Understanding young Black women’s socialisation and perceptions of sexual and reproductive health

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ABSTRACT

Although sexual and reproductive health inequities acutely and disproportionately affect Black women in the USA, there are few studies that consider the sociocultural context in which Black women transition to adulthood and develop their sexuality. The objective of this study was to describe the lived realities of young Black women to elucidate how the sociocultural context informs their current perceptions of sexual and reproductive health. We conducted phenomenological interviews with 22 Black women aged 18–29 years to elicit their life stories. The main categories identified in the findings include how the sociocultural environment informs the self-concept; how the sociocultural environment informs early learning about sexual health; and how together these experiences inform women’s development of a sexual self-concept. Three main groupings of experiences were identified relative to women’s sexual self-concept: fear-based disease and pregnancy prevention; a deeper understanding of bodies and sexuality beyond disease and pregnancy prevention; and sexual pleasure and fulfillment as a priority. To address ongoing sexual and reproductive health inequities that particularly disadvantage young Black women, health systems and interventions should address the sociocultural contexts in which young Black women develop and manage their sexual health.

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Introduction

To address inequities in sexual and reproductive health (SRH) in the USA, national campaigns have primarily focused on reducing teenage and unintended pregnancy and sexually transmitted infections (STIs) through a focus on adolescents, young adults, and members of Black, Indigenous and People of Color (BIPOC) communities (Office of Disease Prevention and Health Promotion (ODPHP) 2020; Office of Infectious Disease and HIV/AIDS Policy (OIDP) 2019; S. Parker 2009). Researchers have reported...
that Black women are more likely to experience unintended pregnancy than their white counterparts (Guttmacher Institute 2019) despite greater contraceptive care utilisation (Borrero et al. 2009). In addition, Black women account for most new HIV diagnoses among cisgender women even though Black adults get tested for HIV significantly more than others (Kaiser Family Foundation 2020).

Because research has shown that unintended pregnancy and STIs/HIV are associated with age, race/ethnicity and income, public health efforts have concentrated on these individual behaviours to address SRH inequities (Centers for Disease Control and Prevention (CDC) 2021, 2020; Guttmacher Institute 2019). Health equity scholars suggest that public health research and practice should also examine the sociocultural and political context that reduces people’s ability to attain optimal SRH (Crear-Perry et al. 2021; Dehlendorf et al. 2021). Using a sociocultural and political lens can help uncover the mechanisms that create structural vulnerabilities and perpetuate SRH inequities.

Scholars have suggested that socialisation is associated with systems, norms, practices and behaviours that create and distribute social and health inequalities (Adler, Glymour, and Fielding 2016; Marmot 2005). For example, interlocking systems of oppression create significant inequities in STIs/HIV (Cipres et al. 2017; Adimora et al. 2021), access to contraceptive methods and fertility control (Dehlendorf et al. 2010; Guttmacher Institute 2020), and pregnancy-related morbidity and mortality (Howell 2018). Given that race is a social, not biological construct, scholars recommend researchers examine race through power dynamics in society (e.g. racism, bias and discrimination based on racial identity) and the consequent distribution of goods and resources (Krieger 2000). Thus, women’s socialisation as ‘Black women’ in the USA shapes their experiences, exposures, risks and opportunities for health.

**Emerging adulthood**

A key aspect of sociocultural context for young Black women is the transition between adolescence and emerging adulthood (Arnett 2000). During this life stage, self-exploration is central to a person’s development (Arnett 2007). Here, young Black women may draw upon their childhood experiences and upbringing to inform health decisions while refining their self-concept through independent pursuits. During this exploratory phase, women likely balance independence with help-seeking. For example, in the context of SRH, young women may access different sources for health information to guide decision-making, including healthcare providers, peers and parents as they gain their sense of how to manage SRH (Blackstock, Mba-Jonas, and Sacajiu 2010; Dehlendorf et al. 2013; Rubin et al. 2016; Sneed et al. 2013).

**Intersectionality**

While concern for emerging adulthood is important, equally significant is understanding the political forces that shape young Black women’s SRH. Adopting an intersectional lens can help explain how socialisation may also inform their perspectives and experiences. As a critical theory, intersectionality acknowledges the intertwined nature
of aspects of social disadvantage (i.e. age-ism, race-ism, and other forms of discrimination based on identities and abilities) (Crenshaw 1991). Although earlier legal scholars had examined these forms of discrimination separately and exclusively, Crenshaw applied intersectionality to describe the social position of Black women explicitly and how power structures such as racism and gender-based discrimination, distribute disadvantage throughout society. Specifically, the intersection of racism and sexism positions Black women at the margins and unprotected.

