HIV/AIDS Perceptions, Attitudes and Behaviors Among HBCU Students

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Abstract

College environments are typically considered somewhat protected zones--protected from the "sins" of the general community. However, a recent report from CDC placed considerable attention on the resoundingly high rates of HIV infection among African American students attending predominately African American serving colleges and universities in North Carolina. In the "outside" world, data show that African Americans lead the nation in the rates of HIV/AIDS infections. This research turns on the light to view more clearly an oft-shielded group in an effort to identify and assess the exacerbating or ameliorating social forces that these campuses imbue. This project uses quantitative and qualitative methodologies to examine how college age young adults attending HBCU's respond to the pandemic / epidemic. In the general African American population typical intervention approaches have had little to no positive effects on reducing the persistently high rates of infection. An in-depth look is taken into the lived-experiences of students at Historically Black Colleges and Universities as it relates to their sexual risk taking in the age of HIV/AIDS.

Introduction

The HIV/AIDS pandemic is a significant social problem at the global, national and regional levels. It impacts persons regardless of gender, race, ethnicity, sexual orientation or age. This scourge may even have reached communities thought to be relatively immune to such incursions—college campuses. A recent report from the CDC placed considerable attention on the resoundingly high rates of HIV infection among African American students attending predominately African American serving colleges and universities (HBCU's) in North Carolina (MMWR, August 20, 2004/53(32): 731- 4). One CDC official states that there is no reason to think that we will not see this same trend on other campuses as well (see Hightower, L., MacDonald P, et al., 2003). This research was motivated by the gaps in the literature on the sexual risk behaviors and attitudes at HBCU's (historically black colleges and universities).

The importance of this project is found in the attempt to identify the sociocultural aspects of the student populations at HBCU's that may place them at greater risk of HIV/AIDS infection. By socio-cultural context, we mean the ways in which people's behaviors are linked to their social settings such as group membership, race, class, and gender. For example, there are gender dynamics that fuel the health disparities between black men and women. Consequently, while black men and women overall account for 40% of the cumulative AIDS cases through 2005, black females drive 60% of this rate (Division of HIV/AIDS Prevention, National Center for HIV/AIDS, Viral hepatitis, STD, and TB Preventions June 28, 2007). Additionally, for 2005, black women constituted 66 percent of the female cases of HIV/AIDS (CDC HIV/AIDS Fact Sheet, June 2007). Although Black men have the highest rates of HIV/AIDS for any of the racial or ethnic groups in the U.S., HIV/AIDS is the leading cause of death for Black women aged 25–34 (CDC HIV/AIDS Fact Sheet, June 2007).

Studies of social context situate health-related behaviors within the framework of the social meaning, social relations and transactions of people's lives (Abel 1991). It is critical to focus on

understanding the social and cultural components of developing healthy lifestyles. Williams, et al point out that African Americans have the highest overall HIV prevalence, HIV incidence, and HIV mortality as well as the greatest number of years of potential life lost to this disease (2003:66). Sero-surveillance reports suggest that the HIV incidence among African American men 25-44 continues to increase and is particularly problematic for men who have sex with men (MSM). Within this group the HIV incidence is 16.7% per year compared to an incidence of 2.5% per year for white MSM in their twenties. (MMWR, Valleroy et al. 2000).

Few health behavior surveys have been conducted at HBCU's. Notably, however, Taylor, DiLorio, Stephens and Soet, (1997) reported that only 35% of students in their study reported using condoms on a regular basis. Until the recent North Carolina survey the only sero-prevalence study among college students was published in 1990 (Gayle et al.). College students were considered to be low risk although at least one publication suggested that African American college students may be the next group affected by HIV (Duncan C, Miller DM, Borskey EJ, Fomby B, Dawson P, and Davis L 2002). For instance, Black females diagnosed between ages 13 to 24 are twice as likely to contract HIV/AIDS through high risk heterosexual contact as their male counterparts. Black females diagnosed in this age group and risk category constitute 17.3% of new cases compared to 7.7% of men. It is important to understand the lived-experiences of these students as they negotiate a complex array of choices within their social settings.

