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‘I make sure I am safe and I make sure I have myself in every way possible’: African-American youth perspectives on sexuality education

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Abstract

High rates of youth pregnancy and STIs play a major role in the physical, mental, and emotional health of young people. Despite efforts to provide sexuality education through diverse channels, we know little about the ways in which young people perceive school- and community-based efforts to educate them about sexual health. Forty-eight African-American young people participated in six focus groups to discuss their sexuality education experiences. Three major themes emerged that highlight experiences and perspectives on optimal strategies for promoting sexual health. These themes were: 1) experiences with school-based sexuality education (SBSE); 2) seeking information outside of schools; and 3) general principles of youth-centered sexuality education. Young people in the focus groups expressed their varying satisfaction with SBSE due to the restricted content covered and lack of comfort with the instruction methods. Participants described how they reached outside of SBSE for sexuality education, turning to those in the community, including local organisations, health care providers, and peers, also expressing variability in satisfaction with these sources. Finally, participants identified three important principles for youth-centred sexuality education: trust and confidentiality, credibility, and self-determination. These findings give voice to the often-unheard perspectives of African-American young people. Based on their responses, it is possible to gain a better understanding of the optimal combination of school, family, peer and community-based efforts to support them as they move towards adulthood.

Keywords

African-American; youth; perspectives; sexuality education; USA

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Introduction

Young people's attitudes toward sexuality education have not been as well documented in the USA as they have elsewhere (see Measor, Millin, and Tiffin 2000; Byers et al. 2003). Consequently, we do not understand the most effective sexuality education, nor the optimal combination of school, family, peer and community-based efforts to support young people as they move towards adulthood. Nor do we know about the ways in which African-American young people, who are disproportionately affected by negative sexual health outcomes, perceive school- and community-based efforts to educate them about sexuality. Accordingly, there are two main goals for this paper. First, we seek to document the sexuality education[i] experiences of African-American youth in a county that provides a combination of restrictive school-based sexuality education (SBSE) and diverse community-based sexuality education programmes. Secondly, we intend to document their perspectives regarding optimal forms of sexuality education. Through these goals the current paper adds the often-unheard perspectives of African-American young adults to scholarship on sexuality education in the USA, and contributes to our understanding of effective sexuality education for this group.

School-based sexuality education in the USA

Formal sexuality education in the United States of America (USA) has been widely delivered through schools since the 1970s. With the introduction of a Title V abstinence-only programme in 1998 and the Community Based Abstinence Education (CBAE) funding programme in 2001, the federal government vastly expanded its funding support for abstinence-only until marriage (AOUM) education, spending an unprecedented $1.42 billion on such programmes between 1998 and 2009. As of 2011, 27 American states legally required that school-based sexuality education (SBSE) stress the value of abstinence in its curriculum, and an additional nine required that abstinence be discussed (Guttmacher Institute 2012).

The content of SBSE programs vary, but they generally provide students with information on sex and sexuality, abstinence, sexually-transmitted infections (STIs), HIV/AIDS, contraception, reproduction, and safer sex practices with a goal of decreasing STI rates and unintended pregnancies (Kirby et al. 1994; Kubicek et al. 2010). However, as a condition of funding, AOUM-based programs have been required to provide either no information or negative information about contraceptives and their use (Boonstra 2010), with AOUM being presented as the only acceptable option (Bay-Cheng 2005). AOUM-based SBSE also typically excludes the issues of lesbian, gay, bisexual and transgender (LGBT) youth (Telljohann et al. 1995; Kubicek et al. 2010). Furthermore, AOUM rejects the core principle that individuals should decide for themselves what proper sexual behavior is (Luker 2006).

Comprehensive sexuality education covers all possible contraceptive and safer-sex methods while still promoting abstinence as the most effective method for preventing unplanned pregnancy and STI transmission (Fine and McClellan 2007). With the 2010 passage of the Personal Responsibility and Education Program, dedicated funding became available for comprehensive sexuality education (Sexuality Information and Education Council of the United States [SIECUS] 2010). Nevertheless, a generation of young people has come of age at a time when AOUM programmes may have been their only form of formal sexuality education.

[i]We use the term sexuality education to encompass any formal or any informal means of gaining sexual health information, informed by previous literature.