Black women’s erasure in society perpetuates disadvantage, which contributes to the social and health inequities they experience. While young Black women are hyper-visible in public health priorities to reduce teenage and unintended pregnancy and STIs/HIV (Office of Disease Prevention and Health Promotion (ODPHP) 2020; Office of Infectious Disease and HIV/AIDS Policy (OIDP) 2019; S. Parker 2009), the structural forces that increase their vulnerability and reduce their access to social and health services make their life experiences invisible. Understanding the intersections of Black girlhood for what it means to be a young Black woman may illuminate the power structures and influences that create or restrict opportunities for optimal health, including how the intersections of racism, sexism and age discrimination combine to influence health needs and outcomes. In addition, examining other intersecting social identities, such as sexual or gender diverse identities, does not simply ‘add’ to the litany of marginalisations but may create new ways of understanding how prevailing sociopolitical systems harm people (Bowleg 2012, 2008).

The current study

Understanding the sociocultural and political context in which young Black women transition to adulthood and develop their identities as sexual beings—using an intersectional lens that recognises the salience of gendered racism—can inform understanding of how to meet their SRH needs both within and outside of the healthcare system. In this study, we sought to describe young Black women’s life stories to consider how young Black women’s socialisation in the context of intersectional oppression influences how they navigate the world and acquire and leverage (or not) the resources to manage SRH.

Materials and methods

Study design

We present data from a larger mixed-methods study which incorporated an online survey and sequential phenomenological interviews. The first author (RL), who identifies as a cisgender Black woman from the Southeastern USA, piloted the interview guide with ten Black women aged 18–29 from a local university and a partnering reproductive health clinic to refine the interview flow, questions and probes. In this study, intersectionality provided the guiding framework for study design, data collection, analysis and the interpretation of the findings. Women were asked to describe their lived experiences throughout childhood, adolescence and young adulthood, including experiences related to SRH.
**Data collection**

The University of South Florida Institutional Review Board approved the study before data collection. Women who completed the online survey were sexually active in the last year with a male partner, 18–29 years old, identified as Black or African American (described here as Black), unmarried, and reported a contraceptive care visit in the last year. The first author completed two sequential interviews with participants (also referred to as co-researchers) between January and April 2019.

This article presents findings from the first interview, which elicited a life story. Results from the second phenomenological interview, including detailed recruitment information, are described elsewhere (Logan et al. 2021). After obtaining verbal consent, each participant was asked to co-construct their experiences with the researcher by serving as the director or storyteller (Miller 1999; Seidman 2013) and explore the impacts of the events they described. Interviews were conducted in-person if women were local or via videoconferencing software, audio-recorded, and lasted between 34 and 126 min. Women received a USD55 e-gift card for completing two interviews.

**Analysis**

Throughout data collection and analysis, various strategies were used to enhance validity: including epoché, openness and reflexivity (Morse and Mitcham 2002; Shenton 2004). The foundation for openness lies in the researcher’s ability to engage in epoché, where assumptions, logic and expectations of the findings are identified and bracketed before engaging with co-researchers. Openness on the other hand pertains to a ‘way of being’ with co-researchers during the data collection process to ensure the emergence of the co-researcher’s narrative. The first author used reflexive journaling and memo-ing (reflexivity) to acknowledge biases and assumptions before and during data collection and analysis. Iterative questioning also took place to summarise the co-researcher’s responses for clarification, and peer debriefing was used to increase the probability of generating rich data.

Following audio file transcription, the first author reviewed the transcripts for accuracy and deidentified them. She then engaged in an independent and iterative analysis process aided by MaxQDA 2018 (VERBI Software 2017) that included: multiple passes of the data to review audio files, transcripts and codes (Seidman 2013). Pragmatic deductive analysis ensued informed by how interviews followed the life stages (e.g. childhood, adolescence and young adulthood) identified a priori. A priori codes were also informed by the application of intersectionality, which served as the basis of codebook development.

