PROVIDER INFLUENCE IN SHAPING WOMEN'S BELIEFS ABOUT PROTECTION AGAINST SEXUALLY TRANSMITTED DISEASES: CASE STUDY

by

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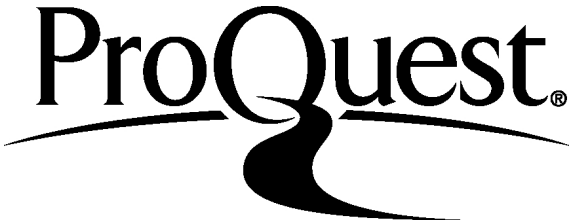

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ABSTRACT

The purpose of this qualitative multiple case study was to explore women's perceptions of provider influence in shaping their beliefs about protection against sexually transmitted diseases during provider-patient consultations. Women indicate they prefer to discuss sexual health issues with providers, yet research was not available to fully understand provider influence on women's beliefs regarding sexually transmitted diseases. Telephone interviews were conducted with a purposive sample of 12 adult women in Baton Rouge, Louisiana. Data collected from these interviews and analyzed for emerging themes using NVivo 10 software revealed how women perceived providers' discussions and the dissemination of STD related information. Findings also revealed how women believed healthcare providers might present sexual health information to motivate changes in risky sexual behaviors. The three major themes emerging from the analyses of the data collected were providers did not initiate discussions about preventing STDs, no information was received about preventing STDs during consultations, and visuals could motivate changes in risky sexual behaviors. Recommendations based on the study's findings involved identifying opportunities to leverage staff members in healthcare providers' settings, illuminate cues to action, develop STD awareness programs specifically for women, and to conduct future research.

DEDICATION

I dedicate this dissertation to my deceased paternal grandparents, Mr. Clinton Green and Mrs. Vivian Green. Although you are no longer here, you remain in my heart and I strive to bring honor to your legacies and the foundation you created for our family. To my parents, the late Charles P. Green and Mrs. Geraldine R. Green, who worked selflessly to provide me with a good education.

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I would like to acknowledge my committee. After losing two chairs and a committee member during the years I worked on this dissertation, I finally came up with a winning team, all of whose input played an integral part in my ability to complete my dissertation. I wish to acknowledge Dr. Craig H. Martin (Chair), Dr. Shana L. Nicholson (Committee Member), and Dr. Sharon B. Buchbinder (Committee Member).

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Chapter 1

Introduction

Research indicates 50% of the annual 19 million newly reported cases of sexually transmitted diseases (STDs) present in women because of women's biological susceptibility and risky sexual behavior (RSB) involving ineffective or lack of condom use during sexual activity (Cavanaugh et al., 2011; East, Jackson, Peters, & O'Brien, 2010; Marcus, Fulton, & Turchik, 2011; Trepka et al., 2008). Epidemiological findings further reveal failure to use condoms properly and consistently causes 72% of women to contract the human immunodeficiency virus (HIV), which is a primary risk factor for the acquired immunodeficiency syndrome (AIDS) disease and women's mortality (Cavanaugh, Hansen, & Sullivan, 2010). In the 30 years following the 1980s safe sex intervention promoting awareness around condom use to block the contraction and transmission of HIV/AIDS in gay males, HIV/AIDS and other STDs such as syphilis, gonorrhea, and chlamydia disproportionately and negatively affect women (East et al., 2010; Logan, Khambaty, D'Souza, & Menezes, 2010).

Based on the shift occurring in the at risk population for STDs, women's RSBs must be addressed. Since individuals' beliefs are predictors of their behaviors (East et al., 2010; Medina, 2009; Zak-Place & Stern, 2004), STD interventions should be designed to address women's beliefs in an effort to change risky sexual behaviors in the at risk population and improve women's health by preventing new cases of STDs (Fishbein, & Middlestadt, 2011; Jemmott, Jemmott , & O'Leary, 2007). Although women indicate they prefer to discuss sexual health related issues with healthcare providers (HCPs) (Friedman & Bloodgood, 2010), little was known about women's

perceptions of healthcare providers influence in shaping their beliefs about protection against sexually transmitted diseases. In the absence of research focusing on HCPs influence on the beliefs driving women's RSBs, women may continue to be disproportionately affected by STDs (Centers for Disease Control & Prevention (CDC), 2012). This qualitative multiple case study explored the provider-patient consultation and women's perceptions of provider influence in shaping their beliefs about protection against STDs. Findings from the study resulted in knowledge that might assist healthcare providers in motivating women to change RSBs and could result in fewer reports of STD cases in the at risk population if HCPs and healthcare leaders design corrective measures based on the specified recommendations.

In Chapter 1, the study's overview is presented. The background of the problem and statements of the problem and purpose are iterated. The theoretical framework, research methodology, and the study's significance to healthcare leaders and stakeholders are described. Other discussions included in Chapter 1 are the nature of the study and the research questions driving the study. Key terms are defined in addition to the assumptions, scope, limitations, and delimitations that underlie the study.

Background of the Problem

Healthcare providers are key stakeholders in the continuum of care and the dispensing of medical services aimed to diagnose, treat, and prevent disease (CDC, 2011b), yet little is known about the influence healthcare providers have on women's beliefs about STDs. Based on the level of responsibility entrusted in HCPs, they are in a position to prevent future cases of STDs (CDC, 2011b) by exercising their influence when engaged in the provider to patient consultation and serving as agents for change in

women's beliefs, which ultimately could change women's behaviors (East et al., 2010; Fishbein, & Middlestadt, 2011; Jemmott et al., 2007). Although the role of HCPs may be instrumental in shaping women's beliefs about STDs and the actions women take to prevent their incidences, Friedman and Blood (2010) stated HCPs were possibly failing to seize all opportunities as teachable moments for STD prevention when consulting with women patients.

A clear understanding of how women perceive provider influence in the STD phenomenon during patient consultations was not available in literature. A gap in knowledge as to how HCPs can lower resistance and motivate women to change risky sexual behaviors by shaping their beliefs in a manner that adheres to provider influence also existed. Efforts to save lives and improve health require HCPs to assume responsibility in influencing patients to adhere to prescribed recommendations (Brincks, Feaster, Burns, & Mitrani, 2010).

Interventions aimed at improving health and sustaining favorable health outcomes required an assessment of women's perceptions of healthcare providers influence in shaping their beliefs about sexually transmitted diseases since women prefer discussing sexual health matters with HCPs (Friedman & Bloodgood, 2010). An exploratory analysis was needed to find out if these discussions routinely took place based on women's perspectives. Women are not likely to change their behaviors if their beliefs about STDs are not addressed (East et al., 2010; Medina, 2009; Zak-Place & Stern, 2004), so evidence from this study adds information to the STD phenomenon and might assist healthcare providers and leaders to design interventions to address women's beliefs.

The relationship between provider and patient is instrumental in establishing trust in the dissemination of information occurring during patient consultations (Brincks et al., 2010). The provider-patient relationship drives patient activation, which researchers Alexander, Hearld, Mittler, and Harvey (2012) define as the action patients take regarding their health. The nature of the provider-patient relationship has the potential to shape [women's] beliefs in a manner supportive of patient activation (Alexander, Hearld, Mittler, & Harvey, 2012). The health statuses of patients who engage in heightened levels of activation improve because these individuals are likely to partake in effective self-management techniques and behaviors (Alexander et al., 2012). Findings from this study revealed women's beliefs about STDs did not shift or change after provider-patient consultations because no information was received to elevate patient activation to change RSBs.

Interactions between healthcare providers and patients are appropriate for pivotal sexual health discussions (Friedman & Bloodgood, 2010). Healthcare providers who leverage teachable moments in their communications with visiting female patients are major resources for STD prevention (CDC, 2011b), yet scholarly research involving this topic was limited and required an in-depth analysis of the parties involved in the STD phenomenon. This study investigated (a) women's perceptions of healthcare providers influence in shaping their beliefs about STDs during the provider-patient consultation; (b) how women believe information could be couched to motivate a change in their beliefs about STDs; and (c) women's perceptions of the information received from healthcare providers and its influence in motivating them to shift or change their beliefs about STDs, ultimately resulting in risky sexual behavioral changes.

Statement of the Problem

The general problem is women contract STDs at a rate disproportional to men (CDC, 2009; CDC, 2010; CDC 2011a; Logan et al., 2010). Although protection against STDs is available to women through effective and consistent condom use during sexual activity, women's failure to comply with this recommended intervention to prevent STDs places them at risk (CDC, 2009; CDC, 2010; CDC 2011a; Trepka et al., 2008). Based on the annual numbers of newly reported cases of STDs in women (CDC, 2009; CDC, 2010; CDC 2011a), a plausible consideration possibly overlooked in research is women do not possess adequate information to protect themselves against STDs and may not have full knowledge of the risky sexual behaviors placing them at risk for contracting these diseases (Barban & Cracium, 2007; East et al., 2010).

The specific problem is there is no research currently available to garner an understanding of healthcare provider influence in shaping women's beliefs about protection against STDs. Women admit they are too embarrassed or uncomfortable discussing sexual health with family and friends and prefer to have these discussions with healthcare providers (Friedman & Bloodgood, 2010). A lack of research addressing provider influence on women's beliefs about using condom protection during sexual contact resulted in a gap in knowledge as to whether women, particularly Louisiana women, receive adequate information needed to promote change in behaviors during the provider-patient consultation. Louisiana is a national leader in reported STD case rates (Louisiana Department of Health and Hospitals (DHH), 2013), which places women in this population at a greater risk for contracting a disease if their beliefs about STDs are based on inaccurate or misconstrued information.