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Alternatives to SBSE

Although SBSE continues to be a central information provider, young people are reaching outside of schools for their sexuality education. There has also been growing interest in the provision of complementary, community-based sexuality education in this country—particularly programmes for youth that experience disproportionate rates of negative sexual health outcomes. Programmes have been offered through diverse channels such as the media, doctors, and community organisations (Thornburg 1981; Wellings et al. 1995; Kubicek et al. 2010).

The continued need for effective sexuality education

Despite efforts to provide sexuality education to young people in the USA, young people acquire about half of the new STI cases each year, despite comprising only about a quarter of the population (Weinstock, Berman, and Cates 2004). In 2009, there were approximately 8300 new cases of HIV in this age group (Centers for Disease Control [CDC] 2011). These negative sexual health outcomes do not affect all young people equally. STIs and HIV disproportionately affects young African-Americans (CDC 2011). Compared to other young people, African-American adolescents tend to become sexually active earlier and are more likely to report having four or more sexual partners (CDC 2012). This raises important questions about the effectiveness of existing programmes and their effects on the burgeoning sexual health of young people.

Current study

Aim

In an effort to create more effective sexuality education programming, researchers and practitioners will need to better match programme contents to the needs of youth. To do that, it is essential that we understand the young people's perspectives about sexuality education. A partnership of representatives from the Genesee County Health Department (GCHD), the University of Michigan School of Public Health, and YOUR Center, a 501(c)3[ii] faith-based community organisation, convened aiming to inform local intervention efforts promoting healthy sexuality.

Design

The study followed Community-Based Participatory Research (CBPR) principles: involving collaborating on all major phases of the research process; encouraging change and promoting knowledge in ways that benefit communities; and furnishing results to the community in a useful manner (Israel et al. 1998). Research activities were approved by the University of Michigan's Institutional Review Board-Health Sciences. Focus groups were held at YOUR Center. The focus group interview method was chosen since it is particularly strong at eliciting group-level assessments, meanings, norms, and processes (Bloor 2001). Each participant read and signed an informed consent form that detailed the potential risks and benefits of participation, as well as assured confidentiality. Participants received a US $20 gift card as a participation incentive. The six focus groups, lasting from ninety minutes to two hours, were facilitated by two people and included an average of ten participants each (range: 3–14 participants). Three groups focused on young women, and two on young men. Questions included: What things are going on in the community that affect people's sexual health; Who do people in your community rely on to stay healthy and safe; and Think about some health information you received recently – where did you get this information? A

[ii]A 501(c)3 organization is designated under the US Internal Revenue Code as a tax-exempt charitable organisation that operates for the benefit of the public interest and is restricted in its political and lobbying activities.

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resource guide was developed and facilitators were trained to provide referrals should the participants request supportive services; some participants requested referrals for STI and HIV screening, as well as free condoms.

Participants and sampling

Young people were invited to participate in a dialogue around healthy sexuality in their community by a collaboration involving community organisations, the local Public Health Department, churches and historically black fraternities and sororities. These groups disseminated flyers at venues frequented by young people, held community forums and participated in local radio talk shows to raise the community's awareness of the focus groups.

Forty-eight young people participated in six focus groups. Focus group participant ages ranged from 14 to 23 years ($M = 17$, $SD = 3$) and about 80% of participants were women (see Table 1). Nearly all of the participants (96%) were Black/African-American. The focus group format did not permit sub-group analyses according to race (for the two white participants). Educational levels ranged from less than ninth grade (14 years old) to some graduate level coursework, with 15% reporting at least some college level education. About two-thirds of participants reported an eleventh grade education (16 years old) or less. Most participants were currently students, 30% were employed part-time and one was employed full-time. Participants reported their sexual orientation as heterosexual (98%) and homosexual (one participant). The majority of participants (63%) were sexually active and 50% had ever been tested for HIV.

Research setting

Genesee County, where Flint, Michigan is located, is a socio-economically disadvantaged area of the USA, with poverty rates that exceed the state average (U.S. Census Bureau 2010). Young people living in this county experience disproportionate rates of STIs/HIV and their STI and teenage pregnancy rates continue to rise (Michigan Department of Community Health [MDCH] 2010). As across the USA, African-Americans who live in Flint are disproportionately affected by STIs /HIV and teenage births, as compared to other racial groups (MDCH 2010).