Within the past decade, programs designed to stem the tide of this epidemic among African Americans have made little to no significant headway (Williams, Ekundayo, Udezulu, and Omishakin, 2003; Smith, Gwinn, Selik, Miller, Gaitor, Maat, DeCock, and Gayle, 2000). In the African American community, positive results are slow to be realized. Clearly, there are barriers to these efforts that go beyond the individual biological and psychological considerations of most intervention/risk reduction programs. Myers, et al (2003), for example, point out that "[T]his underscores the need for more aggressive and targeted risk reduction interventions for African

American men . . . because they do not seem to be getting the message about the need to be more sexually responsible" (p. 75). The scope of these risk reduction programs has not been broad enough in the African American community where, perhaps, cultural issues are more likely to impact people's willingness to participate in open discussions of sexuality and sex, participate in support groups, and other treatments that appear effective in other communities. Even when these programs are focused on 'community' issues, the efforts are directed toward individuals.

The National College Health Risk Behavior Survey (Fact Sheet CDC, 1995) revealed that 79 percent of college students have ever had sexual intercourse and only 37 percent reported having used a condom during their last sexual encounter. However, this same study found that black students take fewer risks than their white counterparts. For instance, while about 10-percent of whites fail to use seatbelts when driving, only about 8-percent of blacks fail to use them. Additionally, about 31% of whites and only 15% of blacks report that they drink and drive. Focusing on sexual risk-taking, the national Youth Risk Behavior Survey of pre-college students revealed that 62.5% of whites used a condom during their last sexual encounter compared to 72.8% of black students – even though black students were reported to have been more likely to have had sex during high school than Whites. Based on an ongoing health behavior survey first conducted of 1,302 first year students in the Atlanta University Center (AUC) by the Morehouse School of Medicine in 2004, 64% of female and 73% of male first-year students reported having had sex at least once in their lives. Only 48% of the females reported using a condom during their last sexual encounter along with 54% of the males. We will explore this rather counter-intuitive finding later in this paper.

Methods

The findings herein are based on a multi-modal data collection strategy, including qualitative interviews and survey research. We briefly describe these techniques. The Internet is an

emerging research tool that is proving to be very useful in the social and behavioral sciences. Most of the studies using the Internet rely on quantitative survey methods. There are a few that have used it for qualitative analyses. Focus groups and chat rooms are typically the choice for qualitative data collection and analyses (see Burgess, Donnelly, Dillard, and Davis 2001; Bowen, Williams, and Horvath 2004; Hudson and Bruckman 2004). The use of interviewing strategies, such as the technique described below, is still in its nascent stages of development (Davis, Bolding, Hart, Sherr, and Elford 2005).

The findings of this research are based on the collection of data from five (5) predominately African American serving institutions within a large southern metropolitan area with diverse student bodies (hereafter called AUC) utilizing secure internet "chat room" sites. The data reported herein is based on surveys and in-depth chats with 37 students. Each interview averaged 2.25 hours. Respondents were paid for their time and potential costs of internet connectivity. Respondents are interviewed "one-on-one" by a trained researcher using the Internet as the medium of communication. This method assures complete anonymity for the respondent, thereby encouraging open, honest, and frank discussions of material that potentially could create an uncomfortable setting for the respondent. Focus groups and dialog sessions were also held with students.

Additionally, more systematic data were collected by survey methodology. The findings discussed below are based on an annual survey completed by first-year students within the AUC. The research protocol was approved by the Institutional Review Board of the Morehouse School of Medicine. The questionnaires were voluntarily completed in large "convocation" settings. While the actual convocations were required, students were given the opportunity to "opt out" if they did not want to participate in the study. The majority of students completed the questionnaires; however, the lack of privacy and the large group setting undoubtedly had some impact on the quality of the data. The analysis below is based on data from the first two years of administration (2004 and 2005). The number of students who voluntarily participated in the

survey (2004 – 2005) was 2,021. The patterns of sexual involvement correspond to other data from large surveys of college students. The number of full time undergraduates at the five colleges (according to published fact books from 2004 – 2006) is 8633. Of this group, 44 percent (3805) is male.