After beginning the analysis phase, we identified the alignment of early concepts and themes with the cultural health capital framework and used this framework to further conceptualise how women’s formative experiences informed their current perceptions of their SRH (e.g. lived realities and experiences and habitus). Next, the first author (RL) and one of the co-authors (SM) reviewed and discussed codes before finalising the codebook. The first author then coded the remaining transcripts and used the refined code structure to develop the themes and overarching concepts.
Pseudonyms are used in the presentation of the findings to ensure participant confidentiality.

**Results**

Participants in this sample, who all self-identified as women, had a mean age of 24 years (standard deviation: 3.0 years). Sixteen of the 22 women had a college degree or higher and others did not have a college degree. Most women reported they currently had health insurance (20 of 22; 91%), two did not have such insurance. Regarding women’s financial situation, 12 of the 22 (54%) women reported their finances only just covered their basic expenses or did not cover these, and 10 women reported that they were able to live comfortably or cover basic expenses with a little left. Seven women were single, 11 were in a relationship but not living with their partner (11 of 22; 50%), and four were cohabiting with a partner. The majority of women were living in the Southern USA (17 of 22; 77%).

As findings followed along the life stages from adolescence to young adulthood, the results are reported on as follows: (1) how the sociocultural environment informs the self-concept (lived realities as a young Black girl); (2) how the sociocultural environment informs early learning about sexual health (how women learned about their bodies and sexuality); and (3) as an emergent theme, women’s development of the sexual self-concept.

**Sociocultural environment informs the self-concept**

Most women described growing up in nuclear families, often in close-knit rural communities or urban environments where extended family members were nearby, including grandparents who had a significant role in helping raise them. Women described strict environments where they had been sheltered from engaging in potential risk behaviours early (e.g. teenage dating, early sexual debut, truancy, etc.).

Growing up, Black women described being made aware of their Black racial identity through their physical and social reality, conveying a dual reality – either they were considered a ‘white girl’ in Black spaces, or a ‘hood’ or ‘ghetto’ girl in white spaces. Neither of these perspectives represented how they viewed themselves. Many reported learning this reality through attendance at specialist, private and other schools outside their communities, motivated by their and their families’ desire so that they get a good education.

Several women recalled the limited resources available to them and their communities in the context of living in a predominantly Black or non-white community. One woman said that the school she had originally been assigned to go to for high school performed so poorly locals believed the myth that ‘if you applied to college and your transcript said one of the two high schools in our district, the admissions person would throw your application away (Brianda, 25 years old, high SES).’ Women also described racial tensions and were taught that being Black, particularly a Black woman, had advantages and disadvantages. As Camille (19 years old, high SES) described:
My parents have always reminded me of this. The fact that being Black and female, not only do I have to work hard, but I have to work twice as hard because I’m up against males, and I’m a Black female. So, it’s like a double negative in a way …

One woman described remembering a healthcare provider constantly ask her about her sexual activity despite being a virgin. As she recalled, ‘they said they tend to highlight girls who are minorities because it is more prominent for them to do things at a younger age (Monica, 20 years old, low SES).’

A prominent feature of growing up as a Black girl was maintaining a standard of excellence. Across women’s narratives, they were expected to perform well in school and be active in their communities through sport, afterschool jobs and church involvement. Another woman whose family was Caribbean, talked about learning traditional values such as: ‘Basically, you have to go to school, work…cook, clean…do all that…. just…keep everything together (Mesha, 20 years old, high SES).’ A young woman who identified as a preacher’s daughter said she and her mother had conversations about ‘what’s a Southern Christian woman. What does that look like? How does that influence your behaviours and how you interact with other people…? (Eboni, 25 year old, high SES).’ She described how her mother ‘carried’ herself and muted aspects of her personality so she could uphold the image of a Southern Christian woman. Together, these descriptions reinforced images of Black women who were defined by service to their families and communities and were rewarded for their performance if it was not accompanied by complaint.

This pressure was frequently applied with respect to standards for physical appearance, especially as it related to their maturing bodies. Some women reflected on how their mothers made sure their hair was neatly done and another woman talked about how her mother stressed the need for appropriate undergarments to have a ‘finished look’ when leaving the house. Other women also described how parents ensured that they did not wear clothing that was too revealing. This was important because women described how adults associated their developing bodies with indecency or an indicator of sexual debut. The following quote illustrates how at 11–12 years old, Kya (27 years old, high SES) learned her body was different than her peers:

Adults started commenting on my butt, then I became more aware of butt and breasts… the first [comment] came from my cheerleading coach. ‘You need to make sure your skirt is a bit longer in the back … to cover your bubble butt’

Overall, the experience of participants as maturing Black adolescents included combined pressures related to their experience of being Black in an inequitable society and being young women with general uncertainties and insecurities associated with adolescence.