The State of Michigan accepted more than US$2.5 million in federal funding for AOUM-based programs in 2009 alone (SIECUS 2010), and state policy mandates only HIV education while leaving decisions about provision of sexuality education to local school districts and allowing parents to opt-out of SBSE (Michigan Department of Education 2006). Flint is a city in which debates about the role of schools in the sexuality education have raged, with some advocates arguing for limited or no role for schools. At the same time, some schools in the area also offer extensive sexual health programmes, such as on-site youth health clinics staffed by nurse practitioners who can test for and provide treatment of, STIs (Beecher Community School District 2011). As in other parts of the country, Flint is home to several social services agencies and programmes that provide sexuality education in a way that is intended to supplement SBSE. However, positive outlets for recreation and socialisation in neighbourhoods have become increasingly scarce due to economic hardships. Notably, these non-school-based sources may have more freedom in the content of information they provide for sexuality education than SBSE, such as condom demonstrations and birth control methods.

Data analysis

Discussions were digitally recorded to facilitate verbatim transcription. Transcripts were analysed using a qualitative content analytic approach (Hsieh and Shannon 2005). The

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following five steps were employed during the coding process: (1) organising the responses in the discussion group notes into a series of *in vivo* statements (data chunks), (2) double checking the statements, (3) coding the statements into categories, (4) combining coded statements across discussion groups and participants to form one consolidated document per case study, and (5) reviewing the consolidated document to identify themes to be included in written discussion group results. Qualitative data analyses were conducted with the aid of NVivo qualitative data analysis software. Data were coded and classified in order to identify themes or patterns. This data coding process involved three of this paper's authors (A.K., T.W., and T.V.).

Members of the partnership then discussed patterns that recurred throughout the focus groups and identified several distinct topics from the emergent themes. Although data analysis was guided by the overarching study aim, we also relied on the data to generate new ideas and understandings. The use of both inductive and deductive codes was important because it allowed new ideas to develop from the data, while also building on previous research and addressing the questions of our community partners. An extensive content analysis was completed to identify and understand important patterns, themes, categories, and sub-categories and how they fitted together. The results of the current study highlight the most prevalent themes specific to participants' perspectives on sexuality education.

Results

Three major themes emerged that highlight the sexuality education experiences of African-American youth in Genesee County and their perspectives on optimal strategies for promoting their sexual health. These themes concerned 1) experiences with SBSE, 2) seeking information outside of schools, and 3) general principles of youth-centered sexuality education. Each theme is discussed below in detail.

Experiences of SBSE: "schools are failing"

Young people's experiences with SBSE were highly variable, and seemed to depend on the school they had attended. Those who disliked their SBSE experience felt humiliated by their peers when they asked questions, such as Angela, age 15, said, "I had raised my hand to ask a question…and the whole class just started laughing at me". Some young people complained that they were taught by adults who were not comfortable discussing sexual topics and that the focus of discussion was excessively narrow. This narrow focus was reinforced by a rigid observance of curricular requirements that stifled their ability to express themselves and ask questions. As Chrissy, 16, said:

> …my sex education class in my school was horrible…we got papers he didn't tell us nothing, he didn't talk about anything, he just did what the book told him to do he wasn't like going into details telling you what you should do, what's safe, what's not safe…

Despite these concerns, some young people still believed that school could be an effective setting to deliver messages about sexual health. Jasmyn, 20, stated:

> Schools are failing when it comes to telling and acknowledging a lot of things. They act as the kids do when they first hear 'bout it, they dust it off to the side until it becomes real serious and then they want to jump and try to take the lead on it. So I think it starts back with the schools. All the information they give—that is when everything gets passed around. That is how everybody finds out…

Young people preferred not to be taught sexuality education by teachers who might be indiscreet or uncomfortable with the topic. Rather, they preferred sexuality education professionals, such as those from Planned Parenthood Federation or school nurses. These

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professionals were also perceived as likely to be less judgmental than teachers. Angela, 15, reported, “Nurses only and not teachers because [teachers] know you, judge you, and they like to talk about you.”

Within SBSE programmes, the focus on basic information on transmission and statistics regarding STIs was perceived as necessary, but not sufficient for young people. Participants mentioned a number of important but often-excluded content for sexuality education programmes. They believed that safer sex education could be enriched through demonstrations of how to use male and female condoms, and the use and importance of lubrication. As Amanda, 21, and Charlie, age unknown, said:

> …if we were taught how to use condoms, you know, that would be better. As far as size and lubrication and all that. I think we should be taught how to use it.