Results

Our multi-method approach yielded several key findings from the survey analysis as well as important themes related to HIV/AIDS risk reduction among African American college students. We will give a brief overview of the survey findings then turn to our more qualitative aspects.

We compiled data from surveys conducted of first year students in the AUC in 2004 and 2005. These data are shown in the tables below. Table 1 shows that males were significantly more likely to report having had sex than their female counterparts. Overall, about 63 percent of these first year students indicated that they had had sex at least once in their lives (56% of females and 71% of males).

Table 1

Have you ever had sexual intercourse?	Female	Male	Totals
NO	420 (44.4%)	245 (29.3%)	665 (37.3%)
YES	527 (55.6%)	590 (70.7%)	1117 (62.7%)
TOTALS	947	835	1782
$X^2 = 42.735$, df = 1, p=.000			

These data indicate that while a greater percentage of males begin having sex at slightly younger ages than females, there was no statistically significant association between gender and the reported

age of first sexual intercourse. However, Tables 2 & 3 reveal that males report a higher number of sexual partners than females (lifetime and last 3 months).

Table 2

# Lifetime Sex Partners	Female	Male	TOTALS
1 partner	162 (22.6%)	90 (14.9%)	252 (19.0%)
2 partners	174 (24.2%)	122 (20.2%)	296 (22.4%)
3 partners	99 (13.8%)	87 (14.4%)	186 (14.1%)
4 partners	124 (17.3%)	90 (14.9%)	214 (16.2%)
5 partners	68 (9.5%)	71 (11.7%)	139 (10.5%)
6+ partners	91 (12.7%)	145 (24.0%)	236 (17.8%)
TOTALS	718	605	1323
$X^2 = 38.936$ (df = 5) p= .000 / Gamma = .213 / p= .000			

Table 3

# Sex Partners in last 3 Months	Female	Male	TOTALS
No partners	302 (43.1%)	199 (33.4%)	501 (38.7%)
1 partner	118 (16.9%)	134 (22.5%0	252 (19.5%)
2 partners	198 (28.3%0	154 (25.9%)	352 (27.2%)
3 partners	69 (9.9%)	57 (9.6%)	126 (.09%)
4 partners	9 (1.3%)	22 (3.7%)	31 (.02%)
5 partners+	4 (.6%)	29 (4.9%)	33 (.03%)
TOTALS	700	595	1295
$X^2 = 45.008$ p= .000 / Gamma = .149 / p= .000			

Interestingly, Table 4 indicates that males are more likely to report having used a condom during their last sexual intercourse than are females.

Table 4

Condom use the last time you had sexual intercourse	Female	Male	TOTALS
NO	246 (34.8%)	193 (28.8%)	439 (31.9%)
YES	461 (65.2%)	478 (71.2%)	939 (68.1%)
TOTALS	707	671	1378
$X^2 = 5.770$, df = 1 p=.016			

We wanted to explore this finding a little more deeply. We analyzed the responses to a 13-item Condom Attitude Scale (DeHart and Birkimer 1997). The 13-item Condom Attitude Scale had a mean of 29.69 and a Standard Deviation of 13.412. The Cronbach's Alpha coefficient was .9214-demonstrating very good reliability. This analysis indicates that males, surprisingly, show more positive attitudes towards condoms than those of our female respondents. Additional analysis was conducted using multiple linear regression to ascertain which variables impacted condom attitudes (see Table 5 below). Surprisingly, neither the mother's nor father's level of education nor parental income had a significant influence on condom attitudes in this sample. Age at first sex and number of lifetime sex partners significantly (and favorably) impacted attitudes towards condoms. This finding reveals that men and more sexually experienced students are more favorable towards condoms and condom use. This may be the result of the socialization of males to favor condoms as a means of disease protection in this collegiate setting. Gender attitudes probably also help to explain this difference as females are socialized to emphasize intimacy and closeness in their relationships.

