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The purpose of this study was to determine the problems community members have with access to sexually transmitted disease (STD) services in Duval County, Florida. Ethnography was used to determine the concerns of the community. Interviews were conducted with key informants. Chain sampling was used to find other informants for individual interviews, casual conversation and focus groups. When possible, interviews were taped and transcribed. Field notes, historical data, statistical information and local documents were used in the data analysis. The primary finding was that people learn about STD services through “word of mouth.” Additional findings include the absence of symptoms, being unsure of where, when and how to access health care services and the lack of transportation. Men and adolescents have specific needs for accessing services. Basic needs take precedence over health care. Community values and the stigma surrounding STDs and sexuality education contribute to the problems. Failure to publicize, market and coordinate the services offered by numerous agencies available to
provide care is a major obstacle. Access can be improved by providing non-traditional
hours and days for care. Primary care clinics in neighborhoods would also meet the needs
of the community. Education regarding STDs and sexuality needs to be in the schools
and involve the community. Non-judgmental education regarding sex, sexuality, refusal
skills and protective skills should be delivered accurately to those who need it the most,
adolescents and young adults. STDs will continue to be a silent plague until the delivery
system is changed to facilitate access across economic, age and gender lines.
CHAPTER 1
THE PROBLEM

High rates of sexually transmitted diseases (STDs) combined with decreased numbers of STDs being diagnosed in the state-run STD clinics have lead to concerns about why people were not attending these clinics. The number of cases of STDs detected in the state operated STD clinics in Duval County, Florida, has declined over the last five years; however the total number of cases reported continues to climb (Appendix A, Table A-1). The STD clinics provide up-to-date treatment according to current Centers for Disease Control and Prevention (CDC) guidelines at little or no cost to residents of the county. Failure to utilize these sliding fee scale services may result in many infected people not obtaining appropriate care for a multitude of reasons. The purpose of this study was to determine the problems community members had with access to STD services in Duval County, Florida. Several research questions were investigated: a) What is the community’s perception of the STD clinics and services? b) Where are people going for treatment of STD’s if not the Department of Health clinics? c) Why are they choosing to seek care outside the DOH STD clinics? and, d) Are there some people who are infected not receiving any STD care who are posing a continued threat to the transmission of disease? Information obtained about the attitudes, lifestyles, health seeking behaviors and experiences of consumers of STD clinic services as well as people in the communities served by the clinics was used to evaluate current services and to make recommendations for improved access and provision of care in the future.
Background and Significance

The number of cases of reportable STDs detected in the state operated STD clinics in Duval County, Florida, has declined over the last five years; however the total number of cases continues to climb (Florida Department of Health [FDOH] Data file, 2002). In the year 2000 the percentage of the total number of STDs reported in Duval County Health Department clinics was 18% while in prior years the number of cases reported has been as high as 40% of the total number reported (Appendix A, Table A-1). The incidence of human immunosuppressive virus (HIV) reported in Duval County has risen from 45 cases in the first six-month reporting period in 1997 to 320 cases in 2001 (Appendix A, Table A-2). Duval County also reports an STD case rate that is at minimum twice that of the rest of the state (Appendix A, Figure A-1). The population has increased by 100,000 over the last ten-year census period. Data from the Department of Health in 2001 reveal that Duval County reported the highest rate of gonorrhea cases in the state and was ranked third in the number of chlamydia cases reported (FDOH Data file, 2002). These numbers may actually be low, since reporting STDs remains a problem area. The authors of a recent study done in three states found up to 36% of gonorrhea cases and up to 22% of chlamydia cases were not reported to public health officials as required by state laws (Centers for Disease Control and Prevention, (CDC, 2002a). Also noted was a lag time in reporting positives to authorities ranging from a week to more than year, though most were received in less than 20 days (CDC, 2002a). This potential delay in identifying contacts with a communicable disease means that a significant portion of the population is unwittingly continuing to spread infectious diseases. Data on delay in reporting in Florida was not available.
Statistically, in Duval County, the DOH reported the highest number of positive STD tests during the most recent five-year period, followed by the area hospitals. Private providers, non-DOH clinics and the hospitals have diagnosed and treated an increasing percentage of people for STDs. Recent research has shown that providers outside the public health system may not use appropriate CDC guidelines and may under-treat or treat with ineffective medicines (Schmitt, 1999).

Studies have been done that offer a demographic profile of attendees at STD clinics. These studies have documented that the attendees tend to be non-white, male, young, uninsured, single and at risk for HIV (Adrien et al., 1996; Brackbill, Sternberg, & Fishbein, 1999; Catchpole, 1996; Cates, 1984; Celum et al., 1997; Donovan, 1997; Fortenberry, 1997; Hughes et al., 2000; Irwin et al., 1997; Johnson, Wadsworth, Wellings, & Field, 1996; Landry & Forrest, 1996; Pagliaro & Gipson, 2001; Panchaud, Singh, Feivelson, & Darroch, 2000; Radcliffe, Gilleran, & Ross, 2001; Sikkema et al., 1999).

The literature documents an understanding of the behaviors of people attending STD clinics. The health risk behaviors seen most commonly in attendees at STD clinics include having multiple partners, failure to utilize barrier contraception, frequent association with substance abuse, failure or delay in seeking care despite symptoms, utilization of paid-for-sex services, a history of having been abused as children and having recently begun having sexual relations with a new partner (Catchpole, 1996; Cates, Toomey, Havlak, Bowen, & Hinman, 1990; Crosby et al., 2000; Donovan, 1997; Foster, 1998; Fortenberry, 1997; Hook et al., 1997; Hughes et al., 2000; Johnson et al., 1996; Petrack, Byrne, & Baker, 2000; Radcliffe et al., 2001; Temin et al., 2001;
Upchurch, Brady, Reichart, & Hook, 1989). Little evidence is available about the behaviors of people who do not attend the public health clinics although Johnson, Wadsworth, Wellings and Field (1996) gathered some data about non-STD clinic attendees in a British study. In this study they compared attitudes and behaviors between those attending STD clinics and non-attendees. They found that the behaviors were different; attendees were more likely to participate in high-risk behaviors such as a higher number of partners, anal intercourse, first intercourse before the age of 16, use of injectable drugs and were more likely to smoke. The difference detected in attitudes between attendees and non-attendees included the attendees’ belief they were at higher risk for HIV, a more liberal attitude to homosexual activity, sexual activity before marriage and abortion.

Despite the extensive study of the demographics, behaviors and attitudes of people attending STD clinics, there is little in the literature about what the needs of the people are regarding STD services and their perceptions of the clinics as they are currently operated. Individuals utilizing the clinics and those who should utilize the clinics have not been given a voice.

**Theoretical Perspectives**

This public health research study utilizes Kleinman’s explanatory model to examine the health seeking behavior of individuals. A critical medical anthropology perspective was used as context for the health care delivery system. In this section I will discuss the rationale for the use of these two frameworks, first the explanatory model followed by the critical medical anthropologic perspective.

Kleinman’s explanatory model regarding people’s perceptions of illness and disease was very useful in this study as I was interested in the community member’s
perception of and issues regarding access to STD health care services. Kleinman suggests that it is important to discover the patient’s explanatory model (EM) in order to provide care. How we communicate about our health problems, the manner in which we present our symptoms and when and to whom we go for care, how long we remain in care and how we evaluate that care are all affected by cultural beliefs (Kleinman, Eisenberg & Good, 1978). Within this conceptual framework community members were asked about what problems they thought people had getting STD care in this community. It is important to know where community members go, why and what their concerns are with the current system. To insure future success, public health care delivery needs to be modified in a manner that meets the needs of the community of consumers.

In his writings, Kleinman discusses culture, health care systems and the clinical reality. He portrays health care activities as being an integration between a psychological, social and cultural reaction. Illness is a socially organized response to disease that constitutes a special cultural system (Kleinman, 1980). He suggests that we study health care systems in this context. Since health care systems are influenced by the cultures in which they develop, the current biomedical model being used in the United States is weighted with Western cultural assumptions and biomedical values. However, health care seeking behavior is based on the sufferer’s judgment rather than that of biomedicine (Loustaunau & Sobo, 1997). The possibilities and the meaning of the possibilities of a disease process or diagnosis are responsible for eliciting the individuals’ reactions to a given condition, and these are culturally constructed (Loustaunau & Sobo, 1997). The decision to seek care is based on an individual’s determination of the need and by “others” who may identify and interpret symptoms (Loustaunau & Sobo, 1997). This
individual determination of need is influenced by the cultural or community values where the individual lives. I believe that this framework will offer some understanding of people’s perceptions of the STD services.

Critical medical anthropology (CMA) provides a framework for evaluating the political/societal/economic determinants that contribute to health care behavior. CMA states that social inequality and power are the primary determinants of health and health care (Baer, Singer, & Susser, 1997). CMA’s view of health, disease, the sufferer experience and the medical system lends itself to application in this study of a public health problem. Like Kleinman’s explanatory model, CMA challenges assumptions of the disease model in biomedicine. CMA asks that we recognize disease and treatment as it occurs in the context of the capitalist world system (Baer et al., 1997).

By combining Kleinman’s explanatory model and critical medical anthropology I create a research environment suitable for studying the relationship between medicine and culture, health seeking behavior and the members of the community. Kleinman says that the purpose of explanatory models is “to analyze the clinically relevant effects of socio-cultural determinants on sickness and care” (Kleinman, 1980, p.xii). Critical medical anthropology asks us to view the issues in the context of political and economic forces that shape behaviors and condition experience (Baer et al., 1997). Public health needs more systematic use of knowledge to translate public health techniques into effective practice and to translate knowledge of public health for use in specific social and cultural settings (Hahn, 1999). By utilizing the CMA and EM frameworks for exploring where the members of the Duval County community go for the treatment of sexually transmitted diseases, the problems can be viewed holistically within the context
of the community and through the political economic environment that dictates the
distribution of care. Only by accessing the culture and beliefs of the community of
concern will alteration in the provision of service to this community be made effectively
(Hahn, 1999). Research has shown that culturally appropriate programs which
acknowledge cultural practices and attitudes, address taboos, and meet needs arising out
of a specific cultural milieu are the most effective, especially when dealing with sexuality
issues (Pagliaro & Gipson, 2001). Staff who represent and understand the target culture
are also required to optimize services (Pelto & Pelto, 1997). Knowledge of the racial mix
and other sub-cultures such as poverty and substance abuse are pertinent to understanding
the differing needs of the community in addressing the issues associated with the delivery
of care.

**Methodology**

Ethnography was used for this study because it is about understanding people’s
lived experience and this type of information requires a few knowledgeable and articulate
informants rather than an unbiased sample of people (Bernard, 2000a). The success of
ethnography depends upon asking good questions about subjects which informants are
knowledgeable. According to Stevens (1993), systematically eliciting and analyzing
narratives is a methodology recognized for its potential to more fully explicate health
related phenomena.

**Conclusion**

The problem of declining utilization of the STD clinics and the reasons for the
decline can be well evaluated by using a qualitative method probing the perceptions of
the community of concern. There are many issues related to access to health care, and
specifically STD health care, that need to be considered in the context of asking questions
about the problems people have accessing STD services in the community. The unique identities of individuals can be respected only when each group and culture is fully respected and equally influential (Loustaunau & Sobo, 1997). Explanatory models and critical medical anthropology recognize the differences of individuals and the political and economic realities of the delivery system. Through the use of these two frameworks the efforts of this study to improve the lot of all persons can be achieved. According to Stevens (1993) if access is assured for the marginalized groups it is likely that access will not be a problem for the majority. The author suggests that access is the key to success and implies that services should be affordable, geographically available, socially and culturally appropriate and geared toward meeting critical health needs (Stevens, 1993). The significance of the current study was that recommendations for change were based on the evidence gathered from the members of the community, which included the above keys to success. These recommendations were based on the desires and needs specified by the community being served.
CHAPTER 2
LITERATURE REVIEW

This chapter contains a review of the recent literature focusing on issues related to access to sexually transmitted disease health care that guided the study. This review reports what is known about the people who attend STD clinics and includes demographic and behavior information, as well as emotional aspects. It also looks at innovative practices or alternatives to traditional delivery systems and the changes in access as a result. First there is a brief overview of public health tradition and access to care. Next comes a presentation of the theoretical frameworks used to guide this study. Key concepts from Kleinman’s explanatory model were used to guide the exploration of community members’ perspectives regarding access to care. Critical medical anthropology was used to guide the portion of the investigation that considers the macro political/policy aspects of public health STD care. This section is followed by a presentation of some of the demographic factors that influence access to care. These factors have been described in the literature and include socioeconomic status, race/ethnicity, gender and age. Subsequently a discussion of behaviors seen in people who attend STD clinics compared to those who do not is presented. Following this, some of the emotional aspects related to STD care such as stigma, confidentiality, fear and embarrassment are discussed. This literature review revealed that while much is known about demographics and behaviors of people accessing STD clinics, little is known about the needs and beliefs of the community of concern. The problems that community members have with accessing services have not been addressed; rather the focus has been
on identification of the demographics and behaviors of attendees. This study was an innovative endeavor to find out what people needed to improve their access to care and what they identified as barriers to accessing care. The goal was to evaluate the current services and provide information to make recommendations for improvements in the current delivery system. These recommendations would hopefully provide a basis for planned change that could contribute to lower rates of STDs in a community with rates of diseases higher than the rest of the state.

**Public Health and Access to STD Care**

The premise of public health rests on a moral assumption that response to the perceived suffering of others is worthy of action and deserves the commitment of resources and efforts to understand the culture and beliefs of the communities of concern (Hahn, 1999). The failings in public health are that the programs may be based on misleading concepts, and there is often no study of, or taking into account, the culture and society of the community (Hahn, 1999). Public health is a profession that should work to reduce the odds against adversity so that more people can succeed; it should not be a profession that simply provides information, service and encouragement to people so that they might be among the lucky few to beat those odds (Wallack, 2002). According to many, listening and understanding the socio-cultural context and recognizing interethnic variability are key principles of medicine that the biomedical model has previously ignored, and this is an obstacle in the delivery of care. Hahn says there are four great obstacles to implementation of techniques to lower morbidity and mortality; they are: a) the ongoing deliberate production of illness, suffering and death, b) poor allocation of resources including discrimination and access, c) lack of commitment of needed resources on the part of those who control the resources, and d) inadequate translation of
public health knowledge into effective action across social and cultural boundaries (Hahn, 1999). This literature review supported Hahn’s hypothesis that there is little evidence indicating that the needs of the community are considered in planning and implementing health care services. This research will address the community’s needs.

Public health generally serves the lower economic level of society, that is the bottom 20% of the population, which is only making 4% of the total income. These are the people who need to receive the services from the government (Wallack, 2002). Therefore the socioeconomic issues related to the cycle of poverty need to be addressed in order to evaluate public health services. Some of the issues include inadequate insurance, lack of emphasis on preventive care, denial of illness because of the more pressing need of providing for basic needs such as food, clothing and shelter and the failure of providers to accept Medicaid. Where do the indigent go for health care? Previously the burden had fallen to public health departments and public hospitals. With shifts in funding from the federal government to the state, the closure of hospitals serving urban minority communities has potentially serious implications for issues related to access. From the point of view of reducing health disparities, we need to have such an analysis of the variance in health explained by different socioeconomic factors in order to understand or predict the health effects of change in other indicators (House & Williams, 2000). A 1983 report by the Jacksonville Community Council, Inc (JCCI) on health care for the indigent stated that “the indigent are more likely to have poor health” and “that it is harder for them to obtain medical care” (Jacksonville Community Council, Inc. [JCCI], 1983, p. 2). Indigent persons are often hindered from obtaining care due to complicated eligibility requirements, transportation, the limited number of providers accepting
Medicaid and Medicare and the manner in which services are provided (JCCI, 1983).

Research in the social and behavioral sciences has established a consistent set of findings indicating that neighborhoods and communities are related and health care behaviors are an outgrowth of the setting (Sampson & Morenoff, 2002). Research such as this study looking at the needs of the members of the community will be a useful tool in the ongoing development and refinement of the delivery of public health care.

More than 85% of the communicable diseases reported annually in the United States are sexually transmitted diseases (Brackbill, Sternberg, & Fishbein, 1999). In Duval County, Florida, the rate of detection of STDs in the public health clinics has declined over the last ten years from 40% to 18% despite an increase in the population and incidence of disease (Appendix A, Table A-1). Publicly funded STD clinics have been the primary location for public health prevention and control of STDs in the United States; however little is known about patterns for seeking medical care for STDs outside of public clinics (Brackbill et al., 1999). This lack of knowledge exists in spite of the fact that an estimated 40-60% of people with STDs are treated outside of the public clinics (Brackbill et al., 1999; Landry & Forrest, 1996). There is little information about the sexual behaviors, attitudes and lifestyle of consumers of STD clinic services, and knowledge about these characteristics would be useful in evaluation of current services and in planning for improved access and provision of care (Johnson, Wadsworth, Wellings, & Field, 1996). According to Brackbill et al. (1999) a conceptual model of health care seeking behavior for STDs may help us to understand where people go for treatment of an STD, and behavioral theory could also afford some understanding of why people choose to go there.
Many issues surrounding access to health care need to be considered in the context of asking the people about their perceptions of the STD services in the community. Demographic, behavioral and emotional issues all contribute to where and why people access STD health care. A number of sources have noted that many of the ethnic and other conflicts in the world are generated by the demand for economic, political and social recognition and power, and that only by recognizing and respecting the unique identities of individuals and each group’s culture can they become influential (Loustauanau & Sobo, 1997). So it is with health care. The understanding of the socio-cultural and biological effects of public health problems is essential in addressing the problems of access (Hahn, 1999). As potential agents for change we must take into account not only the society for which the intervention is intended but also its social, economic and political environment.

**Theoretical Framework**

**Kleinman’s Explanatory Model**

The understanding of the cultural context of health behaviors related to access to STD services facilitates the design of health promotion/prevention programs that fit with the community, making compliance more likely (Adrien et al., 1996). Kleinman suggests that it is important to discover the patient’s explanatory model (EM) in order to provide care. The explanatory model states that how people communicate about their health problems, the manner in which they present their symptoms and when and to whom they go for care, how long they remain in care and how they evaluate that care are all affected by cultural beliefs (Kleinman, Eisenberg, & Good, 1978). Kleinman (1980) says that regardless of which society we examine we will always find patients, healers, and universals about how illness is constructed and experienced and how treatment is selected.
and organized. He believes that this is a fundamental part of the social world and needs cross-cultural comparison. Health care behavior, according to Kleinman, is a socially organized response to disease that constitutes a special cultural system and includes people’s beliefs and patterns of behavior that are governed by cultural rules. From the perspective of the EM, the design of an effective program to reduce the prevalence of STDs for various groups with respect to age, gender and social position in communities requires an understanding of these relevant factors (Adrien et al., 1996). The relevant factors are thought to influence behaviors in a particular way. According to Adrien et al. (1996), these factors contribute to norms, which influence behavior by affecting habits, the conditions in which the behaviors occur, on affects, and social determinants, which create the intention to behave in a certain way.

**Critical Medical Anthropology**

Critical medical anthropology is a useful framework for this study. It concerns itself with many factors that contribute to disease and the human response to illness (Baer, Singer, & Susser, 1997). It is an important meeting place between cultural and biological anthropology. Critical medical anthropology (CMA) emerged as a direct response to perceived shortcomings and limitations of conventional medical anthropology in an effort to include political-economic approaches and engage and extend the political economy of health (M. Singer, 2001). According to M. Singer (2001), CMA provides recognition of class, race and gender as defining characteristics of a capitalist society and is therefore a useful framework for this study. Race by itself does not explain differences in survival, morbidity and mortality; class factors are also involved, as is income. It is hypothesized that the values of the community that arise from these characteristics will influence how and when people access STD health care.
According to Hahn (1999), translating knowledge of public health practices for use in specific social and cultural settings is related to the need to understand, address and respond to local perspective, concerns and values. As early as the first part of the 20th century Virchow noted that improving social conditions could prolong life more rapidly and successfully than improvements in medicine (Baer et al., 1997). This study is concerned with the opinions of the members of the community that could potentially improve access to STD health care for all.

There are a number of problems that CMA is specifically designed to address. It is an effort to understand and respond to issues and problems of health, illness, and treatment in terms of the interaction among the macro level, the political and class structure, the health care system, and the community level of beliefs (M. Singer, 1998). It is also concerned with the micro level of illness experience, behavior and meaning, the human physiology and environmental factors (M. Singer 1998). One of these problems is that disease is more than a straightforward outcome of an infectious agent or pathogen; rather it represents a variety of problems in a more macro viewpoint of the culture or society (M. Singer, 2001). The connection between social context and disease according to CMA entails a recognition of class, race/ethnicity and gender as defining characteristics of capitalist society (Singer, 1998). CMA lends itself to the analysis of the community’s perceptions of access to STD health care.

**Demographics and Access to STD Care**

The following section begins with an overview of demographic issues in health care access. The demographic issues examined in this overview include socioeconomic status, employment, education, insurance and poverty. Race and ethnicity are combined into one category because both are self assigned in census data and blurred between
phenotype and cultural categorization. Following the overview of socioeconomic issues, race/ethnicity, gender and age will be explored as they are described in the current literature and as they relate to STD services.

**Overview**

Funkhouser and Moser (1990) described the basic concept of poverty, a lack of access to resources and unequal life chances as the foundational cause of poor health and the inability to obtain health care. They estimated that two out of five members of the population were at risk for not being able to obtain health care in time of need. House and Williams (2000) looked at the issue of access to health care and stated that the barriers are large, persistent and increasing. They said the issues preventing people from accessing health care in 1990 are the same if not worse in 2001.

According to the Centers for Disease Control and Prevention (CDC), despite great improvements in the overall health of the nation, a disproportionate number of Americans fail to receive adequate preventive health services (Centers for Disease Control and Prevention [CDC], 2002b). Economics are a dominant force in the issues related to allocation, distribution, quality and delivery of health services; however it is not easy to separate economics from race/ethnicity. The National Institutes of Health has identified the reduction of socioeconomic and race/ethnic disparities in health as major priorities for public health practice and research in the next decade. The CDC is spearheading efforts to eliminate racial and ethnic disparities in health by disseminating findings from studies developed to foster a better understanding of the relationship between health status and different minority backgrounds (CDC, 2002b). The CDC believes that this better understanding will enable communities to identify effective and culturally appropriate implementation strategies.
**Socioeconomic Status**

Socioeconomic status refers to the individual’s position in a system of social stratification that differentially allocates the major resources enabling people to achieve health or desired goals. Disadvantaged socioeconomic status exerts effects by shaping the behavior and environmental risk factors for health (House & Williams, 2000). Buried within socioeconomic status is education, occupation, income, and assets or wealth. It is difficult to separate the components from the whole. As far back as the 1920’s neighborhoods characterized by poverty, instability and poor housing were found to have disproportionately higher rates of health problems (Singer & Ryff, 2001). In Duval County, Florida, in 2003, a conservative estimate is that 100,000 residents have income too high for government insurance but too low to afford employer-offered health insurance programs and of these, 58% are White, 33% are Black and 7% Hispanic (Sundin, 2003). Alternatively, some people may be insured but have high deductibles or co-pays and be unable to afford care, or work for a small business that does not provide health care benefits but renders the employees ineligible for government assistance. Finally, people working part-time even if they have several part-time jobs may remain ineligible for health care benefits.