Purpose of the Study

The purpose of this qualitative multiple case study was to explore women's perceptions of the provider-patient consultation regarding the prevention of potential disease resulting from sexual relations. Findings from the study addressed the specific problem that there was no research available to understand healthcare provider influence in shaping women's beliefs about protection against STDs. A purposive sample of adult women from the Baton Rouge, Louisiana area was selected to participate in open-ended telephone interviews. Interview questions were designed to solicit responses to questions focusing on adult women's perceptions of provider influence in shaping their beliefs about protection against STDs. The study explored how women believe healthcare providers could couch STD related information to lower resistance and motivate women to change risky sexual behaviors. Based on women's perspectives, the study investigated how women perceive the information received from healthcare providers during provider-patient consultations influences them to change or shift beliefs about STDs.

A qualitative multiple case study was limited to individuals who met the following criteria: female, age 18 to 45, and visits made to healthcare providers during the 2012 to 2014 time period. The purposive sample of women solicited from the Baton Rouge, Louisiana area self-reported the criteria were met. Participants revealed findings that addressed the specific research problem and answered the interview questions. In addition to participants' interviews, written articles, published statistical reports, and healthcare journals helped with the triangulation of data.

The data obtained from this research study might be relevant to all individuals in general and women in particular because the STD epidemic found in Louisiana is not

homogenous and is capable of spreading globally (Smith & Whiteside, 2010). Findings identified in this study may be useful for future studies and collectively work toward benefiting government entities such as CDC, World Health Organization (WHO), and National Institutes of Health (NIH) by providing information needed for STD intervention programs and collaboration (CDC, 2011b). Research findings might help in bridging the gap in the information written about the STD phenomenon and add knowledge about women's perceptions of healthcare providers influence in shaping women's beliefs regarding STDs.

Significance of the Problem

The long term effect of bridging the gap in literature regarding healthcare providers' influence in the STD phenomenon may assist healthcare providers, healthcare leaders, government officials, and other stakeholders in intervening and promoting strategies that help to shape women's beliefs about these diseases, resulting in fewer cases (CDC, 2012). Within the general public, STD education, the promotion of regular STD testing, and technological innovations lose their momentum when STDs are perceived as less threatening (Smith & Whiteside, 2010) and people do not die by the thousands like they did in the 1980s. Newer interventions are needed to maintain momentum and function in tandem with revolutionary programs initially integrated in public health to prevent STDs (Smith & Whiteside, 2010).

Significance of the study. Sexually transmitted diseases may continue to occur disproportionately in women in the absence of effective preventive strategies addressing women's beliefs about these diseases. The general significance of the study is findings from the research conducted may assist healthcare providers to develop strategies to help

shape women's beliefs about STDs. The Health Belief Model (HBM), which is the theoretical framework for this study, supports behavioral health changes as a result of changes in beliefs (Zak-Place & Stern, 2004).

The specific significance is the study used a qualitative multiple case study approach to investigate Louisiana women's perceptions of healthcare providers influence in shaping their beliefs regarding the prevention of potential disease resulting from sexual relations during the provider-patient consultation. Although Yin (2003) determined the results of qualitative case studies are not generalizable, findings from the study may transfer to larger populations. Women state they prefer to obtain STD information from healthcare providers, yet opportunities to engage women in discussions relating to STDs and sexual health were not known to occur (Friedman & Bloodgood, 2010). A review of scholarly literature pointed to a gap in knowledge involving sexual behavioral changes made by women after consultations with healthcare providers. Further evaluation was needed to determine how women perceive the provider-patient consultation.

Significance of the study to leadership. The revelation of new insights involving healthcare providers' influence in shaping women's beliefs regarding STDs might add knowledge to the STD phenomenon. The significance to leadership is findings from the research will enlighten healthcare providers and leaders to the importance of involving HCPs in future STD intervention strategies targeting women. This study was conducted to improve upon previously adopted interventions and programs aimed at reducing new incidences of STDs in gay males by addressing the gender shift in the spread of STDs and the HIV epidemic (Smith & Whiteside, 2010). Individuals affected by an epidemic in connection with higher prevalence are indicative of the shifts that must occur in

preventive and health care interventions (Hall, Espinoza, Benbow, & Hu, 2010; Smith & Whiteside, 2010).

Nature of the Study

Neuman (2006) indicated research questions drive the research study and help to guide the selection of the research methodology and design. An inquiry into women's perceptions of healthcare providers influence in shaping women's beliefs about using protection against STDs and the changes women make in risky sexual behaviors aligned with a qualitative study because of the focus on study participants' personal viewpoints involving sexual health matters (Buetow, 2010). As noted by Yin (2003), qualitative research is flexible and unveils holistic findings embedded in social behaviors. Studies involving a qualitative method embody deductive or inductive approaches to arrive at new insights from the data collected. Campbell (2014) determined qualitative research is exploratory and often used when there is limited information written about a topic. Findings derived from qualitative research are based on social behaviors and a phenomenon (Bansal & Corley, 2012).

Employing the rationale of Neuman (2006), a qualitative multiple case study design was chosen for this study. A qualitative multiple case study was appropriate for this study because the objective of the study was to investigate women's perceptions of provider influence in shaping their beliefs about the severity of STDs and women's susceptibility to acquiring these diseases. Since the focus of the study was based on a contemporary issue, the case study was appropriate (Yin, 2003). In studies focusing on health issues, the case study can be used when the emphasis is on participants' experiences (Yin, 1999). Findings and conclusions drawn from case studies are not

based on the assumptions of the researcher (Yin, 2003). In case studies, assumptions are considered as data warranting a deeper analysis and the possibility of future research (Yin 2003). During provider and patient consultations, provider influence is needed to shape women's beliefs regarding STDs and ultimately to change women's sexual behaviors (East et al., 2010; Jemmott et al., 2007). An investigation of women's perceptions of healthcare providers influence was critical for the implementation of future STD preventive strategies and to build upon prior interventions (East et al., 2010; Jemmott et al., 2007).

An invitation to participate in the study (see Appendix B) was emailed to a purposeful sample of women belonging to professional associations and organizations in Baton Rouge, Louisiana. Email addresses were readily available because of the researcher's active membership in several women's associations and organizations. The purpose of the study was included in the body of the invitation to participate along with demographic questions that allowed women to self-report their gender, age range, and the number range of provider visits made between the 2012 and 2014 time period. Individuals willing to participate were asked to return the invitation to participate document to the researcher's email address. The woman with the range of most visits made during the criterion time period was selected first. Selection continued based on highest number range of visits made. If women self-reported equal number range of provider visits made, women were selected based on the order their invitation to participate documents were received.

The participants' email addresses were used to schedule telephone interviews. Telephone interviews were used to solicit responses to the research questions since the

participants and researcher were unable to meet face to face during the time data collection was scheduled to occur and the duration. Effective questioning is needed to collect information about a phenomenon (Patton, 2002).

Open-ended, structured interview questions were tested for internal validity during a pilot study conducted on the last three adult women not selected from the returned invitations to participate documents. Data collected from telephone interviews scheduled to take approximately one hour of adult women were analyzed to identify emerging themes. The analysis for emerging themes and ideas was conducted using the NVivo10 qualitative software and will be discussed in Chapter 4. NVivo10 is a program that organizes and simplifies unstructured qualitative data for analysis (QSR International, 2012).

Research Questions

The qualitative multiple case study intended to arrive at information that may assist in improving upon earlier STD interventions and preventing the onset of new cases of diseases in women. Abstinence, education, and consistent condom use are previous methods earlier studies indicated would result in STD prevention (Oyekale & Oyekale, 2010). Although these interventions are responsible for increasing knowledge and awareness about the harmful effects of STDS, reports and statistics obtained from the CDC, World Health Organization (WHO), and National Institutes of Health (NIH) indicate STDs continue to occur and most notably in women.

Women's health beliefs influence their decisions to engage in at risk sexual practices, which may compromise their future health statuses and possibly lead to an STD (Marcus et al., 2011; Medina, 2009; Trepka et al., 2008; Zak-Place & Stern, 2004). In

the study conducted by Friedman and Bloodgood (2010), women indicated they were aware of STDs and were most comfortable talking with healthcare providers. Although individuals use the internet to search for sexual health information (Buhi, Daley, Fuhrmann, & Smith, 2009), women assert healthcare providers are a preferred resource for STD information and sexual health issues (Friedman & Bloodgood, 2010).

Given the purpose of the study, the research questions underpinning this qualitative multiple case study were as follows.

RQ1: How do women perceive provider-patient consultations regarding the prevention of potential disease resulting from sexual relations?

RQ2: How could healthcare providers couch STD related information to lower resistance and motivate women to change risky sexual behaviors?

RQ3: How do women perceive the information received from healthcare providers regarding method and concept of use of contraceptives in the prevention of sexual transmission of disease during sexual relations?

Theoretical Framework

The theoretical framework is the logical structure underpinning the study. Ontological and epistemological concepts embodied in the research inquiry sharpen and anchor the focus of an identified problem. The articulation of the problem or an undesired result such as women acquiring STDs because they failed to use protection during sexual relations becomes a lot clearer when a social cognition theory is introduced to understand the beliefs driving behavior (Baranowski, Perry, & Parcel, 2002).