TABLE 5

Condom Attitudes	Beta Coefficients	Significance
Sex (female = 1)	B = -4.915	P = .000
Age of first sex	B = 1.566	P = .000
Number lifetime partners	B = .820	P = .043

For women, this may prove to be a dangerous attitude given the nature of the HIV/AIDS epidemic in the U.S. While the greatest numbers of Blacks that are diagnosed with HIV/AIDS are between the ages of 35 to 44, Blacks between the ages of 13 to 24 constitute 60.1% of all recent HIV/AIDS diagnoses. The Centers for Disease Control and Prevention surveillance data reveal that the primary modes of transmission among Blacks include MSM (men having sex with other men, 30,154 new cases), high-risk heterosexual contact (having unprotected sex with a person who is HIV+, 14,698 new cases) and injection drug use (10,415 new cases). Black females diagnosed between ages 13 to 24 are twice as likely to contract HIV/AIDS through high risk heterosexual contact as their male counterparts (CDC, 2002). Black females diagnosed in this age group and risk category constitute 17.3% of new cases compared to 7.7% of males. The primary mode of transmission for Black males diagnosed at ages 13 to 24 is MSM behavior (19.9%).

These quantitative findings are closely linked to the evidence provided in our qualitative analysis of students from these campuses. Careful analysis of indepth interviews, focus group sessions, and student dialog sessions yielded a number of interesting themes that provide contextualization of the findings expressed above. These themes are important determinants of the socio-cultural context of the AUC. Our findings are also consistent with other research findings that examine traditional gender roles (see, for example, Hill-Collins 2004; Cole and Guy Sheftall 2003; Roberts, McNair & Smith 2004; Sobo 1995). Unpublished data from surveys conducted

by one of the co-authors over the last two years also indicate that "serial monogamy" and low or inconsistent condom use are common among undergraduates in the AUC. This research will help to inform approaches to risk reduction and HIV testing for young African Americans inside and outside of the academy.

One of the main ideas promoting risky sexual activity on this consortium campus was the popular media. In particular these respondents focused on what they termed highly sexual videos. They suggest that African Americans are more influenced by the combination of the music and what is seen than their white counterparts. These respondents see the media, not so much as causing sexual activity, but at least promoting a carefree sexual lifestyle. As one respondent said,

> Yes, Media do influence my sexual thinking and especially my behavior. Sex on TV is free. TOO free sex is so simplified on TV, this makes it seem so cut and dry. I feel that TV promotes the need and pressure for sex….

Another respondent believes that "media encourage this behavior and our generation is easily influenced." An interesting conversation centered on these videos and the movies that they [college age students] tend to watch. They said that none of the videos or movies ever show or suggest the use of protection in the sex scenes. They move directly from some minimal foreplay to a naked scene in the bed to the sleep scene or cut away to another shot.

> Sex has been limited to just a normal human activity for any age these days especially on videos and shows. i guess its all cos of the change in the way we think and our being able to be more outspoken than humans were years ago. the media does influence our sexual thinking and attitudes and behaviors in a way but then i wouldnt put too much blame on them cos i think each and everyperson has the responsibility to process that information and interprete it as to whether they want to go by what they have seen or live by statutes that protect them.

Another respondent makes comment on the amount of sexualized imagery in contemporary media presentations:

> There are a lot of shows on television, and in the movies that promote having a lot of sex with a lot of people, without having any regard to the safety of the individuals involved. These depictions of glamorous and desirable life stages do not present the realities of sex and sexual encounters. Clearly, no one in these movies gets an STI or HIV.

An important finding, captured in the students' comments above and that is revealed from many of these qualitative interviews is the normalizing of risky sex. These respondents do not think that media are setting out to increase risky sex among the viewers of these images; however, the respondents clearly indict media for depicting risky sex as normal. In this way, these respondents say, the media presents sex in such a way that what would be seen ordinarily as risky behavior is now normal, and even expected. One respondent was particularly cogent on this point:

> It encourages the thinking that promiscuity is not so bad, and in fact is at times encouraged. And none of the people represented with the popular media go out of their way to promote safe sex. This heavily influences college students, who emulate what they see more than they would like to admit...like its nothing. Like its money, and everyone should rush to get as much as they can from as many different sources as possible.