**Sociocultural environment informs early learning about sexual health**

In addition to these more general influences on the self-concept, the sociocultural environment had specific influences on how participants understood and learned about their bodies and sexual health in general. Women’s youth was marked by silence regarding sexual health, their bodies and sexuality. For example, upon being asked about their menarche, few women had a parent provide useful information
about their changing body or how to manage their periods. Women talked about the ‘silence’ as ‘...just an issue in the Black community...’ ‘just brush everything to the side, put it under the rug. Oh, just pray about it’ ...don’t talk about it, hush-hush kind of thing...’ (Zakia, 20 years old, low SES).’ A common influence was religion, as the faith community was part of many women’s early and continued development. Some described spending a considerable amount of time attending church or engaging in religious practices. Although many described their religious institution or beliefs as conservative, Brianda (25 years old, high SES) talked about her church being progressive:

A radical church where my pastor was always okay with LGBTQ people...being in the church...they had an AIDS ministry...they had an abstinence thing, but...they knew what was going on, they weren't hiding it from us...my church was one of those “come as you are” churches

The majority of women reported, however that messaging about sex within their religious institutions was fear-based or non-existent. Eboni (25 year old, high SES) shared, ‘We never had a “birds and the bees” talk because that was just, “You ain’t havin’ sex ‘cause you’ll get pregnant, and you’ll go to hell.”’ Even if parents were not religious, they still held conservative beliefs. For example, Zakia (20 years old, low SES) described being verbally and physically abused by her parents as a teenager after they discovered she had a girlfriend.

Related to this lack of communication, women had limited knowledge and information about their bodies, sexual health and sexuality. Women described being keen to acquire information but did not always have access to it, particularly as some did not receive formal sex education in schools. Sometimes parents wanted to provide them with information about sex but were ill-equipped to engage in meaningful one-on-one conversation. Instead, women described being given books to read, searching for information in encyclopaedias at home or, in one case, being provided with an age-appropriate video and having a parent ask if they had any questions. When parents did communicate about sex, women often found these interactions confusing. One example includes Deena (28 years old, high SES), a young woman who was punished for asking her mother about birth control after deciding to have sex with her first boyfriend at age 15:

She said, ‘I know you’re getting older...if you ever think you’re getting ready to have sex and you want to be on birth control, let me know and I’ll take you to get it.’ That was a trick from the enemy...I listened to her. I tried to be open with my momma...and she lost it...basically, that I was a loose girl... ‘You a ho’... I kind of internalised it. I mean...I got wild for a minute

After this incident, Deena (28 years old, high SES) visited her local health department to obtain birth control without her mother’s knowledge. Several other women described parents, particularly mothers, being preoccupied with ensuring they did not become pregnant. An example is Camille’s (19 years old, high SES) experience. Camille described having to provide proof she was not pregnant at nearly every period, ‘...there [was] no convincing my mom until she gets proof, so...when I got my period, I’m like, “See...told you”...she [was] so fearful of me repeating her footsteps.’ In describing their mothers’ efforts to help them avoid teenage pregnancy, women
seemed to understand why their mothers did so, yet also recognised that the messaging they received about sex and relationships was generally negative.

Silence around sex, sexual health and developing bodies remained present even when women experienced reproductive health issues. Often women described having to manage these problems for long periods without medical involvement or in a context where pain was treated as normal. In their families, women talked about aunts, mothers, sisters and other family suffering from menstrual and reproductive health issues. Two women suffered from incessant and heavy menstrual bleeding. The first was Tasha (28 years old, low SES), a Muslim woman whose parents had objected to her taking oral contraceptive pills as treatment for this, finally received them only after attending a hospital emergency department because of significant blood loss. The other woman, Shae (24 years old, low SES) said that at high school she bled for more than 12 consecutive months and was wearing her grandmother’s diapers, keeping sanitary pads in her car, and discarding bedding routinely. ‘I’m literally blowing through super plus tampons and overnight pads during the day at school. I mean I’m bleeding … I had to get a doctor’s note … that documentation needed to go around to all my classes.’ Other women remembered receiving diagnoses of polycystic ovarian syndrome, suffering from severe unexplained pains fainting during their menstrual cycle, experiencing nausea and vomiting each time they had a period, having late onset of their cycle, or had periods so irregularly it caused concern. Women became accustomed to dealing with discomfort and pain, since many of the women they knew were in similar circumstances. Few, if any women, described being able to talk to siblings, parents or other guardians about these reproductive health issues.