The social cognitive theory and the Health Belief Model imparted knowledge in the study. The social aspects of the research and the behavioral change model were

supported by literature involving women and risky sexual behaviors, women and STDs, women's beliefs about STDs, STD prevention, and healthcare providers' influence in shaping women's beliefs about sexual health matters. The research conducted on women's sexual health and the negative affect of STDs in women illuminated the general significance of the study and the need for cognitive learning of and behavioral changes to women's risky sexual behaviors.

Both the social cognitive theory and the Health Belief Model posit behaviors are the result of individuals' beliefs (Baban & Craciun, 2007; Baranowski et al., 2002). HCPs influence on women's cognitive learning might motivate women, who are in control of making changes to behaviors, to achieve better health outcomes. Based on the interpretations of researchers Revere et al. (2011) that disease prevention is the basis for the Health Belief Model, the constructs of the model were used to develop research inquiries to better understand women's perceptions about STDs and STD prevention efforts made by healthcare providers.

Social cognitive theory. Theories involving social learning were first developed and introduced in 1962 by Bandura, a behavioral scientist, who sought knowledge to better understand humans in social contexts (Baranowski et al., 2002). Two decades later, the social cognition theory evolved from Bandura's earlier research to include constructs explaining the reasons why individuals, who were believed to control the changes in their lives, made social changes in their behaviors. The newer approach to social learning is reflective of the transformation from the behavioral theory or learning through observations to cognitive learning, where individuals control the changes occurring in their lives (Baranowski et al., 2002).

At the root of social cognitive theory is the understanding individuals' behaviors are influenced by their beliefs and attitudes (Baranowski et al., 2002). The underlying principle of social cognitive theory is best explained as self-efficacy, which is an individual's ability to make changes to achieve a desired outcome. Self-efficacy, a construct found in other models of change behavior, drives individuals to make life changing decisions and is critical for behavioral change because individuals need to know they are capable of achieving a desired outcome (Baranowski et al., 2002).

The social cognitive theory was part of the framework for this study because women have the ability to change their behaviors (Henshaw & Freedman-Doan, 2009). Social cognitive theory is associated with studies involving changes in health behaviors (Henshaw & Freedman-Doan, 2009). Premises embodied in the social cognitive theory were used to explore women's beliefs about how healthcare providers could present STD related information during consultations to change risky sexual behaviors.

The Health Belief Model. The social cognition model and theoretical framework for this study was the Health Belief Model, which emerged as one of the first models associated with health behavior change following the development of the social cognitive theory (Zak-Place & Stern, 2004). The model was developed by United States Public Health Service researchers to determine why individuals requested X-ray exams when faced with the tuberculosis (TB) disease. In 1966, the work begun by the public health researchers was transformed by Irwin M. Rosenstock, a behavioral scientist, and later redesigned into a model with four major constructs (Zak-Place & Stern, 2004).

The constructs of the model are (a) susceptibility to disease, (b) the severity of disease, (c) perceived benefits of changing behavior, and (d) perceived barriers to

changing behavior (Zak-Place & Stern, 2004). These constructs are significant to the public because health beliefs play a role in individual's actions and responsibility (Shanks, 2009). Understanding women's perceptions of healthcare providers influence in shaping their beliefs regarding women's susceptibility to STDs, the severity of STDs, the benefits of adhering to provider influence, and the barriers women face in changing their behaviors, may prove helpful as an intervention for preventing new cases of STDs.

Henshaw and Freedman-Doan (2009) emphasized the HBM is useful in explaining factors either inhibiting or encouraging an individual's engagement in a health-related behavior. Since the inception of the HBM, researchers posit beliefs may include cues to action, optimism, and knowledge (Montgomery & Bloch, 2010). Researchers agree knowledge is important to shaping beliefs, yet knowledge about sexually transmitted diseases is insufficient to drive changes in risky behaviors as evidenced by annual documents of newly reported cases (Thompson & Caltabiano, 2010). Since the HBM focuses on beliefs, the underlying rationale is beliefs about an illness determine the likelihood of an individual engaging in a particular health behavior. Baban and Craciun (2007) determined the HBM is a motivational model based on

> the extent to which she/he believes that she/he is susceptible to a particular illness; her/his perception of the severity of the illness consequences; perceived barriers/costs of adopting a health behavior; perceived benefits of adopting the targeted health behavior. These cognitive factors determine beliefs in personal health threat and in the effectiveness of a health behavior. (p. 48)

Henshaw and Freedman-Doan (2009) asserted social cognitive theory is now part of the HBM and is influential to behavioral outcomes. The researchers believed certain

triggers influence health behaviors and internal or external cues to action, which are incidents reminding an individual [woman] of an illnesses' severity or threat. For example, a woman may experience an internal cue if she has a prior history of a sexually transmitted disease. A woman may experience an external cue if she reads printed material in a doctor's office about the health risks associated with acquiring a sexually transmitted disease. Following the triggers created by the printed material, healthcare providers could reinforce external cues about STDs by exercising their professional influence during the provider-patient consultation to increase patient activation. The efforts taken by HCPs to elevate patient activation are driven by the roles established in the provider-patient consultation and may ultimately shape the beliefs of women by establishing internal cues leading to [sexual] behavioral changes in women (Alexander et al., 2012; Henshaw & Freedman-Doan, 2009).

Sociopsychological variables of social class, personality, peer norms, and sensation seeking have been included in the model and are in addition to cues to action (Payne, Davis, Feldstein-Ewing, & Flanigan, 2009). Social and environmental constructs play an important part in health related decisions because they help to influence outcomes (Henshaw & Freedman-Doan, 2009). Self-efficacy aligns with cognitive theory and suggests a woman is capable of achieving efficacy expectations. Social constructs are critical in understanding whether a woman may achieve desired outcomes (Henshaw & Freedman-Doan, 2009).

The HBM is widely utilized as the framework for the development of health-related behavioral change interventions and is found in studies about the transmission of HIV/AIDs caused by unsafe sexual practices (Oyekale & Oyekale, 2010; Payne et al,

2009). Researchers find the model useful for conducting studies involving sexual risk behaviors. In an effort to minimize the probability of women acquiring STDs as a result of risky sexual behaviors, more research using the theoretical framework of the HBM was needed to arrive at new information.

The constructs of the HBM are viewed independently and the relationships between each component have not been clearly documented (Munro, Lewin, Swart, & Volmink, 2007). In the absence of formulated comparisons, the HBM may indicate behavioral change is high when one variable is high and another variable is low. For example, the assumption is change action is high when perceived severity is high and perceived susceptibility is low.

Since women are vulnerable to acquiring STDs, empowerment strategies aimed at STD prevention are critical to reduce STD transmission rates (Macleod-Downes, Albertyn, & Mayers, 2008). Perceived vulnerability is an HBM construct as determined by Ross, Ross, Rahman, and Cataldo (2010). In quoting Ross et al. (2010), the components of the HBM are defined as "perceived vulnerability, benefits, cues to action, severity of consequences, and fewer barriers" (p. 34).

Gender contributes to women's susceptibility to HIV. Macleod-Downes, Albertyn, and Mayers (2008) aimed to identify and categorize the factors influencing women's vulnerability to HIV. By identifying and categorizing factors, the scholars intended to determine how women's abilities to adopt protective behaviors against incurable viral infections increased. Macleod-Downes et al. (2008) discovered five clusters. The clusters of (1) bio-psychosocial and demographic factors; (2) cultural and societal factors; (3) communication factors; (4) perceptions; and (5) efficacy, determine

women's vulnerability to HIV [and other STDs]. The researchers arrived at these clusters through a meta-analysis of peer-reviewed literature. Factors associated with each cluster were also examined. For example, age, education, religion, race, and relationship status were associated with bio-psychosocial and demographic factors.

Although studies involving STDs have used the HBM to predict the likelihood of behavior, no research was found regarding women's perceptions of healthcare providers influence in shaping women's beliefs regarding STDs. Prior STD interventions focusing on safe sex practices appear ineffective in changing behaviors that could result in an STD because women continue to acquire these diseases. Woman are negatively affected by preventable STDs and suffering long-term consequences as a result of behavioral choices. Healthcare providers could help change these behaviors because women seek their expertise for sexual health matters (Friedman & Bloodgood, 2010). This study was conducted because more research was needed to explore women's beliefs, which may ultimately help to change their risky sexual behaviors and lead to fewer STD cases. This study utilized the theoretical framework of the HBM to explore women's perceptions of healthcare providers influence in shaping their beliefs about the STD phenomenon.

Definition of Terms

This study involved specific terms associated with STD research and interventions. The analysis presented in this study intended to provide the reader with a better understanding of associated terms and definitions regarding STDs. The list of terms associated with STDs and STD intervention ensues.

Sexually transmitted diseases (STDs). Sexually transmitted diseases are diseases transmitted from one individual to another through sexual contact (CDC, 2010).

Syphilis, gonorrhea, chlamydia, human immunodeficiency virus, acquired immunodeficiency syndrome and human papillomavirus are examples of STDs (CDC).

Acquired immunodeficiency syndrome (AIDS). Acquired immunodeficiency syndrome (AIDS) is a sexually transmitted disease that weakens the immune system and develops from contracting the human immunodeficiency virus (CDC, 2010).

Healthcare providers. Individuals [or institutions] engaged in the identification, prevention, or treatment of illness (The Free Dictionary, 2012).

Human immunodeficiency virus (HIV). The human immunodeficiency virus (HIV) is a viral sexually transmitted disease and a precursor of acquired immunodeficiency syndrome (CDC, 2010).