These respondents point to many of the popular music videos and some movies where there is no sense of safe sex. Actors are depicted as having sex with multiple partners, without any indication of condom usage. And, as pointed out by Hill-Collins (2004), the lyrics and themes of the videos are also misogynist and patriarchal.

> I think that since most young black males want to be a "player" and try to have sex with as many women as they can, causes diseases to be spread in our community. I think that the media encourages this behavior and our generation is easily influenced.

And, as one male respondent put it, "they allow videos that exploit sex(naked women)." Consequently, females are tacitly encouraged and shown to be passive in sexual relationships.

Another theme that is clearly present from the data targets the sex education received as a teen in high school and from home. We see these focal socializing agents as integrally connected providing both complementary as well as conflicting messages. Both agents seem to be missing the mark on sex education of children. The respondents agreed nearly unanimously that the standard approach used in high school was ineffective. They said that high school sex education tries to scare students away from sex while the realities are not discussed.

> It needs to start in the homes. I think the parents needs to be knowledgeable about the dangers of sexual behavior, so that they can relay the info to their children. So there should be programs implemented to inform the adults.

A 20 years old male respondent very directly assesses the problem:

> Well, I think the fundamental factor lies in the condition of the home. When I say family grounding, I mean a person may lack parental reinforcement, concerning sexual activity.

The men in the group said that the extent of the sex education received at home was their fathers telling them do not get anyone pregnant so wear a condom. One respondent said "my father started giving me condoms in 6th grade." Another respondent said that he felt his father was telling him to have sex. His father told him that a "Viagra erection" was somehow superior to the natural erection thereby encouraging the use of drugs with his sexual encounters. (Note: there is information surfacing about the use of Viagra in young men for whom it is not prescribed and not recommended in combination with other drugs including crack cocaine and methamphetamines).

One of the most frequently stated ideas about college life among students is the notion of "freedom from parents." They indicate that college provides them with the freedom to engage in all sorts of activities. Without a strong foundation about sex and

sexuality, the likelihood of risky sexual behavior is enhanced.

We note that the majority of HIV prevention programs focus on male-to-male sexual contact, male bisexual behaviors, injection drug users, and low-income women considered "at-risk". By default, such efforts ignore the needs of Black college women attending HBCU's. Our evidence highlights that societal norms, cultural productions, as well as the college environment itself encourage sexual experimentation and all types of sexual negotiation. African American women in college, many of whom arrive from inner cities and single-parent households, are part of a most recent hip hop generation that is besieged by misogyny, materialism and sexual risk-taking. Many African Americans strive to overcome their ascribed and inferior social status by constantly struggling against widespread stereotypes and assumptions regarding their very being. Their patterns of racial identity formation and maintenance influence how they respond to such representations, even within intimate relationships. The research herein reveals patterns of thinking among students, both men and women, which need to be addressed. A female freshman student reveals her thoughts in a focus group setting:

> It's hard being a Black woman, you're fighting off negativity at every moment. You gotta be strong, when you're in the bedroom setting you don't want to fight anymore. You become submissive. You relax and let things flow.

Findings in the AUC corroborate those of Foreman (2003). She suggests that students used certain strategies to create philosophical and emotional rationalizations for their behaviors. Women also rely on a perceived level of commitment in their romantic relations to determine safer sex practices. Forman also finds that students had difficulty discussing condom use with sex partners and that many perceived that they had low levels of HIV knowledge. Our findings differed from those of Foreman in the area of HIV knowledge. Respondents had relatively high levels of knowledge even though many did not use condoms consistently. They were also less likely than those in the Foreman (2003) study to cite material reasons for

having unprotected sex.