The experience of trauma had also been met with silence. In this sample, five women disclosed experiencing sexual violence. Three had been victimised during childhood, one in early adolescence, and another in college. In the three childhood cases, the perpetrator was the mother’s male partner. In one case, siblings were also abused by the same perpetrator. Women said they were believed, and the mother’s partner was removed from the home, but there was no further discussion about the events. Another participant disclosed that she had been molested at her place of worship. Her parents were divided on how the issue should be addressed—have the offender make amends or wait for karma or God to resolve it. Despite parents knowing that their children had experienced trauma, the steps toward healing were not clear and often the solution was to forget the violence occurred and move on. A couple of women shared that they went to therapy regarding these experiences.

For many women it was not until they attended college that they were able to talk openly about sex, take classes about human sexuality or explore their sexual identity freely. College attendance also served as a means to access sexual health services and opened up parent-child communication about sex. Kenya (20 years old, high SES), an undergraduate woman said she and her mom finally had ‘the talk.’ She shared ‘… a year ago, she sat me down like, “Have you had sex yet?” And I couldn’t lie to her … I was like, “Why are you talking to me about this here [restaurant]?” … but yeah, that was pretty late ….’ Although parent-child sex communication occurred, conversations were often broached timidly and took place after women had already had sex. Although they described being more comfortable talking to parents, partners and
healthcare providers about sex now, a degree of reluctance remained. Women were unsure about how or what to share with healthcare providers, as it was important to not convey the appearance of being ‘promiscuous’.

**Development of sexual self-concept**

In the context of this gendered and racialised development of a self-concept, and general lack of communication and openness around issues related to sexuality and their bodies, young women described evolving perceptions of sexual and reproductive health. This evolution contributed to the formation of a ‘sexual self-concept’, a term used to connect how women’s formative experiences related to their current perceptions of sexual and reproductive health.

The responses revealed three schemata underlying sexual self-concept development: that whose major concern remained one of disease and pregnancy prevention \((n = 9)\); that which advanced a deeper understanding of the body and sexuality beyond disease and pregnancy prevention \((n = 7)\); and that which considered and prioritised sexual pleasure and fulfilment as part of sexual health \((n = 4)\). Examples of these can be found in Table 1.

As described, women’s exposure to ‘sexual health’ information and communication mostly consisted of fear-based messaging about teenage pregnancy and STI/HIV acquisition. Therefore, some women focused their current perceptions on preventing these outcomes, ultimately showing a defensiveness towards sex where one should always be on guard to avoid ‘becoming a statistic’ (i.e. another pregnant Black teenager or Black person with an STI). Other women began to consider their sexual health as an important part of overall health and well-being and wanted to learn more about

| Sexual self-concept                                | Illustrative quotes                                                                                                                                 |
|---------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|
| Sexual health is about disease and pregnancy prevention | I still wanna protect myself. Now, I wouldn’t pursue anybody in a sexual way, not unless they got tested … you can’t tell what somebody has just by looking at them—that’s one thing that’s changed as far as my sexual education. (Dani, 26 years old, high SES) … just be cautious … still [can’t] trust in everyone … I mean, it’s [sex] something that can be light, it can be fun, but it also can be serious and have consequences, so guard yourself accordingly. (Shayla, 23 years old, low SES) |
| Sexual health is part of overall health and well-being | I do feel more confident talking about my sex life and sexual health. I think having had a couple more partners now, and having them all be different, that exposure has helped with my understanding of how I feel, what I want out of it, whether or not be a relationship or a purely sexual relationship. (Shacara, 25 year old, low SES) I took a human sexual behavior [course]. That was my favorite class, probably because I was so interested in it. Now I know that you can have things [issues/STIs] and still be okay … It’s like a spectrum of health … it [your body] doesn’t have to be perfect for you to be healthy. (Kenya, 20 years old, high SES) |
| Sexual health includes pleasure and fulfilment      | I’d just love people to be sexually free. I am sad that like 30% of women aren’t having orgasms … if you’re gonna do it, enjoy it, with whoever you wanna enjoy it with, how you wanna enjoy it. (Brianda, 25 years old, high SES) I see it more encompassing pleasure as well … rather than scaring the hell out of everybody: ‘You’re gonna get pregnant, you’re gonna die’ … it’s more … you can enjoy sex and it can be pleasurable for both of you. (Eboni, 25 years old, high SES) |
how to care for themselves. Some women developed a broader view of sexual health through formal sexual education or through healthcare encounters; however, these experiences only sparked a desire to acquire more knowledge.