Income and education are two of the most robust predictors of health in the United States with several studies indicating that racial and ethnic minorities have lower levels of access to medical care in the United States (House & Williams, 2000). These disparities exist even in contexts where difference in economic status and insurance coverage are minimized (House & Williams, 2000). While not all Blacks or non-whites are poor, there is a disproportionate number when compared to Whites, indicating that while the issue may remain largely socioeconomic it can be viewed in a racial context as
well. There is an inextricable link between race and poverty, and according to some, poverty, is the root of the problem.

**Education**

Knowledge and information are not the only determinants of behavior according to Berkman and Mullen (1997). Education more strongly affects health behavior patterns which form early in life (House & Williams, 2000). Economic levels influence the ability to obtain an education. It can be argued that people living at the poverty level are more concerned with issues related to survival rather than the pursuit of education and the behaviors that might improve their health. They are at higher risk for dropping out of the educational system in order to work to generate income for the survival of the family. According to one study of people attending STD clinics, 55% have a high school education or less (Celum et al., 1997). In Duval County, Florida, young Black males are more likely than others to score less well academically, be physically punished, be suspended from school and more likely to assigned to special classes for slow learners (Jacksonville Community Council, Inc. [JCCI], 1992). The disparity in test scores begins at an early age suggesting that the home environment, neighborhood and lack of resources all contribute to continuing the cycle.

**Insurance**

Insurance issues are tied to access, utilization and delay in presentation for services (Andrulis, 1998; Ayanian, Weissman, Schneider, & Zaslavsky, 2000; O’Grady, 2000; Politzer, Yoon, Huges, Regan. K, & Gaston, 2001; Weinick, Zuvekas, & Cohen, 2000). People without insurance account for between 20-33% of the disparity in accessing care (O’Grady, 2000; Weisman & Henderson, 2001). People without insurance and the underinsured often delay seeking care until the symptoms become severe enough to
interfere with activities of daily living. Then, they require a visit to the emergency room instead of seeking care at an earlier time in the continuum of morbidity. Most authors were in agreement that the issue of insurance is the strongest indicator in improving access to care, and decreasing morbidity and mortality (Andrulis, 1998; Ayanian, Weissman, et al., 2000; O’Grady, 2000; Politzer, Yoon et al., 2001). Insurance is connected to employment, which is related to the amount of education one gets, and this goes back to socioeconomic status and the value placed on education at home. People without insurance go without health care until more serious symptoms force them to seek help for a more serious illness, generally in the emergency room where the hospitals have to absorb the cost of providing care for free.

**Race/ethnicity**

Race is characterized primarily by phenotypic features and is distinct from ethnicity, since ethnicity is described as a set of common practices, beliefs and values held by a group of individuals and transmitted from one generation to another (Michaud, Blum, & Slap, 2001). Ethnicity is a social construct and refers to self-association to different social categories of history, heredity, religion, language and so forth (Brown, Barret, & Padilla, 1998). Previous thinking had conceptualized racial variations in health as genetically determined. Current thinking suggests that we are more biologically alike than different (House & Williams, 2000). Therefore, race is more of social than a biological category and seems to be responsible for much of the inequality in health care. Upon examination the issues are related, and include power, economics, education, insurance and status difference between groups as opposed to race itself. There are measurable disparities in health outcome; however they are not from a biological gradient as much as disparities in socioeconomic status (Baer et al., 1997). Race seems to capture
more of the inequalities related to power and status differences between groups, and perhaps race is an easier concept to blame, as opposed to the issue of power.

National mortality data reveal that African-Americans have an overall death rate that is more than 1.5 times higher than Whites. This elevated risk exists for almost all the leading causes of death in the United States. In contrast, other ethnic groups have an overall death rate lower than Whites (House & Williams, 2000). It is difficult to sort out the causes of these disparities, in part because race is a self-determined category on the census.

Current research indicates that people attending STD clinics come disproportionately from minority groups (Adrien et al., 1996; Brackbill et al., 1999; Catchpole, 1996; Celum et al., 1997; Fortenberry, 1997; Hughes et al., 2000; Irwin et al., 1997; Pagliaro & Gipson, 2001; Radcliffe, Gilleran, & Ross, 2001; Upchurch, Brady, Reichart, & Hook, 1989). The issue of race is pertinent to this study as the primary users of STD clinics in Duval County are Black. The highest rates of STDs occur among Blacks. While representing only 28% of the population, they carry 79% of the burden of STDs. It may be important to know if there are issues associated with Black culture that are different from the White and Hispanic cultures in the pursuit of care. Values can differ across racial/ethnic groups and this needs to be considered in the provision of STD services. It is important to know the values of the community being served in order to meet the needs of its members. It may be that the values of the Black community are not the same as the White community or the Hispanic community and that each of these groups may require a different delivery system.
In Duval County the demographics from the 2000 census reveal the county to have a racial mix of 65% White, 28% Black and 4 % Hispanic. The knowledge of this mix is pertinent to this study in terms of determining whether there are different needs for the delivery of health care to the various racial/ethnic groups. There is a need for culturally appropriate programs for STD care (Pagliaro & Gipson, 2001). Several studies called for ethno-specific programs for delivery of care and partner notification (Adrien et al., 1996; Faxfield & Ramstedt, 1997). The Adrien study utilized Kleinmans’ explanatory model as a framework for examining the delivery of a culturally appropriate HIV transmission reduction program. Kleinman’s model calls for utilizing knowledge from the disciplines of anthropology and sociology to get health care providers to breakaway from an ethnocentric professional framework and recognize that each patient’s clinical reality is constructed in part from their culture and is pluralistic (Kleinman, 1980).

**Gender**

Gender is an issue in STD care. There is argument as to who is more likely to seek care and more likely to be infected. According to Brackbill (1999), men are significantly more likely than women to go to the STD clinic. Landry & Forrest (1996) say that women are the primary clients. The reason for this is unclear, however women have many more portals of access to the health care system than men, including family planning and maternity services which may account for some of the variation in diagnosis and treatment. Women are more likely than men to be infected as they are more susceptible and they are less likely to have symptoms (Donovan, 1997; Landry & Turnbull, 1998). Women are diagnosed with STDs at almost twice the rate of men in the Duval County, Florida (Florida Department of Health Data files, 2002). Men are more likely to have high risk behaviors, multiple partners, be sexually active and deny
symptoms (Bradner, Ku, & Lindbery, 2000). A national survey on men’s health revealed that men fail to access services because they are designed for women. There is a lack of funding for men’s health care and a lack of knowledge about what men want or how to market to them, however, once they were enrolled in the system, they obtained good health care (Schulte & Sonenstein, 1995).

Age

Most of the issues related to access of services for STD care are the same throughout the life span with the exception of adolescents. Adolescents are at increasingly high risk for STDs and HIV (Catchpole, 1996; Celum et al., 1997; Donovan, 1997; Landry & Turnbull, 1998; McEvoy & Coupey, 2002). Adolescents are at increased risk because of risky behaviors, increased susceptibility, vulnerability and the perception that they are more likely to be disease free (Donovan, 1997; Landry & Turnbull, 1998). Adolescents have barriers to accessing care that adults do not. They are dependent on others for transportation, they cannot always make and keep appointments without parental knowledge and they are unfunded, uninsured or unwilling to disclose the need for funds and insurance due to the nature of the visit. Over a ten-year period from 1990 to 2000, Duval County teens aged 15-19 have exceeded the state rates of gonorrhea, chlamydia and syphilis (Appendix B). While much has been written about the incidence of STDs in young people, little is known about their concerns regarding access to care. Pagliaro and Gipson (2001) documented the need to tailor programs for adolescents that are directed at altering attitudes and behaviors among particular populations of adolescents. These programs should be gender specific, culturally appropriate and utilize staff that represents the target culture. Brown and Simpson (2000) argue that it is ethically correct for health care providers to act in the best interests of adolescents and
society, and this includes comprehensive STD/HIV education to halt the epidemics (Brown & Simpson, 2000).

**Health Behaviors**

Human behavior has many determinants. Health and well being are affected by a dynamic interaction between biology, behavior and the environment that unfolds over the life course of individuals, groups, families and communities (Smedley & Syme, 2000). Behavior is difficult to change. In addressing issues related to health care one must focus on individual behavior and on the social forces that support the behavior (Smedley & Syme, 2000). Human behaviors, cognitions and emotions are largely a function of culture and social learning (Ferguson, 2000). Risk behaviors are closely linked to social and economic conditions and account for approximately half of preventable deaths and injury in the United States (Smedley & Syme, 2000). There is a tremendous differential between what we know about preventive health and positive health habits and what we do. A perfect example is the current recommendation that we all eat five fruits and vegetables a day, though most of us do not. Given the failure of knowledge to cause change, when it comes to a behavior as simple as eating fruits and vegetables, if we juxtapose the differential between knowing and doing to sexual behavior the gap probably widens; after all sex feels good. Sexual behavior is also far less likely to be a topic for discussion or public information segments in the media.

Berkman and Mullen (1997) state that while individuals perform behaviors, individual behaviors occur in a social context. Since behaviors occur in a social context it is important to learn more about the community where the problem exists. Lawrence Gostin discussed the use of legal and public policy as an influence on health behaviors. He presented the need to balance autonomy against public benefit. He stated that the field
of public health is deeply concerned with the communication of ideas and that human behavior is a powerful contributor to injury and disease (Gostin, Lazzarini, Neslund, & Osterholm, 1996).

House and Williams (2000) presented compelling evidence that disadvantaged socio-economic status exerts effects by shaping the behavior and environmental risk factors for health. They said that while race/ethnic disparities are to a great extent socioeconomic, the disparities go beyond just socioeconomic factors. Many factors influence behavior; information is a prerequisite for informed decisions to be made about behaviors. The ability of legal consequences related to unacceptable behavior as determined by the political boundaries of the community can be a deterrent to poor health behavior. For example the law now requires us to wear seat belts when in the car or be subject to ticketing and fines. Part of the limitation of the law however is found in its enforceability. This relates to the issue of education as being influential in health behavior. Studies have found that education is the largest variable in examining how people behave regarding health issues, but at the same time it is tied to economic issues and the ability to pursue education.

Attendees of STD clinics were found to have high-risk behaviors such as participation in anal sexual intercourse, being younger at first intercourse, having multiple partners, having homosexual experience, having an increased number of sexual partners, having a higher number of abortions, using paid sex workers, smoking and using alcohol and or drugs (Catchpole, 1996; Johnson et al., 1996; Radcliffe et al., 2001; Upchurch et al., 1989). Most of the studies examined included behavioral characteristics culled from large numbers of clients in a variety of settings, urban, suburban and rural,
giving credibility to the list of behaviors identified with the clientele at the clinics (Brackbill et al., 1999; Catchpole, 1996; Hook et al., 1997; Johnson et al., 1996; Landry & Forrest, 1996).

**Culture**

A significant determinant of health behavior is culture and this is determined by setting and personal choice. It is a fluid construct subject to change at both individual and societal levels (Michaud et al., 2001). The culture of poverty, a particular race, or ethnic group, an age group or a community can be a contributing factor to the behavior of that group in relation to their pursuit of health care. Research suggests that the prevalence of negative stereotypes and cultural images of stigmatized groups can adversely affect health status, since one response of minority groups is to accept the dominant society’s ideology of their inferiority. In addition, racism is positively related to psychological distress, depressive symptoms, substance abuse and chronic health problems (House & Williams, 2000). Recognition of social inequalities in health care access, service quality and health outcomes is prompting the incorporation of culture, ethnicity and social status as components of health service planning and delivery (Michaud et al., 2001). The explanatory model is a theoretical framework supporting inclusion of cultures.

In different cultures, values are assigned to social conditions in different manners. It is important to be aware of these differences. For example in Sweden the problem of poverty is considered a product of the economy and therefore viewed as a societal problem (Misir, 1999). In a study by Soler (2000), the issues of Hispanic men and the concept of machismo and gender roles and the hierarchy of power in the African American group were considerations in explaining the difference among women in these two groups in negotiating the use of condoms. Sikkema (1999) found that community
trials utilizing interventions tailored to the members of the community were effective in changing behavior related to the transmission of STDs. Through a multi-layered program including incentives, utilization of community leaders as educators and the use of “word of mouth” to recruit friends and neighbors to join community groups, there was a reduction in high risk sexual behavior. Thomas et al. (2001) documented the success of using lay health educators (peer educators) in a rural community to change behaviors leading to the transmission of STDs. These studies all used culturally specific interventions to accomplish the goal of reducing the transmission of disease. The authors concluded that cultural/ethnic relevance was key to the success of any intervention.

A study by Kramer (1980) found that while African-Americans have a higher rate of disease they also respond more appropriately, seeking care earlier and being more likely to abstain from sex until they are seen in a clinic. In South Florida both Blacks and Hispanics were found to be more effective at negotiating condom use than Whites, although the authors hypothesized that the effectiveness may have been related to the large political and economic power base that the Blacks and Hispanics enjoyed as opposed to it being a racial/ethnic issue. A community intervention trial in Harlem concluded that community participation was necessary for success in changing the behavior of women related to reproductive health (Mullings et al., 2001). The interventions in this study included creating advisory boards from members of the community and from this group creating smaller groups for networking and sharing information about reproductive health. This was a similar intervention to the Sikkema study. These studies all point to the cultural components of health care behaviors.
Risk Taking

As discussed in other sections, risk taking or high-risk behavior is associated with a higher rate of STDs and attendance at STD clinics. Young men, adolescents, men having sex with men and substance abusers are the groups most likely to employ risky behavior (Donovan, 1997; Brown & Simpson, 2000; Radcliffe et al., 2001). Additional studies found risk takers were likely to be of a non-manual labor social class, unmarried, smokers and younger (Johnson et al., 1996).

Discrimination

Discrimination is an issue related to quality of care, adequate referral and follow-up continuity of care and access to treatment plans. Racism is a form of profiling which can structure our understanding of racial inequalities in health (House & Williams, 2000). The term refers to an ideology of inferiority that is used both by individuals and societal institutions, usually accompanied by negative attitudes and beliefs toward groups (House & Williams, 2000). According to Funkhouser and Moser (1990), patients may not receive the same level of care based on color, income, ethnic group, insurance or lack of insurance, high co-payments, lack of transportation, cultural and bureaucratic hostilities or outright discrimination that sets up barriers to obtaining health care. While health care provider training does not specifically instruct in profiling patients on the basis of ethnicity or race, failure to understand variations in cultural beliefs, medical care traditions, financial ability and knowledge level of the patient can lead to disparities between the provider’s treatment plan and the patient’s intent to carry out the plan. According to House and Williams (2000), discrimination and racism in the health care system may perpetuate the inequity.
While it may be interesting to know how healers make their diagnosis or how people in different cultures decide whether they are well or ill, knowing cultural rules is not enough. It is essential for those providing care to examine their own attitudes, beliefs and motivations relating to racism. An understanding of the effects of poverty and empathy for low-income patients on the part of health care providers can go a long way toward making patients more comfortable and open avenues for care (Loustauanau & Sobo, 1997). All interactions take place within complex social settings. There are cultural differences that contribute to knowledge and understanding of clients. It is important to try and understand their social and cultural context (Misir, 1999).

**Delay**

Delay in seeking treatment is a behavioral issue seen in clients needing STD services. Fortenberry (1997) found that in men “cognitive variables were related to longer duration of the total care seeking” while among women “it was symptomatic and cognitive factors” that prolonged the delay in seeking care. The delay in seeking treatment can lead to increased opportunities for transmitting disease. Hook and colleagues concluded that the delay in seeking care was usually due to the lack of knowledge of symptoms of STDs and the fact the symptoms were not a priority (Hook et al., 1997). They also noted that over one-third of the patients might delay seeking care up to one week. This delay in seeking care points to a need to improve public knowledge of signs and symptoms of STDs (Sampson & Morenoff, 2002). Upchurch et al. (1989) and Hook et al. (1997) found that a substantial number of patients would continue to have sexual activity in spite of knowledge of having a known contact with someone that was identified as having an STD. Hughes et al (2000) noted that people with a history of an STD were more likely to acquire another STD.
Denial is also related to socioeconomic conditions. People who are uninsured and marginally employed tend to delay seeking health care until things have reached emergent proportions and a visit to the emergency room is required.

**Emotional Components**

**Stigma, Embarrassment and Fear**

Stigma is defined by the early Greeks as bodily signs designed to expose something unusual or bad about the moral status. It can be defined as a negative social attribute placed on people because of their disability or illness, or when the individual is devalued and shunned because the illness or disability makes him or her different or “not normal” (P.J. Brown, 1998). In Christian times it became a bodily sign of holy grace, a medical illusion or a sign of a physical disorder. Today it is used as a sociological term to describe the disenfranchisement people may experience as a result of a physical or mental condition that may or may not be apparent.

Historically STDs have been associated with stigma. At the turn of the century in the United States it was believed that STDs needed to be perceived as a punishment of immoral behavior (Temkin, 1994). Throughout the world STDs are frequently viewed as stigmatized conditions that reflect the morality of the patient (P. J. Brown, 1998). Infection rates remain high among minority groups and adolescents who may be the targets of negative bias by providers with an overarching prejudice about STDs that stems from a judgment about the disease and its route of transmission.

The media and society are responsible to a large extent for the perceptions of STDs as a stigmatized condition. There is reluctance to discuss sex (Donovan, 1997; Fortenberry, 1997). With the advent of viral STDs that are not treatable, and the fatal course of HIV, there has not been a change in the perception of STDs, only a change in
the groups now affected by them. Prior to the 1980’s and the advent of HIV, herpes (HSV) was viewed by the media as the new “scarlet letter” (Inhorn, 1998). HSV infiltrated an otherwise healthy group of well educated, well employed, Caucasian, upper middle class men and women. People with HSV were viewed as “thoroughly bad or weak,” as tainted and discounted persons a result of media hype (Inhorn, 1998). Subsequently, HIV became the new scourge. The onset of this disease originated in an already stigmatized group.

In relation to the stigma of an STD, the explanatory model is useful in conceptualization. Kleinman discussed culture, health care systems and the clinical reality. According to Kleinman (1980), health care activities are interrelated and comprise a socially organized response to disease that constitutes a specific cultural system. Illness behavior is the perception of the person involved in the experience of the disease. The concept of stigma (or societal treatment) of the illness is part of the community’s perception of the disease and in some cases, like HIV, its fatal clinical course. In other cases such as HSV, which is chronic but not fatal, a judgment of the behavior of the infected person stems from the mode of transmission and is included in the perception of the disease (Inhorn, 1998). The social and psychological dimensions of the stigma associated with the disease may be worse than the diagnosis; this is especially true with STDs.

Confidentiality

The issue of confidentiality surrounding the diagnosis and treatment of STDs is important. As mentioned previously, this is related in part, to the stigma associated with these diseases and the manner in which they are acquired, which was discussed in another section. There are two primary philosophical arguments in favor of preserving medical
confidentiality. The first argument is utilitarian and refers to the possible long-term consequences. This argument says that without confidentiality the health care provider-patient relationship would be impaired and patients would be hesitant to seek care for any reason for fear of public disclosure (Walter, 1991). The second argument is non-utilitarian and speaks of respect for the rights of persons (Walter, 1991). This has to do with the right to know and the issue of partner notification. Privacy is a basic human right, however in STD care there is reason for argument. As discussed by Winston, Sissela Bok has made the argument for the ethical justification of confidentiality. These arguments are the individuals’ rights flowing from autonomy to control personal information and protect privacy; the moral relationship that exists between physicians and their patients, and the utilitarian consideration that without confidentiality patients would not seek care for fear of the disclosure precipitating discrimination (Winston, 1991).

The issues in STD care must deal with the right to confidentiality versus the right to warn, the harm principle and the vulnerability principle. The provision of STD care requires a higher degree of trust than diseases that are not stigmatized such as high blood pressure (Kahn, Moseley, Johnson, & Farley, 2000). The issue of confidentiality affects behavior (Cates, Toomey, Havlak, Bowen, & Hinman, 1990). Confidentiality in STD care is related to secrets and the issue of protection of confidentiality versus the duty to warn (Temkin, 1994). Adolescents fear betrayal of confidentiality more than any other barrier to seeking care (Temin et al., 2001).

Partner notification in STD care is a core issue related to confidentiality. There are arguments both for and against the value of partner notification. The arguments are the
right to privacy versus the right to know. There is a need for service to be confidential and available for people to enter voluntarily and a need to protect the innocent. Studies have looked at variations in notification options and all are found to be cost effective (Peterman et al., 1997; Varghese, Peterman, & Holtgrave, 1999). Cost is not the value in partner notification programs according to Potterat (1997).

**Summary**

Much exists in the literature about who the people are that attend sexually transmitted disease clinics. Studies have been done examining their income, housing, education, employment, age, gender, race/ethnicity, insurance status and behaviors yet little is known about what their needs are for the delivery of care. Utilizing quantitative data, these studies provide a good demographic, socioeconomic and behavioral profile of people who attend STD clinics. The studies offer information about the advantages and disadvantages of different delivery options. They have made recommendations for improving access to adolescents, discussed the pros and cons of partner notification or contact tracing, and compared attendees to non-attendees but have offered little evidence that the needs of the community are given consideration in developing programs.

**Conclusions**

The purpose of this study was to explore and describe the perceived problems members of the community had with utilization of the STD clinics in Duval County, and why attendance at these low cost clinics is declining. Asking community members what their needs were and incorporating those needs into public policy was a timely way to achieve positive changes in the delivery of STD care. A lofty goal would be to create ways to increase the access to cost effective, state of the art, subsidized services, decreasing the prevalence of the STDs in Duval County Florida.
CHAPTER 3
METHOD

The purpose of this study was to determine the problems community members have with access to STD services in Duval County, Florida. A goal was to develop new ideas and strategies to make the clinics more accessible. A description of the specific procedures used is presented in this chapter. A review of ethnographic method, the definitions of the terms, sampling issues, participant recruitment and demographics are also presented. The data collection and analysis is described. Finally, issues concerning reliability, validity, reflexivity and generalizability are covered.

Ethnographic Method

The method used to conduct this study was ethnography. Through the use of open-ended question interviews, focus groups, interviews with key informants and the perusal of local documents relevant to the development and functioning of the STD clinics, factors contributing to problems with access to the STD clinics were identified. Ethnography is a scientific approach to discovering and investigating social and cultural patterns and meanings in communities, institutions and other social settings (Schensul, Schensul, & LeCompte, 1999). It involves exploration (Germain, 2001), and is a highly detailed account of how other people live is based on the human capacity for observation. It is concerned with the everyday because it can address attitudes, emotions, perceptions, social networks and behaviors of groups (Schensul et al., 1999). The method is best suited for defining problems when they are not clear, when they are complex and embedded in the social framework, and for exploring factors associated with the problem
According to Wolcott (1999), ethnography provides a picture of the people or product through process.