A disturbing circumstance was noted in discussions with many of the respondents. The main thrust of the issue centered on attitudes towards risky sexual activity. When the question was asked why college students might engage in risk-taking behaviors, the respondents began a type of rational choice process in their responses. They believe that they weigh (accurately) the risks and determine that the risk is worth it. Of course, this position is wrapped up with all the other notions of their sexual activities – from seeing images in the media, to sex education in school and home. One respondent summed it up this way: "I'd rather have sex and take the risk and hope that I don't get it [HIV/AIDS] than not to have sex." Another added: "we continue to have sex because we are scared that we may not be able to have sex again." Yet another respondent states that "disease is not something we think about, we are young and figure we have time to fix whatever may happen [based on current actions]." All of these themes fall squarely into the category of invincibility or a false sense of invulnerability. In other words, these college students feel that they are incapable of suffering harm from their actions. All of these behavioral factors appear to be linked to the sociocultural constraints of the college experience.

Sociocultural Findings

Many of the conversations settled on concerns of a sociocultural nature. For example, the respondents began to focus on topics such as what it means to be a college student (particularly at a black school). Many suggested that college life means that you have to be having sex, and a lot of it. If you are not participating in sexual activity, peer groups view you as a child. As one respondent put it: "you're told you're not grown until you get a piece." Many of these students may be trying to gain some sense of adulthood through risk-taking behavior. The links between college culture and behaviors of the students, no doubt, are complex. Distressingly, these respondents seem to navigate this complexity in ways that may enhance the probability of risky sex. The college culture provides the first sense of independence from parental control. Peer pressure

may lure students to engage in activities so that one will not feel left out or be seen as an odd-ball.

One of the most interesting conversations centered on the idea of sex as a proxy for the need to feel loved. The interesting thing about this conversation was that it was most often discussed by the males in the sample. The discussion from these young males is similar to literature suggesting that one of the reasons for underage pregnancy is the girl's need to feel unconditional love. She is able to give love and have that love unconditionally reciprocated through her dependent infant. It can be intoned from this discussion that students are using sex as a stand-in or substitute for their need to feel loved. Females are also socialized to emphasize intimacy and continuity in their relationships. As Sobo (1995) suggests, this need for intimacy increases the likelihood of sexual risk-taking among working class women. Our findings suggest that this need for intimacy among women may also contribute to less favorable attitudes about condoms and less condom usage - especially in on-going (vs. casual) relationships with their male partners (see Wade 2007). More investigation is needed to understand the mechanisms of this phenomenon.

Discussion

Gender as Cultural Context

Cole (2005) aptly describes the HIV/AIDS epidemic among black women as "a disease of mass destruction" (2005:51). She points out the limitations of the "ABC trilogy" of prevention. For many Black women, providing or "teaching" the facts about abstinence, faithfulness and consistent condom usage (ABC) are not enough to stem the tide of the epidemic given the societal issues that impact the broader African American community. The issues of "infidelity, rape, incest … secret bisexuality, fears of rejection and loneliness, and serial monogamy" (2005:53) make it necessary to supplement the ABC model with other approaches to risk reduction. Cole agrees that it is crucial that Black women receive tailored and "comprehensive sex education" (2005:57) in response to this set of

issues. Such gender specific programs must: 1) Convey the gravity of the HIV/AIDS epidemic to women; 2) Influence personal behaviors and notions of responsibility (abstinence, alternative forms of intimacy, risk implications of multiple partners); 3) Enhance women's sense of personal empowerment (self esteem, self efficacy, condom negotiation skills), and 4) finally, emphasize HIV/AIDS advocacy to overcome community apathy, fatalism and conspiracy theories.

Another question related to gender role expectations and sexual risk-taking for women and men is how to combat the "valorization of thug life, misogyny, homophobic violence, and a constant need to prove one's manhood" (Hill Collins, 2004:81 – 82; Cole & Guy Sheftall, 2003). Such beliefs, norms and "contextual factors influence sexual risk-taking" (McNair, 2004:107). These factors include environmental stress, relationship history, perceived victimization status, an imbalanced sex ratio – fewer available partners and an attenuated ability for females to negotiate condom use (McNair, 2004). In a setting with an unbalanced sex ratio, there is considerable pressure on women to compete for the attention of men. Further, Black women in college are less likely to date outside of their race than men. Consequently, more attention must be given to these environmental pressures within the framework of HIV/AIDS prevention for HBCU students.