I wish more things about women’s bodies and their reproductive systems were talked about… talking about birth control early, talking about side effects of birth control… even talking about sex, what you should do before and after sex, how to treat your body… (Brianda, 25 years old, high SES)

Other women shared how through positive sexual encounters, they had developed an understanding of their bodies that incorporated pleasure and enjoyment into their conceptualisations of sexual health. Additionally, several women also talked about the responsibility they have to others and themselves to learn and communicate about sexual and reproductive health differently than their families and communities of origin. Zakia (20 years old, low SES) shared that as the eldest child in her family that she would be ‘better for other people … my sisters … my kids [in the future] … whoever else that I have to educate about it’. Women reflected upon how they could continue improving their knowledge, understanding and management of their sexual health and several shared their commitment to achieving these goals.

Discussion

Our findings showed how gendered and racialised contexts shape young Black women’s perceptions, attitudes and behaviours regarding their self-concept and current sexual and reproductive health over the course of adolescence and young adulthood. Women’s experience of sexuality and their bodies are influenced by their interactions and contexts as girls, including through lessons about what it means to be a Black woman in society (Crooks, King, and Tluczek 2020), as well as through how sexuality was, or was not, addressed. In their childhood and adolescence, women had limited access to accurate and affirming sexual health information, with many experiencing sexual violence, and suffering adverse reproductive health outcomes. As they reached early adulthood, these early experiences were integrated into their socialisation as Black women to inform their current sexual and reproductive health perceptions— their sexual self-concept. The sexual self-concept ranged from a continued focus on pathology and prevention to a fuller appreciation of the importance of sexual pleasure and fulfilment.

The ways in which young Black women’s SRH was pathologised during childhood and adolescence must be considered alongside public health narratives regarding SRH, in which young Black women are described as a demographic most impacted upon by SRH issues such as unwanted pregnancy and high STI/HIV rates (Office of Disease Prevention and Health Promotion (ODPHP) 2020; (Office of Infectious Disease and HIV/AIDS Policy (OIDP) 2019; S. Parker 2009). While attention to historically and currently marginalised communities offers a strategy to mitigate disparate health outcomes to achieve health equity, young Black women’s experience of this type of health promotion can be harmful (Crooks, King, and Tluczek 2020). Women’s parents and communities viewed them and their bodies as problematic—their young developing bodies were sexualised, they were blamed for receiving male attention (Crooks
et al. 2020; Parker 2018), and little if any discussion included their male partners in conversations about pregnancy or STI prevention (Littlejohn 2021). Due to these negative messages and socialisation, several women in this study subscribed to these conceptualisations wherein they also pathologised their bodies and described their sexuality in terms of fear and disease avoidance (Leath et al. 2020; Warren-Jeapiere et al. 2010). This limited view of SRH and their sexual self-concept may have significant consequences for later health and well-being, including holding fatalistic views about their sexual and reproductive health (Rocca and Harper 2012) or feeling disempowered to exercise sexual and reproductive autonomy. A limited sexual self-concept is the result of the intersections of sexism and anti-Black racism (e.g. misogynoir; Bailey 2021) and other structural oppressions that deny young Black women their humanity and sexual freedom.