Ethnography was used because it provides knowledge that can help us understand socio-cultural problems and provide a basis for planned, positive change (Germain, 2001; Lecompte & Schensul, 1999). In this study, high rates of STDs combined with decreasing numbers of STDs being diagnosed in the state-run STD clinics led to concerns about why people were not attending these clinics. According to Patton (1990), programs, in this case health care clinics, develop cultures and the culture can be thought of as part of the programs’ treatment. Data was collected from patients and health care providers in the STD clinics, and from community members. It was analyzed and used to make recommendations for planned change. The approach is distinct because findings are interpreted and applied from a cultural perspective (Patton, 1990). By gaining a sense of the community through an examination of demographics, history, and geography, as well as determining the community members’ perceptions of the clinics, recommendations could be made for modifying access to care. A goal was that the Department of Health would be able to make changes that would increase attendance at STD clinics and promote a decline in disease rates. This would allow prevention to be addressed as opposed to only case finding and treatment.

Ethnographic Principles

According to Schensul there are four principles that govern the use of ethnography:

a) it is research that is guided by and generates theory, b) it is qualitative and quantitative, c) it is conducted locally and is applied, and d) ethnographic theory is constructed recursively (Schensul et al., 1999). Reexamining existing information on the community and the topic, reviewing literature, the researchers experience, popular and media sources
and the experience of a local community, generates ethnographic theory. Thus, it lends itself to an examination of problems that members of the county have with access to the STD clinics (Schensul et al., 1999). It does not generate formative theory. Ethnography expands and fills in the model by discovering qualitative and quantitative associations among the domains.

**Ethnographic Perspective**

There are two perspectives in ethnography, the emic and the etic. The emic approach allows the researcher to get to the heart of the matter; it is an insiders view (Gittelsohn, Pelto, Bentley, Bhattacharyya, & Jensen, 1998). The emic approach allows for differences that are important within the community to be identified (Wolcott, 1999). The etic approach provides a structure for organizing an account, it is person centered and highly influenced by the ethnographer’s interactions with some particular individuals or one individual in a close-knit group (Gittelsohn et al., 1998; Wolcott, 1999). The etic approach is the outside researcher’s point of view and it allows the differences that are important as noted by the social scientist to be seen (Agar, 1996; Wolcott, 1999). A goal of this study was to provide an emic approach; one that set out to define the phenomena from the perspective of those being studied. This included the problems associated with declining attendance at the STD clinics, and providing insight into the reasons for this decline. Additionally it provided an etic approach in that I am a Women’s Health Nurse Practitioner, and this influenced informants’ comfort in talking to a health care professional about their observations, opinions and recommendations. I also brought the perspective of twenty years of providing health care to women and the biases associated with having a fourteen-year old daughter.
Definitions

This section contains definitions of the terms used in the ethnographic study.

Purposive Sampling: Selecting individuals on the basis of the level of their cultural knowledge. Effort was made to include individuals from all major ethnic groups represented in the county.

Key Informants: Individuals who were purposively selected and interviewed, sometimes more than once.

Respondents: Community members who were selected using information from key informants.

Chain Referral: This involved asking initial key informants to name other individuals they know who were willing to be interviewed. This was used with members of the community only, not patients. Chain-referral can limit the type of informants, or the number of different groups interviewed because of restrictions in the social networks of informants. Having people suggest other to be interviewed is an inherent limitation of the method.

Participant Observation: This involved time spent “hanging around” observing the clinic activities, staff and patient behavior, including the length of time required for service.

Physical Observation: This included observation of clinic setup, mapping of the clinic in relation to the population it was meant to serve, facilities for transportation and eating. It also included observation of the location of facilities in the community in terms of convenience, type of neighborhoods and community make-up.

Focused Group Interviews: These interviews consisted of 6-10 individuals who were representatives of their respective communities. They were recruited from the ranks
of the key informants. Sensitive issues that were not considered appropriate group topics were avoided. Focus group interview guides are flexible, more open-ended and seek to identify new lines of inquiry related to the focal issues (Coreil, 1995). No identification of individual members were used in the transcription of focus group recordings.

Documentary and Archival Information: This included census data, statistics from the Department of Health on numbers of patients and demographics, historical documents on the development of the clinics and county, past and current usage patterns, documentary accounts of political problems and community sentiment that affect the clinics.

Rapid Assessment Procedures (RAP): Using the ethnographic methods defined above under physical observation for quickly gathering social, cultural and behavioral information relevant to specific health-related problems and prevention programs (Harris, Jerome, & Fawcett, 1997; Ong, Humphris, Annett, & Rifkin, 1991, Utarini, Winkvist, & Pelto, 2001).

Triangulation: The use of multiple methods to investigate the same research question, e.g. interviews, observation, focus groups, and archival data. This technique is used to verify credibility.

Codes and Coding: Codes are short or abbreviated words (or numbers) that label important topic/concepts for later retrieval and analysis.

Explanatory Model: Cultural knowledge, beliefs and attitudes with respect to a particular illness or other aspect of health. The explanatory model for an illness includes presumed causes, processes, preferred treatments and expected outcomes (Kleinman et al., 1978).
Cultural Domain: A group of words or concepts that go together from the perspective of a particular theme.

**Research Design**

This study took place in Duval County, Florida. It began in February of 2002. Data collection was completed in December of 2002. Data collection included interviews with key informants, transcribed interview data, field notes, focus groups, recorded observations, relevant documentary and archival information pertinent to the community and subject. The data was examined for patterns and relationships. Content areas or themes were determined by coding the data. These codes were then examined and grouped according to content categories and used to describe the community’s perceptions of the STD clinic services and problems obtaining them. Based on the analysis, a report was submitted to the Department of Health, Division of Sexually Transmitted Diseases detailing the findings and making recommendations for modification of the delivery system.

**Data Collection Techniques**

**Archival data**

Archival data has multiple categories; it can be data collected for bureaucratic or administrative purposes such as census data. It includes data collected by other researchers which is then broken down further into data collected by researchers on the same population and that collected in related populations (Schensul et al., 1999). Archival data was useful in this study. The schools, county, hospital systems, and state DOH have extensive databases that provided important information about the services they have provided to the members of the community of concern. Information gathered from archival data provided context for understanding the current structure of the systems
in place in the community for the delivery of care. Additionally the archival data provided a history of the community and sense of why some of the issues existed and persisted through time.

Archival data collection included information obtained from the United States Census regarding the demographics of the county. Data was also collected from the state Department of Health, state and national web sites providing prevalence and incidence data regarding STDs and the names and locations of the top providers of positive STD test results. Materials documenting the historical development and functioning of the STD clinics, protocols used by the facilities, and past state evaluations of the clinics were used. Key informants who were active in the community of public health also provided knowledge and historical perspective. Additional sources of archival data included numerous reports issued by agencies in the area. Specific reports reviewed included those relevant to the issue of STDs. Also a sense of the racial issues as they related to the governance and history of the county were gleaned from reports from local agencies.

**Rapid assessment**

Rapid assessment techniques included walking tours of areas surrounding clinics, schools and other agencies included in the study. Driving around the county included making brief notes about the appearance of the neighborhoods, location of transportation facilities, distances of facilities to transportation hubs, health resources available, major buildings, evidence of economic and sanitation conditions, noting who was encountered and if there was any interaction (Gittelsohn et al., 1998). It involved drawing maps, plotting the location of the clinics on a map of the community, superimposing zip code and prevalence data, and coding and comparing this information with observations and field notes.
Transportation options were noted. The clinics were visited and notes taken on the size and condition of the facility as well as the settings for waiting, being interviewed and examined. Note was made of the numbers of people in the waiting room, their demeanor, and peripheral activities such as television, reading materials, levels of activity and sound were noted.

**Participant observation**

Participant observation refers to the process of learning through exposure to or involvement in the day-to-day routine activities of the participants and is often the starting point in ethnographic research (Schensul et al., 1999). The practice of participant observation allows the enhancement and interpretation of the quality of the data (DeWalt, Dewalt, & Wayland, 1998). There are many descriptions of the degree of involvement of the participant observation physically and emotionally ranging from detached observation through to and including “going native” and “becoming the phenomenon”. Interviewing is included under the heading of participant observation. There are many types of interview techniques that can be used in ethnography. They include casual conversation, life history, key informant interviews, semi-structured and structured interviews, survey, census data and questionnaires (Wolcott, 1999). Through the use of semi-structured interviews with predetermined questions we can collect data related to domains of interest as opposed to direct questioning which always involves certain risks, as it tends to emphasize an extractive element in fieldwork. You may get what you want or you may damage your chances of learning more (Schensul et al., 1999; Wolcott, 1999). While question guides may be used they are merely guides and each interview opportunity directs its own line of questioning helping to shape the domains of interest. Guides were
used in this study (Appendix C). Wolcott recommends getting only as involved as necessary though this is also an arguable point in the literature.

Community members were contacted, the study was explained, and interviews and focus groups were done. Key informants and focus group members were asked to suggest other community members who might be willing to be interviewed. Many people were interviewed in the context of their jobs that entailed providing services in the community. They shared information with the researcher as part of their job descriptions. Interviews with patients regarding their experience getting to and at the clinics were done anonymously and were brief. Only age, gender and ethnicity/race were documented. The researcher transcribed the interviews that were recorded and reviewed them with the committee chair verify accuracy.

Focused group interviews were used in the study. They were used to have participants react to some of the results from preliminary data collection and analysis. While a questionnaire was used to direct the discussion, the participants guided the direction of the questions.

**Sampling**

Bernard (2000a) notes that unlike questionnaires or surveys where a random sample ensures adequate representation, ethnography is about understanding people’s lived experiences. This kind of information requires a few knowledgeable and articulate informants rather than an unbiased sample of people. It also involves emic explanations of how things work, for example, insider explanations of why people think they are poor, why they think some ethnic groups are successful and others are not, or what they think people can do to prevent or treat colds, etc. The success of ethnography depends on choosing good informants and asking them about things they know. In other words
ethnographic informants are selected for their competence rather than for their representativeness (Bernard, 2000a). Good key informants are people you can talk to easily, who understand the information you need and are glad to give it to you or get it for you.

Interviews began with clinic staff members who were familiar with the system, the local problems and could also provide names of members of the community who would be concerned about the issues. Each of these individuals were asked to suggest other members of the community who might be knowledgeable about the problems and willing to talk about them. Efforts were made to obtain referral to community members representing the major ethnic groups attending the clinics in the county. Each of the initial key informants were asked to suggest the next person or set of people to be contacted, based on the data gathered and the questions generated.

Because this study was conducted in an ambulatory setting, the patients and community members interviewed were in relatively good health. It was recognized that some of the patients and community members who most needed to be heard would be the hardest to reach. For this reason the selection of appropriate key informants was important. Every attempt was made to develop rapport with the informants and the local community.

It was anticipated that approximately 30 interviews would be conducted. In fact, over twice as many people were included in the study. The age range of the participants was 14-65 and included people of both genders and several race/ethnicities. People interviewed anonymously in the clinics were between the ages of 18-50. Adolescents between the ages of 14-17 were interviewed anonymously, with parental consent, in a
focus group as part of their participation in an after school sexuality education program. They represented most of the high schools in the inner city area. People interviewed in the community within the context of their employment at agencies providing services related to STDs did not provide their ages. Once contact was established, no one refused to participate. A few people contacted failed to return telephone calls. Twenty-five agencies provided information. Saturation or completeness of the process was determined when the list of contacts suggested by people being interviewed were people or agencies that had already been included and the information obtained was repetitive.

**Adolescents**

By law, STD clinics in Florida may see and treat adolescents under the age 18 for STDs without parental consent. According to DOH Bureau of STDs 2000/2001 statistics, this age group has one of the highest rates of certain STDs such as chlamydia and gonorrhea (Appendix B). These young people may also lack resources, thus making the STD clinics a primary means for them to obtain treatment. Logically, therefore, it was important to include them so that we could determine how to better serve them. Only Black adolescents participated in the focus group. It would have been beneficial to have had included a group of White adolescents.

**Women**

The clinics serve both women and men. There is always a possibility that a woman interviewed may be pregnant. It is during STD testing that many women find out they are pregnant or their maternity care providers may have referred them to the STD clinic for treatment. Because of the impact that STD’s have on pregnancy outcomes in Florida it was important not to exclude women from the interviews (Schmitt, 1999).
More women were interviewed than men. In fact for every man interviewed almost three women were interviewed. Some of this disparity can be accounted for by the greater number of women found in the health care professions, the greater number of services provided for women rather than men, and the difficulty associated with finding men willing to talk to a middle-aged White woman about health care issues, specifically STDs.

**Inclusion Criteria**

Qualitative inquiry typically focuses in depth on relatively small samples, selected purposefully. Quota sampling as described by Bernard (2000b) was used to select a set of key informants from patients, staff and the local community to represent the variation in cultures in the County. Chain referral selection as described by Schensul was also used though this can present some limits in diversity of the sample (Schensul et al., 1999). Key informants included males and females from various ethnic backgrounds who consented to be interviewed. There was almost an equal distribution of Blacks and Whites among the participants. People of all ages were involved.

**Exclusion Criteria**

Individuals who were unwilling or unable to be interviewed were excluded.

**Informed Consent**

I explained the project to all participants. Key informants were asked to sign a consent form. Some informants answered questions within the context of their employment; therefore staff at clinics, social workers, administrators and program directors did not sign consent forms. They shared information as part of their employment responsibilities in a field related to the area of concern.
Adolescents were interviewed in focus groups in settings where they were already participating in a sexuality education program as part of an existing program of supplemental education and enrichment. These adolescents had signed parental permission forms, including an assent form, which they signed.

All patients, including adolescents, were interviewed anonymously in the clinic setting. They were given a letter telling them about the study and invited to participate. Adolescents were legally able to participate. Waiver of documentation of consent was obtained for those interviewed anonymously because of confidentiality issues. A waiver of parental consent was obtained from the University of Florida Institutional Review Board for adolescents interviewed in the clinic setting. The National Commission for the Protection of Human Subjects and Behavioral Research has suggested that parental consent is not a reasonable requirement when adolescents participate in research designed to identify factors related to the incidence or treatment of certain conditions for which they may legally receive treatment without parental consent (English, 1995; Levine, 1995). Although it was not required, when the study began, a waiver of the Health Information Patient Privacy Act (HIPPA) authorization was obtained in March of 2003. The rationale for the waiver was that we were not collecting protected health information, only information about experiences with the health care system.

No names were used in data analysis and findings. No names were used in the transcription of tapes. Only demographic information such as gender, age and race/ethnicity were recorded. All field notes, transcribed interviews, computer disks and observational data were kept in a locked file cabinet in my home with a copy in the office.
of the committee chair. In the case of focus groups, no names were used or recorded in the transcription.

**Data Analysis**

In accordance with the principles of qualitative research, the data analysis included transcribed interview data, field notes, recorded observations and relevant documentary and archival information pertinent to the community and the study. In qualitative research, data analysis is an ongoing process, occurring both during and after each interview. Field notes were used to interpret the data. Data was gathered until saturation was reached. This was realized when names given for further consideration had already been interviewed and the data became repetitive. Data was examined for patterns and relationships, and compared and contrasted with archival information, categories from the literature review and between subjects. Content areas or themes and cultural domains were ascertained. The themes were examined and used to describe community member’s perceptions of the STD clinics, services and their reasons for not attending.

**Bias**

Bias, is defined by Wolcott, in terms of what does and does not make its way into the archives or gets recorded at all, what does and does not get talked about, and self-understanding. Bias occurs in sampling, observing, data recording, analysis and reporting, non-response, interviewer effects, history and maturation, which affects internal validity (Bernard, 2000b; Germain, 2001). Researchers can avoid bias by being aware of their own assumptions and through self-reflection (Bernard, 2000b). Additionally age, gender, ethnicity, size, social class, religious and cultural background, educational level and personal style all contribute to the bias associated with the
researcher as the instrument and should be accounted for in the analysis (Schensul et al., 1999). Every effort was made to acknowledge the biases in this study.

I am a Women’s Health Nurse practitioner, which in some cases may have increased my ability to access the community since nurses engender trust. This was a health related research project with the potential to benefit the participants’ future access to health care. In some cases my gender and age may have been a deterrent to some of the subjects but again because of my health care affiliation there seemed to be minimal numbers of occasions where access was not provided and interviews not obtained. In one instance in a neighborhood that was predominately Black and poor, with evening approaching, and no contact with the liaison having yet been made I felt it prudent to leave the area for concerns regarding personal safety. This may have limited one aspect of the study especially since the data from this site was going to deal with the issues Black men had with getting STD care. Numerous interviews were conducted with people working as providers of care to the Black male population so a perspective was collected. These included Black male informants who, when interviewed, said that it would be impossible for me to talk directly with a group of Black men because of my race, gender and age. They felt that they were able to provide both a direct and an indirect perspective on the needs of Black males. As the mother of a fourteen year old, I had concerns about adolescents and STDs and sexuality education. In particular biases about how much education adolescents should receive exists, however this did not seem to be a barrier to accessing or interpreting the findings from adolescent interviews.

Validity

There are two types of validity, external and internal. The researcher as the instrument confounds validity. Researchers can evidence anything they wish. Validity
hinges on the skill and rigor of the person doing the research (Patton, 1990). This was an initial effort on my part, which might have had an effect on the results; however I had many years experience developing interview skills within the context of my position as a nurse practitioner. Additionally, many of the findings of this study had been noted in the archival review process in previous studies so this was felt not to have interfered with the internal validity. Validity is affected by sample bias, observer bias, accuracy in recording field notes, selecting of what to report and assessment of the informants as accurate portrayers of their culture. The use of chain sampling technique increased the validity of selecting informants, each informant suggested the subsequent informants.

Threats to external validity include problems with generalizing due to the selection process, the study setting, and the ability to apply to either the past or the future (Bernard, 2000a). Lack of external validity or generalizability is often criticism of ethnographic studies as they are descriptions of specific groups. Generalizability occurs when the findings fit other contexts as judged by the readers (Germain, 2001). This study was specific to Duval County but may have applicability to other metropolitan health departments with a similar delivery structure and racial composition. The lessons learned may have applicability in other counties with more mixed ethnicity as the issues may be found to be more universal and less culturally specific than hypothesized.

Validity in ethnography refers to how accurately the instrument (the researcher) captures the observed reality and portrays the reality in the research report. Validity was addressed by triangulation between findings, archival data and statistics, through peer and colleague review of the findings to challenge or support the ethnographer’s interpretations and through the use of negative case analysis. Negative case analysis is
defined as cases that do not fit the model or that suggest new connections (Ryan & Bernard, 2000).

**Reliability**

Reliability is defined as the consistency of the sources of data, including participants, and the researcher and the methods of data collection (Germain, 2001). Reliability is enhanced by asking the same questions of different informants over a long period of time and in different circumstances, obtaining repeatability of the data and seeking explanation for discrepancies (Germain, 2001). Inquiry and confirmation audits can be done on field notes, journals and transcriptions (Germain, 2001). Morse redefines reliability as adequacy (Morse, 1995). The concept of adequacy is described as interviewing and sampling that are performed until there is saturation and repetition of data and the presence of negative cases or exceptions (Morse, 1995). This was the more workable definition for this ethnography. Data was collected until there was saturation, no more new themes were emerging and negative cases were present for some of the themes.

**Risks**

It was highly unlikely that an informant would suffer any health risk as a result of participating in this study. It is possible that some informants might be uncomfortable with the subject matter. The assumption was that if they were not comfortable talking about problems associated with obtaining care for STDs, they would not agree to participate. Every effort was made to insure that potential informants understood the interview content and were comfortable with it. Consent or negative consent, the desire to stop the interview, was offered throughout the interview process as well as by providing the participants with phone numbers to contact my committee chair or me if they desired
to withdraw from the study. In the event that any interview did trigger some emotional stress, participants would have been offered a number at the local STD clinic that they could call for counseling. This service was not needed during the course of the study.

**Benefits**

There were no direct benefits to the participants. The information they provided was used to make recommendations for improved service delivery.

**Financial Risks and Benefits**

There were no financial risks. Individuals were asked to participate in focus groups but these were done at locations where they had already gathered for other purposes. Coupons valued at $20.00 were issued to compensate focus group participants for their time. Key informants were offered coupons worth $10.00 which some accepted and some did not. Individuals interviewed anonymously were offered coupons worth $10.00. Community members who participated as part of sharing their functions and work in the community received no compensation. Informants who declined to receive payments were still eligible to participate.

**Limitations**

The limitations of ethnography are virtually the same characteristics as the reasons given earlier to choose the method. According to Wolcott (1999), individuals who conduct ethnography are generally not licensed or trained, though most go through a mentoring process with an experienced ethnographer. Ethnography is essentially a human observer observing other humans and as such the researcher can draw upon personal skills and strengths to advantage. In this case, I brought twenty years of interviewing patients as a background for conducting research interviews. The method can emphasize either scientific or humanistic aspects depending on the subject of the study. Ethnography
emphasizes working with people as the variable and the researcher as the instrument rather than intervening with a specific treatment and measuring some objective finding. It is used when the problem is not defined and has to be determined from the society in which it is immersed.

**Strengths**

The strengths of ethnography is its ability to enhance understanding and interpretation of the links between what happens locally, in the region, nationally and globally (Schensul et al., 1999). It is an excellent tool for linking the explanatory model of health seeking behavior to community members concerns regarding the STD services in the community. The critical medical anthropologic perspective of the economic and political structure provided context for the issues associated with this study and its application to the public health system. Ethnography can be an effective tool for both understanding and improving conditions faced by the participants and decreasing the amount of time between generation of the knowledge and its translation into policy (Schensul et al., 1999).

**Conclusion**

According to Kleinman, illness is shaped by cultural factors governing perception, labeling, explanation and valuation of the experience (Kleinman, 1980). He says that because the illness experience is an intimate part of social systems of meaning and rules for behavior, it is strongly influenced by culture; and it is culturally constructed. Hahn (1999) concludes that the understanding of socio-cultural and biological effects of public health problems may be essential in addressing those problems. It is the purpose of this study to take into account not only the society for which the intervention is intended but also its social, economic and political environment. Ethnography, critical medical
anthropology and Kleinmans’ explanatory model provided an optimal foundation for achieving this purpose.
CHAPTER 4
THE NUANCE OF THE COMMUNITY

In order to better understand the findings, recommendations and discussion sections of this study it is important for the reader to have some sense of the history of the county. The history will provide insight to the current issues affecting policies and therefore the people of the Duval County community. This chapter will provide a brief history of Jacksonville and attempt to create a verbal picture of the community. The first hundred years will covered briefly and then the most recent twenty-year period will be explored in more depth as this has the most relevance to the current state of the opinions of the members of the community. Reports from local agencies, web resources, newspaper articles and information from key informants were used to put the issues that are pervasive throughout Duval County at this time into context. These issues are mostly racial.