Human papillomavirus (HPV). Human papillomavirus (HPV) is a viral sexually transmitted infection that affects the genital area. The virus may cause cervical cancer in women (CDC, 2009).

Patient activation. Action taken by patients to actively manage their health is patient activation (Alexander et al., 2012).

Risky sexual behavior (RSB). Risky sexual behavior (RSB) is defined as failure to use a barrier during sexual contact, engaging in sex with more than one partner, or having sex with someone who is having sex with multiple partners (Marcus et al., 2011).

Self-efficacy. Self-efficacy is an individual's ability to make life changes to achieve a desired expectation or outcome (Baranowski et al, 2002).

Assumptions

The first assumption of the study was a purposeful sample of adult women in the Baton Rouge, Louisiana area agreed and was willing to participate. The second

assumption was interviews of participants in the study revealed significant information regarding women's perceptions of the provider-patient consultation. The third assumption was participants in the study were honest and open in revealing their perceptions of the provider-patient consultation regarding the prevention of potential disease resulting from sexual relations. The fourth assumption was that the researcher, who is an adult woman, did not allow personal bias to influence the collection of information from study participants. The researcher conducted open-ended inquiries to let themes emerge from the data. The fifth assumption was a qualitative multiple case study was the appropriate research method and design needed to solicit new insights from participants to add information about the STD phenomenon involving women.

Scope of the Study

The scope of this qualitative multiple case study was to interview adult women in Baton Rouge, Louisiana to gain a deeper understanding of their perceptions of healthcare providers influence in shaping women's beliefs about protection against sexually transmitted diseases. Adult women were targeted because they are the population most likely to contract an incurable STD in Louisiana. Women aged 18 – 45 were chosen from a purposive sample of women.

The criterion for participant selection was to choose adult women between the ages of 18 - 45, who made patient visits to healthcare providers between the 2012 – 2014 time periods. The time frame began with 2012 to ensure respondents were relying on recent consultations. Data obtained from telephone interviews were analyzed to arrive at themes. The data collected from the participants' interviews along with published public health information and scholarly articles and journals were used to increase the study's

validity. The method of collecting information from different sources to unveil deeper meaning is known as triangulation (Guion, Diehl, & McDonald, 2011).

Limitations

Study limitations are defined as weaknesses associated with the research (Shank, 2006). In this research study, the investigation was limited by the participants who agreed to be part of the study. The level of honesty in self-reporting of women's perceptions of provider influence in shaping their beliefs about protection against STDs may have limited the information they provided. Data collected in the study might also be limited by the participants' abilities to recall the discussions that occurred during provider-patient consultations. As a result of using a purposeful sample of adult women in the Baton Rouge, Louisiana area, findings from the study may not generalize to women in other jurisdictions. The final limitation of the study was the researcher, who as an adult woman may have brought perceptions of patient-provider consultations to the study. In qualitative studies, researchers should find themes in the data collected and not allow their personal biases to enter into the study (Rubin, 2008; Shank, 2006).

Delimitations

The study was delimited to telephone interviews of a purposeful sample of adult women in Baton Rouge, Louisiana. Only women aged 18-45 who granted their informed consent were included. The study was delimited to the inclusion of these participants because the additional time needed to collect data from a larger population in the metropolitan area could be used for analysis. The interview questions were limited to inquiries about women's perceptions of the provider-patient consultation and not about age, race, cultural, religious, or economic factors affecting women's beliefs.

Summary

The current state of the STD epidemic indicates interventions first introduced when gay males were the population most at risk for acquiring these diseases are deficient in preventing newly reported cases in women. Programs designed to promote abstinence and consistent condom use appear ineffective in women because they are disproportionately affected by STDs (CDC 2009; CDC 2010; CDC, 2011a; Oyekale & Oyekale, 2010). The shift from gay males to women may require stakeholders in the STD epidemic to design strategies addressing the shift in populations most at risk for these diseases (Hall et al., 2010; Smith & Whiteside, 2010).

Healthcare providers are women's preferred resource for sexual health information (Friedman & Bloodgood, 2010). HCPs are responsible for diagnosing, treating, and preventing sexually transmitted diseases (CDC, 2011b), yet little was known about HCPs influence on women's beliefs about protection against STDs. Public health concerns such as the contraction and transmission of STDs require healthcare providers to serve as agents for change by addressing the unmet needs of populations most at risk for the incidence and prevalence of disease (CDC, 2011b). HCPs who effectively influence patient activation during the provider-patient consultation, have the potential to change the beliefs of women and ultimately their at risk sexual behaviors. Missed opportunities by HCPs to continuously educate women regarding their sexual health could contribute to unfavorable health outcomes in a population identified as at risk for sexually transmitted diseases. Women should experience the influence of HCPs in addressing their beliefs about protection against STDs regardless of the reason for or the number of patient visits made by women. Continuous discussions with HCPs during

provider-patient consultations may work better than other venues to trigger change in women's beliefs and ultimately reduce STDs resulting from women's RSBs.

Chapter two presents a literature review of studies, documents, articles, and databases reviewed. Information regarding sexually transmitted diseases, women's beliefs about STDs, the Health Belief Model, an overview of the STD epidemic in Louisiana, and HCPs role in STD prevention will also be discussed. The chapter will conclude with the concerns STDs place on stakeholders in the healthcare industry.

Chapter 2

Review of the Literature

The purpose of this qualitative multiple case study was to investigate women's perceptions of healthcare providers influence in shaping their beliefs about protection against STDs during the provider-patient consultation. Chapter two embodies a literature review focusing on women's beliefs about STDs, risky sexual behaviors, and the role of healthcare providers. Major sections included in chapter two are: literature search and documentation, overview of sexually transmitted diseases, women' s beliefs regarding sexually transmitted diseases, risky sexual behavior, alcohol and sexual behavior, the role of healthcare providers, and concerns regarding sexually transmitted diseases. The objective of conducting a literature review is to reveal findings previously written about a topic and to add to the body of knowledge by introducing new information into research (Shank, 2006). Gaining a better understanding of healthcare providers influence on the beliefs contributing to behaviors that could cause women to contract an STD is important to the enhancement of prior interventions and for the implementation of newer strategies focusing on the prevention of STDs in women.

Title Searches, Articles, Research Documents, and Journals

The literature review includes sources from the University of Phoenix library and internet websites. The EBSCOhost and ProQuest databases accessed through the University of Phoenix library contained scholarly, peer-reviewed articles and research studies. The retrieval of journals and research documents are the result of key word searches such as women and sexually transmitted diseases, women's beliefs about sexually transmitted diseases, women's sexual behaviors, women's perceptions of

healthcare providers, provider-patient consultations, provider roles and responsibilities, and STD interventions.

Access to statistical information was provided by the following websites: CDC, WHO, NIH, and the Louisiana Department of Health and Hospitals. Although the search for literature produced a plethora of articles, journals, documents, and research studies about the STD phenomenon, the information found in this literature review is relevant to this research study. Scholarly, peer-reviewed journals and articles represent the majority of the references used for this study.

Overview of Sexually Transmitted Diseases

Sexually transmitted diseases, also referred to as sexually transmitted infections (STIs), transmit through bacteria or viruses from one individual to another during intimate sexual contact (CDC, 2010; Weeks et al., 2010). Twenty-five percent of the sexually active United States population is comprised of individuals aged 15 to 24 years. Statistics indicate the 15 to 24 year age group are most at risk for STDs because they believe the use of condoms, which is a safe sex practice, is inconvenient (Crosby & Danner, 2008; Garcia-Retamero & Cokely, 2011). This age group represents 50% of all newly reported STD cases, including HIV. The STD cases accounting for 88% of new STD cases for the 15 to 24 age category are human papillomavirus (HPV), chlamydia, and trichomoniasis. In conjunction with chlamydia, syphilis and gonorrhea are the three major bacterial STDs reported to the CDC by primary and clinical providers (CDC, 2010).

The effect of STDs differs in women than men because infected women face unique psychosocial issues in addition to physical health issues and disproportionately

experience the long term impact of STDs (Squires et al., 2011). In some instances, STDs are asymptomatic and go undetected, which may lead to major health complications such as cervical cancer or pelvic inflammatory disease (Brackbill, Sternberg, & Fishbein, 1999). Although women are aware of STDs, their health depends upon reducing the risk of acquiring these diseases by consulting with healthcare providers who remain a primary resource for conveying sexual health information (Friedman & Bloodgood, 2010). This study was timely and relevant because an exploration of women's perceptions of the provider-patient consultation was conducted to better understand provider influence in shaping women's beliefs about protection against STDs.

Viral STDs

Although the etiology associated with women acquiring an STD involves the transmission of bacteria or viruses during sexual encounters (Weeks et al., 2010), bacterium caused STDs are curable, whereas viral STDs are incurable. Viral STDs, most notably human papillomavirus (HPV) and human immunodeficiency virus (HIV), receive widespread attention and are more likely to afflict unfavorable long-term consequences on women's health (CDC, 2009; CDC, 2010; CDC, 2011a; Medina, 2009). Of the new STD cases reported for the 15-24 year age groups, genital HPV is the sexually transmitted infection found to occur the most (CDC, 2009).

Eighty percent of women will acquire HPV before reaching the age of 50, which may suggest women lack knowledge or possess ambivalent beliefs about the viral disease (Graziottin & Serafini, 2009). College aged females are more at risk for contacting HPV because of their sexual behaviors (Caron, Kispert, & McGrath, 2009). "Sexually active female college students in the 20-24 age group are often unaware of HPV and become

aware of HPV only after being diagnosed with the HPV infection by a healthcare provider" (Caron et al., 2009, para. 5).