The concept of cultural health capital is relevant to interpreting how these formative experiences and early socialisation among young Black women impact the development of their sexual self-concept, as well as their opportunities and resources to manage SRH later in life. Derived from Bourdieu’s (1977) theory of cultural capital, which posits how people can leverage their culture as a form of currency in multiple spaces, Shim (2010) described how people leverage their knowledge, skills and other resources to navigate healthcare. As a power structure, the health care systems and providers ascribe value to particular social and personal characteristics that often align with whiteness, wealth, and high income and education levels. Along with these characteristics are people’s lived realities navigating the world and political systems whereby they learn their position in society and ways of being (habitus). Shim frames cultural health capital in terms of interactional dynamics between patients and providers while considering the influences before the healthcare visit (e.g. previous experiences and habitus) and management following the visit (health action). As a power structure, the healthcare system equips those with capital to have added opportunities to gain capital while those with limited resources and networks are further disadvantaged.

The gendered and racialised life experiences described by study participants resulted in both negative and oppressive views of sexuality. Additionally, the sociocultural context during women’s youth failed to help them cultivate cultural health capital to manage their sexual and reproductive health in young adulthood (Crooks 2019; Leath et al. 2020). Together, these factors resulted in a lack of access and disengagement in care. When these individuals did access care, the health care system was not always viewed as a trusted space (Logan et al. 2021). The cultural health capital framework describes how in the context of one’s lived experiences and existing power dynamics, rather than healing, healthcare interactions can exacerbate low cultural health capital, which may perpetuate existing inequities in SRH.

Of note, some women described their SRH using sex-positive frames and developed a holistic view of SRH as part of their sexual self-concept, despite having no examples of this language shared with them in their youth. Factors contributing to this trajectory included the experience of accessing healthcare and receiving sex education as they moved into adulthood, which helped them cultivate cultural health capital through exposure to information and support that was much lacking during their formative years. Also, as cultural health capital suggests, experiential learning helps one
gain additional tools, skills and resources to navigate their sexual health independently. For example, young women who successfully initiated contraceptive use, had positive sexual encounters with partners or who accessed SRH services were more likely to have greater cultural health capital than those with limited or negative experiences. Once women who had reached an affirming sexual self-concept felt responsible for ensuring that they helped others reach these same conceptualisations.

These findings, placed in the context of the cultural health capital framework, suggest that early intervention for young Black women could have long-term positive benefits by building cultural health capital, facilitating engagement in care, and helping create a positive sexual self-concept. Such interventions might include comprehensive sexuality education, using a positive sexuality lens, that includes family and community and other culturally relevant and liberatory interventions. This work can build on ongoing efforts to promote SRH care with the goal of achieving sexual and reproductive well-being, as opposed to focusing on disease and pregnancy prevention. This re-envisioned goal, and its more holistic concern for SRH and well-being, aligns with human rights and reproductive justice principles (SisterSong n.d.; WHO 2006) — which is essential to utilise when tackling the systemic inequities that disproportionately impact Black women.

Although this study focused on the lived experiences and realities of cisgender Black women, a holistic approach to SRH has wider benefits through its concern for other systems of oppression (e.g. homophobia, transphobia, ableism) and their intersection(s) with gender and race. Its findings also underscore the need for more affirming, culturally responsive, and comprehensive forms of sexuality and sexual health education (United Nations Population Fund (UNFPA) n.d.) and services for young Black women and their families in different environments including at home, in school, through after-school programmes, in college settings, and via religious institutions (In Our Own Voices 2017).

**Limitations**

Like all studies, this one is not without its limitations. First, it would have benefited from including more Black women across the African diaspora and could have used purposive sampling of women born in the USA and elsewhere to examine how different sociocultural contexts impact socialisation and sexual self-concept. Second, women’s responses are likely subject to recall bias as the life story causes them to reflect on past experiences from their childhood and adolescence. Additionally, the study’s focus on women’s SRH-related experiences may cause us to overlook other experiences during childhood and adolescence that significantly contribute to development. Lastly, instead of engaging in a three interview sequence of lived experience as recommended by Seidman (2013), we only conducted two interviews with participants, which may have limited the richness and scope of the narratives shared.

**Conclusions**

In this study, young Black women’s early socialisation as Black women informed their self-concept and sexual self-concept development. Women’s narratives about family
relationships and social environments identified factors that predisposed them to sexual risk or helped them avoid outcomes such as unintended pregnancy. As older Black women, they became more aware of gaps in information and issues they now needed to address so as to maintain sexual and reproductive health and well-being. To address the persistent health inequities that particularly disadvantage young Black women, greater investment in work with this population is required to foster sexual and reproductive health and well-being throughout the life course.

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