> A demonstration period. Because I’ve never seen a demonstration. I have never seen a demonstration of a female condom.

Similarly, they believed that sexual activities other than intercourse should be discussed, such as manual sex (fingering) and use of sex toys, as Jasmyn, 22, expressed:

> Safe sex. You know, if you want to get your little groove on, they have little vibrators, you know, they friends. That’s another way safe sex. If he waitin’ on test results, he can get down there and he can use that toy. You can sanitise that toy, you can put a condom on that toy. It’s, you know, they always say don’t have sex or use a condom. Throw other options out there.

Young people also felt SBSE lacked conversation concerning the emotional and relational aspects of sexuality. As a part of navigating this complicated terrain, young people felt that assistance with decision-making would be helpful. For example, Kristin, age unknown, said that she wanted to know about: “…what sex is or when to have sex or what sex is for.” Tina, 23, described:

> Not only abstinence, but a lot of us learn by experience that after you have sex you have this emotional attachment with that person and that’s not taught in, no where…that emotional attachment with that person, that is a big factor in sex and why people keep on having it with that person, even though she know he might have sex with twelve other girls.

Some young people advocated the view that abstinence promotion could be a valuable part of sexuality education. Aesha, 21, said, “I think [abstinence] should really be promoted.” Yet, participants strongly felt that abstinence should not be the only content covered, and wanted other options presented, as Andrea, age unknown, stated: “You [have to] throw options out there. You can’t just be like, ‘Don’t have sex’. [You’re] tellin’ us, ‘Don’t have sex’. Guess what? Don’t mean do to us, don’t mean do.”

Similarly, SBSE was not always presented in a manner that was meaningful and engaging to young people. As Aesha, 21, noted:

> … let’s get out there and do some things so that people can understand and in a way that they can understand it where it’s not boring. Education is important. Awareness is important. Teacher responsibility is important. But the way that you do it is the way that they accept it. If they’re not receptive to it, it’s not going to do them any good. So we have to bring it to them in a way that it’s okay for us to talk about this, it’s okay for us to do this and have a good time with it.

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Seeking information outside schools: "Y'all could be a little more aggressive."

Young people sought sexuality education from sources outside of the school such as health professionals, parents, peers, and community organisations. Overall, their sexuality education experiences included a very broad range of solicited and unsolicited information sources, although some of these supplementary sources presented their own barriers. For example, nurses and doctors were seen as credible sources of information because of their expertise. Additionally, nurses were understood to be both approachable and confidential. Krystal, 16, noted, "Because the nurses don't know you personally as well… and since they are certified they cannot talk about you, they have to keep it private."

However, some young people felt that health services required them to surrender more personal information than they were comfortable. They also reported that some health care providers also made inaccurate assumptions about their sexual behaviour – an experience that some found alienating. For example, young people who sought health care for unrelated concerns complained of being asked to take pregnancy or STI tests or being given condoms they had not requested. Jasmyn, 22, described: "[The doctor] just assumed that since I'm young and I'm in here and my stomach hurt, I have an STD and I think that's wrong."

Although health professionals were perceived as important, young people stated that parents should also have significant responsibility for educating their children about sex. A few young people felt that it was the most obvious thing to turn to one's parents to learn about sex and that they received positive messages on the topic from them: Marcus, 22, reported, "Because that is probably the first place the kids gonna learn about sex is their parents". However, they believed that other young people may be scared to discuss sex with their parents or that some parents would not be interested in communicating about sex. Angela, 15, said:

> …people don't have a lot people of to talk to about sex to like you know, so I think like it should be like maybe, I don't know, like maybe some little community thing and like people get the parents together and try to encourage them more like to talk to their child about sex…

Some young people felt that when they did talk to adults in their lives about sex, the adults were judgmental and pushing a point of view rather than listening to them. Thus, parents and other adults were also seen as sources of rules and admonishments as often as they were sources of help. Young people described that adults seemed to feel that young people should not be having sex, and that was where the conversation stopped. Jean, age unknown, stated:

> There are some parents that say don't do this, don't do that, and you don't really get to experience nothing – you aren't experiencing sex, but you not experiencing no one talking to you about it, like sex is just not allowed in your house. You won't hear about it. You don't hear about STDs.