The fact that 80% of women will encounter HPV at some point in their lifetime is indicative of the need to seize all opportunities to ensure women's knowledge and beliefs align with documented evidence of the need to use protection against the disease's cause and effects. All women must be informed of the dangers and consequences of HPV because the virus is known to cause cervical cancer 99% of the time (Montgomery & Bloch, 2010). The consequences associated with cervical cancer should not be ignored because this type of cancer is a leader in cancer-related deaths in women (Montgomery & Bloch, 2010).

HIV is another virally transmitted sexual disease increasingly affecting the female population. Maynard, Carballo-Diéguez, Ventuneac, Exner, and Mayer (2009) indicated women are engaging in anal sex with HIV infected men, which is a "highly efficient mode of HIV transmission" (p. 142). Researchers Maynard et al. asserted "to develop effective interventions for HIV prevention, it is important to better understand both women's motivations for engaging in anal intercourse and the circumstances in which they choose to use a condom" (p. 142).

The CDC (2010) also reported women are acquiring HIV through sexual intercourse with HIV infected men. The HIV infection may result in AIDS and progress to an AIDS related death (CDC, 2010). Based on current trends, the CDC estimates the number of women infected with HIV will soon outnumber the men. Since 1983, the proportion of HIV infections caused by sexual contact between gay White males has

declined and is accompanied by a shift in racial and gender groups (Hall, Espinoza, Benbow, & Hu, 2010).

In the three decades following the first reported cases of HIV/AIDS, minority females, particularly those geographically located in southern areas, are disproportionately affected by HIV/AIDS (Hall et al., 2010). By the nature of the disease and its ability to attack and weaken different parts of the body, the prevalence of HIV/AIDS creates unique needs in the populations most at risk and future generations experience its consequences (Smith & Whiteside, 2010). Given the future estimated cases of HIV/AIDS in women, stakeholders in the healthcare industry might benefit from gaining a better understanding of women's perceptions of HCPs influence on women's beliefs that result in behaviors placing them at risk for STDs.

Louisiana

Geographic location is a significant factor associated with STD incidence rates (Hall et al., 2010; von Sadovszky, 2008). The mobility of the population is the linkage to geographically pervasive epidemics and intensive HIV transmission (Deane, Parkhurst, & Johnston, 2010). In the United States, heightened rates of STDs are reported throughout the country. Women who live in southern states acquire STDs at a higher rate than women who live in other areas (Hall et al., 2010; von Sadovszky, 2008). Louisiana, as part of the southern region of the United States, ranked first in the nation for incidence and prevalence of primary and secondary (P&S) syphilis from 2006 – 2011 (Louisiana DHH, 2011); Louisiana DHH, 2013). The *2012 STD Surveillance Report* published by the CDC ranked Louisiana seventh in the nation for congenital syphilis (Louisiana DHH, 2013). The CDC report illuminated gonorrhea and chlamydia rates caused Louisiana to

rank as the second and fourth highest, respectively, in the United States (Louisiana DHH, 2013).

In 2012, Louisiana continued to trend higher than its neighboring southern states and the national average for P&S syphilis (Louisiana DHH, 2013). Although 2012 is the first year since 2005 that Louisiana experienced a decline in the incidence rate for P&S syphilis, the state was third in the United States for case rates per 100,000. Louisiana's rate was 7.4 compared to the national average of 5.0 (Louisiana DHH, 2013).

Gonorrhea rates exceeded the national average from 2003 through 2011 (Louisiana DHH, 2013). In 2012, the Louisiana rate for gonorrhea experienced a decline over the 2011 level. The 2012 rate for gonorrhea was 192.8 per 100,000 and was 84.2 higher than the national average of 107.5. The rate in females was 216.2 per 100,000. The goal of *Healthy People 2020* is to reduce the gonorrhea rate in females (Healthy People, 2010).

Louisiana's chlamydia rate of 594.4 per 100,000 exceeded the national average of 456.7 in 2012. Based on this data, the incidence rate for chlamydia was 1.3 times higher than the national rate. The 2012 female rate was 872.7 (Louisiana DHH, 2013).

The statistics presented about STDs in Louisiana invoked a desire to better understand the perceptions of individuals involved in the phenomenon. Since the 1980s, the government and healthcare leaders have promoted awareness about the need to use condoms for protection against STDs, yet statistics indicate individuals, particularly women, in Louisiana are not adhering to the required behavioral change. Women may not change behaviors until they possess adequate knowledge and believe they are at risk for a disease. Since women are not likely to discuss STDs with family members and

friends, the patient-provider consultation represents an excellent opportunity to have these types of discussions (Friedman & Bloodgood, 2010). The study is important because women were interviewed to understand how they perceive provider influence in shaping women's beliefs about protection against STDs. Behavior change can occur as a result of changes in beliefs (Zak-Place & Stern, 2004).

Risky Sexual Behavior

Behavioral theorists determined human behavior plays a key role in maintaining health and preventing disease (Barban & Craciun, 2007). Sexual behavior, a form of human behavior, is unique to an individual and is influenced by age, race, gender, religion, education and other factors. Alcohol and drugs, both of which are mind-altering substances, as well as an individual's perceptions, are also known to influence sexual behaviors and may cause risky sexual actions between individuals (Barban & Craciun, 2007).

Younger aged individuals tend to engage in non-committed sexual relations with someone who is classified as a friend. Most sexual behaviors by young adults are likely to happen in non-committed relationships and involve various forms of behavior accompanied by differences in exposure to sexually transmitted diseases (Furman & Shaffer, 2011). Younger adults do not believe monogamy is a prerequisite for sexual contact and frequently indulge in sexual behaviors that place them at risk for STDs (Furman & Shaffer, 2011).

Sexual behaviors as categorized by younger aged individuals involve light non-genital contact, heavy non-genital contact, and genital contact. Light non-genital contact involves kissing on the lips and cuddling. Heavy non-genital contact is described as dry

sex. Genital contact is the riskiest form of sexual behavior because it involves anal, oral, or vaginal sex (Furman & Shaffer, 2011).

Risky sexual behavior is failure to use a condom during genital contact, sex in uncommitted relationships, and engaging in genital sex with more than one partner whose sexual history is either risky or unknown (Marcus, Fulton, & Turchik, 2011). In a qualitative study conducted by Bolton, McKay, and Schneider (2010), the researchers examined psycho-social dynamics of condom discontinuation by 13 adult women, aged 18-24 years, using survey and interview instrumentation. The study's participants self-reported they were in dating relationships. The authors believed dating women used condoms during first sexual encounters with new partners. Discontinuation occurred as birth control pill usage increased and relationships progressed. The behavior pattern of discontinuing condom use was consistent with at risk sexual behavior and placed women in compromising situations to acquire sexually transmitted infections (Bolton, McKay, & Schneider, 2010).

Women's perceptions about their relationships influence their decisions to engage in consistent condom use (Bolton et al., 2010). A woman who believes STDs are nonexistent in her partner's sexual history and that she is in a monogamous relationship is more likely to discontinue condom usage. The discontinuation of condoms occurs because women experience increased levels of trust, intimacy, and pleasure as the relationships with their partners progress and transition (Bolton et al., 2010).

Sexual behaviors are not necessarily controlled by one partner engaged in a sexual relationship (Billy, Grady, & Sill, 2009). In a study conducted by Billy, Grady, and Sill (2009), the authors believed focusing on couples adds information to previous literature

regarding risky sexual behaviors. Billy et al. intended to gain an understanding of the dynamics existing between couples who self-identified as being in committed relationships and their sexual behaviors. The researchers concluded interventions focusing on couples may help to influence individual attitudinal changes about safe sex practices because relational influences between couples form the groundwork for addressing the STD infection rate in the United States (Billy et al., 2009).

Failure to communicate sexual histories is indicative of risky sexual behaviors. Women may unknowingly have sex with male partners who are having sex with men (MSM). The behavior of women having sex with women (WSW) also falls in the category of risky sexual behavior. Heightened risks for sexually transmitted diseases permeate through a population because of undisclosed sexual histories and risk levels of relational partners (Wasik & Kachlic, 2009).

Researchers assert variables are associated with RSB. Risky sexual behavior variables are categorized as dependent, predictor, or demographic (Robinson, Scheltema, & Tonya, 2010). Dependent RSB variables include multiple concurrent partners and inconsistent condom use. Predictor variables associated with risky sexual behavior involve forms of abuse such as drugs and alcohol. Other predictor variables included domestic and sexual abuse. Demographic variables are age, marital status, education, employment, and regular attendance at religious services (Robinson et al., 2010).

Women who experience partner violence are less effective at negotiating condom use in comparison to women who are not abused (Cole, Logan, & Shannon, 2007). Women in abusive relationships are less likely to experience sexual exclusivity because of the lack of trust and the accumulation of abusive episodes. Other risky behaviors

prevalent in abused women are substance abuse before sex, low levels of decision-making regarding safe sex practices, and sex with non-monogamous partners. Interventions are needed within the population of abused women because their risky sexual behaviors place them at risk for contracting HIV and other STDs (Cole et al., 2007).