Jacksonville has a history of racial segregation and discrimination (Crooks, 2003). Jacksonville’s present is built on its past. Its history of division and race-based mistreatment plays a significant role in its institutions and how people view the current situations (Jacksonville Community Council, [JCCI], 2002). The tensions in race relations stem not only from racial disparities, but also from the cumulative effect of historical grievances, differences in perceptions and the ongoing frustration with the government and other institutional efforts to “fix it” (JCCI, 2002). As recently as the first quarter of 2003 there existed a division between Black and White perceptions of the issues facing voters in the mayoral election. A poll conducted for the newspaper found
that Blacks felt that neighborhood development, affordable housing, race relations, the Better Jacksonville Plan, public health care and downtown redevelopment are very important issues by a margin of two to one over Whites in the community.

**Early History**

Jacksonville was originally home to the Timucua Indians. It was settled by the Europeans in 1564 and called Cowford because this is where ranchers crossed the St. Johns River with their herds. In 1822, when Florida territory went under United States rule, a more formal community was laid out and named for the then governor, Andrew Jackson. Jacksonville was an important port for lumber, cotton and citrus fruits. At the end of the century with the advent of rail travel it became a Mecca for northerners looking for an escape from winter. A yellow fever epidemic and the fire of 1901 destroyed much of the city, however it recovered and prospered.

The development of south Florida pulled the tourist industry away in the early part of the 20th century; however World War II made Jacksonville one of the most important military bases in the southeast. Currently it serves as a base for the Coast Guard and the Navy, with a large airfield on the West side of the county and an active port on the Atlantic Ocean. In the past, the primary industries were paper and chemical companies, which gave the city a bad reputation due to the smell from the paper mills and the emissions from the chemical manufacturers. Subsequently banking and insurance companies came to the area, the service industry began its stronghold in Jacksonville and the paper mills and chemical companies began cleaning up the environment.

**The Racial Past**

Racial prejudice is deeply ingrained in the city’s history. Throughout time racial issues have always been a concern. Initially, Jacksonville was populated with Whites and
runaway slaves (Kennedy, 1999). Following the civil war freedmen came to Jacksonville and made efforts to be incorporated into the society. Black people viewed Jacksonville as the most liberal of southern cities after the civil war despite the fact that they were political eunuchs, stringently segregated and that chattel slavery gave way to a system of chattel slavery (Kennedy, 1999). Post civil war Jacksonville held promise for Blacks, and a local Black leader wrote that Jacksonville was a “good town for Negroes.” After the recession of 1914, he subsequently left town as did 16,000 of the best and brightest Black residents, describing it to be a “cracker town” (JCCI, 1992). In the period from 1908-1945 sixty-three Blacks were lynched to serve as a reminder of their role in the community. The Klu Klux Klan was resurrected in Jacksonville in 1915 and the area served as the state headquarters for the Realm of the Grand Dragon (Kennedy, 1999). During this time nocturnal parades were held in “colored town to keep them in their place” (Kennedy, 1999, p. 3). Although Blacks comprised one-third to one-half of the total population they had few opportunities to advance, as most Black owned businesses were “mom and pop” shops. As a result many left for better opportunities. There was reluctance on the part of both Blacks and Whites to patronize minority owned businesses (JCCI, 1992).

The city has a long history of efforts to disenfranchise Blacks. In 1885 a poll tax was passed by the legislature in an effort to affect the poor Blacks and Whites (Crooks, 2003; JCCI, 2002). The elected government was suspended in 1887 because the city council had a majority who were Black or Republican (Crooks, 2003). Blacks were excluded from the City Council from 1907-1967. They were also denied access to the city parks, segregated in public areas such as the train station and retail establishments.
and excluded from city jobs (JCCI, 1992). As recently as 1968 when the city and County
governments merged into one entity the rationale given for the merger is split along racial
lines. If you ask a White person why the city and county governments merged they will
tell you it was because of the potential for increased efficiency and to remove the
corruption at city hall. If you ask a Black person they will tell you it was because of
White fears due to the political power of Blacks since they had the ability to elect Black
leaders within the city limits (Crooks, 2003; JCCI, 2002). The most recent mayoral
election had racial overtones. The majority of Black voters cast their ballot for the Black
Democratic former sheriff only to see their candidate be defeated by the White
Republican candidate. The racial division was fodder for the local media.

**School Desegregation**

The desegregation of the Jacksonville schools was another racial fiasco. Before the
Civil War it was illegal to teach Black people how to read, thus prior to the second half of
the 20th century there was little concern about segregated schools because learning to read
was viewed as progress (JCCI, 1992). In 1963 the first Black children attended White
schools. In all-Black neighborhood schools the bond between Black teachers and students
was an important nurturing element as the teachers were mentors as well as educators
(JCCI, 1992). There were disparities between the White schools and the Black schools.
One example given is that the Black schools received the used, defaced, and torn texts
from the White schools as they were replaced with new editions. Jacksonville schools
failed to desegregate completely, drawing federal court orders to mandate desegregation
according to the 1954 Supreme Court decision (JCCI, 1992). The 1972 court-ordered
plan to desegregate the schools and abolish the dual education system was flawed in
numerous ways. It lead to busing of Black children out of their neighborhoods and
frequent changes in schools, which destroyed the continuity of their education and prevented parental involvement in the education process because of the physical distance between home and schools (JCCI, 2002). The busing did not apply to all neighborhoods and as a result of this, Black children were removed from schools with primarily Black faculty and administration and sent to schools with White teachers who had little preparation for teaching in a desegregated school system (JCCI, 1992). This created a void in mentoring and positive role models for Black students. The teachers had little prior contact with Blacks, feared for their personal safety and feared their students, especially male students (JCCI, 1992). This prevented them from doing an effective job of educating and motivating (JCCI, 1992). As a result of desegregation many schools in Black neighborhoods closed and many Blacks perceived these decisions to be political and not benefiting the Black students’ education process (JCCI, 1992). In 1990 the school system adopted a new program to desegregate the schools by developing a magnet school program that allowed the busing to be more voluntary (JCCI, 2002). In 1999 the federal district court declared the Duval County Public Schools to be “unitary”, meaning they operated without discrimination. This ended the court supervision of the desegregation efforts though the schools were hardly integrated and education was not equivalent between the races (JCCI, 2002). The problem of unequal education as measured by test scores, drop out rates, enrollment in gifted programs, and the numbers of children in special education programs demonstrates the disparity to be ongoing (JCCI, 2002).

**Health Care and Race**

According to a 1983 report examining indigent health care services in Jacksonville, in 1980, 54% of the residents with incomes below the poverty level were Black although they represent only 24% of the population. About half of these households were in the
“core area” which is downtown Jacksonville (JCCI, 1983). When discussing indigent health care I am talking about a problem with racial overtones due to the disparity in income, education and employment opportunities. The indigent health care study found that although there were many agencies designed to meet the needs of the population each had different eligibility requirements and multiple sources of funding. One only has to look at the directory for Ryan White agencies to see how many health and related service agencies exist today in Jacksonville, each competing for funding, clients and a niche. At the time of the 1983 study there were no formal planning mechanisms linking the hospital responsible for indigent care with the Department of Public Health and the Visiting Nurse Association even though they were serving the same population (JCCI, 1983).

The report also defined the barriers to health care as accessibility, affordability and acceptability of the care. The accessibility is limited primarily to the hospital as few physicians have offices in the “core” area of the city where most of the indigent reside. For poor people living outside the core area transportation to the few facilities that will see them is an obstacle and the hospital may be the only portal of entry into the system. The affordability is tied to the requirements and paperwork associated with Medicare and Medicaid and the lower level of benefits paid to the providers accepting these plans. The medically indigent spend a disproportionate share of their budgets on health services, are more likely to have inadequate nutrition and live in unhealthy environments, thereby increasing their likelihood of having poor health (JCCI, 1983). The acceptability has to do with the way in which services are delivered. Patients complain of long waits, and being referred to other facilities because of funding or service limitations. There is also a
cultural conditioning causing people to go to the hospital because that is where family members have traditionally sought care. These remain issues in 2003 with a recent newspaper poll reflecting the community’s concern that people are going to the hospital for less urgent conditions, driving up the cost of their care because they have no neighborhood clinic options available. These issues are the subject of this report and will be examined further in the next two chapters.

**Young Black Males**

Another report by the Jacksonville Community Council, Inc. (JCCI, 1992) offers several theories about why a disproportionate number of Black males fail to survive or fail to thrive and how this contributes to the current racial climate in the county. The JCCI report found persistent racism, suspicion and fear surrounding all Black males because of stereotyping, the decline in family values, diminished church authority, inadequate diversionary programs, disparity in the criminal justice system, and problems in school related to achievement and behavior. All of these factors are believed to account for the problems facing this group. The study of the problem is complicated and has implications for the public, the Black community and the individual.

At the public level, concerns about desegregation in multiple institutions was cited as contributing to the failure to survive and thrive. In addition to the desegregation of the schools, there was desegregation in the workplace and housing, a lack of economic security, pervasive crime and violence. As recently as the 1960s, Blacks were included only at the lowest rungs of the employment ladder (JCCI, 1992). As a result of federal legislation Blacks became more upwardly mobile, filling jobs in supervisory and managerial capacities. This created a problem of Blacks being perceived as a “necessary evil” and as taking jobs that Whites were entitled to hold (JCCI, 1992).
Federal housing rules changed allowing Blacks to move to previously all White neighborhoods. The outward migration of Blacks from a core area had four negative consequences: a) the Black community was no longer self-contained, b) the political strength was diluted, c) fewer mentors were available for Black youth in the old neighborhoods, and d) there was stress associated with being Black in a White neighborhood (JCCI, 1992). The problems associated with the Black community are also related to the flight of the middle class out of the downtown area. This lead to blighted areas with few businesses, unpaved streets, vacant lots strewn with trash, padlocked recreational sites and numerous liqueur stores adjacent to residential areas. In some areas the JCCI committee members compared neighborhoods in Jacksonville to those in underdeveloped nations. Further, the church and the pastor were no longer the focal point of the community. The nurturing environment where shared childrearing by teachers, shopkeepers, parents and multiple generations that would raise a child were diminished by the end of legal segregation which ended the close knit Black community (JCCI, 1992). Finally, according to the JCCI report, the decline of the family with few Black youth growing up in a two parent household was seen as contributing to the plight of Black youth.

At the individual level, dysfunctional behavior, homicide, HIV/AIDS, low academic achievement and exposure to criminal activity, and drugs contribute to the problems of young Black men failing to survive and thrive. The employment problem for Black males is based in part on their high drop out rate, low income potential as a result of the lack of education and the high economic benefits of drug trafficking. Dysfunctional behavior does not affect all young black males and it is important to note that most young
Black men grow up to be productive members of the community. The behaviors of the proportion that do not are described in the following section.

Jacksonville’s firearm homicide rate for Black males age 15-19 was the fourth highest in the nation in 1992 (JCCI, 1992). Nationally, death by a firearm was the leading cause for death for young Black men in a similar age range. In the Health Planning Council of Northeast Florida, Inc. 2000/2001 Region IV Health Plan that includes Duval County, homicide is still the leading cause of death among young Black males (Health Planning Council of Northeast Florida, 2000/20001). Black males account for about one third of the local cases of AIDS with the percentage increasing since 1988. Like STDs, while only representing 28% of the population, Blacks carry almost half of the burden of HIV/AIDS.

Black youth have low academic achievement as measured on the standardized tests and are more likely to be enrolled in exceptional education programs related to mental handicaps than White children (JCCI, 1992). A powerful form of negative peer pressure that further confounds the academic achievement issue is that students who apply themselves and learn, are accused by their peers of “acting white.” In the grades K-9 young Black males receive in school discipline or out of school suspension more than any other group (JCCI, 1992). It is hypothesized that the reason they do not have similar high rates in high school is that they have already dropped out. Young Black males have a disproportionate number of arrests; many have multiple arrests (JCCI, 1992). They are also more likely to be arrested for a violent crime that carries greater penalties exposing them to even more criminal and violent behavior than if they were to remain in the juvenile justice system. Finally, drug trafficking or use is responsible for two thirds of
those being sent to prison. Black youths are reported to get involved with selling drugs with youth as young as 9-13 years of age being able to make money as lookouts or runners for neighborhood drug dealers. By 16 years of age they can earn more lucrative amounts by being dealers themselves, though they do not use drugs as much as their White counterparts (JCCI, 1992).

At the beginning of the twenty-first century, 53 percent of the Whites and 67 percent of Blacks felt that racism was a problem in Jacksonville (JCCI, 2002; Kennedy, 1999). The JCCI felt that some of this was due to biased portrayal in the media to the point that all Black males now suffer from a skewed perception based on the lack of sensitivity on the part of the local media outlets.

In the last ten years, Jacksonville acquired a NFL franchise and began a renaissance of the downtown area including the riverfront, the center for the performing arts, a new government facility, library, ballpark and arena. Residential housing was added to the downtown area and the Westside has begun development. Many of the racial issues remain however. As documented throughout this chapter Jacksonville has a heritage of racial segregation and discrimination. It has improved, but more needs to be done to diminish the disparities between races as indicated by education, income, employment, health care indicators and the criminal justice system (Crooks, 2003). In 2002, the JCCI report on Race Relations stated that significant race-based social and economic inequalities still exist, that past and current efforts to address the problems have not been sufficient and that the intentional change will require efforts at the individual, family, business and community level. Surveys included in this report measured Black/White disparities in quality of life; which included education, income, employment,
neighborhoods, housing, health, criminal justice, and the political process. It found significant differences in the perceptions along racial lines. They made twenty-seven recommendations for implementing change including mayoral, public, organizational, and agency support. The JCCI (2002) recommended that the Duval County Health Department should work with area associations and institutions to ensure that they are aware of racial disparities in health outcomes and treatment. They also suggested training for medical professionals to improve health care delivery for all people. The JCCI supported the development of an annual health summit, bringing together many health related agencies to provide comprehensive health screenings targeted at the Black community. They also charged the United Way with convening leadership in all racial groups to address behaviors that are self-destructive and which contribute to poverty and racial disparities.

**Relevance to Health Care**

Access to health care in Jacksonville is not solely about race. As other authors have noted, it is about poverty, education, and employment and it is impossible to separate and blame any one component. During this study, it became apparent that race is part of the equation since the community is largely split along Black and White lines. The other ethnic groups represent less than five percent of the mix and do not have a lot of influence on the nuance of the County. During the recent mayoral elections, divisions in the community along racial lines concerning health care were documented in the media. In a poll conducted by the Times-Union in February of 2003, looking at issues that divided voters by race, one of the top five issues was health care. Ninety-one percent of the Black voters rated health care as an issue compared to only 58% of the White respondents (Appelbaum, 2003). This perception of health care as a priority does not
compare proportionately with the racial distribution of those without insurance. The uninsured in Jacksonville are those who do not qualify for government assistance and cannot afford private coverage. They live in every zip code and 58% are White, 33% are Black and 7% are Hispanic which is not consistent with the division represented in the community’s priorities as documented in the poll by the Times-Union (Filaroski, 2003). This skew may exist because the 58% of the uninsured who are White are employed and earn too much to qualify for assistance, or are not employed by companies that offer benefits. The estimated 12-20 percent of the population that is uninsured gets its care from Shands at University Hospital and the state run clinics. In 2001 Shands hospital, which is not-for-profit and barred from turning patients away nearly went bankrupt. It was saved from bankruptcy with cash infusions from the city. However by a margin of 65% to 28% respondents to the Times-Union poll said the city should do more (Appelbaum, 2003). The candidates had few or no concrete plans, “none of the candidates had said more than a few words about health care” (Appelbaum, 2003, p.A-7). The voters also felt that bridging gulfs between racial and ethnic groups was important with 43% weighing in on this issue (Appelbaum, 2003). Providing care to the uninsured cost Duval County hospitals $90 million in 2000 (Filaroski, 2003). Clearly, more than race affects health care and access to care. Economics, the history of where people go for care, the perception of Shands hospital, and the perception of the Department of Health also enter into the issues of access to care.

**Summary and Conclusions**

Examining issues mostly in a Black/White context presents the nuance of the Duval County community, as this is the primary racial makeup of Jacksonville from its inception to the present. While the community is becoming more diverse, understanding
the Black/White issues applies to other members of the community regardless of race/ethnicity. To understand the issues related to access to STD services in Duval County and to explore the perceptions of community members related to current services requires an understanding of the disparity in the quality of life, which is dependent on race/ethnicity. Analysis of local documents provided a context for data analysis and interpretation that added depth to the findings. Since the Black community carries almost 80% of the STD disease burden in the County with only 28% of the population it is important to examine potential causes for the misdistribution of morbidity. Without question, these disparities in Jacksonville, as perceived by members of the community had application to the discussion of the findings and the recommendations made to the State of Florida regarding the delivery of services.
CHAPTER 5
FINDINGS

The purpose of this investigation was to determine the problems community members have with access to STD services in Duval County. This chapter shall present the findings that were discovered through the use of ethnography. During the course of the study, I talked with 65 informants either through structured interviews, casual conversation or focus groups. The field notes, archival data and transcribed interviews offered rich data about the problems people have with accessing care.

The overarching concept that emerged from the analysis of the data was that access to services is limited by what people know or their knowledge of the system. There are several components to this knowledge. The concept is operationalized in this chapter under some specific categories. First is the knowledge of logistics including transportation and clinic operations, location, hours of service and how to get there. Second is the social/cultural knowledge derived from community values, including views on sexuality, how the information is communicated, the culture created by economic and family circumstances, neighborhoods, churches and the values derived from these factors. Third are beliefs and emotional issues that are associated with the stigma surrounding STDs, the mode of transmission, methods of diagnosis and treatment, embarrassment and fears.

Through the analysis of the data it became apparent that knowledge or what people know was a necessary component for access to STD care. People have to know the logistics of the system, where to go, when to go, how to get there and what to do when
they get there. People have to know about the risk factors for diseases, the signs and symptoms, how to protect themselves and prevent transmission. They need to know the community’s expectations for behavior, those of family, friends, church, social groups and the amount of help one may receive when dealing with an STD as a result of these cultural values. They have to know how to deal with the emotional aspects of the disease, the stigma associated with STDs that gives rise to shame, guilt, fear and embarrassment. They must also overcome denial. Additional findings include blockades to being able to learn about services; some of which is limited by Florida state statutes; parents failing to talk to children, inappropriate societal messages about sexual activity, and a lack of effective community coordination of services.

**Logistics**

There are many components associated with the logistics of accessing the clinic services that were described as obstacles by those seeking care. An informant said that clients need to know “hours, services and transportation” in order to be seen. These categories include what people need to know about the hours of service, days of operation, clinic locations, appointment system, transportation, how the clinics are publicized or marketed and the limitations of services; specifically gender and age limitations. Additional logistical barriers include financial and insurance issues.

**Clinic operations**

The clinics were described as “being hard to get to” and “hard to get into.” Clinic hours are, by and large, Monday through Friday, with few or limited evening hours, no weekend hours and no services on Wednesday afternoons, as they are reserved for clinic staff meetings and administrative activities. The only way this information can be learned is by calling the clinic by telephone or presenting for services. Not all clinics offer
services in the evenings. The waits are long, up to four hours, and some clinics require
two visits in order to be seen. The first visit is a financial aid determination and the
subsequent visit is the actual physical exam. All this information is obtained only upon
making a telephone call or arriving for an appointment and learning of the need for the
financial qualification interview. An individual could lose up to two days of time from a
job or school in order to be seen for an STD. People seeking services need to know what
to bring to clinic for proof of identity, residency and financial eligibility. Even at the
“easy to access” Pearl Street clinic, a visit requires people seeking service to present a
social security card plus the $10.00 fee. This would only be learned after a telephone call
or upon arrival at the clinic. Some illegal aliens do not have social security cards.

Some people view the need for appointments as a barrier to accessing care. It can
take two to three weeks to be given a time to be seen at some of the clinics. If you want to
be seen for a problem, being told to wait for two weeks can be two weeks too long,
contributing to continued utilization of emergency rooms for less than urgent care or
continuing the cycle of infection. Having to make two visits, the first the financial
interview and the second the actual physical exam is a tremendous inconvenience. People
want to be able to “walk in” for care. In many cases the need is now and that is when they
want to be seen. In clinics where appointments are made, asking patients to state the
nature of the complaint or problem can be a barrier. Older clients said, “if I knew what
was wrong I wouldn’t be making the appointment to find out what was wrong.” Many are
unwilling to disclose the nature of the complaint to clerks, who were seen as enforcing
the rules as opposed to enabling people to get into the clinics.
There are methods of circumventing the system. If patients call and say they have a discharge they will be seen that day, but it is not clear how they would learn this. Some priority is given to suspected STDs, but you have to “know” what to say to get into the system quickly. You either have to have been referred for STD care by a partner and have a referral letter, or disclose that you suspect you have an STD. Financial evaluation is expedited for those with suspected STDs, but you have to “know” what to say and who to say it to in order to receive the expedited appointment.

The issues associated with the logistics of accessing STD services were similar to the findings of the Ryan White Needs Assessment from 2000, a report looking specifically at HIV services in Duval County. The Ryan White Needs Assessment documented that the lack of knowledge about available services and how to access them was a barrier to accessing care (Davis, 2000). It also included findings from several focus groups, including both patients and providers, who cited the hours, the wait, transportation and the bureaucracy as issues that interfered with peoples’ ability to access HIV health care (Davis, 2000). Members of the community infected with HIV included in the Ryan White Needs Assessment also complained that the wait was too long between diagnosis and the first visit.

Adolescents, in particular, need walk in services since they have limited control over their lives. These limited controls include their ability to keep what is perhaps a secretive appointment, and physically getting to get to the clinic. Adolescents think very much “in the moment” and therefore often cannot plan several weeks ahead. Adolescents do not want to disclose their need to be seen for a suspected STD or family planning to a clerk on the telephone. They also have a great deal of difficulty learning about the
Department of Health clinics, as school board employees cannot disseminate this information in the public school system. Adolescents only learn about the clinic through outside programs or public health nurses that might be working in a school. They may be unable to discuss the nature of their visit due to lack of privacy when they are making the telephone call.

The Rapid Assessment, Response and Evaluation (RARE) report, published in 2002, looked at beliefs, attitudes and behaviors in two neighborhoods in Jacksonville, focusing on women and drug users at high risk for HIV. This report documented the lack of knowledge as being a barrier to care as well. This study reported that people know there is a Health Department but they do not know what services it provides, where it is located and if that is known, the hours and locations are not convenient. They also said that clients do not know where to go so they are not accessing care and they are unaware of the services in the community (RARE, 2002).

