis. My research topic surrounds the cultural beliefs of incoming BGSU international students' about their home country's views toward sexual behaviors, sexual health, and sexual education. You are being asked to take part in this study because you are an incoming international student at BGSU. However, you must be at least 18 years of age in order to participate in this study. Please do not complete a survey if you are not.

Purpose:
The purpose of my research is to explore cultural differences in sexuality. The questions you will respond to, should you choose to participate in this study, surround your home country and culture's views toward sexual behaviors, sexual health, and sexual education. The benefit to society is that it will help us better understand the diverse backgrounds of international students, and how colleges and universities can better respond to these differences. From a public health standpoint, we can improve our disease prevention efforts. The benefits to participants will simply be to contribute to research that is aimed towards improving awareness and educational opportunities. However, there is no direct benefit to a participant of this study, such as a monetary award, course credit, a raffle, etc.

Procedure:
To complete my research, most of my data will come directly from a survey with open-ended questions, which will take approximately 20-30 minutes to complete. If you choose to participate in this study, the survey will also contain a few demographic questions to help develop a “cultural profile” of you as the responder.

Please keep one of the two copies of the consent form for yourself. Should you choose to participate in this study, a completed consent form and your survey should be re-inserted into either the provided envelope or another blank envelope, sealed shut, and turned back in through one of three different ways:

1. At a survey drop-off box (if completed at the same time you receive it)
2. Into the survey drop-off box located in the International Student Services Office (219 University Hall) between the hours of 8am-5pm, Monday-Friday
3. Through the free BGSU Campus Mail service, marked to Kristen Bunner, 108 Hanna Hall

After the survey, this will be the end of your involvement, unless you are willing to be contacted for a follow-up interview with the researcher, which you can indicate on this form. Upon meeting for the interview, which will last approximately 30 minutes, you will be provided with another consent form that requires a signature. The information discussed during the interview will be helpful towards further understanding of your particular culture(s) and its views on sexual behaviors and sexual health education.

Voluntary Nature:
Your participation in this study is completely optional. You are free to leave the study at any time. You may decide to skip questions, avoid discussing certain topics, or end participation at any time without penalty, and at any point during the survey or interview. Deciding to participate or not will not affect your enrollment or your relationship with BGSU or International Student Services/Orientation.
Confidentiality/Anonymity Protection:
The research data collected during this project will be safely stored in a locked container in a secure location, and when compiled electronically, the data will be protected on a password-protected computer. The principal researcher (Kristen Bunner) and her faculty advisor (Sherri Horner, Ph.D.) will be the only two individuals who will have access to the data, which will be kept for four years.

To maintain anonymity, the initial consent form requires a checkmark rather than a signature. This ensures that your identity is never known. However, if you agree to be contacted for a follow-up interview, your data will no longer be anonymous, as you will sign a consent form with your signature.

Your responses may be quoted directly in my research, but they will be associated with your demographics rather than your identity. Both your survey data and interview data will still be treated confidentially, and your name will never be associated with your responses in any publication or report.

Risks:
The risk of participation is no greater than that experienced in daily life. However, students may be uncomfortable answering questions about sexuality. If so, you may decide to skip questions, quit at any time, or choose not to complete the survey at all. You can throw away the survey if you decide not to participate – it does not need to be returned to the researchers.

Contact Information:
If you have any questions about the research or your participation in the research, please contact Kristen Bunner at 419-350-3885 or kbunner@bgsu.edu, or the faculty advisor of this project, Sherri Horner, Ph.D., at 419-372-7343 or shorner@bgsu.edu. You may also contact the Chair, Human Subjects Review Board, at 419-372-7716 or hsrb@bgsu.edu, if you have any questions about your rights as a participant in this research. Thank you for your time.

Consent to Participate:
☐ I have been informed of the purposes, procedures, risks and benefits of this study. I have had the opportunity to have all my questions answered and I have been informed that my participation is completely voluntary. I agree to participate in this research.