Participants also felt that poor parental relationships could leave young people vulnerable to sexual health challenges. They were vocal about parental failures to encourage responsibility in, or monitor, their children. Yet, these complaints were often directed towards unnamed others in the community, rather than their own parents. A few participants felt that family dynamics left them vulnerable to unhealthy sexual relationships. Jayla, 21 said, "A lot of us don't have fathers, we don't have people like in our family that we can rely on". For such young people, sexual relationships could become a pathway to the love and attention they craved.

These challenges in discussing sexuality with parents and professionals made some participants more comfortable talking to their peers about sexuality. However, this openness was characterised more by gossip and bravado than actual information or assistance.

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Jasmyn, 22, explained, “We’re snooping up about who sleeping with who, but we can’t be nosy about how to protect ourselves”. Moreover, young people felt that they could not trust their friends as sources of information, because they did not know any more than they did, despite their similarity in experience. Natasha, age unknown, described, “People ask their peers about sex, but they don’t know anything about it”. Some participants wanted to be positive role models for others and felt a responsibility to educate their friends by sharing their experiences with STIs. Jamie, 19, expressed, “Say we friends, good friends, say I went through a situation, I tell her like, I’m just letting you know, don’t, that’s not a road you want to go down.”

Participants also identified community organisations as sources of sexuality education. Provision of free condoms and HIV/STI testing were particularly valued services from these agencies. Young people wanted these organisations to be more present and influential in their communities. Jayla, 21, said:

> Organisations like these, like the YOUR Center, what y’all are doin’ is really, really good, but y’all could be a little more aggressive and get your names out a little more…you guys are really, really influential and have a big impact on our community.

Still, some participants found it useful to independently obtain information through a variety of outlets, including books, television commercials, newspapers, educational pamphlets and the Internet (specifically Facebook and MySpace). However, other outlets, such as movies, TV shows and songs were viewed as a source of messages that sometimes reinforced unhealthy behavior. Amy, 22, reported, “And also, little kids are watching this…So they seeing it and they, many of my friends lost their virginity at age 9, age 8. You see this stuff on TV, you are gonna do it.”

General principles of youth-centered sexuality education

Participants expressed that a belief that the responsibility for sexuality education belonged not only to the schools, but also to the wider community. Young people identified many strategies for improving sexuality education, and for making it more relevant and accessible. General principles included trust and confidentiality, credibility of the source and self-determination.

Trust and confidentiality were desired features of sexuality education, regardless of the source of that education. Unfortunately, as described previously, trust and confidentiality were not always present in SBSE programmes. The importance of these factors was evident in the fact that when seeking sexual health information, young people spoke to people who they deemed trustworthy, whether or not they were knowledgeable about the topic. Study participants discussed sexual health with, and sought information about the topic from, others with whom they were comfortable and trusted to keep their personal information private. In many instances, young people confided in relatives such as cousins and older siblings, and supportive adults in their community who listened and did not judge – even if they could not provide them with the answers they sought. As Anthony, 21, put it:

> I would have to say my close friends and some of my family members and other adults in the neighbourhood – more old people – so we go and talk to them about certain things they normally know, but they don’t have answers to any question you have so I would just say the people that love me and who care and you know and take time out of their lives to love me and care for me and educate me about certain thing.

Rebecca and Lindsey, both 18, voiced similar sentiments:

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> But it's whoever they think they can trust the most. Whoever they depend on.
>
> So it just depends on who you can trust and what you can understand in your mind.

Participants also expressed greater trust in people who were closer to their age, and who were seemingly objective in their perspectives. In particular, participants favoured adults under 50 years of age. Bethany, 15, said, "They should not be too older a person that we cannot relate to them… someone in the early 30s, 40s, not 50s." Adults over 50 were perceived to be intimidating and young people mentioned feeling uncomfortable discussing sex around them. Amber, also 15, explained, "We were getting taught by old women and that was like really uncomfortable. It was just real uncomfortable to be talking to older women. Even though they have more experience, to be talking to them about sex, period."

In regards to objectivity, strangers were sometimes preferred over relatives and friends because their lack of bias. Anthony, 21, said:

> It is probably easier to talk to strangers than it is to talk to peers, relatives or friends. Strangers don't know you or your history…they're only there for the information and to help guide you whereas if you're spilling your guts to someone you know there can be blow back from that and people might be afraid to [spill their guts].