In the study performed by Cavanaugh, Hansen, and Sullivan (2010), 136 women who had been in violent situations with a partner six months before the study were examined for risky sexual behavior. Posttraumatic disorder as a result of intimate partner violence (IPV) and problems with drugs and alcohol correlates to risky sexual behavior (Cavanaugh, Hansen, & Sullivan, 2010). Risky sexual behavior was defined as (1) unprotected sex with a primary partner who indulged in risky behavior; (2) unprotected sex with a non-primary partner who indulged in risky behavior; and (3) traded sex in the six months before the study. Cavanaugh et al. determined "behavioral interventions focused on HIV-risk alone are inappropriate for women experiencing IPV. In fact, women may be nonresponsive to risk reduction messages given their preoccupation with personal safety" (Cavanaugh et al., 2010, p.325) and other extenuating circumstances that may exist at the time sex is initiated.

Common themes emerged from the studies focusing on risky sexual behaviors. The researchers who conducted studies regarding risky sexual behaviors categorically identified the lack of consistent condom use, noncommittal relationships, abusive partners, sex with partners whose sexual histories are unknown, and women who have sex with male partners who have sex with male partners, as risky sexual behaviors. The aforementioned behaviors are all factors that should be addressed by healthcare providers

who are responsible for educating and counseling women about STDs because women might not knowingly attribute these behaviors to at risk sexual behaviors (Royer & Cerf, 2009).

The HIV/AIDS disease continues to remain a health concern for larger urban areas as it did when the disease first emerged in the early 1980s (Hall et al, 2010). The number of infected individuals living with HIV and residing in Baton Rouge, also referred to as Region 2 of Louisiana, shows a steady increase in the number of HIV cases between 2001 and 2010 (Louisiana DHH, 2011; Louisiana DHH, 2013). Current trends and statistical data for populations most at risk for HIV/AIDs in Louisiana are consistent with epidemiologic findings for at risk populations in the United States.

An intermingling of Louisiana demographics and high incidences of STDs is indicative of an at risk population in need of medical intervention. Louisiana invests heavily in STD prevention programs, yet STD rates continue to rise. Epidemiological differences found in an area may require providers to approach STD prevention and treatment efforts differently than other areas [of the United States] to stave off new STD incidences and to improve health outcomes (Hall et al., 2010).

Although a review of the information regarding Louisiana reveals high incidence and prevalence rates for STDs and heavy investment in STD prevention, there is no literature available to understand women's perceptions of HCPs influence on their beliefs. Since beliefs cause individuals to engage in certain behaviors, delving into the root cause of women's risky sexual behaviors could lead to behavioral changes and ultimately prevent new cases of STDs. Without HCPs influence in shaping women's beliefs about protection against STDs, the risky sexual behaviors placing women at risk

for an STD will continue. This study is relevant because findings will result to better understand women's perceptions of provider influence on their beliefs.

Alcohol and sexual behavior. Alcohol is a situational factor driving risky sexual encounters because it affects a woman's ability to appraise a situation (Davis et al., 2010). The Alcohol Expectancy Theory suggests alcohol "influences behavior through individuals' outcome expectations about alcohol's emotional, physiological, and behavioral effects" (Davis et al., 2010, p. 482). The Alcohol Expectancy Theory are concepts suggesting individuals in western society hold the beliefs that enhancement in sexuality and an increase in sexual risk taking result from alcohol consumption situations (Davis et al., 2010).

Alcohol is a determinant in women's sexual behaviors and a factor for risky and consistently risky sexual behaviors in college students. In a cross sectional study conducted by Trepka et al. (2008), 1,130 participants at a South Florida minority-serving university with a high prevalence for HIV/AIDS were investigated for the effects of alcohol on sexual behaviors. Findings from the study revealed college administrators must include the use of alcohol in intervention strategies aimed at reducing the transmission of STDs because safe sex practices involve more than consistent condom use (Trepka et al., 2008).

Alcohol intoxication or alcohol consumption may impair a woman's ability to make sound decisions. In the event sexual contact begins, alcohol use could cause women to ascribe to risky sexual behaviors (Griffin, Umstattd, & Usdan, 2010). In the study performed by Griffin, Umstattd, and Usdan (2010), alcohol use was prevalent in

young college aged women and resulted in sexual behaviors that placed them at risk for acquiring STDs.

In another study regarding alcohol consumption, Davis et al. (2010) conducted an experiment on unmarried, heterosexual, college-aged women. The purpose of their study was to understand risky decisions made by women who engage in alcohol consumption. Davis et al. emphasized consistent use of male latex condoms helped to reduce the risk of transmitting STDs. The researchers determined college women who engaged in alcohol consumption did not consistently use condoms and ran the risk of contracting an STD.

The impact of alcohol intoxication on intentions to engage in sexual intercourse and the determinants of the intentions were examined in a study performed by Conner, Sutherland, Kennedy, Grearly, and Berry (2008). A written hypothetical approach was used to investigate participants' judgments regarding sexual encounters while under the influence of alcohol. The study revealed the decision to have sex is impacted more by alcohol than the decision to use condoms (Conner, Sutherland, Kennedy, Grearly, & Berry, 2008). Since alcohol influences a woman's decision to engage in sex, HCPs should ensure women's beliefs about its consumption during sexual encounters are not misconceived because alcohol and sexual behavior could lead to a woman contracting an STD.

The Health Belief Model. The Health Belief Model (HBM) is a behavioral theory originating during the 1950s (Zak-Place & Stern, 2004). The theory's founder, Irwin M. Rosenstock, along with other behavioral scientists intended to predict behaviors that ultimately affect an individual's health status. The Health Belief Model epitomizes health related beliefs and forms the basis for behavioral change theories. The theoretical

framework of the Health Belief Model conceptualizes an individual's intent to engage in particular behaviors to prevent the occurrence of disease and illness (Zak-Place & Stern, 2004).

The premise for the Health Belief Model is prevention, which is also the goal for public health interventions (Revere et al., 2011). The Health Belief Model was developed by the U.S. Public Health Service area to understand the reason people sought X-ray screenings for tuberculosis (Zak-Place & Stern, 2004). In theory, public health interventions are consistent with the Health Belief Model. In reality, practical applications may require modifications to previous interventions to better serve the demographics of a particular population and to align with the constructs of the Health Belief Model.

The Health Belief Model theory conceptualizes behavioral change may occur if an individual believes (1) the disease or illness is severe; (2) susceptibility is imminent; (3) benefits may occur as the result of a change in behavior; and (4) perceived barriers are present (Montgomery & Bloch, 2010). Behavior change is a controllable factor and excludes factors such as dominating male partners who infringe upon a woman's intentions to engage in safe practices to prevent an illness. For example, a woman who has an abusive male partner may refuse to use condoms. The woman's final decision to exclude condom use during sexual intercourse is likely dominated by fear of her partner's abuse more than fear of a disease (O'Leary, Jemmott, & Jemmott, 2008).

Empirical data supports the HBM's four main constructs, which evolved from explaining why individuals fail to engage in disease prevention programs, particularly tuberculosis, to other health related preventable conditions such as HIV/AIDs, HPV, and

other STDs (Manika & Golden, 2011). During the HBM's evolution, self-efficacy was incorporated as a new construct. Manika and Golden (2011) asserted self-efficacy involved an individual's competency to make recommended health changes.

Since its inception, the HBM now includes modifying factors called cues to action (Manika & Goldman, 2011). Cues to action affect an individual's preparedness to take action. Education, printed material, and media influences are cues to action. A woman visiting her gynecologist office takes note of a pamphlet addressing the harmful effects of sexually transmitted diseases. The information contained in the pamphlet regarding sexually transmitted disease may now serve as a cue to take action to prevent STDs. Radio announcements and television commercials geared toward STD prevention are also cues to action and may help motivate an individual to engage in behaviors that will reduce the likelihood of an STD occurrence (Manika & Golden, 2011).

The intention behind the HBM's design was to target communications toward the beliefs most likely to result in favorable health outcomes. The HBM was designed to investigate which beliefs were primary contributors to health behaviors (Carpenter, 2010). In an 18 study meta-analysis of 2,702 human subjects, Carpenter (2010) identified the beliefs that were useful in predicting behavioral outcomes. Individuals were likely to adopt a change in behavior if the perceived health outcome of a disease was negative and severe, their susceptibility to the disease was high, the benefits of adopting a change in behavior were high, and if they perceived the barriers for electing the behavior were low. In Carpenter's study, individuals' beliefs regarding benefits and barriers emerged as major behavioral influences over disease severity and their susceptibility to an illness.

Munro, Lewin, Swart, and Volmink (2007) reviewed the HBM in their study of health behavior theories to evaluate the usefulness of differing theories in developing interventions for individuals to adhere to long-term medication for tuberculosis (TB) and HIV/AIDS. The HBM recognizes health behavior change based on the appraised balance between an action's barriers and benefits. A woman's perception of a health behavior's effectiveness is the result of the influence perceived benefits and perceived threats has on the health behavior. For example, a woman is likely to adopt a recommended behavior if perceived threats and perceived benefits are high and barriers are low. An examination of the constructs of the HBM suggested perceived threats might result in avoidance of the protective action because women [individuals] may not equally equate the level of importance for perceived threats and perceived severity (Munro, Lewin, Swart, & Volmink, 2007).

In the research conducted by Sherman et al. (2008), 425 cancer patients were involved regarding the role of health beliefs to support group participation. The researchers constructed a survey based on the HBM where participants evaluated rates of utilization, health beliefs, and characteristics associated with demographics and medical variables. Group participation was consistent with the HBM. Stronger group participation was associated with the following beliefs about an illness: (1) high perceptions of severity; (2) high perceived benefits; (3) low perceived barriers; and (4) high cues for action.