OPTIONAL:
If you would also be willing to potentially be contacted for a follow-up interview with the principal researcher, Kristen Bunner, please provide your contact information as follows:

Full Name: __________________________________________________________

BGSU Email Address: _________________________________________________

Phone Number (Optional): _____________________________________________
APPENDIX C. INTERVIEW CONSENT FORM

Informed Consent for Interview

Purpose:
The purpose of my research is to explore cultural differences in sexuality. Should you choose to participate in this interview, the questions you will respond to relate back to your survey responses about your home country and culture’s views toward sexual behaviors, sexual health, and sexual education. The information discussed during the interview will be helpful towards giving the researcher a better understanding of your particular culture(s) and its views towards these subjects.

Procedure:
You indicated on your survey consent form that you were willing to take part in a face-to-face interview with the principal researcher, Kristen Bunner. Upon meeting for this interview, which will last approximately 30 minutes, you will be provided with this form, which requires a signature of consent. This interview will be the end of your involvement in this research study.

Voluntary Nature and Risks:
Your participation in this study at any stage is completely optional and you are free to leave the study at any time. The risk of participation is no greater than that experienced in daily life. However, respondents may find themselves uncomfortable answering questions about sexuality, and so you may decide to skip questions, avoid discussing certain topics, or end participation at any time without penalty, and at any point during the interview. Deciding to participate or not will not affect your enrollment or your relationship with BGSU or International Student Services/Orientation.

Confidentiality/Anonymity Protection:
The research data collected during this project will be safely stored in a locked container in a secure location, and when compiled electronically, the data will be protected on a password-protected computer. The principal researcher (Kristen Bunner) and her faculty advisor (Sherri Horner, Ph.D.) will be the only two individuals who will have access to the data, which will be kept for four years. By agreeing to be contacted for a follow-up interview, your responses on the survey are no longer anonymous. Both your survey data and interview data will still be treated confidentially, though, and your name will never be associated with your responses in any publication or report.

Contact Information:
If you have any questions about the research or your participation in the research, please contact Kristen Bunner at 419-350-3885 or kbunner@bgsu.edu, or the faculty advisor of this project, Sherri Horner, Ph.D., at 419-372-7343 or shorner@bgsu.edu. You may also contact the Chair, Human Subjects Review Board, at 419-372-7716 or hsrb@bgsu.edu, if you have any questions about your rights as a participant.

Consent to Participate in Interview:
I have been informed of the purposes, procedures, risks and benefits of this study. I have had the opportunity to have all my questions answered and I have been informed that my participation is completely voluntary. I agree to participate in this interview.

Signature: ________________________________ Date: ________________
When introducing the study to individual students or a small group of students at an informal venue or event:

My name is Kristen Bunner, and I am a Master of Arts student in the Cross-Cultural and International Education Program as well as a current Intern for International Student Services at BGSU. With the help of my advisor Dr. Sherri Horner, I am now doing research for my thesis. My research topic surrounds the cultural beliefs of incoming BGSU international students’ about their home country’s views toward sexual behaviors, sexual health, and sexual education. The purpose of my research is to explore these cultural differences in sexuality.

To complete my research, most of my data will come directly from a survey with open-ended questions, which will take approximately 20-30 minutes for you to complete, if you decide to participate in this study. The questions you will respond to surround your home country and culture’s views toward sexual behaviors, sexual health, and sexual education. The survey will also contain a few demographic questions to help develop a “cultural profile” of you as the responder. Your responses may be quoted directly in my research, but they will be associated with your demographics rather than your identity. You will be given the option to take this survey home and complete it at another time.

You are being asked to take part in this study because you are an incoming international student at BGSU. However, you must be at least 18 years of age in order to participate in this study. Please do not complete a survey if you are not.

The benefits to you will simply be to contribute to research that is aimed towards improving awareness and educational opportunities. However, there is no direct benefit to you if you participate in this study, such as a monetary award, course credit, a raffle, etc.

Soon I will give you an envelope, which contains two identical copies of the consent form and a copy of the survey. Read these over when you have time. (If it is during an event that is ongoing, I will indicate where I will be located – such as nearby a back door – so that they can come ask questions if they have any). Please keep one of the two copies of the consent form for yourself, and note my contact information on this form if you have any questions about the research, your participation in the research, or if you decide at a later point that you would like to withdraw from the study.