Although most intervention programs target the individual, health behaviors can illustrate how the health problems of Americans and especially youth are embedded in the social, economic and political structures of society. Evidence suggests that prevention programs need to begin early in life, before risk-taking behaviors cement themselves as a part of people's behavioral repertoires. Holtzman and Rubinson (1995) observed the impact of parent versus peer communication about HIV/AIDS among high school students in the U.S. They found that students who discussed HIV with their parents were significantly less likely to engage in risky sexual behaviors and drug injection than their peers who primarily discussed HIV with other students. Other studies have found convincing evidence linking family organization and interaction styles to risk-taking behaviors (see Walker, Vaughn, and Cohall 1991; Leland and

Barth 1993). Strategies that facilitate development of pro-social environments are needed to stem the tide of risk taking behaviors. Uncovering the social and cultural elements of the lived experiences of specific at-risk groups will provide much needed information for positive interventions of their risky sexual behaviors. This type of preparation for a productive life style may hold the most promise for reducing unhealthy life choices and the negative outcomes that seem to be endemic to many communities (see Stokes and Hodge 2000; Harris, Duncan, and Boisjoly 2002).

Youth and Sexuality in the Age of HIV/AIDS

A study sponsored by The Kaiser Family Foundation/Children Now initiative (1999) surveyed 348 children between the ages of 10 and 15 in an effort to understand where youth receive information about subjects such as sex and AIDS. What the survey revealed was that youth between 13 and 15 years rely on peers as much or more than on parents for information on sex and sexual relations. For example, the respondents were asked to whom they would likely talk if they were thinking about sex. Over one-fourth (27%) responded that they would talk to friends. When asked if they had ever talked to their parents about a range of issues, 24% indicated they had never talked to either parent about AIDS, 19% had not talked to either parent about basic facts of sexual reproduction, 26% had not talked about issues surrounding becoming sexually active, and 21% had not talked to their parents about pregnancy or sexually transmitted diseases. Respondents also indicated interest in knowing more about issues concerning sex and its consequences. This and other studies show that youth are indeed interested in issues pertaining to reproductive health and health issues in general. Students come to college campuses with these questions and issues still unresolved. Many have already engaged in risky activities.

Social forces in the larger societal context operate to either aggravate or attenuate the behaviors on the college campuses. For instance, research indicates that African American adolescents initiate sexual encounters, on average, at an earlier age than their white and Hispanic counterparts (Bakken and Winter 2002). Most

interventions, therefore, focus on information processing. The idea is that the more knowledge students have about the negative outcomes, the less likely they will be to participate in risky behaviors. Seminars that provide factual information are clearly a necessary component for reducing risky sexual activity; but they may not be wholly sufficient. Programs that address the "cultural baggage" of students are needed to complete the package for effective behavior change. And, it is important that these programs are based on sound scientific foundations. We are looking to delineate the social and cultural structures that circumscribe the behavioral repertoires of these actors; but, moreso, we seek to understand the inter-relationships or interaction of the social context with the actor. In essence, we examine the mutual interpenetration and interdependence of agent and structure. We do not ask simply what are the social forces impinging upon each actor; but, what are the actors' perceptions of these social forces as they negotiate the cultural milieu of on their campuses.

Interaction of Culture and Individual

We believe that a major issue hampering effective intervention on college campuses, particularly HBCUs, is the belief that it is ultimately the individual that controls his/her behaviors and is the author of one's own fate. Yet, sociological theory holds that individuality is constrained by social forces such as class, race, gender and social institutions such as family, education, religion, and work, among others. Factors relating to these social institutions must be included when trying to implement behavioral change strategies. Link and Phelan (1995), for example, demonstrate the connections between family interaction dynamics and risky sexual behaviors. Bakken and Winter (2002) show that there is an association between family characteristics and age of sexual initiation as well as the lifetime number of sexual partners (both variables that are important in assessing sexual risk). Hence, consistent with long-standing social science theory, the relationship between health-related behaviors, risk and knowledge can be incorporated in studies of social structure, social practices, and agency (Abel 1991).