Although the HBM was designed to predict a change in future behaviors, Thompson and Caltabiano (2010) indicated retrospective behavior was reliable in predicting future behaviors. Thompson and Caltabiano believed asking participants'

questions addressing knowledge of a particular condition reflected their perception of threat. In their study, other researchers who had different ideas about how knowledge factored into risk and susceptibility perceptions were referenced. Knowledge alone does not necessarily translate into health related behavioral change. In addressing women's knowledge about an illness or condition, it is plausible to arrive at the beliefs that women possess. Knowledge, age, ethnicity, education, and gender are considered socio-demographic factors that influence a person's level of perceived threat and beliefs regarding an illness (Macleod-Downes, Albertyn, & Mayers, 2008). These factors are contributors to women's vulnerability to disease because if a woman does not believe she is susceptible to a disease or that the disease is severe, she may avoid taking disease preventative actions. A person's knowledge, age, ethnicity, education, and sex are also important factors in preventing disease because they help to guide and promote the betterment of social welfare and the development of preventive interventions in the public health system.

The theoretical framework of the HBM was used in this study to determine if healthcare providers exercised their crucial roles in shaping women's beliefs about STDs. Efforts to improve health and the quality of life depend on preventive interventions such as those healthcare providers can promote. Health care providers are in a unique situation to make a difference in saving lives and improving women's health by stifling the STD and HIV/AIDS epidemic. By incorporating concepts of the HBM in their discussions with women seeking medical services in an office setting, healthcare providers become proactive and instrumental in shaping women's beliefs and potentially changing unhealthy behaviors (Manika & Goldman, 2011).

Women's Beliefs About Sexually Transmitted Diseases

Young women become infected with HPV, chlamydia, genital herpes, or trichomoniasis more than any other types of STDS (CDC, 2009; CDC 2010; CDC 2011a). These STDs are known to affect women and are common occurrences. Studies indicate women have various levels of knowledge and misconceptions about STDs (Royer & Cerf, 2009). Nearly one-third of the participants surveyed by Royer and Cerf (2009) believed gonorrhea and syphilis may be diagnosed by visual inspection of the genital area. Women who participated in the study were unaware that STDs may be asymptomatic and could transmit even with condom use. Approximately 50% of the 302 women who participated in the study did not believe sexually transmitted disease and sexually transmitted infection have the same meaning. The study's findings indicated women's beliefs are responsible for the transmission of STDs and may continue to influence STD prevalence (Royer & Cerf, 2009).

Healthcare providers (HCPs) and patients have different thoughts about the terms STDs and STIs (Royer & Cerf, 2009). HCPs use the term STIs to describe curable illnesses and STDs to describe those conditions that are incurable. Gonorrhea and syphilis are considered STIs, while HPV and HIV are considered STDs. Royer and Cerf (2009) surmised sexually transmitted diseases are caused by 30 different pathogens, may be curable or incurable, and can be symptomatic or asymptomatic. The researchers stated that because STDs may result in negative outcomes, developing strategies to reduce transmission of STDs are important (Royer & Cerf, 2009).

The identification and targeting of critical beliefs is one such strategy because it serves to promote communication strategies aimed at those beliefs (Boudewyns &

Paquin, 2009). The Theory of Planned Behavior (TPB) was used to predict and understand STD behavior testing in a research study conducted by Boudewyns and Paquin (2009). The researchers intended to reveal new concepts regarding women's beliefs by using TPB. Research questions were designed to determine which construct of TPB would be the strongest predictor of an individual's intention to test for STDs and which beliefs are associated with intentions to test for STDs (Boudewyns & Paquin, 2009).

The purpose of the study conducted by Crosby and Danner (2008) was to test the attitudes of adolescents about the use of protection to safeguard themselves from STDs. The researchers determined interventions aimed at 15-24 age groups are imperative to prevent sexually transmitted diseases because approximately 50% of reported STD cases occur in this population. Adolescents who believed practicing safe sex was a hassle were more likely to acquire an STD in young adulthood. Crosby and Danner asserted STD protection may be considered less of a hassle if adolescents demonstrate they have the skills to practice safe sex. Skills may include refusing to engage in unwanted sex, limiting the number of sex partners, and the effective and consistent use of condoms. The aforementioned skills involve negotiating and self-restraint when sexual arousal occurs. Women may benefit by strengthening their negotiation skills because studies indicate negotiation is situational (Crosby & Danner, 2008).

A randomized trial of a five group intervention, which focused on social and individual beliefs about condoms, self-efficacy, and impulse control, was performed by O'Leary, Jemmott, and Jemmott (2008). The study's participants were 564 women, aged 18-45, who were recruited from an outpatient women's health clinic in Newark, New

Jersey. Follow-ups were performed at three, six, and 12 month intervals. The study's results foster doubt about women's abilities to safeguard them against HIV/STD. The reason for this doubt is men appear to control the use of condoms. Rates of domestic violence are higher in communities where HIV/STD is prevalent and women feel culturally disempowered. Negotiation skill building in women for condom use must be emphasized more than practicing self-control because women may believe they are powerless in relationships to insist on safe sex practices. The burden men place on women's sexual behaviors places women at risk for other issues and possibly factors into their health beliefs (O'Leary et al., 2008).

HPV is an STD receiving widespread attention because the majority of females will have an HPV encounter during their lifetime. The percentage of the female population most likely to become HPV infected is approximate at 80% (Daley et al., 2008). Given the fact the majority of women will have an HPV encounter, numerous studies were retrieved to determine the beliefs women hold regarding HPV and Gardisil, the vaccine designed to prevent HPV occurrences.

The purpose of the study performed by Daley et al. (2008) was to identify knowledge gaps and information seeking practices in HPV positive women. Using a mixed method research design, the researchers engaged women who had scheduled gynecological exams at clinic sites in Florida. The study's findings revealed women were often confused or unsure about receiving HPV diagnoses. An opportunity exists to bridge the gaps in knowledge and information women have about HPV.

In a study conducted at Northeastern University, a cross-sectional design was used to explore the attitudes, behaviors, and beliefs of female college students. The

human papillomavirus vaccine was the topic the researchers used to investigate 367 female college students about the disease. Statistical analysis was used and included Pearson's correlations, paired sample t-tests, and descriptive statistics (Caron et al., 2009).

Questionnaires were administered to evaluate self-reported knowledge about HPV and Gardasil, the HPV vaccine, prior to participating in the study. The questionnaires were designed to collect information from participants by allowing yes, no, or not sure responses when asked about pre-survey knowledge of HPV and the Gardasil vaccine. The researchers intended to reveal students' awareness about HPV and the sources students access for information. Although the results may be limited because of the study's design, the findings suggested a correlation existed between knowledge and attitudes, behaviors, and beliefs (Caron et al., 2009).

The purpose of Cates, Brewer, Fazekas, Mitchell, and Smith's (2009) study was to identify beliefs, knowledge, and attitudinal differences regarding HPV, the HPV vaccine, and cervical cancer of rural, Southern women. Interviews were conducted of 138 women. The need to educate women in the rural South about HPV and the HPV vaccine exists (Cates, Brewer, Fazekas, Mitchell, & Smith, 2009).

Women underestimate the risks associated with HPV infection (Graziottin & Serafini, 2009). HPV 1) is sexually transmitted, 2) may represent a risk factor for sexual pain disorders, and 3) may be a threat to women's health. Research findings suggest "testing positive for HPV may have an adverse psychosocial impact" (Graziottin & Serafini, 2009, p. 638). Women tend to experience fear, anger, anxiety, and depression as a result of an HPV diagnosis. Graziottin and Serafini (2009) asserted more research is

needed regarding the psychosexual impact of genital warts on HPV positive women. Although the HPV vaccine may reduce the incidences of HPV and the psychosexual consequences, there is no evidence available to support this conclusion, nor the fact a relationship exists between HPV and female sexual disorders.

Munsell, Gray, Reed, Vasquez, and Vlasak (2010) used a cross sectional survey on Texas women aged 17 years and older to test their knowledge about HPV, the consequences of HPV, and the Gardidil vaccine. The results of the study suggested knowledge was important to HPV risk reduction. The findings revealed educating women was needed more to lower HPV risks. This study was limited because of the absence of a standard sampling method. Surveys were handed out to random women in Texas. Munsell et al. validated previous findings about HPV and stated HPV is the most common STI in the United States. HPV causes anogenital warts and may lead to cervical cancer. HPV is normally asymptomatic and its presence may go undetected. Women's awareness about HPV and the possible harmful side effects are driven by education, healthcare accessibility, religion, and age (Munsell, Gray, Reed, Vasquez, & Vlasak, 2010).

Gardasil, the HPV vaccine, is more likely to find acceptance among young women than mothers of young girls (Munsell et al, 2010). The Giles and Garland survey was used on women between the ages of 17-26. Factors of low risk perception, media, belief symptoms, and financial costs were believed to challenge the implementation of the HPV vaccination. It will take time to persuade young women and mothers of young girls to get vaccinated against HPV. Costs to the healthcare industry will continue to rise

if women fail to recognize the importance of getting vaccinated for the virus that causes women to suffer with genital warts and cervical cancer (Munsell et al., 2010).