There are no injectable drugs available at any of the outlying clinics. Any patient requiring treatment for syphilis must be seen at the central STD clinic located in downtown Jacksonville, which can be very inconvenient for people at the periphery of the County. This leads to the transportation issue. People may arrive at one clinic expecting to be seen and be told to go to another clinic for treatment. It may be impossible or impractical for them to get to the downtown clinic. If they are traveling by car, they may not know how to get downtown, if traveling by bus it may take half a day and require several transfers to get to the Pearl Street clinic. Since each clinic operates a little differently, you have to know the system.
Gender

The disparity in the services offered at the various sites in the County is a barrier. Men are not seen at some of the neighborhood clinics and there are no alternatives offered in a geographically convenient area. It is difficult to find out where men can be seen for an STD and almost impossible to determine where they can seek primary care services if they are needed. This information is not found in the telephone directory, as services provided are not listed under the locations. Men may not be cared for where their partner was diagnosed and treated and although they may know that they need to be seen, they may be unable or unwilling to travel to the central STD facility on Pearl Street. This diminished access contributes to the reinfection rate. Informants said, “there are no buildings out there that say men’s health care” but several that say “women’s health care.” “There are not enough places for men; men don’t want to go to Pearl Street.” These findings are similar to those in the RARE report that stated women get health care more than men, and women have more points of access (RARE, 2002). On a positive note in early 2003 the Department of Health began operating Men at Magnolia from 4:30-9:00 PM on Monday evenings. The Magnolia clinic is a Women’s Health Clinic in a high morbidity area that was established with federal funds but is now operated by the County Health Department. Services are provided to men and include screening for HIV, STDs, cholesterol, high blood pressure and prostate exams. The services are delivered in a mobile van parked in the Magnolia Women’s Health clinic parking lot, so the men do not actually enter the clinic.

Most informants agreed that men are not socialized to take care of their health. There are few written standards of care for men and in the absence of symptoms they will not seek care. “Men don’t want to know they have an STD because knowledge,
particularly of HIV, could be a life-altering event.” “Black men are more private, men only want to talk to men; men don’t talk to women and they deny health issues.” Informants said that men were “uncomfortable seeking health care,” “they didn’t understand procedures,” “were afraid of having cultures taken” and were more “likely deny that there was anything wrong with them.” “Men only seek care when they are in pain” and most of the STDs do not cause pain. People thought the reason that women get identified with STDs more often than men was because they are routinely screened during family planning and maternity visits. Findings in the RARE report corroborated that there are few portals of entry for men (RARE, 2002). They reported that there are no centers for men, only for women. The consensus of many informants in this current study was that “access to health care for men is the pits.”

Age

The rates of gonorrhea, chlamydia and syphilis are much higher in Duval County than the rest of the state. The highest rates of disease are found in the 20-24 year olds, followed closely by those 15-19 years of age (Appendix B). Adolescents have particular issues related to difficulty making and keeping appointments as mentioned earlier. These issues include impaired mobility, difficulty planning ahead, unwillingness to disclose the reason for the visit to clerks, gatekeepers or parents, plus a reliance on adults for transportation and financial assistance. They also have a very strong need for trust, secrecy and confidential services. Denial is a strong mechanism for teens. In the words of informants, “they don’t see anything wrong so there’s nothing wrong with me” and “they don’t think about I’m going to get STDs or problems like that they just go, they just go and do it, and I mean, think its pleasure and its fun, and ah, its nice.” Teens don’t “talk about clinics; its not in conversation.” According to teen informants, they do not have a
source of information about clinics at the schools, as it is information that cannot be provided according to school board policy. Only teens involved in off site outreach programs are aware of services available and the confidentiality of these services.

The age of puberty is decreasing and the age of marriage is increasing leading to an increase in the number of years of sexual tension in adolescents. In 1982, the Jacksonville Community Council, Inc. (JCCI), reported the issues concerning the teen pregnancy rate to the community. The authors documented societal changes as having the greatest impact on teen sexual behavior. The report stated that the ethical codes chosen by teens in the 80’s were being influenced by the media messages and by friends and that those messages were very different from the ones at home (JCCI, 1982). Most informants in the current study indicated that this continues to be a problem. In the data from both this research and the JCCI report, the media was often referred to as contributing to the permissiveness of teen sexuality. In this study informants said, “sexual activity is portrayed without consequences” on TV, in the movies, and in music videos.

Adolescent girls have “no clue” as to how they get STDs, they “solicit advice from friends and it is often the wrong advice” and they are “afraid to ask for help.” The problem is a lack of “awareness of signs and symptoms.” One informant, a health care provider, said that for adolescents it was “a status thing to have an STD, the more you have the cooler you are.” Other informants did not corroborate this. There is also peer recognition and possibly status related to the mode of transmission of disease, in the words of one informant, “it (sex) is something I can do and do well.” Adolescent males, once they complete their immunizations, have little reason to seek health care services with the exception of sports physicals. At a sports physical little screening is done
surrounding risk taking behaviors such as sex, drugs, smoking and alcohol use, although this would be an optimal time to do so. Boys “learn from older brothers; most boys learn from older brothers and, and cousins and stuff.” An informal “show of hands” survey by Planned Parenthood staff conducted at presentations held in local schools revealed that when young men were asked who was responsible for birth control they still viewed it as a woman’s problem and responsibility.

**Staff/Turnover**

The attitude of staff, particularly clerical staff was cited as a barrier to accessing care. They were described as enforcing the rules as opposed to helping to navigate the system. “You have to know the rules of the clinic, where to check in, where to wait, who to see first, second and third, when to refill your prescriptions, what has to be done prior to obtaining services” and so forth. Many informants said it would be useful if patients had a “buddy” or ombudsman to help with the system, particularly for the HIV/AIDS patients requiring chronic care. People said that staff yell at the patients and that they (the patients) are not treated with dignity. Providers included in the Ryan White Needs Assessment indicated that there was a need for better customer service, more user-friendly services, especially at the first visit so patients will return (Davis, 2000).

A number of respondents that were interviewed in the clinic said that staff members were knowledgeable; they “knew the routine” and “know their job.” They also indicated that the knowledge for the favorable judgment came from previous experiences at the clinic when they were treated before. Most respondents said once they were with the provider of care there were few complaints; their complaints were with the ancillary staff. The Ryan White Needs Assessment from June of 2000 did not corroborate this finding. In that report members of several focus groups felt that medical staff needed to be more
sensitive to the needs of patients, and doctors needed to listen more (Davis, 2000). The sample from the Ryan White Needs Assessment also indicated the need for more choices in providers, greater consistency with providers, and a need for increasingly comprehensive services instead of referrals to the emergency room for non-HIV related concerns (Davis, 2000). The Ryan White Needs Assessment also documented the need for more non-traditional hours (Davis, 2000).

Some of the faith-based agencies provide support for patients navigating the system and encourage them to return when overwhelmed while seeking services, especially in the case of HIV/AIDS. “We try to educate them on what kind of questions they need to ask the doctor so they will more informed and be a part of the treatment process for themselves.” The Ryan White Needs Assessment revealed that there is some discontent with the providers of care. They reported that informants said physicians are not on time, there is a lack of sensitivity on the part of doctors and nurses and that they are not listened to (Davis, 2000). People want advocates and peer support to help them through the HIV/AIDS process (Davis, 2000).

Administrators complained that when time and money were invested in training staff members to improve patient relations, these staff members frequently did not remain in the employment of the agencies long enough for any benefit to be realized. The Ryan White Needs Assessment focus groups described concerns surrounding the physician turnover. They reported that the physicians kept changing, and they had to go to a new doctor every time and tell them the same information all over again. Informants with HIV indicated they were interested in having one primary care doctor instead of changing all the time (Davis, 2000). The providers interviewed in the Ryan White Needs Assessment
indicated that they needed more providers of all kinds, especially those who are more culturally sensitive and more providers and services in the outlying counties (Davis, 2000)

**Insurance**

Insurance or the lack of insurance was not an issue brought up by informants, but became apparent as an issue through an article in the Florida Times-Union posing the question “What is the county’s plan for the uninsured?” More than 100,000 people in Duval County do not have insurance (Poirier, 2002). Uninsured health care is the most expensive health care as it is generally obtained through the emergency room. There are several categories of uninsured individuals that fall into this needy group. These categories include people who may work for companies without benefits but do not qualify for Medicaid and people who work part-time are not eligible for health care benefits. Some people may be employed full time and have insurance but be unable to pay the deductible or co-pay on the policy offered through their companies. Another group includes children or partners of insured individuals who are afraid to seek care specifically for STD services because they might be discovered through explanation of benefit documents from the insurer. Finally, illegal aliens and the unemployed make up the remainder. These people are in need of STD services.

The uninsured wait until symptoms become a crisis and then they may get good care, but only after working themselves through the “maze” of the Shands hospital system (deCordova-Hanks, 2002). One informant called this the “emergency room mentality;” people wait until the symptoms precipitate a crisis scenario and then present at the emergency room. As the informant said, “it may be a long wait but it is only one wait.” There is a history in the community of being treated at Shands Hospital and this is
where people go because they know their health care needs will be met (JCCI, 1983). This finding was noted in both the Jacksonville Community Council, Inc. report on Indigent Health Care in 1983 and in the RARE report from 2002.

According to the Director of the Duval County Health Department, the health insurance system is based on curing, not preventing, and the public health infrastructure is deteriorating (Goldhagen, 2002). This seems to be a summation of the disparity between what people want for health care and how it is currently being delivered. Informants cited the need for “a one stop shop, on every corner” for health care. The reality is a system of clinics that are not well marketed or necessarily convenient in location or hours of service. These factors are contributing to the problems encountered accessing health care. People seeking care within “the system” may have to miss work several times before being seen, causing problems not only with work but with transportation and child care (de Cordova-Hanks, 2002). These problems are especially significant for the poor and the marginally employed.

**Finances**

Money or the lack of money is an obstacle. If you have money you can see a private provider, seek treatment in an area removed from where you live or work and choose whom you utilize for health care. When receiving care through the Department of Health people need a financial visit and clinic card prior to being seen, or people can be seen at Pearl Street for a ten-dollar co-pay. People seeking services at the Department of Health have few choices regarding providers. People who are marginally employed often have difficulty taking time off from work. If they are not at work they lose income, if they lose income they may not be able to meet their financial obligations for food clothing and shelter. Furthermore if they cannot fulfill basic needs the co-pay at Pearl
Street may be insurmountable. Additionally the poor may not have the funds to purchase prescription drugs, pay for additional child-care or transportation to the clinic. The JCCI Report on Indigent Health Care (1983) also documented that poor families may have fewer resources to secure the basic necessities of food, clothing and shelter, therefore preventive medical care is a lesser priority. The poor also have less exposure to health education and are not aware of how to be effective consumers (JCCI, 1983).

**Transportation**

Transportation was described as barrier for getting care, “you have to know the buses.” Most informants cited transportation as an issue. It was reported that the local bus service is often late or does not run at all, making it difficult for people to get to their appointments in a timely manner. The interval between buses can run up to an hour and a half. Many clinics are not on the bus line or require transfer from one line to another. People arrive at the central STD clinic by bus, foot and automobile. For adolescents, riding the bus is stigmatized and they hate to use public transportation even when provided with free bus passes. At the HIV treatment center however, people said that transportation was not an issue, if people wanted to get there, they would. They cited two examples, one, a man who biked and walked a great distance to get to the clinic, and the other, a woman who lived around the corner that consistently failed to keep her appointments.

If people are late they may be refused service. One informant reported a case of a 19 year-old mother with one child, being marginally late for a pregnancy test appointment. She was turned away without being seen because she was late for her appointment. Informants note that patient transportation services offered to the disabled can take up to a whole day from the time they are picked up until they are returned to
home, requiring long absences from work, school or necessitating extended child-care arrangements. It was also reported that people in the periphery of the County may have automobiles but they are of such poor quality they are not suitable for driving to the central STD clinic. In the Ryan White Needs Assessment, focus groups reported that transportation is often late causing them to miss their appointments, which are difficult to reschedule. They felt that more reliable transportation was needed (Davis, 2000). After missing an appointment due to the unreliability of the public transportation system, a person seeking care has to spend another day to get to the rescheduled appointment, at a time further in the future, necessitating more time off from work or school, or additional problems with childcare.

Marketing

There is little or no marketing of the clinics, including the locations, hours, services offered and what is needed to receive services. Every informant said that people find out by “word of mouth” about where the clinic is, how to get there and what is needed at a visit. There is no listing of the Department of Health services in the telephone books except in the Blue government pages. The listing for the dedicated STD clinic is found in the government Blue pages under “Center for Prevention Services.” There is no listing under STDs, sexually transmitted diseases, venereal diseases or any other more descriptive term. The clinics are not listed in the yellow pages under physicians, health services, sexually transmitted diseases, nor are they found in the newspaper, though there are numerous advertisements for escort services and people looking to meet other people. People interviewed in the clinics stated they found out about the clinic “from a friend,” “a relative,” “their hooker” and so on. Only one attendee said she found the clinic information in the telephone book and her mother assisted her. I had difficulty finding the
listings in the telephone book though once numbers were located the response via telephone was usually pleasant, courteous and helpful. Occasionally the voice mail system proved to be frustrating and messages left requesting information did not garner a returned telephone call. The RARE report also noted this finding regarding the marketing of the Department of Health. They found that many informants did not appear to be aware of where clinics were located or what services were available (RARE, 2002). Informants in the Ryan White Needs Assessment reported wanting a centralized source of helping agencies (Davis, 2000).

Community Values

The social and cultural aspects regarding what people need to know to access STD services will be discussed in the following section. The topics included in this category are, misinformation, sexuality education, community resistance, societal representation of sexual behavior, “everyone knows,” family communication, poverty, negotiation and consequences.

Misinformation

“The problem is knowledge, knowledge of diseases and knowledge of what they need.” There is much misinformation in the community. People said, “adolescents don’t know much” and “kids learn word of mouth.” Urban myths still abound such as guys still telling girls they will die from “blue balls,” (an erection without intercourse), coke douches will prevent pregnancy, and drinking vinegar will kill sperm. Perhaps most troubling is that adolescents believe that only penis in vagina intercourse is intercourse, and that anal and oral sexual activity does not constitute sex, loss of virginity or pose a risk for STDs. “Friends ask one another for advice and it is often the wrong advice.” The
RARE report also stated that people get their information from one another and it is not accurate (RARE, 2002).

People think it will not happen to them; they are not knowledgeable about diseases and misinformation about diseases abounds. Many believe that one shot will treat all sexually transmitted diseases, or in the case of HIV that they do not need to take medication continuously or continue to be tested and undergo follow-up. Women with HIV are not aware that they can continue to receive care after the birth of a child and that they need to continue to medication. A fifty-year old man married to an HIV positive woman was tested and found negative. He believed he was told that he did not have to come back for further testing unless he felt ill. His wife knows this is incorrect but he is doing what “the doctor told him” and not going in for further follow-up. According to informants, “The system is not educating people.” The RARE report presented findings that indicating HIV risk and prevention were not understood by the community members they interviewed (RARE, 2002). They also reported that there was distrust of the Health Department and other “Official” reports because some people believe HIV is caused by a government experiment, or an effort to eradicate the African American community (RARE, 2002).

There is a misconception about who the diseases affect, particularly with HIV. The community’s perception is that if you get AIDS you will die and there is no treatment. People think you are fast to fail and if you are diagnosed you will die within a very finite amount of time. They are unaware of the resources available for treatment, the importance of treatment and the “how to do’s” of ongoing care. There is much denial of the disease, especially HIV. HIV is still perceived as a disease affecting gay white men in
spite of the reality that the highest incidence of disease is in Black heterosexual men. Additional misperceptions of who is at risk included the belief that if you are married or only have one partner you are not at risk (RARE, 2002). Many health care workers who deal primarily with HIV populations supported these findings. According to the RARE report, HIV risk and prevention are not well understood by the community. The information is often a mixture of facts, misinformation and myths; such as HIV/AIDS will never hit them, people over 50 are not at risk and it is a gay disease (RARE, 2002).

There is a lack of knowledge of the signs and symptoms of the sexually transmitted diseases and how and by whom they are transmitted. Many of the diseases have few or no symptoms making them low priority in terms of obtaining health care. According to informants, men come in for symptoms; usually gonorrhea, and girls only come in after being alerted through word of mouth from the grapevine that they might have been exposed. The state statistics show that women are being diagnosed at almost twice the rate of men, though it is doubtful that they are infected twice as much. Lack of symptoms, or as an informant said “I don’t see anything wrong,” results in denial that there is anything wrong and prevents most people from accessing care. Thus care is delayed until an urgent or a crisis situation develops. There is little motivation to seek care unless something is painful. People think that if you do not have symptoms you do not need to be treated. Most of the STDs do not have symptoms. Denial mechanisms such as the belief that they are going to die anyway were methods of not dealing with the diagnosis and seeking care (RARE, 2002). Additionally, RARE reported people think if the person they are having sex with looks clean they are not at risk (RARE, 2002).
Race

Race is an issue in Jacksonville. This was discussed at length in the preceding chapter. According to the Jacksonville Community Council, Inc., perceptions about life experiences, feelings of mistreatment and discrimination vary by race. In the area of health, Duval County parallels state and national trends with higher death rates for infants, higher incidence of heart disease and rates of death from stroke, diabetes and AIDS in the non-white community (JCCI, 2002). Blacks are diagnosed with STDs at almost four times the rate of Whites (FDOH, 2002).

Race was not identified as an issue in accessing health care according to some and was seen as an issue by others. Some informants felt that it was important to have people of many races/ethnic groups disseminating information about health throughout the community. Some said that there is a heightened level of trust in information provided from sources of the same ethnic background. Many also felt that peer educators were the most effective source. One informant said that white middle-aged women are not the most accepted source of accurate information for all groups; “the messenger and the medium are important.” Another informant said it was easier to offer testing and information about services to “ones own kind” and that a Black person would not be as effective at communicating to a Hispanic group as a Hispanic might be.

It remains unclear why Blacks are diagnosed with STDs more than Whites. One suggestion was that Blacks access public services more often than Whites, accounting for much of the skew in reporting. Another hypothesis was that Whites seek and receive treatment for STDs from the private sector without diagnostic testing that would generate the statistical report to the state. A related concern was that there were many resources for the urban core in Jacksonville, representing mostly Black poor youth and there was a
dearth of services for the White middle-class who may have the same rate of exposure as their counterparts in the “core district”. Most informants felt there is a potentially large pool of individuals that are not identified, tested or treated. Estimates given by informants of the number of people thought to be undiagnosed and therefore untreated ranged from 20-80% of the population. Many informants thought that the White middle class may represent a largely untested and undiagnosed pool of sexually transmitted diseases for many of the reasons already cited; they do not look like they have a disease, they only have sex with one person, or they are married.

**Sexuality Education/Abstinence**

The Duval County school system sexuality curriculum is very limited and is steeped in historical challenges. The state of sexuality education today is the result of a long contentious court battle stemming back to the early nineties when Planned Parenthood took on the school board and the inadequate sexuality curriculum that was based on abstinence with religious overtones. The curriculum was fear based, inaccurate and racist with fabricated condom failure rates and little information about how reproduction actually occurred (Knight, 2003). An informant said that the Baptist church controlled policy in many arenas related to health care and it was apparently the city’s conservative religious community that blocked this case from being heard. Buses of angry church members came to the hearings and the case was dropped when the judge refused to hear it after it became apparent that a compromise curriculum that would still prominently featured abstinence was at hand (Knight, 2003). The new curriculum was adopted bringing us to the present, a curriculum that is still abstinence-only till marriage focused. In addition, there has been a proliferation of outside programs such as Project SOS. Project SOS is an abstinence-only till marriage program that was developed in
1993. The program was born out of a desire to give adolescents alternative information. The program begins in grades 8 and 9, is presented through the school systems and is currently used in five counties in the Northeast Florida area.

The Duval County school sex education curriculum is limited in its ability to provide information about protection from STDs as it is based on the concept of abstinence until marriage. While the content includes information about STDs the students complain there is not enough information on the consequences, the lack of symptoms, when, where and how to be tested and how to protect themselves against STDs. A 1983 report, concerned with teenage pregnancy rates in Duval County, documented that the school curriculum was ineffective. The report documented that the curriculum was not being offered at all, not being taught well and that some components were being left out (JCCI, 1982). It appears to be no different today. In the current program adolescents complain that they do not learn negotiation skills; how to negotiate for safe sex or no sex. They are not taught how to refuse and mean it. Paradoxically, if you are a teen parent there is a comprehensive sexuality program available to you in the schools. The adolescents interviewed appreciated the irony involved in having to demonstrate you were sexually active by having a child in order to take the sexuality course.

Perhaps most alarming was the disclosure by adolescent informants that sexual intercourse occurs in the schools, during school hours and yet they cannot get condoms, counseling on birth control or referrals to health care centers on most campuses due to the limitations imposed by the school board policy.

“In the bathroom, they be on the stairways, no they like the bathroom, no the open stairways, they be in the bathrooms in the back, or the stairways, the toilet, you
have to cut to get into the toilets . . . I mean you go in there, no security guards, there is nobody in there that you know goes in the bathroom to tell you get out of there . . . you can walk in there anytime you want and I mean they do it all the time, there is nobody in school checks, bathrooms, even though that’s where they be, nobody checks the bathrooms, locker rooms, everybody is the gym, oh yes. (Transcribed Interview, Focus Group, 9-5-2002)

These informants also described sexual activity occurring in the women’s locker room on one campus where there was no female coach at the time. The young people reported opportunity for uninterrupted sexual encounters, as no male coaches would enter the women’s dressing room.

When I went to a local high school to review the current curriculum I was presented with the Project SOS curriculum at the reception desk. Access to the county sexuality curriculum was garnered after signing in, being escorted to the library by a student, asking a librarian for the course content and finding it located behind the circulation desk in the librarians’ workroom. The curriculum available for review in May of 2002 was the 1997 version. It required perseverance to access the curriculum. In addition to finding the sexuality education content stored behind the librarians’ desk, also stored behind the desk were numerous DOH pamphlets on STDs, birth control, pregnancy and similar topics. These were available for the asking but again required anyone wanting the information to know it was there and have the confidence to ask a grown-up for the information. Additionally, the librarians asked me where and how to get additional copies of these pamphlets; apparently being unaware of how to contact the Department of Health to request more.

Employees of the school board cannot refer students for care to resources in the community unless the school board approves them. Any facility providing abortion services cannot be a referred source. Department of Health employees working at the
schools, such as public health nurses, were not limited by school board policy; they have to comply with Department of Health policies and could refer to resources not approved by the school board. There are only two nurses employed by the school board to provide services to the 16 High Schools. It is apparent by the ratio of nurses to students that they are very limited in the scope of what health information and screening they can provide. Informants said that what is and is not presented in the schools is controlled by the administration at each school; the administration can make access to information as difficult or easy as they want. Informants said that instructors are uncomfortable with the curriculum and there is misinformation. Planned Parenthood is invited into some schools to talk and the limits on the topics covered are set by the administration. Project SOS, the abstinence only promotion program is invited into some schools but not all. Some schools invite both. Planned Parenthood is not offered to students as a resource because of their provision of abortion services, though at one point they had a walk-in clinic across the street from a high school in a high-risk area. Planned Parenthood reported that the clinic was well attended however after the funding cuts for care to adolescents they closed that clinic. The Department of Health STD mobile van cannot come to schools. In the words of an informant, “the school board is conservative.”