The perceived credibility of the information source was also important for these young people. For some respondents, credibility of the information source was determined by formal education: Katie, 16, said, "Someone who had an STD or HIV education." This was also true for organisations. Anthony, 21, suggested, "I think it would be a lot better [if health departments went to schools] because they know the material and they know what they need to teach people." Information sources that were direct with young people were deemed as credible. Phillip, 22, explained, "They answer your questions, they're up front with you. I think [names a health clinic] is a good organisation." However, credibility was linked to trust and confidentiality of information sources. If the source was not trusted, then the credibility of the information that they provided came into question. For example, lack of trust in government led to a belief that the information they provided was not valuable. Tina, 23, asserted, "The Center of Disease Control (*sic*), they know that African-Americans are dying out, they know that Latinos are dying out. What, from HIV and AIDS. What are they doing about it? OK, we'll throw in sex education in seventh grade. It's like they want us to die out."

A third general principle of sexuality education voiced was that of self-determination. Young people wanted to be able to seek the information they desired on their own terms, from individuals or available information sources on a range of topics. Participants also emphasised additional unused opportunities for sexuality education information dissemination, such as in clubs, corner stores, the mall, and bowling alleys, which could widen the net of young people reached. Danielle, age unknown, expressed this desire as:

> I can ask my doctor about birth control, ask him about the risks of getting sexual disease, ask him about those and coming to the health department if I want to know more and so I make sure I am safe and I make sure I have myself in every way possible.

Discussion

This study is one of few studies so far to ask urban African-American youth about their sexuality education experiences, both in school and outside of school. It is also one of few studies that has actively sought recommendations from young people to improve these experiences in the future. Through the three themes presented, young people in focus groups

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expressed their varying satisfaction with SBSE due to the restricted content covered and lack of comfort with the instruction methods. Participants described how they reached outside of SBSE for sexuality education, turning to those in the community, including local organisations, health care providers, and peers, also expressing variability in satisfaction with these sources. Finally, participants identified three important principles for youth-centered sexuality education.

Study participants described that although SBSE generally lacked important content, schools could be an effective space for sexuality education. This finding is also noted in Lloyd et al. (2012) in which African-American adolescents and adults from the rural South voiced frustrations with SBSE, describing it as restrictive and a barrier to preventing disease, even as schools could serve as access points to sexuality education and health care. Other literature shows that young people would like information on a wide range of topics (Forrest et al. 2004). This desire for more comprehensive content is consistent with the findings of the American Academy of Pediatrics (2001) that showed the value of programmes that encourage abstinence, but also offer a discussion of HIV prevention and contraception.

Prior youth focused studies also indicate the need for a range of sources of sexuality education and the development of audience-specific programmes (Coker-Appiah et al. 2009; Flores, Blake, and Sowell 2011). Young people have previously identified non-school based sources such as parents and other family members as primary sources of sexuality education (DiIorio, Pluhar, and Belcher 2003; Somers and Surmann 2004). However, our findings also show that fear and discomfort often leave young people under-informed about sexual health. Although alternative sources for sexuality education existed, younge people reported that their experiences using these sources ranged from helpful and pleasant to embarrassing and useless, such as the concern of being stereotyped by doctors (Jacobson et al. 2001).

Culminating from these experiences, study participants presented three general principles for youth-centered sexuality education. For these young people, the general principle of trust played an important role in the quality of sexuality education communication between them and others. Given the sensitive and personal nature of sexual questions and behaviours, it is likely that a perceived caring relationship enhances comfort in disclosing (Daddis and Randolph 2010). Research also suggests that people looking for information expect emotional support, which may lead them to value the supportiveness of a response above information quality (Harris and Dewdney 1994).

The desire for trust can also be situated historically. The exploitation of African-Americans by government institutions in the USA, including the government, is well documented. Gamble's (1997) original paper traces the historic mistreatment of African-Americans from the antebellum area to post-Tuskegee Syphilis Study. In 1990, *Essence*, a popular US magazine, ran a story titled, "AIDS: Is it Black Genocide?" (Bates 1990). More recently, the *New York Times* non-fiction bestseller *The Immortal Life of Henrietta Lacks* (Skloot 2010), detailing the use of a poor African-American woman's cells for scientific and financial gain without her knowledge, has brought the topic of the American biomedical community abuse of African-Americans to the forefront again. Within this context, African-American young people's desire for trustworthiness in sexuality education is better understood.