Social structure is defined as the factors involving individuals' relationships to each other and the attendant power relations. Social practices are the reflexive activities in which people engage to make and transform the world. Agency is defined as the ability for people to deploy a range of causal powers—to "make a difference to a preexisting state of affairs or course of events" (Giddens 1984). In-depth qualitative analysis of case studies is the only way to fully assess the actor within the particular context of the college culture (Burawoy 1991; Feagin, Orum, and Sjoberg 1991).

Ample evidence exists demonstrating the relationship between social factors and effective health behavior intervention strategies. For example, research has shown that carefully designed interventions that take into account the socio-cultural context play an important role in reducing risky behaviors of adolescents and young adults for a variety of problem areas. Kirby et al. (1994) provide a review of school based programs designed to reduce sexual risk taking behavior among adolescents. They found that a number of programs were able to successfully reduce risk taking behaviors. Additionally, Frost and Forrest (1995) identified five programs that were successful in either reducing rates of sexual initiation by young adolescents or increasing the use of contraceptives for those who are engaging in sexual intercourse. More recently, Stokes and Hodge (2000) examine the effects of programs such as Upward Bound on the risk taking behavior of adolescents. These studies and others demonstrate the substantial influence social factors have as determinants of health behaviors. For instance, Myers, Javanbakht, Maritinez, and Obediah (2003) examine the behavioral, demographic, social, and psychological factors that may be associated with high sexual risk activities. They find that for heterosexual African American males, social support provided significantly deacreased risk-taking activities. In other words, for every mean point increase in social support there was an associated 2.3% decrease in the likelihood of risky behaviors among this population group. A recently published study examined the influence of social context on individual behaviors that may place people at risk for negative health outcomes (Adimora and Schoenbach 2005). These researchers found important socio-

cultural factors that may put African Americans at greater risk for STIs and HIV. They find that sharply contrasting social settings for blacks and whites, particularly in their social networks, is likely to maintain the gap in HIV rates. They note that overlapping sexual partners is more prevalent among blacks. A lot of this finding can be traced to contextual factors such as incarceration rates of black males, segregation, and poverty. The study of sexual networks on Black College Campuses has not been done, to date. Numerous studies of college students have explored the relationship of knowledge about HIV and risky sexual behavior (see Parsons JT, Halkitis PN, Bimbi D, Borkowski T; Bazargan M, Kelly EM, Stein JA, Husaini BA, Bazargan SH 2000; Dilorio C, Dudley WN, Soet J, Watkins J, Maibach E. 2000). In many studies knowledge of HIV is not correlated with safe sex practices (Valentine PA, Wright DL, Henley GL. 2003; Lewis JE, Malow RM, Ireland SJ 1997) and interventions based on social cognition models have had limited success in changing risky sexual behavior (Ogden 2003). Other researchers have suggested the need to integrate social group process into cognition models for youth and young adults (Schofield PE, Pattison PE, Hill DJ, Borland R. 2003; Young RA, Lynam MJ, Valach L, Novak H, Brierton I, Christopher A. 2001). Several scholars have noted the importance of social factors and culture on sexual health behaviors of African Americans (Plowden K, Miller JL, James T. 2000; Plowden KO, Young AE 2003). College campuses provide an interesting social setting where lives are very closely intertwined on a number of levels.

Conclusion

Students work, live, play, etc. in a very small space and issues of privacy are heightened by this type of organic density. These concerns are particularly salient on Historically Black Colleges and Universities where there is greater density than on traditionally larger majority campuses (literally, everyone is, at minimum, familiar to everyone). Institutional culture develops and changes as the nature of the interactions of its members adjust to social forces from inside and outside the institution. The findings chronicled herein, at least,

begin to focus much needed attention on the dynamic interplay among students at historically black colleges and universities. Given the cultural baggage African Americans bring with them to college, the lack of (or inconsistent) parental information provided to youth regarding sexual relationships and the inconsistent condom use among HBCU and other college students, it is crucial to provide students with culturally specific risk reduction programming that addresses the lack of risk knowledge, erroneous and problematic early life socialization about intimacy and relationships, and the gender imbalances in intimate relationships.

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