Kids are getting information from the Internet. Even in “poor” neighborhoods they have access to the Internet. On-line searches for information about sexually transmitted diseases can lead to pornographic sites as opposed to informational sites. Adolescents also report getting information from the library or a trusted adult. Adolescents and many leaders of agencies providing services to adolescents agreed that sex education and sexuality information belongs in the schools. As noted earlier, adolescents participating
in a focus group revealed that sex was occurring on campus, in bathrooms, locker rooms and stairwells. Since this is the case they felt it was only appropriate that information about protection, negotiation, more graphic depictions of the consequences of diseases, and help deciding who to trust as an source for information should be offered. They wanted role-playing to be included in the curriculum in order to help them to develop skills in refusal and negotiation in difficult situations. Adolescents also stated that they felt that if they had become sexually active they had failed to live up to the community standard and that they were failures for having done so. This contributed to feelings of low self worth. They talked about the hazing that occurs among them associated with sexual behavior; and that the topic of STDs was not just part of their culture or conversation.

Most adolescents interviewed agreed that parents need to educate their children but conceded that many cannot or do not; so trusted alternatives need to be cultivated. The group of adolescents participating in the focus group were involved in an after school program aimed at offering kids at risk for dropping out of school an opportunity for a better future. A Planned Parenthood staff member also reported that when groups of adolescents were asked if they would talk to their parents about sex and sexuality none would raise their hands. The 1982 report on teen pregnancy cited the failure of parents to talk with children about sexuality as a major issue (JCCI, 1982). All informants agreed that the abstinence only curriculum is not enough, and that programs on sexuality need to be offered to students and their parents in schools, churches and through after school programs. It was suggested that these programs begin in third grade and include the
parents in teaching refusal skills, coping skills and information about access to birth control.

Recent editorials, letters to the editor and opinion pieces in the Florida Times-Union indicate that the content of sexuality curriculum is still very controversial. Some in the community are supporting the abstinence only curriculum and others calling for an abstinence plus curriculum with information about birth control provided. Any editorials or articles appearing in the paper about the sexuality curriculum always produced a reply from the SOS program staff supporting the abstinence only content. It was interesting to note that the editorials supporting abstinence only education usually appeared in the same issue in which an article about the need for concern about the rise of STDs in teens, oral sex and teens or teen pregnancy was published in another section of the paper.

**Sex in the Media**

There are mixed messages in society. Sex was said to be part of the current culture. In the words of informants “sex is everywhere,” “it’s different than it used to be.” Kids learn by example, from what they see at home, in the media, on TV and in the music. Parents set the example. Many informants said that promiscuity was everywhere in the media with few sources about STDs, pregnancy protection and the consequences of sexual intercourse. One opinion shared was that the family influences children. This informant was concerned that many children come from families with siblings from the same mother but each having a different father or from homes where mothers have intercourse without the benefit of marriage.

Children participate in “hunching,” a behavior where they rub on one another with clothing on and this was reported to begin at very young ages. It was said that you could see children as young as seven or eight hunching. The adolescents said, “it is not all about
Bill Clinton” though he is held out as an example of why they think oral sex is not sex. Another informant said, “although Bill was a good guy he was a little misdirected and set a bad example for the youth.” The 1982 Report on Teen Pregnancy listed inappropriate societal messages about sexual activity as contributing to teenage pregnancies (JCCI, 1982).

**Substance Abuse and Sex Trade**

Several informants identified drugs and the sex trade as part of the problem. This research did not include people who were known drug abusers or sex trade workers, however several other reports did provide some insight into issues these subgroups have with access to STD health care. The sex trade includes street prostitution, bachelor parties and escort services, and involves women, men and transsexuals. This information is discussed in the following section.

Substance abusers do not always view themselves as being at risk for STDs. According to the RARE report (2002), drugs are the major cause of unprotected sex. Informants report that everyone is smoking “the rock,” and that they do not know any better when they are on that stuff. The RARE report also found that risky behavior is considered a normal way of life; prostitution and drug use are accepted by many of the community members as a way to make a living. There was no desire or motivation for substance abusers to change their behavior since they did not perceive themselves to be at risk, or because it was not as great a priority to them as basic needs (RARE, 2002). The RARE report further documented that

“drugs, lack of knowledge of HIV, low self-esteem- they don’t care about their bodies” and “a lot of homes, this is all they see. The mother is using drugs, the father is using drugs, alcohol- stuff like that, prostitution, mother’s having sex in front of the kids, the kid’s think it’s all right for her - it’s okay for me and so this is
what they do. Unless they have someone to come along and take them under their wing, this is what they do” (RARE, 2002, p.22).

Despite community belief that prostitutes pose a threat to public health it is documented that convicted prostitutes have a low rate of infection with STDs including HIV/AIDS (JCCI, 2000). At a clinic in suburban Jacksonville alcohol was implicated as the precipitating event to unplanned and/or unprotected sex. The RARE report also states that people from all walks of life and from all areas of Northeast Florida come to two particular areas of Jacksonville known for their drug and sex trade and then carry the diseases back to their homes and neighborhoods (RARE, 2002).

**Community Resistance**

For over twenty years information has been available to people in policy planning positions to change many of the factors identified as contributing to behaviors leading to teenage pregnancy. Many of these behaviors are the same ones responsible for the transmission of STDs. According to my informants, the people in charge are not using the information they have. The recommendations for change in the curriculum that were made in 1982 in response to the high teen pregnancy rate in the County have not been incorporated. People said that the community is very conservative and dominated by the wishes and values of the First Baptist Church, which is the dominant faith in the downtown area. Interestingly in the spring of 2003, as an example that no group is pristine, the newspaper reported that a former deacon of the same Baptist church was charged with engaging in pornographic activity and suggestive emails with young men. He was found guilty, sentenced to a prison term, and in the future has to register as a sex offender.
Another example of community resistance is found in the editorial pages of the newspaper. A recent editorial quoted a study that noted that eight-five percent of parents favor a curriculum that teaches both abstinence and protection, however the editors support abstinence only education. In another piece, the editors suggested that children are learning how to have sex as a result of schools teaching sexuality education, which; ironically they do not in Jacksonville. They also stated that children should be told the truth, condoms merely reduce the risks, however, this information is not provided in the current curriculum.

As described in the previous section about the sexuality curriculum the conservative religious community remains a proponent of the current value laden curriculum that is used. The adolescents interviewed indicated that anything that they did other than the community standard of abstinence till marriage leads them to believe they are failures with no where to turn for help and advice since they had already failed in living up to the community standard. Although there are many reasons that adolescents have babies, informants in this study thought that the desire for unconditional love is the reason adolescents have babies; having a baby is a way to get unconditional love.

Self-worth

The issue of self worth or the lack of self worth was brought up by informants while discussing the issues surrounding access to STD care, who is acquiring them and why. Usually Black adolescents were described as having poor self worth, though references to this are also found in the Ryan White Needs Assessment about HIV/AIDS patients (Davis, 2000). According to the JCCI report on Young Black Men, part of the poor self concept of young Black people was tied to the desegregation of Jacksonville, specifically as it changed the influence of the church, schools and the neighborhood
The JCCI Race Relations report also indicated that desegregation created a loss of Black teachers and administrators in predominately Black neighborhood schools leading to a dearth of positive role models for Black youth (JCCI, 2002). “Poor self concept” was identified in the 1982 Teen Pregnancy Report as contributing to sexually active teens. The JCCI cited a failure to establish and sustain friendships as part of the problem associated with sexual activity (JCCI, 1982). The RARE report documented many problems associated with those at risk for HIV/AIDS, and these included denial, stigma, abandonment, despair, discrimination, poverty, marginalization, drugs, lack of knowledge and low self esteem (RARE, 2002).

Teens, particularly those in the cycle of poverty, marginal employment and poor education have difficulty thinking of the future and utilizing delayed gratification to defer sexual behavior for long term goals. Some children born in poverty view having a child as a way out of an unhappy home and an opportunity to become eligible for financial support.

Confidentiality and Stigma

The beliefs of individuals and the community about STDs are part of the issues surrounding access. This section will include information learned about stigma and how it is tied to fear, guilt, embarrassment, and suspicion to prevent people from accessing care. The findings expressed about the need for confidentiality will be presented.

Stigma

Many informants stated that the stigma associated with STDs and HIV/AIDS was a barrier to seeking care. There is stigma associated with going to a clinic that is dedicated to STD care even though in Duval County it is called “The Center for Prevention Services.” According to informants “if you are there you must have an STD and
everyone who sees you there knows.” They also indicated that if you are at the Boulevard Comprehensive Care Clinic (BCC) you must have HIV/AIDS. There is no sign on the outside of the building or on the directory indicating that this building houses the Boulevard Comprehensive Care Clinic or that the center treats HIV/AIDS, however, community members refer to it as the AIDS building.

There is stigma associated with going to the Department of Health. It was perceived as being for low-income people and therefore not a viable option for those who are not poor. Some people said that you get inferior care at the Department of Health, or that it is just “for poor people.” Informants all talked about the stigma associated with the diagnosis of STDs. They feel that the community views anyone with STDs as “dirty or nasty, or shameful.” There is also a huge stigma associated with the diagnosis of HIV/AIDS.

The RARE report included findings about stigma and HIV, noting stigma prevents people from getting testing and accessing services (RARE, 2002). The RARE report also included findings from community members expressing fear of accessing services because they were afraid someone would see them at a clinic and they would subsequently be rejected by family and friends (RARE, 2002). The Ryan White Needs Assessment documented peoples’ concerns regarding stigma also. They detailed patient perception of the diseases, the fear that people will find out, fear of discrimination at work or home and the prejudice against people living with AIDS (Davis, 2000).

Tied to the issue of stigma are those of embarrassment and shame. People think that STDs are dirty and shameful. This is related to the taboos in the local community about talking about sex and sexuality. Embarrassment associated with the nature of the diseases
and shame surrounding sexual behavior that leads transmission of diseases causes people to delay in seeking treatment, fostering the spread of disease and more costly care.

Community attitudes about sexuality have resulted in a climate of fear. People are afraid of the diagnosis, and afraid of knowing that they have a disease. They are afraid of a rapid decline in their health and well-being once diagnosed. They do not know they have the disease, and they do not want to know about the outcome. They are afraid of negative reactions from friends, neighbors and family if they have an STD. They are afraid to protect themselves. Adolescents are afraid their parents will find out. In the words of informants if you are having sexual intercourse, “you are nasty,” “you are wrong,” “you shouldn’t have done that.” People do not report partners because they are afraid of what their partners will say or think. They are fearful of telling family and fearful of being seen at the clinic. As an example, one informant gave an approximation of the numbers of people living with the knowledge they have HIV/AIDS. They said that one third know their status and are in care, one third know their status and are not in care and one third are unaware of their status.

Guilt is related to stigma and fear. People have guilt about being diagnosed with an STD leading to speculation or confirmation that they have had a relationship outside the marital or primary relationship. They feel guilty for having betrayed a loved one. Guilt is used as a tool for leveraging or manipulating a relationship. The thinking is that, “it wasn’t me, it must be you” that strayed in the relationship.

People are distrustful of the Department of Health. There were differing opinions about why this is so. Some thought it was related to the residual suspicion resulting from the Tuskegee syphilis trial. Others felt that there was a level of bias on the part of the
providers when caring for people not of the same racial background, and that people of color may feel that the providers are judging them. Some informants thought that people wanted to be treated by providers of the same race; others said it was not an issue as long as they were treated respectfully. Many people however, emphasized a need for culturally appropriate treatment.

Through word of mouth community members can rapidly transmit a perceived or actual transgression regarding a clinic, advising people that they should not go to a particular center for care. One or two unfortunate incidents can change the perception of the clinic to a negative view that can take years to overcome. The community is suspicious and prior situations where bad things were associated with government programs including long waits and getting the “run around” still contribute to the distrust of the Department of Health.

Confidentiality

Confidentiality was an issue for people. They want to go where they can be seen anonymously. Many people do not get care because it is not private enough. Fear of disclosure is a barrier for people of all ages seeking care. Some people do not want to be seen in the same neighborhood where they live or work. Another issue is that sexual matters are not always handled sensitively, or they do not want to talk about sexual matters with strangers. People think it is on their permanent record and do not want information about diagnosis and treatment for an STD to be reported to their insurance carrier. They do not want to be seen at a clinic that treats people for STDs because of the stigma associated with the diagnosis. People are afraid that a visit to the clinic will trigger phone calls to their home or business.
It is an especially important issue for adolescents who fear disclosure to parents. Adolescents need secrecy. According to health care providers and adolescent informants, teens especially need a trusting environment, which has to develop over time. Continuity of care is important, especially with the adolescent population. They are often unaware they can be seen confidentially and without parental permission. One informant, however, felt that confidential care was not an issue as many people with a positive test willingly offered names of known contacts; others stated partners names are not given for fear of retribution or revenge.

Hospitals do not routinely test people for HIV even if they have been treated for a suspected STD in the emergency room. They do not test for HIV in most cases because they send out bills for services and the invoice sent to the reported address could fall into the hands of someone other than the patient and be a violation of confidentiality policy.

People go to alternative providers such as prescribing pharmacists, alternative care centers, herbalists and homoeopathic medicine providers. They go to urgent care centers, also referred to as “doc in the boxes.” Informants thought that people went to these alternative centers as they were more anonymous, more convenient, required less documentation, cost less, did not file insurance, and were compatible with their belief systems regarding medical care.

**Ineffective Community Wide Coordination of Services**

Many informants felt there was no coordination of services and that many agencies are dealing with one specific catchment area. Many of these agencies overlap services with other agencies. There is no shared database making many of the processes for applying for various services redundant and time consuming. People felt that agencies were competing for goods and services and funding. The Ryan White Directory of
agencies is a strong indicator of the plethora of agencies offering services. This directory lists 179 agencies providing services or support to people with HIV in Northeast Florida. One informant said that the older Northeast Florida AIDS Alliance that was organized by physicians was a more effective and efficient case management agency, however this was dissolved and restructured under Federal mandates creating the multiplicity of agencies.

**Ineffective Parent-child Communication**

Parents either do not or cannot talk to their children about sexuality, STDs and contraception. Teens said that if you ask a parent something hypothetically they get upset and yell at you because they think it is about you. Some parents became parents at a young age (often as adolescents) and do not want to address issues of sexuality. Informants said that sexuality education programs should include parents however most agreed that in reality this would not work in most of the cases.

**Summary**

The barriers to getting care can be summarized as follows. People find out about STD services via word of mouth. There is little marketing of services, publicity of locations, hours and limitations (women only). People do not agree on what sex is, adolescents in particular think that anal and oral sexual activity is not intercourse and does not contribute to STDs. People do not know their options for receiving care; men do not have enough places to access health care. Adolescents do not know they can be seen confidentially and without parental permission or knowledge. People seen in the emergency room think everything has been taken care of, but the reality is they have not received comprehensive STD care. Most people do not know enough about the diseases, the consequences of diseases, the signs and symptoms of the diseases or when, where, and how to be screened. They do not want to know if they have a disease, especially
HIV/AIDS and they do not want anyone else to know they have a disease. Since they have other priorities, they wait until things are a crisis before seeking care. People said, “the problem is knowledge, knowledge of diseases, knowledge of what they need to know,” and how to manage and negotiate the system.

In conclusion, problems of access to STD services are all about what people need to know and how they find out. How the community learns and what it knows about STDs is the key to perpetuation of misinformation and continued transmission. Potential exists for the beginning of a system based on honesty, direct answers, knowledge and correct and complete information instead of one that is value based or judgmental partial truths.
CHAPTER 6
DISCUSSION

This chapter presents a discussion of the findings of this research study. In addition to the original findings, studies, articles and reports that offer explanations and support of the results, validation and additional context for consideration are included. The overarching finding of what people know about access to services and how they find out will be detailed. Following the discussion about what people know, information will be presented regarding the specific needs identified for two sub-groups that emerged from the data, adolescents and men. This will be followed by a discussion of socio-cultural and economic issues that include race and ethnicity. Aspects of the stigma surrounding STDs and how this affects people accessing care will be presented. Finally, recommendations for change in the delivery of STD care and implications for further research will be made based on the findings and the discussion.

Brief Review

This study set out to determine the problems community members have with access to STD services in Duval County. It was concerned with the successes and failings of the current system. Ethnography was used to find out these concerns. Interviews, field notes, transcriptions, focus groups and archival data were used to identify what people wanted and what they identified as barriers to accessing STD health care. The findings were grouped into related categories; these included logistics, community values, and emotions and beliefs. The data was reviewed multiple times, coded and grouped according to themes. The findings and interpretations were validated with a key informant.
A literature review identified what was known about people who attend STD clinics. Multiple authors have gathered demographic information and studied behaviors of attendees of STD clinics. This study was designed specifically to try to ascertain what people thought the problems with the current system were and what could be done to improve their ability to receive health care. Employees of the Department of Health reported that although much data exists evaluating services delivered at the Department of Health clinics, little information is available about what people want, particularly those who may not be going to public health departments but may need low cost health care.

Kleinman’s explanatory model was used as framework for examining an individual’s concept of health, care and cure as well as providing understanding of the rationale of cultural groups for using folk, lay and professional sectors in creating plans of care. Different race/ethnic groups may have different perceptions of health and health care, and this might influence access to services. According to Kleinman (1995), health planners need to conceive of ways to strengthen the adaptive health care functions of the popular sector by rationalizing and increasing its decision-making and therapeutic roles. This study sought to elicit information from the community in order to make recommendations to health planners regarding the needs of the community of concern, people needing care for STDs. Ethnomedical models show that change in health care is a function of the interaction between the macro-system and the micro-system (Kleinman, 1995), and this study is an attempt to communicate the needs of the community to the policy makers.

Critical medical anthropology (CMA) was utilized to put into context the political-economic forces that drive the provision of health in the public sector. The provision of
public health is dependent on financial support from local, state and federal government sources, therefore the political-economic climate has impact on services and the numbers of citizens who might need to access subsidized health care. Funding in the state of Florida for STD services has remained constant for the last twenty-five years, despite substantial increases in the population and the incidence of disease (K. Schmitt, personal communication, July 30, 2003). One of the goals of this study was to find out why the numbers of people seeking STD care were declining at the Department of Health and where they might be going, or if they were not going at all. Likewise, the knowledge that public health programs are based on seeking and treating as opposed to prevention and promotion contributes to the financial forces at work in the provision of health care. The findings indicate the problems with access to care are not new, but long standing.

The key concept found in the data was that access to care is based on what people know. The limitation of this knowledge is that most people find out about services by word of mouth. Knowledge is defined in Webster’s Encyclopedic Unabridged Dictionary as an acquaintance with the facts, truths, principles or awareness. According to Meleis, knowledge can be acquired through hearsay, general impressions, deduction and intuition (Meleis, 1997). People need to be aware of the facts about STDs. Unfortunately; STD information in Duval County is largely acquired through hearsay as opposed to learning through knowledgeable sources. Because they learn how to access STD services primarily by word of mouth, people are in part, players, in a power relationship.

Power and resources are maintained by control of knowledge (Goodman & Leatherman, 2001). According to Goodman and Leatherman (2001), logical and appropriate behaviors may differ by class, gender and ethnicity as was noted in this study.
What works for one group may not work for all groups. The poor are disenfranchised. They are dependent on the Department of Health subsidized STD services. Those needing STD care in Duval County are disenfranchised also. The resources are available but the ability to find out about them very limited. Individuals try to balance their imperfect knowledge through the use of personal experience, local cultural knowledge and available resources to meet specific goals (Goodman & Leatherman, 2001). It became apparent that personal experience and local knowledge were the guides to access STD resources in Duval County. Goodman and Leatherman (2001) say that the social contexts influence fact gathering and the generation of knowledge. This study found that the members of the community of concern were able to find out about STD services though that knowledge was acquired through personal experiences. There is an invisible group that may need services but do not have access to this knowledge and do not know how to proceed. Those needing to access STD services have to embark on their own private mission of trying to access the system.

Walker and Avant (1995) say that to know is to be cognizant, conscious or aware to perceive or comprehend with clearness a certainty a personal internal experience of cognition that may or may not include understanding. Understanding involves knowing not just facts, but having insight into the meaning, significance and implications of those facts. People who know about the STD services had access. The people interviewed in the clinics all had found out about the clinics via word of mouth from friends and family. Finding out what they needed to know was difficult. Access to care or problems associated with access were primarily related to what people knew either intuitively, through experience or having learned it somewhere. There were other issues involved in
access, but the overarching problem that was knowledge of the clinics, the where, when, and how that was limiting people getting to clinics.

**Strengths and Weaknesses**

This study has several strengths. It is one of only a few studies using a qualitative method to find out what problems are associated with accessing STD care. A qualitative method is an excellent tool for delineating a problem and directing areas of future quantitative study (Munhall & Boyd, 1999). The members of the community of concern provided the data. The findings are those described by the participants, coded by the researcher and verified by key informants. The triangulation of archival data and reports such as the Jacksonville Community Council reports, Guttmacher Institute papers and other research in the area of STDs lends strength and supports many of the findings. All the informants had something to say. There was no difficulty accessing the community of concern. This data is useful for those developing health policy and planning for future delivery systems.

The weaknesses of this report included the limitations of time and money restricting the ability to talk to all potential informants as well as the problems associated with accessing a seemingly invisible population, those not accessing care. The answer to the question of where people are going for STD care is not found specifically in this study, some of that is learned from health department statistics documenting those providers reporting positive tests. More important is the knowledge that was gained about why people are not going to the Department of Health STD clinics and how that information could be used for future planning. Statistical reporting from the state provided information about where positive tests are obtained which led to the questions about how patients are treated at those sites. Some potential informants would not return
telephone calls. The military community was not accessed though they are one of the top five agencies reporting positive STD test results to the state. Even though they are a source of a large number of positive reports, since they are a separate entity with their own system of health care it was felt this group was not part of the community of concern. There may have been selective recall by participants and bias on their part depending on their situation at the time of the events in question as well as biases inherent in their unique perspective of the community and parties involved.

The biases I brought to the study are those that come from being a Women’s Health Nurse Practitioner for the past twenty-two years. The opinions that I have developed over that time about what people should know in order to care for themselves, particularly in regard to sexuality are also my biases. I also bring biases from being a parent to a 14-year-old daughter, stepmother to two grown daughters and having preconceived notions of what these women need to know to protect themselves. Finally I bring the bias of my own sexual experiences throughout four decades of life as a female in the United States at the turn of a new century.