Tied to trust and confidentiality was the principle of credibility. Rieh and Danielson (2007) noted that if a source was perceived as credible, it may invite trust. The variety of sources and information desired suggest that young people have differing opinions on what is credible. Further, young people determine credibility by measuring one source against others; for instance, an adult with a formal education in sexual health could be deemed more credible than an adult without formal education. This highlights that young people's

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preferences must be known about, and is in-line with previous research that describes individuals as having their own understanding of credibility (Hilligoss and Rieh 2007). The complexities of desires for sexuality education are reflected in the variety of sources participants described that balance the credibility of the source with the trustworthiness of the source.

Finally, the third general principle of self-determination was found in the desire for diversity in sexuality education, particularly as it relates to the content and format. Self-determination theory (Deci and Ryan 2002) describes basic needs for physical and cognitive functioning: competence, relatedness, and autonomy. Competence refers to an individual's opportunity to improve their capacity; relatedness entails the sense of community; and autonomy describes the ability to express one's self, with and without outside influence (Deci and Ryan 2002). Participants in this study expressed a desire for competence in sexuality education, through the development of broader content that includes messages not only around abstinence, but also messages around the practicalities of condom use, less risky sexual behaviors, emotional aspects of sexuality and community resources.

Participants described the concept of relatedness by citing several community spaces that sexuality education could occur, such as churches, community-based organisations, and schools. Schalet (2004) explained that when young people have access to desired, credible, and trustworthy information, they gain self-ownership of their behaviours. A youth-centered approach to sexuality education would allow young people to make autonomous informed decisions regarding their own sexual health.

Implications for practice and research

Focus groups, such as those employed in this study, can assist in identifying specific youth needs in a given community. While young people very much wanted to gain information and recognised they held personal responsibility for their behaviours, their perspectives also suggested that sexuality education needs to be embedded in the community as a whole, including peers, parents and traditional authority figures, such as older adults, teachers and trained health educators. Attention should also be given to the promotion of policies that encourage comprehensive sexuality education, inclusive of the above strategies, within schools. Support for diverse sexuality education resources, could also boost a community's ability to serve as a resource, a need strongly desired by youth. Our findings should encourage youth-serving adults to consider sex-positive approaches that better guide young people towards safely understanding and experiencing sex, but ways that remove the shame and judgment that is sometimes attached to the discussion (Levine and Elders 2002).

More research is needed to fully understand the specific forms that youth-centered sexuality education could take. There is a dearth of literature on what young people desire from sexuality education, within and outside of schools, as well as their attitudes towards current offerings. The present study takes the first step to add to this knowledge. As young people identified several opportunities for and concerns around sexuality education, research investigating how these suggestions could be optimally leveraged to develop relevant sexuality education programming. Working directly with young people, researchers can further investigate these questions.

Study strengths and limitations

The current study has a number of strengths and limitations. Consistent with the principles of CBPR (Israel et al. 1998), the current study built on the existing strengths of the community, namely a trusted community- and faith-based social service organisation, as well as the local health department and their leadership. Engaging respected institutions in

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the community facilitated the recruitment of participants as well as provided a safe space to discuss sexual health issues. Indeed, a number of participants stated that they wished to attend more focus groups, since they afford them a much-needed opportunity to discuss sexual health issues. In addition, the findings of the current study have been used to inform the design of sexuality education programming in Genesee County.

In terms of limitations, young people were not included in the design of the interview protocols. Future researchers might consider incorporating young people's voices as a part of university-community partnerships, so as to ensure appropriateness for this audience. In addition, as many of the participants were affiliated with the YOUR Center, it is possible that the sample was biased towards service users. Moreover, as participants only participated in only one focus group, this snapshot of their perspectives may have been influenced by their most recent and current sexuality education experiences rather than their lifetime experiences. Finally, there are limitations to using focus groups as a research method, including the lack of generalisability to the larger population and the possibility of discussion being dominated by a vocal minority of participants (Stewart and Shamdasani 1998). However, the use of skilled facilitators can diminish the risks posed by the latter problem.

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Table 1

Characteristics of study participants.

Characteristics	**Number**	**Percent**
Gender		
Male	9	9%
Female	39	81%
Age		
Mean	17	
Range	14–23	
Race/ethnicity		
African-American or Black	46	
White or Caucasian	2	
Sexually Active	30	63%
Sexual Orientation		
Heterosexual	47	98%
Homosexual	1	2%
Education Level		
Some college	7	15%
11th grade	32	66%
Employment Status		
Part-time	14	30%
Full-time	1	0.02%