If you agree to participate, please complete one of the consent forms as well as the survey itself. These two documents, which are stapled together already, should be re-inserted into either the provided envelope or another blank envelope, sealed shut, and can be turned back in three different ways:

1. At a survey drop-off box (if completed during an event – indicate where it will be located)
2. Into the survey drop-off box located in the International Student Services Office (219 University Hall) between the hours of 8am-5pm, Monday-Friday
3. Through the free BGSU Campus Mail service, marked to Kristen Bunner, 108 Hanna Hall
After the survey, this will be the end of your involvement, unless you are willing to be contacted for a follow-up interview with me, which you can indicate on this form. Upon meeting for the interview, which will last approximately 30 minutes, you will be provided with another consent form that requires a signature. The information discussed during the interview will be helpful towards further understanding of your particular culture(s) and its views on sexual behaviors and sexual health education.

Your participation in this study at any stage is completely optional and you are free to leave the study at any time. The risk of participation is no greater than that experienced in daily life. However, respondents may find themselves uncomfortable answering questions about sexuality, and so you may decide to skip questions, avoid discussing certain topics, or end participation at any time without penalty. Deciding to participate or not will not affect your enrollment or your relationship with BGSU (add on “or International Student Services/Orientation” if it is during an associated event). If you choose to not complete the survey, you may throw it away.

(Note: After reading the script, the researcher will pass out the envelopes containing consent forms and surveys, and answer questions. Depending on the environment, the students may either be able to complete the consent/survey at that time if they wish to, and return it to the marked box, or take it home to be completed and turned in at a later date).
APPENDIX E. LETTER OF SUPPORT

23 June 2014

To Whom It May Concern:

The International Student Services Office at BGSU is granting permission for Kristen Bunner to conduct data collection and distribute surveys for her thesis during the international undergraduate and international graduate student orientation “Get Involved” Sessions during the month of August.

We are also permitting Kristen to have a designated survey drop-off box located inside our office (219 University Hall).

Please let me know if you have any questions about this information.

Regards,

[Signature]
Andrea M. Voogd
PDSO, Assistant Director, International Student Services
avoogd@bgsu.edu
419-372-4761
DATE: September 5, 2014
TO: Kristen Bunner
FROM: Bowling Green State University Human Subjects Review Board
PROJECT TITLE: [626784-4] The Cultural Complexities Surrounding Sexual Health Knowledge of Incoming Collegiate-Level International Students
SUBMISSION TYPE: Revision
ACTION: APPROVED
APPROVAL DATE: September 4, 2014
EXPIRATION DATE: July 17, 2015
REVIEW TYPE: Expedited Review
REVIEW CATEGORY: Expedited review category # 7

Thank you for your submission of Revision materials for this project. The Bowling Green State University Human Subjects Review Board has APPROVED your submission. This approval is based on an appropriate risk/benefit ratio and a project design wherein the risks have been minimized. All research must be conducted in accordance with this approved submission.

The final approved version of the consent document(s) is available as a published Board Document in the Review Details page. You must use the approved version of the consent document when obtaining consent from participants. Informed consent must continue throughout the project via a dialogue between the researcher and research participant. Federal regulations require that each participant receives a copy of the consent document.

Please note that you are responsible to conduct the study as approved by the HSRB. If you seek to make any changes in your project activities or procedures, those modifications must be approved by this committee prior to initiation. Please use the modification request form for this procedure.

You have been approved to enroll 190 participants. If you wish to enroll additional participants you must seek approval from the HSRB.

All UNANTICIPATED PROBLEMS involving risks to subjects or others and SERIOUS and UNEXPECTED adverse events must be reported promptly to this office. All NON-COMPLIANCE issues or COMPLAINTS regarding this project must also be reported promptly to this office.

This approval expires on July 17, 2015. You will receive a continuing review notice before your project expires. If you wish to continue your work after the expiration date, your documentation for continuing review must be received with sufficient time for review and continued approval before the expiration date.

Good luck with your work. If you have any questions, please contact the Office of Research Compliance at 419-372-7716 or hsrb@bgsu.edu. Please include your project title and reference number in all correspondence regarding this project.
This letter has been electronically signed in accordance with all applicable regulations, and a copy is retained within Bowling Green State University Human Subjects Review Board's records.