**Discussion of the Findings**

This study has several important findings that have implications for people needing access to STD services in Duval County Florida. These findings may have application in other geographic areas. The biggest problem people had was finding out what they needed to know to access services: the locations of clinics, hours of operation and community transportation. Most of what is known about where to go, how to get there and what you need in order to be seen is learned by word of mouth. The signs and symptoms, prevalence and the risk factors associated with methods of contracting the diseases were unknown to most, especially adolescents. Another aspect of the problems
associated with access was the differing needs of various groups of people. Specifically, the issues are for men and adolescents are different from those of women. There are also differences in accessing care related to socio-economic status that can be tied to race/ethnicity and the culture of the community in which people live. Finally, there are emotional issues surrounding STDs that are summarized in a discussion about stigma. Each of these items will be discussed at length in the remainder of the chapter.

**Word of Mouth**

A consistent finding throughout this study was that most of what people know about how and where to access STD services in Duval County is learned by word of mouth. To learn about the clinics, locations and services by word of mouth is inefficient and not always accurate. In Jacksonville the population has grown from approximately 678,900 to 778,800 in the last ten years. If you are new to the area, relying on a friend or associate to give you STD health care advice may not be the most acceptable route to obtaining care. Further, this group of 100,000 people relatively new to the area need a resource to identify health care centers. They may not be connected to a member of the community who “knows” where to go and how to access care, especially STD care. As informants said “you don’t just go to work and ask your colleagues questions about STDs.”

All of the informants interviewed within the context of the clinics stated that they found out about the clinic by word of mouth. Other informants interviewed outside the clinics validated that word of mouth is how people find out about the clinics and services, “everybody just knows.” It is the consensus of the informants and this author that this is not an adequate system. Clinics need to publicize locations, services, and hours of operation. There is a need to develop a comprehensive referral resource and this needs to
be distributed to churches, schools and on TV in addition to word of mouth. Since there are high rates of diseases that are being detected and a decline in the number of people seeking care at the Department of Health centers that provide low cost care according to the current Centers for Disease Control and Prevention Services (CDC) guidelines, there is cause for concern that people may not be receiving adequate treatment elsewhere (Schmitt, 1999). In May of 2003 a notification from the Florida Department of Health was delivered to all health care providers notifying them of an increase in infectious syphilis cases in the first month of this year that is seventy-one percent higher than the rate the previous January. This is a disturbing trend, indicating that needs are not being met. Clearly, more needs to be done to spread the word about STD health care.

In his book *The Tipping Point*, Malcolm Gladwell discusses how trends occur from an epidemiological perspective. He presents the mystery of “word of mouth, a phenomenon that everyone agrees is important but no one seems to know how to define” (Gladwell, 2002). He argues that we are about to enter the age of word of mouth despite living in this world with 24-hour cable news, e-mail, cell phones and almost limitless opportunities for instant communication. Word of mouth, in spite of all of the advanced communication technology is going to be what we rely on more and more for dealing with the complexity of the modern world because we want to rely on information from sources we know (Gladwell, 2002). While this may be correct when considering fashion trends or places to eat, sexually transmitted disease services are not given the same societal sanctions for general conversation.

Gladwell details three components necessary for reaching the tipping point in disseminating information and creating trends. They are the Law of the Few, “stickiness”
and the context in which it occurs. The Law of the Few says that there are exceptional people out there who are capable of starting epidemics. “Stickiness” refers to ideas having to be memorable and moving us to action (Gladwell, 2002). Context refers to the conditions and circumstances of the times and places in which they occur. If we accept the new paradigm espoused by Malcolm Gladwell, word of mouth is the strongest method of getting word out to people. Goodman and Leatherman (2001) alluded to these concepts when they talked about utilizing cultural knowledge and available resources to meet specific goals. While acknowledging the potential of word of mouth, I contend that it is not a sufficient system; especially as the primary resource for disseminating information about sexually transmitted diseases. Word of mouth has, however, been the only system in place in Jacksonville for many years. While much information about the Department of Health exists, you had to be “in” the system in order to learn about the services. All informants said that people learn by word of mouth. People cannot access information about sexually transmitted diseases in the same manner that they learn about a new restaurant or clothing trend because of the social taboos surrounding discussions about sexuality.

In the process of talking to people it became apparent that two groups emerged as having different needs for access to health care services; they were adolescents and men. The next sections will review the findings from the research and what was learned about these groups. Contemporary research relevant to adolescents and men will be included. This research was reviewed and included after the differing needs of these subgroups became apparent. Additionally there are access problems related to socio-cultural issues that are tied directly to economic status and race/ethnicity. In this discussion, the findings
of this study and other contemporary studies will provide insight and understanding of these concerns.

**Adolescents**

As mentioned earlier, this study found that adolescents had different needs for accessing care. These included the need to know where to find information and services without having to consult a parent. They needed to know how to access services and needed the ability to access services outside of school without enlisting the aid of adults for transportation or financial assistance. They had a strong need for confidentiality and trust as well. They cited the need for more honest, straightforward, non-value laden information about sexuality, including negotiation and refusal skills, self-protection, and knowledge of risk factors for STDs.

According to the CDC report on Sexually Transmitted Disease issued in 2001, national statistics reveal that adolescents 10-19 years old and young adults 20-24 years old are at higher risk for acquiring STDs (Center for Disease Control and Prevention [CDC], 2001). This increased risk may be a result of them having more partners sequentially or concurrently, and because they select partners who are at higher risk. Additionally, young women are at a higher risk for chlamydia due to the physiology of increased cervical ectopy (CDC, 2001). The report also details the higher prevalence rates of chlamydia in adolescents. Further, women 15-19 years of age had the highest rate of gonorrhea in 2001 and women 20-24 years of age, the highest rates of primary and secondary syphilis (CDC, 2001).

Regionally, the south has higher rates of chlamydia, gonorrhea and primary and secondary syphilis(CDC, 2001). The reasons for this are not generally understood though it is believed that it may include differences in the racial and ethnic distribution of the
population, poverty, and the availability and quality of health care services (CDC, 2001). Locally, in 2001, Duval County reported the highest rate of gonorrhea cases in the state, is third in the rate of reported chlamydia cases and most of these cases are in adolescents and young people in their early twenties (Appendix B).

There are pros and cons to having services dedicated to adolescents in order to meet some of their specific needs such as ease of access, confidentiality, consistency and trust. The informants in this study did not agree that separate services dedicated to adolescents were needed. According to informants and confirmed in a study from the Guttmacher Institute, what appears crucial to success is that adolescents know where they can go to obtain information and services, can get there easily, are assured of receiving confidential, non-judgmental care, and that these services and contraceptives are free or cost very little (Darroch, Frost, & Singh, 2001). There are a number of programs that have successfully reduced teen pregnancy and therefore probably decreased the transmission of STDs (Philliber, Kaye, Herrling, & West, 2002). Eleven programs that have been reported to work well with adolescents are presented in an article from 2001 that includes research from Jemmot, Carrera, and the National Campaign to Prevent Teen Pregnancy (Pagliaro & Gipson, 2001). Elements that should be included in programs directed to teens are culturally appropriate information and instructors, comprehensive sexuality education, access and opportunities (Pagliaro & Gipson, 2001). In 2002, Douglas Kirby reported findings indicating that of ten programs that claim proof that their programs reduce sexual activity, nine failed to provide credible evidence (Kirby, 2002). The standards used were the standards developed by the Effective Programs and Research Task Force of the National Campaign to Prevent Teen Pregnancy.
The Guttmacher Institute Report on Teenage Sexual and Reproductive Behavior in Developed Countries released in 2001 presents a detailed discussion of the issues surrounding teens and their behaviors related to sexuality, reproduction and health care in five industrialized nations. They report the United States has the highest number of teens having sex and abortions among the five nations studied. The Institute details five key areas related to the disparities in adolescent sexual behavior noted between the United States, Sweden, France, Canada and Great Britain. The key points are: a) the high levels of teenage childbearing in the United States are probably related to the fact that there is less effective contraceptive use among teens, b) a higher number of teens are living at a disadvantage in the US when compared to other countries predicating higher levels of early childbearing, c) there is stronger public support and expectations of youth to adopt adult economic roles leading to a delay in childbearing in countries other than the United States, d) there is provision of comprehensive and balanced information about sexuality along with clear expectations about commitment and prevention of pregnancy and STDs in other countries, and finally, e) the easy access to contraception in other developed nations (Darroch et al., 2001). This is in marked contrast to how services are provided to adolescents in the United States and specifically in contrast to what teens in Duval County reported about what they know, what they are taught and how they access STD care. Teens reported getting information in the library and on-line, but that it was very difficult to talk to parents or identify a trusted adult. This is in contrast to Sweden, France, Great Britain and usually Canada, where the sexuality education is mandatory in the schools and the focus is not on abstinence promotion, but the provision of comprehensive information about prevention of HIV and other STDs, and pregnancy
(Darroch et al., 2001). These nations also provide information, in the schools, about respect, responsibility within relationships and where to get contraceptives (Darroch, et al., 2002). The limitations imposed by the school board in Duval County prevent teachers or school nurses from discussing STDs with adolescents outside the context of health education, and what is discussed has to be couched in the framework of abstinence till marriage.

Great consideration needs to be given to the educational programs for the youth in the Duval County area. The adolescents and informants who work directly with adolescents were extremely frustrated by the limitations of the current curriculum. In the mid 1990’s the current curriculum that espouses abstinence till marriage was adopted. In 1993 Project SOS was developed. This program of abstinence till marriage is presented in the schools but is external to the school curriculum. If this program and the current curriculum were effective at reducing adolescents’ decisions to participate in sexual intercourse one would expect to have seen an appreciable drop in the rates of STDs in both the 15-19 and 20-24 year old age groups as measured by a decline in positive tests. In fact, data comparing the County to the State reveals that the rate of STDs for Duval County in these two groups remains consistently higher than the state by a wide margin, casting doubt on the efficacy of the sexuality curriculums (Appendix B). Additionally, data looking at birth rates in 15-19 year olds reveals that in Duval County the rate is approximately 70 per thousand and the state rate is 57.3 per thousand (National Campaign to Prevent Teen Pregnancy, 2003). While teen pregnancy rates have declined by 13% nationally since 1990, the decline in Florida is only 9% (National Campaign to Prevent Teen Pregnancy, 2003). According to the Guttmacher report, and substantiated
by several other studies, comprehensive sexuality education, not abstinence promotion, is most effective in reducing teenage pregnancy levels (Coyle et al., 2000; Darroch et al., 2001; Jemmott, Sweet Jemmott, & Fong, 1998; Pagliaro & Gipson, 2001; Philliber et al., 2002). Adolescents and people who work with adolescents said that information about puberty, sexual development, and gender identity needs to be provided to teens earlier, before middle school; and it needs to be accurate, unbiased, and straightforward and from people they trust.

Duval County teens are not aware of services available to them for sexual and reproductive health care. “They don’t talk about where the clinics are and where to go.” People also thought that there were fewer resources available to middle class adolescents than those in the lower income groups. Findings from the Guttmacher report document that society, history and government have influence on teens’ behavior. Social and economic well-being and equality are thought to lower teenage pregnancy rates and birthrates (Darroch et al., 2001; Santelli, Lowry, & Brenner, 2000). Compared with adolescents in other countries, U.S. teens are more likely to grow up in disadvantaged circumstances, and those who do are more likely to have a child during their teenage years (Darroch et al., 2001). Only in the United States do substantial proportions of adolescents lack health insurance and therefore have poor access to health (Darroch et al., 2001). U. S. teenagers have greater difficulty obtaining contraceptive services than do adolescents in the other study countries (Darroch et al., 2001). This difficulty accessing contraception is seen in the Duval County statistics indicating high rates of STDs in the 15-19 and 20-24 year old age groups and the information gathered from the interviews with teens themselves.
Men

This study found that men are different when it comes to access to health care and STD services; men view the need for health care differently from women. Some informants also said, and other studies verified that, Black men are different than other race/ethnic groups in relation to health and health care (Rich, 2001). In Duval County men in general have fewer portals of access to health care than women and children. This problem is, however, not unique to Jacksonville, but occurs in other areas as well (Rich, 2001). Informants said, “Access to health care for men is the pits.” Data from the Department of Health revealed that women are diagnosed with two-thirds of all the STDs with the exception of gonorrhea. One explanation for this may be since gonorrhea provokes more symptoms in men than women, men present with symptoms and are diagnosed with gonorrhea more often than women. It is unlikely that the diseases occur in women at two or three times the rate of men, so it seems that men are not being diagnosed and treated for many of the STDs.

Findings in this study suggest that men rely on women for birth control. The Guttmacher report (2002) indicates that most adolescent males are sexually active by age 20; males of poor or minority background initiate intercourse earlier than their counterparts; condom use declines over time and men increasingly rely on women for birth control. At minimum all sexually active men need information and education about contraceptive use, STDs and how to avoid them, where to obtain and how to use condoms, and how to talk about these issues with partners (Guttmacher, 2002). Pagliario and Gipson (2001) also noted the need for gender specific education in their survey of effective programs for adolescents.
This study found that obstacles for men seeking care included the male tendency not to seek regular, routine checkups, failure to seek care in the absence of symptoms, and the lack of facilities for men. A literature review found other articles detailing additional findings such as a large number of men being uninsured, insurance not covering services related to prevention for men, and few and poorly trained health professionals specifically for men’s health care (Guttmacher, 2002; Rich, 2001; Serrant-Green, 2001). The Guttmacher Institute issued a report in 2002 detailing the sexual and reproductive health needs of men as individuals and not simply as women’s partners. In this report they suggested that these needs have been ignored (Guttmacher, 2002). This is corroborated in other research (Guttmacher, 2002; Rich, 2001; Serrant-Green, 2001). Between first intercourse and first marriage the typical American man spends around ten years being single but sexually active, pointing to the need for protection against STDs and indicating that there is a large potential for failure of abstinence till marriage in that time frame. Standards of reproductive health care are available for women but no consensus exists for what constitutes good sexual and reproductive health care for men (Guttmacher, 2002). This leads to a vicious circle where the lack of information and inadequate training of professionals contributes to the gaps in obtaining financing for this type of health care (Guttmacher, 2002).

In Duval County the majority of HIV/AIDS cases are found in Black men. Men are also diagnosed with AIDS at twice the rate of women in Duval County (FDOH Data files, 2003). Florida ranks third in the nation with the number of AIDS cases (CDC, 2003). Eight of ten adults living with AIDS in the United States are men and more than one in ten men diagnosed in 1999 were exposed through heterosexual activity (Guttmacher,
Men are a vulnerable group and need more portals of access to care for STDs and HIV/AIDS.

**Socio-cultural/Socio-economic**

This study focuses primarily on the relations between Blacks and Whites in Jacksonville because of both the history and demographics in Duval County. Data from the Department of Health indicate that a preponderance of STDs are located in the “core” of Jacksonville where income is at a low or poverty level and many of the residents are Black. Statistics from the Department of Health reveal that Blacks carry 79% of the positive test results for STDs but census information reveals that they represent only 28% of the population. The demographics of the downtown area reveal that the test scores for children in schools in the core area are lower than the rest of the County and the graduation rate from high school is lower even when household income is factored in (JCCI, 2002). There are also a large percentage of people in the “core” neighborhoods qualifying for free or reduced fee school lunch programs as an indicator of low income. There is a link between early sexual activity and income that is seen in this and other studies (Darroch et al., 2001; Santelli et al., 2000). This link can be related to race/ethnicity in Jacksonville, as well as income since the majority of the people in the “core” districts are Black.

Some informants said that race was an issue in accessing health care and others did not. Informants said that the race of the provider had an effect on those obtaining care. They said that providers of a race different from the patient made judgments those of the same race did not. People who were interviewed who worked for outreach agencies that go into clubs and neighborhoods to test people for HIV said that “like” races were most effective “with their own kind.” Perceptions in Jacksonville differ by race, not only
about race relations but about how life is experienced by members of another race (JCCI, 2002).

The Jacksonville Community Council, Inc. (2002) documents that significant disparities exist in health outcomes between white and nonwhite populations in Jacksonville, mirroring state and national trends. The data the JCCI uses includes information regarding death rates, which are higher for Black infants, stroke, diabetes and AIDS related causes (JCCI, 2002). Nationwide there are consistent patterns of relationships between socioeconomic disadvantage and adolescent sexual and reproductive behavior (Darroch et al., 2001). Poorer and less-educated young women are more likely to have a child during adolescence, and Hispanic and Black teens are more likely to have a teenage birth (Darroch et al., 2001). Many people have said that the effects of race/ethnicity in American society are often difficult to disentangle from those of socioeconomic status. Poverty status is closely related to race/ethnicity with a greater proportion of Black, Hispanic and Native American men being in poor or low-income groups than White men (Guttmacher, 2002). This is the case in Jacksonville; the minority population is mostly Black with four percent or less being Hispanic. Almost 44% of the Black population reported income less than $15,000 in 1990. In 2000 67% of the Black and 55% of the Hispanic population participated in the free or reduced fee lunch program (JCCI, 2002). This suggests that a large number of people in Jacksonville are both minority and poor. This is also the group that is being seen in the STD statistics where most of the positive tests are coming from Blacks.

Jacksonville has a history of racism that remains pervasive today. Informants said that financial disadvantage is associated with problems. The Jacksonville Community
Council report on Race from 2002 also confirms the inequity between Blacks and Whites regarding income, education and life style. The Guttmacher report notes that more minorities are affected by the unequal distribution of wealth and more widespread poverty that is seen in the United States when compared to other countries. They relate this to the history of slavery and persistent racism in the United States (Darroch et al., 2001).

According to the findings, those in marginal jobs often have a lowered priority for health care, delay seeking treatment until crisis situations develop and then present at the emergency room (ER). As one informant said, “it might be a long wait but it is only one wait.” Informants also noted and the Guttmacher report confirmed that disadvantage is associated with lowered personal competence, skills, motivation, limited access to health care and social service, lack of successful role models, and living in dangerous and risky environments (Darroch et al., 2001). Disadvantage has been characterized by factors such as living in poverty, being poorly educated, having poorly educated parents, being raised in a single-parent family or in an economically struggling neighborhood and lacking education and job opportunities (Darroch et al., 2001). In some cases belonging to a racial or ethnic minority group may have links to socioeconomic disadvantage (Darroch et al., 2001). According to this study these conditions are present in Jacksonville, and confirmed in the JCCI report on Race Relations.

Community resistance was reported by informants and exemplified by editorials in the Florida Times Union. On May 29, 2003 an article appeared in the Health section of the paper reporting that school condom distribution does not mean adolescents are more likely to have sex. In the same issue an editorial reported that twenty percent of all
Americans under the age of 15 have been sexually active, and of those, one third of the parents know what their children are doing. The editors indicated they felt that by having this knowledge, parents were letting or possibly encouraging the children to have sex. An editorial in February of 2002 compared telling teens about birth control and abstinence to driving after drinking. The editors’ stance was that if parents say “if you have sex, use a condom” was equivalent to saying “if you are going to drink and drive wear a helmet to protect yourself” as opposed to saying “don’t drink and drive.” In the same editorial they documented lower rates of sexual activity in teenage men in 1990 that subsequently increased to 51% in 1997, which is the time period when the abstinence only Project SOS program came into being in Duval County. One would expect if abstinence only programs were effective the numbers would have been reversed. This resistance is also apparent in a December 2002 editorial. This editorial said that children are learning about sex in the schools, and that “social liberals” are opposed to teaching abstinence because young people are going to engage in sex no matter what. The editors cited a study indicating that 85% of parents favored a combination of abstinence and condom use. However, they ignored their own evidence of parental preferences and stated that this approach, using condoms and abstinence, tells adolescents it’s “OK” to have sex if they use protection, is wrong. The editorial stance seems to be an indication of community resistance to and general confusion about comprehensive sexuality education. This study, however, suggests that changes in the sexuality education curriculum in the schools will continue to be resisted by a vocal minority of the Duval County residents.

Media

Many informants mentioned the role of the media and its influence on sexuality and sexual behavior. According to Guttmacher and other sources, youth in all countries are
exposed to radio, TV, videos and films that often portray sexuality in an exploitative way and that seldom portray or discuss contraception or condom use as part of sexual behavior (Darroch et al., 2001; Gallagher, 2002). Media is used less to promote positive sexual behavior in the United States than other industrialized nations (Darroch et al., 2001). Most other nations do a better job of providing a balance through pragmatic parental and societal attitudes and sexuality education (Darroch et al., 2001). Darroch et al (2001) reported that the United States media focuses on negative aspects of sexuality as a way of “scaring” youth into abstinence or more responsible behavior. An example that emphasizes the importance of the media is found in surveys of sexually experienced men aged 15-19 who report that they get most of their information about contraception from television; and many felt that this was the best way to get information out (Guttmacher, 2002; Temin et al., 2001). The media cannot be overlooked as an important tool in delivering messages about sexual behavior and sexuality. Informants recommended that the media be used as a great source for information. On a positive note, for the last two years one television station Jacksonville has offered a program called “Straight Talk,” directed to teens that are or may become sexually active. The content is repeated on a variety of evenings and times. The program uses local radio, sports and television personalities that young people recognize to moderate the sessions. The show does a fairly good job of presenting information in response to questions from teens in the audience.

This study found that the Baptist Church has a large influence on policy in downtown Jacksonville. According to the Guttmacher report personal or community values and religious beliefs grounded in family or social groupings may play an
influential role (Darroch et al., 2001). Community values can be especially important in defining acceptable patterns of behavior or establishing models of the kinds of relationships between men and women that are considered normal, respectable or worthy of emulation (Guttmacher, 2002). Adolescents in this study indicated that failing to maintain the community standard of abstinence till marriage led to feelings of failure and that they had no one to turn to for advice since they were now considered failures.

**Stigma and Confidentiality**

All the informants mentioned the stigma of STDs as contributing to the problems with access to care. Stigma is defined as a bodily sign designed to expose something unusual or bad about moral status. It is a negative social attribute placed on people because of their disability, illness or when the individual is devalued and shunned because the illness or disability makes her or him different or not normal (Brown, 1998). The social and psychological dimensions of the stigma associated with the disease may be worse than the diagnosis (Brown, 1998). This is the case with STDs. The stigma of STDs is the overarching concept that contributes to most of the other emotions surrounding the group of diseases including guilt, denial, embarrassment, shame, suspicion, and fear. These emotions all contribute to peoples’ reluctance to seek care for STDs or to attend a dedicated STD clinic, as “everyone would know why you were there.”

Kleinman talks about the social course of a disease and the equating of the moral status with the bodily status. He also says that health care activities are interrelated and a socially organized response to disease that constitutes a special cultural system (Kleinman, 1980). The concept of stigma (or social treatment) of a disease is part of the community’s perception of the disease and in some cases, like HIV, its fatal clinical
course. In other cases, such as HSV or herpes virus which is chronic but not fatal, the connotation of the behaviors thought to be involved in its transmission are involved in the perception (Inhorn, 1998). Due to the sexual nature of the STDs the stigma remains a burden for people accessing care.

Confidentiality was an area of concern for people of all ages when asked about attending STD clinics. The predominant finding was that people wanted to be seen anonymously. Two concerns of informants were that if you were seen at the Pearl Street Clinic everyone would know you were there for STD care, and if you were seen going in the Boulevard Comprehensive Care Clinic everyone would know you had HIV. People were concerned that if it became known that they had HIV they would be terminated from their jobs, or fail to secure a job or be shunned in some other manner. The Ryan White Needs Assessment also detailed confidentiality as a need. Informants did not indicate that partner notification was an issue associated with accessing STD care.

Confidentiality was found to be especially important to adolescents. Their concerns were focused on parents finding out that they had sought care for birth control or an STD, or that their friends would learn that they had been to a clinic. Confidentiality is tied to the adolescents heightened need for trust. An informant said that adolescents take more time than adults to develop a trusting relationship, and it can be shattered in a moment if they suspect you are not being truthful with them.

Confidentiality is a confounding variable for people seeking STD care in the emergency rooms. HIV testing is not done in most emergency room situations as a financial statement would be generated and sent to the addressee, breaching the confidential nature of the test if it was received by anyone other than the intended
recipient. Similarly, anonymous HIV testing that was done at the outreach clinics often-generated results that were positive but that were never obtained by the person who was tested. Because of confidentiality, the outreach agencies were very limited in the amount of searching they could undertake to seek out the individuals who did not come in for results.

There are two ethical arguments in favor of preserving confidentiality in regards to STDs. One is utilitarian and concerned with long term consequences and the other non-utilitarian concerned with respecting the rights of persons (Walter, 1991). The argument of medical confidentiality is based on the probably consequences of violation and the violation of the right to privacy (Walter, 1991). This rests on probable consequences of the violation of that right versus the right of privacy, which is tied to autonomy and beneficence. With communicable diseases it is felt that society at large must be protected. However in this study people were only concerned with being treated for an STD without it becoming general knowledge. They did not like being seen at dedicated STD centers for that reason.

**Recommendations**

According to the 2000/2001 Regional Health Care plan for District IV, which includes Duval County, access to health care is key to achieving a healthy community and is a primary goal for health policy in Florida (Health Planning Council of Northeast Florida, 2000/20001). The informants in this study provided many recommendations for improving the delivery of care. The recommendations that were made are presented by topics. These include suggestions about improving the logistics, recommendations for methods that could change the socio-cultural values of the community surrounding
sexuality and STDs and the emotional and belief systems that affect everyone in the community.

The greatest number of recommendations for change fell under the category of logistics. Almost all informants had suggestions. These ideas included the following points:

- Non-traditional service hours
- Identify locations of the health department
- Improved signage indicating the services offered at that site
- Mobile services available to affiliated agencies on a regular reliable schedule
- A central referral source/listing that is publicized where people can find it
- Public service announcements
- List clinics and services in the white and yellow pages of telephone books and provide information in newspapers

Suggestions to reduce the stigma associated with seeking care for STDs included the following:

- Primary care clinics in neighborhoods, including services for men
- Sports physicals that screen for STDs and high-risk behaviors particularly in adolescent males
- Health fairs, screenings at stores, malls, churches and other places where people congregate.
- An integrated school curriculum that is not value laden, just honest and contains information about birth control and STD protection in addition to abstinence till marriage
- Develop public service announcements
- Parental involvement in discussing sexuality with children through educational programs affiliated with schools, churches, after school programs and health clinics

Educating the public about STDs, the signs and symptoms and treatments available can reduce all stigma, fear, embarrassment, suspicion, shame and guilt. The socio-cultural climate of the county is reflected directly in the school curriculum. Data from this study indicated that adolescents and people serving the adolescent population wanted non-value
laden comprehensive sexuality education in the schools. The 1983 report on teen pregnancy issued by the JCCI detailed similar findings and recommendations. One of the best programs that developed in Jacksonville in response to this report was the The Bridge. The Bridge is an adolescent program offered to students in the core neighborhoods in Jacksonville. It provides academic, social and health care support to qualified students through supplemental programs after school and on weekends. It also provides comprehensive sexuality education for students who wish to participate and have parental consent. It is an outstanding program that should be considered for funding to expand to other neighborhoods.

One of the most obvious ways societies socialize youth about attitudes and expectations related to sexual and reproductive behavior is through school based sexuality education (Darroch et al., 2001). Brown and Simpson argue that it is the ethical obligation of health care providers to act in the best of interest of adolescents (Brown & Simpson, 2000). Guided by the principles of autonomy and beneficence, the authors suggest we should provide comprehensive STD/HIV prevention education to adolescents (Brown & Simpson, 2000). The authors argue that while everyone is welcome to opt out of programs, they do not have the right to limit information available to others; especially in view of the research findings that document that these programs reduce high risk behaviors associated with the transmission of STDs (Brown & Simpson, 2000).

Acceptability of services was another area of concern. Recommendations made by the informants included:

- Train clerical staff to enable rather than enforce the rules
- Hire more staff with diverse cultural backgrounds
- Hire staff with multi-lingual skills
- Increase numbers of providers in order to decrease waits
• Improve staff retention so that there is consistency in the care givers
• Re-evaluate the appointment system, determine whether walk in clinics can accommodate the need/demand for services

It would be marvelous if the clinics created more ways to help people. This could be accomplished by converting from a business type management style to a service style, incorporating phrases such as “a pleasure to serve you,” and “how can I help you” as opposed to a system that seems to thrive on enforcing the rules as opposed to enabling people to navigate system.

Another suggested means of improvement was to remove the competition between agencies through consolidation. Informants suggested that agencies be consolidated and coordinated so that more funds might be spent on services instead of administration. Many of the smaller agencies could reach more members of the community if they were expanded through this consolidation to become County wide instead of being restricted to small catchment areas. Further, it is possible administrative costs could be decreased through consolidation. People thought that by combining agencies the competition for goods and services would cease, and one source would be available for all, and the one agency would be more adequately provisioned. Increased efficiency through shared databases could speed consumers through registration and referral processes and help coordinate their services.

These recommendations are compatible with the critical medical anthropology approach where the micro and macro political economic forces are viewed as being major influences on how, where and when people seek health care (Baer, Singer, & Susser, 1997).
Further Research

Additional research topics for future study could include an examination of why the rates of STDs are so much lower in the surrounding counties. It would also be useful to study the effect of screening programs on the incidence of STDs, examining the effect of switching from a seek and treat mode to broader population based screening. A quantitative study comparing rates of STDs in populations that get information about abstinence and methods of protection versus abstinence only would be a very strong head to head comparison of the effectiveness of the two programs. Further study focusing specifically on the needs of adolescents would be beneficial in designing services. A study examining the issues men have accessing health care could offer insight about how to best create and market services to men who have different values concerning health maintenance and disease treatment than women. Evidenced based studies looking at the effects of abstinence only curriculum on behaviors would be difficult to do but more useful than the current studies underway which are measuring changes in attitude.

Summary

Critical medical anthropology suggests that social inequality and power are the primary determinants of health and health care (Baer et al., 1997). The data analysis in this study revealed that Blacks more than Whites are affected by STDs. Through triangulation of the data from this study with reports on indigent care and race relations in Jacksonville, it became clear that this group is among the less powerful both politically and socially. According to Critical Medical Anthropology (CMA), disease is not just the result of a pathogen but a variety of social problems such as economic insecurity, occupational risks, bad housing and political powerlessness (Baer et al., 1997). It is well documented in Jacksonville’s “core” neighborhoods these conditions are met and this is a
probable contributor to the inequity in disease burden. While this issue was not the focus of this study, the question of why Blacks are affected more than Whites may be related to these inequities.

Kleinman suggested that anthropological investigations force the health profession and society at large to consider fundamental changes in health care of the popular sector to enhance its adaptive efficacy, and that this would lead to changes in the health care system as we know it (Kleinman, 1980). He suggested that after ethnographic study we would shift the way health care is organized and practiced. Hopefully a shift will result from consideration of the findings of this study.

In *The Tipping Point*, Gladwell suggested word of mouth would become the technology age method of choice for disseminating information. Two studies, Sikkema et al., 1999 and Mullings et al. 2001, looked at changing high risk sexual behavior. They both concluded that by identifying community leaders (The Law of the Few) and creating social/educational opportunities (context) for women at risk, their behavior would change. Of course the message must be “sticky” or one that is memorable or meaningful for the participants. Additionally the socio-cultural values and belief systems could be changed by creating educational programs that are not value laden but equitable in the presentation of facts regarding reproduction, sexuality and protection against disease.

**Conclusions**

A goal of critical medical anthropology is to create a new system that will serve the people (Baer et al., 1997). Through reorganization and rethinking, the delivery of public health care could be changed to a prevention primary health care model instead of a disease model. If each separate disease was not housed or treated within a specific clinic, housed in a different facility or division of the DOH, health could truly be improved. The
findings of this research suggests that there needs to be a shift in the delivery of public health care to a more service oriented delivery system providing non-traditional hours of service, locating services in neighborhoods, not limiting services to one gender or age group, advertising the clinic services, locations and hours, and creating an atmosphere where agencies were more cooperative and less competitive providing services.
### APPENDIX A  
**BUREAU OF STD DATA FILES**

Table A-1. Reported cases in Duval County.

<table>
<thead>
<tr>
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<th></th>
<th></th>
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</thead>
<tbody>
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<td>61.7</td>
<td>1515</td>
<td>63.1</td>
<td>1150</td>
</tr>
<tr>
<td>Total</td>
<td>2773</td>
<td>2402</td>
<td>1913</td>
<td>39.9</td>
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Total: Syphilis, Gonorrhea, Chlamydia  
Non-STD represents all reports from all sources other than a specified DOH STD visit.  
Reported cases: Florida 1996-2000 by county and source. Extracted from Florida Department of Health, Bureau of Sexually Transmitted Disease Data Files  
www.myflorida.com/SexuallyTransmittedDiseases

Table A-2. HIV/AIDS cases in Duval County.

<table>
<thead>
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<td>246</td>
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<td>307</td>
<td>229</td>
<td>272</td>
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<tr>
<td>Total</td>
<td>352</td>
<td>475</td>
<td>527</td>
<td>594</td>
<td>591</td>
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</table>

Reported cases HIV/AIDS 1997-2001 (1997 was the first year of reporting and it is a partial year. Extracted from the Florida Department of Health, Bureau of Sexually Transmitted Diseases Data Files. Accessed at www.myflorida.com/SexuallyTransmittedDiseases.
Figure A-1. Duval County v State Rates of reported Sexually Transmitted Diseases Ten Year Period.
APPENDIX B
RATES OF GONORRHEA AND CHLAMYDIA IN DUVAL COUNTY IN MEN AND WOMEN 15-19 YEAR OLDS AND 20-24 YEAR OLDS
### Data Table

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<tr>
<td>cases</td>
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<td>1,313</td>
<td>882</td>
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<td>780</td>
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<td>884</td>
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<td>860</td>
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<td>cases</td>
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<td>833.84</td>
<td>683.34</td>
<td>626.73</td>
<td>625.70</td>
<td>599.78</td>
<td>704.54</td>
<td>723.86</td>
<td>709.16</td>
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</tbody>
</table>

Data Source: Florida Dept. of Health, Division of Disease Control, Bureau of STD data files. Chlamydia was first reported in Sept., 1993.
APPENDIX C
INTERVIEW GUIDES

Focus Group Guide for Adolescents
Client Access to STD Clinics in Duval, Broward, Palm Beach and St. Lucie Counties
Contract # COA7V

We have asked you to participate in this group discussion because we want to find out about any problems people are having in getting treatment for STDs. The rates of STDs are increasing but the number of people going to the department of health is decreasing. We want to know more about the needs this group can identify that could improve access to the clinics.

What do you think young people know about STDs? How do they get this information?

How do young people find out they have an STD?

Do you have any sense about where young people are going if they are concerned?

Who do young people talk to if they are worried about STDs?

Where do you go for your information?

Who are the most trusted sources of information for young people?

What are some of the issues involve in going to the clinic for services? Transportation? Hours? Cost? Location? Confidentiality? Fear?

What could make these clinics more accessible?

Do you think young people need their own place, separate from grown ups?

Do you think there should be information in the schools? Curriculum or through the school nurses? Or both? At what age should this education begin?

Should there be services available at school?

Do young people know they do not need parental consent to be seen and treated?

How can young people be reached?

Who else do you suggest we talk to in order to find out more about this?
We have asked you to participate in this group discussion because we want to find out about any problems people are having in getting treatment of STDs. Rates of STDs are increasing. We want to know more about the needs this group can identify that would improve the access to the clinics. What do you think people know about STDs? How do people find out they have an STD?

There are fewer people attending STD clinics, what do you think is going on? What is/are the reason(s) fewer people are going to the clinics? Do you have any sense about where they are going? Why? Are they being treated appropriately at these other centers? Are there alternative healers that treat people for suspected STDs? If yes, what kind of treatment do they use? Who do people talk to if they think they have an STD?

Do you think this is a problem? Or do you believe people are being treated elsewhere? What are some of the issues that make going to clinics a problem? Where are people going for treatment? Has it changed over the last few years? Why? Is this an economic issue?

Where are people going for treatment of STDs? Where are the young people going? Do men and women get care at different places? Why? Should they get care in different places? Do they get treated equally? Are men or women more upset with the diagnosis of an STD?

Do young people know where to go? Do they need a special place separate from older people? Do young people know how to get care? Do they know they don’t need parental permission? Should the schools be allowed to help the student population seeking care? Should there be treatment available at the schools?

What do you see as the major problems related to the increase in STDs? Is it money? Drugs? Paid sex workers? Not knowing the signs and symptoms? Believing it could not happen to me? What can be done about these problems? How can access to care be improved? Where should programs to increase knowledge and prevention be directed? How do you think that can be done? Do people trust the health care system?

What kinds of strategies would be helpful for making sure people are getting good STD treatment? Should people with a known infection be given medicine for their partner(s) to take without them having to come in? Should everyone be treated with the one time dose when possible? What could improve the access to getting care? How do you suggest more adolescents be reached? How do we reach people that are currently not getting care? Why do think they are not getting care? Where would they go?

Can you suggest people who would be willing to talk to us (me) about these issues?
Interview Guide for Clients
Client Access to STD Clinics in Duval, Broward and St. Lucie County
Contract # COA7V

How are things going? Prompt Questions: How do you feel? How are you today?

Did you have any problems getting to the clinic today?
Tell me about them.
Prompt Questions: How did you get here? Was transportation a problem? Do you have
know the bus system? Was getting a ride a problem? Did you drive yourself? Or did
someone bring you? Did you get lost? Did you stop and ask for directions? Did the
people you asked know where the clinic was? Are there other places you could have gone
for treatment that are not medical centers? If yes how are you treated there?

What do you have to know to get to clinic?
Prompt Questions: Were you seen somewhere else first? Did you have to get a clinic
card? What did you have to show when you got here today to be treated? Did you know
what you needed to bring before you came? Did you call before you came? How did you
find the phone number? Who do you talk to about your health? How did you know to
come to __________ (wherever you are interviewing).

Has it changed? Prompt Questions: Is it harder or easier to get here and be seen? Have
you been somewhere else? Is it harder or easier to be seen there?

Is it hard to find the information you need? Prompt questions: Did you have to look
the information about the clinic up anywhere? Where? Was it hard to find? Who told
you about the clinic? How did you find out about the clinic?

Is there somewhere else you could go for care? Prompt questions: Where else do you
go? Why do you go there instead of here? Do you believe in health practices (alternative
healing) that are not offered here? Is it easier to be seen there or here? Why? What do
you need to be seen there? Identification? Clinic card? Are men and women treated
equally here? Should they be treated differently?

What makes it comfortable here? Prompt Questions: Did you have to wait long?
Have people been pleasant to you? Have your needs been met? Would you come back
here again? Do you understand what the plan for your care is? Do you believe in the
plan? Can you follow the plan? Is your care confidential? Do they send you bills that
someone might find? Do you get your medicine here? Does it cost extra to get your
medicine?

What makes you not comfortable coming here? Prompt Questions: Have you had any
problems today? Tell me about it, them. Did you have to take time off from work?
Were you gone longer than you thought? Have your questions all been answered so that
you understand?

What are some barriers to getting to the clinic? Prompt Questions: Is money an issue? Insurance? Do you believe this is the right way to treat this problem?

Interview Guide for Community Members
Client Access to STD Clinics in Duval, Broward and St. Lucie County
Contract # COA7V

How are things going? Prompt Questions: How are you today? As an expert about this community can you answer a few questions for me about health care? Specifically about sexually transmitted disease health care?

Where do people in the community go for health care? Prompt Questions: Why do they go there? What kind of problems do they have getting there? What do people have to know to get there? When they are there, are their needs met? If people don’t go anywhere, tell me more about why you think they don’t? Do you or people you know have beliefs in alternative methods of caring for themselves? Who do people talk to about health care?

What are some of the good things about going there? Prompt Questions: Do they meet needs? Do people understand the plan of care? Can people follow the plan of care? Do they answer all of the questions? Do they listen to the concerns? Do they consider needs and limitations of the people they serve? Do they refer to other community resources if they need them?

Tell me about some of the things people don’t like about going there. Prompt Questions: Do they have a long wait? Do they have to go somewhere else to get the medicine? Can people afford the medicine? Do they give resources to get the medicine? Is it convenient to go for follow-up visits? Is it easy to get to? Is it available when it is needed to be available?

Are there other places available to people of the community for health care? Prompt Questions: Where are they? Why do folks go to one over the other? Are their needs met? Do people understand what is going on when they leave? Where are they? Why do people go to one instead of the other? What do people like about one over the other? Is the care confidential? How do people decide where they are going to go? What does it depend on? Time of day? Nature of the problem? Transportation? Money?

What are some of the good things about going there? Prompt Questions: Do they have a long wait? Is it convenient to home, work? Do people have to have proof of residence? Identification? Do people have to have an appointment? Can people be
seen if they just walk in? Are they available after hours? Can people get their medicine there also? Do they send bills? Is it confidential? Are both men and women treated there? Are they treated the same? Should men and women be treated at the same clinic?

Tell me about some of the things you think people don’t like about going there?
Prompt Questions: Is it hard to get there? Do people have a long wait? Is it expensive? Do they explain everything people want to know about what is going on with them? Do these places see people when they need to be seen or do they have to make an appointment and wait? Do they people you any of the medicine they might need? Do they answer all of peoples’ questions?

Are there any other places available to people for care? What are they?
Tell me about the problems people in the community have getting health care.
Prompt Questions: Have they always had these problems? Are these new problems? Do you believe it is important to get health care? Did your family get health care for you when you were little? What could make it easier for people to get health care? Is it easy to follow the instructions given? Do you get the medicine at the same place or do people have to go to a pharmacy and pay more? Do they have insurance? Would insurance make it easier or harder to get health care? Do you think there are problems specifically affecting adolescents trying to get health care services?

How could it be easier to get health care? Prompt Questions: Would people like Saturday clinic hours? Would another location make it easier? Would more locations in the neighborhood make it easier? Would evening hours be helpful? What prevents people from getting health care? What programs have been more effective at delivering health care? Tell me more about that? What do you see as the problems in your community that are not being met? How could these needs be better met? Are the community agencies competing or working together to meet the needs of the community?

How did you hear about the clinic (facility) where you go? Prompt Questions: Was it word of mouth? How does the word get out? Do they have limits on how many patients they can see? Are you satisfied with the care there? Would you recommend it to a friend?

What do you think people need to know about sexually transmitted diseases? Prompt Questions: Where do you think they go for care? What are the problems that you think people have with getting care? Does the system need to be changed? How would you change it?

Is there anyone else you think I should talk to about these issues?
Interview Guide for Staff
Client Access to STD Clinics Duval, Broward, Palm Beach and St. Lucie County
Contract # COA7V

These main questions are presented with prompts to guide the conversation.

What problems do you think clients have getting to clinic? Prompt Questions: Is it different for different age groups? Is it harder for adolescents? Is it hard to find out where the clinic is? What are the hours of operation are? Do people know the clinic is here? How do they know? Are both men and women treated here? Do you think they should be? Where else can people in the community go? Are there “healers” that treat people in the community?

What do people need to know about STDs? Prompt Questions: Where do they find that information? Is the information they get accurate?

What do people have to know to make the system work? Prompt Questions: How do they get this information? Where do they get this information? Do you think there are problems with the system now? What are they? What could make it easier for the patients to get here? Who do patients talk to to get information about STDs? Are they getting accurate information? What do people believe about STDs? Is it harder for men than women to deal with the diagnosis?

How do people find out about the clinic? Prompt Questions: Is it word of mouth? How do they find the telephone number? Has the clinic always been here? Are they sent here by other clinics or providers? Do the schools refer kids here? How do people know what services you provide and the hours you are here?

What good things do clients tell you about their experience here? Prompt Questions: What do they like about this clinic? Do they like the information they get? Do they mind coming back for results a week later? What do you like about the clinic? What do you think you do really well here? Do you think people are getting good information and treatment here? Do you think they understand the diagnosis, the cause, the treatment and prevention? Do you see a lot of repeaters? Can they follow the instructions you give them or are their families or partners barriers to their care?

What criticisms do clients have about their experience here? Prompt Questions: Do you think they would have the same complaints about other clinics or facilities? Do you think the complaints are justified? Is there something that could be done to address those complaints? What do you think is not going well here? Is language a problem?

What could be done to make it a better experience for patients? Prompt Questions: Do they need more services? More hours? More clinicians? More information? Do teens need their own place to go? Do women need a different place to go? Men? What do you think would make it better, easier to get to? Do you think clients’ needs are being met? Why or why not?
Let’s talk about barriers to patients. Prompt Questions: What makes it difficult or impossible for people to get here? Is money an issue? Do they need proof of insurance or Medicaid? Do teens know they don’t need parental permission? What is working well here now? Did you have some programs in the past that you think worked better? Why or why not? Should patients be given treatment for their partners or should their partners have to come in? Why or why not? What could improve clients’ access to this facility?

Can you tell us (me) about any community members who might be willing to talk with us (me) about these issues either individually or in a group?
LIST OF REFERENCES


BIOGRAPHICAL SKETCH

Kay Hood is a Women’s Health Nurse Practitioner. She received her undergraduate degree from Skidmore College in Saratoga Springs, New York. After a brief career in the hospital she became involved in ambulatory women’s health care where she has remained. She earned her master’s degree in nursing from the University of Pennsylvania and was certified by the National Certification Corporation as a Women’s Health Nurse Practitioner. Following a twenty-two year career developing the role of the Nurse Practitioner in several settings in the Atlanta, Georgia, area Ms. Hood enrolled in the doctoral program at the University of Florida.

She has been active in many organizations on the local, regional and national level. These include the Association of Women’s Health Obstetric and Neonatal Nurses, the National Association of Nurse Practitioners in Women’s Health, the American College of Nurse Practitioners, as well as serving on the test development committee for infertility and reproductive endocrinology for the National Certification Corporation. She has spoken locally and nationally on a variety of women’s health issues over the years.