Education about HPV and the HPV vaccination are critical to women's health (Dursun, Altuntasa, Kuscu, & Ayhan, 2009). Knowledge about the virus does not appear to have improved because 33% of women have no knowledge of HPV and its relationship to cervical cancer. Turkish women were the focus of a study by Dursun, Altuntasa, Kuscu, and Ayhan (2009). Questionnaires were distributed to women at gynecological clinics between April 2007 and June 2007. Dursun et al. (2009) believed knowledge about HPV and the vaccine designed to prevent its occurrence were important for the success of the vaccination program.

The information found about HPV indicates the incidence rate for this disease is high. Although the Gardisil vaccination is available, an intervention designed to change sexual behaviors is needed because HPV may result in cervical cancer (Shepherd, 2011). Since all women may not choose the Gardisil vaccination to prevent an HPV infection, an intervention designed to promote a behavioral change associated with sexual activity may prove to be more effective in preventing new incidences of HPV infection in women (Shepherd, 2011).

The lack of knowledge regarding STDs extends beyond HPV and transcends into other classifications of STDs. Ozdemir (2011) conducted a two stage study to investigate the change in college student's awareness of sexually transmitted diseases. Participants in the study were students of Social Science faculty instructors. Stage 1 of the study occurred between the 2000-2001 timeframe, while Stage 2 occurred between the 2009-2010 timeframe. The study revealed students' awareness levels regarding sexually

transmitted had not increased in the 10 years since the first study was done. Based on these results, provider influence in shaping women's beliefs about protection against sexually transmitted diseases may prove effective in increasing awareness about the STD phenomenon and serve to shift or change women's beliefs, resulting in changes in their at risk behaviors.

The Role of Healthcare Providers

Healthcare providers are qualified professionals who identify, diagnose, treat, relieve and rehabilitate individuals' health problems (Guidotti & Ragain, 2008). The services offered by HCPs should include the prevention of diseases in individuals who are well. HCPs' opinions are influential and important information sources for public health issues (Guidotti & Ragain, 2008).

Although HCPs are responsible for diagnosing and treating diseases, the CDC tasks providers to prevent the occurrence of diseases such as sexually transmitted diseases (CDC, 2011b). Most HCPs understand the benefits of preventing disease, yet they encounter difficulties in offering preventive services. The reason HCPs fail to address medical services needed to prevent disease is because the health system fails to reward such efforts (Guidotti & Ragain, 2008; Jozkowski, Geshnizjani, & Middlestadt, 2013).

Human welfare stands to benefit if healthcare providers shift their approach in caring for patients from a treatment orientation to a prevention orientation (Manika & Goldman, 2011). Diagnosis and treatment measures must intertwine with preventive measures to reduce the emergence of preventable conditions. Healthcare providers who

understand their roles in preventing STDs may influence women to adopt sexually safe behaviors and to reduce their exposure to diseases.

The dissemination of information and the discussions that take place in a healthcare provider's office setting may prove effective as an intervention strategy (Warren, 2010). HCPs who do not routinely discuss STDs are noncompliant with their medical associations suggested practice recommendations for STD prevention (Cates, 2008). In a study conducted by Cates (2008), it was determined the majority of American HCPs do not initiate sexual health discussions with young patients because healthcare providers do not believe they are responsible for STD prevention. Findings obtained from the study aligned with making STD discussions part of standard care practices (Cates, 2008). A major observation made from Cates' analysis is omission of key information involving responsible sexual activities alternately harm individuals' sexual beliefs and behaviors.

STD prevention is primarily driven by changes in the sexual behaviors that potentially expose individuals to risks associated with acquiring sexually transmitted diseases. The CDC is the United States agency responsible for implementing STD preventive strategies and interventions. Based on information obtained from the CDC, effective STD preventive measures motivate individuals to change their at risk behaviors (CDC 2011b; CDC, 2012).

The concepts upon which the CDC builds it strategies are education and counseling to at risk populations on ways to incorporate behaviors aligning with safer sex practices (CDC 2011b; CDC, 2012). Healthcare providers are expected to assist the CDC's strategic enactment of STD educational and counseling preventive measures by

ensuring that women who seek sexual health services receive ample information regarding the sexual behaviors to avoid. The CDC's position is that educating and counseling individuals in areas of the population most likely to become infected with an STD is an efficient strategy to reduce STD transmissions within a community (CDC, 2011b; CDC, 2012).

Detection and treatment efforts by health care providers must support STD preventive measures (CDC 2011b; CDC, 2012). Primary and clinical providers are aware that detection and treatment of STDs are important public health concerns. A major consideration is whether providers' efforts tend to focus more on diagnoses and treatments to the extent that opportunities to educate women about the behaviors exposing them to STDs are missed (Friedman & Bloodgood, 2010).

STD prevention requires a commitment from all stakeholders in the healthcare industry (Sharpe, Harrison, & Dean, 2010). The role of the healthcare provider is instrumental in shaping young women's beliefs regarding STDs, yet women surveyed as part of the study conducted by Friedman and Bloodgood (2010) repeatedly acknowledged healthcare providers miss opportunities to address women's beliefs and concerns about STDs. The reasons providers miss opportunities to educate and counsel women about STDS are unclear because of limited information documented in literature.

Since women admit they are uncomfortable talking about STDs, their sexual histories, and their sexual health outside of the confines of a healthcare setting (Friedman & Bloodgood, 2010), women tend to avoid discussions regarding STDs. In most instances, women prefer to avoid discussions regarding their sexual health and STDs even in the presence of healthcare professionals. While visiting primary and clinical

settings, women express mixed emotions and feelings about the patient to provider communications that take place.

Healthcare providers should remain mindful that women usually will not initiate STD discussions. During provider-patient consultations, women stated conversations regarding STDs only included discussions about condom use (Friedman & Bloodgood, 2010). Since condom use in isolation of other skills and behaviors in women fail to prevent new incidences of HIV, O'Leary et al. (2008) identified the importance of self-efficacy in reducing risky sexual behaviors. Women should believe they are able to change behaviors and the associated outcomes of those behaviors. Interventions promoting STD risk reduction through women's negotiation skills prove useful when dealing with a partner who does not wish to wear a condom (Jemmott, Jemmott , & O'Leary, 2007). Although instilled behavior is more likely to drive a change in sexual behavior, the influence of healthcare providers was investigated to determine the role they play in shaping women's sexual beliefs and ultimately changing women's risky sexual behaviors.

Opportunities to implement STD interventions are available during patient visits to healthcare providers' offices (Kalichman, Cain, Eaton, Jooste, & Simbayi, 2011). The office location is a private setting where healthcare providers may be instrumental in addressing the population shift that has occurred in HIV transmission and STD rates of infection in women (Jemmott et al., 2007). In the office setting, HCPs could seize teachable moments and help to shape women's beliefs by exercising their influence and implementing STD prevention strategies in their discussions with female patients (CDC, 2011b).

As identified earlier in the chapter, risky sexual behaviors may involve various factors and forms of activities. Discussions about STDs should be treated as a minimum standard of care and focus on the risky sexual behaviors that place individuals at risk. Healthcare providers should be cognizant of these behaviors and capitalize on the opportunity to educate women of these behaviors in an effort to correct any misconceptions and to prevent STDs (CDC 2011b; CDC, 2012). Knowledge gained from this study illustrates women's perceptions of the provider-patient consultation and the influence HCPs have on their beliefs about STDs.

Concerns About Sexually Transmitted Diseases

The incidence and prevalence of sexually transmitted diseases place a heavy burden on stakeholders in the general population and the healthcare industry. Although efforts are undertaken to reduce new cases of STDs, the CDC reports approximately 19 million new cases of these diseases each year (Trepka et al., 2008). Misconceptions about STDs are not easily eliminated as a cause of these diseases because women possess individualized beliefs about STDs based on factors of age, education, location, culture, and socio-economic statuses (Macleod-Downes et al., 2008).

Healthcare costs. The HPV infection burdens the public health system because of associated screening and treatment costs (Daley et al., 2008). Direct medical costs associated with cervical abnormalities cancer screening were $2.3 billion in 2004. Cancer that required colposcopy and cancer assessment and treatment ranged between $700 million and 2.3 billion (Daley et al., 2008).

HPV and HIV are two of "the most costly STDs in terms of estimated direct medical costs" (Chesson, Blandford, Gift, Tao, & Irwin, 2004, p. 11). Researchers

believe the slightest reduction in STD incidence may help to lower the economic burden and estimated $14.7 billion in treatment costs resulting from STDs (Chesson et al., 2004; "STD quarterly", 2009). State governments invest funds in STD prevention, yet the federal government bears the majority of the economic burden for investments in STD prevention. During 2007, the amount contributed by the federal government was $181,319,992 ("STD quarterly", 2009). The medical costs associated with STDs should motivate stakeholders in the healthcare industry to consider all possible strategies as an intervention.

Prevention costs in Louisiana. The federal government 's investment is $0.60 per capita for STD prevention while the average or mean per capita investment at state levels is $0.23 (American Social Health Association (ASHA), 2009). STD prevention is primarily assessed by data obtained in four key indicators. These indicators of state funding for STD prevention are (1) the percentage of state funding in STD prevention budget; (2) per capita or average cost per person in state STD prevention funding; (3) per capita or average cost per person in state public health funding; and, (4) the percentage of state public health funding directed toward STD prevention (ASHA, 2009). The percentage of state funding in STD prevention budgets is indicative of the contributions made at the state level for STD prevention (ASHA, 2009).

The southern state of Louisiana reportedly shares a minimum of 50% financial responsibility for STD intervention and is one of nine states to demonstrate a strong economic commitment to STD prevention (ASHA, 2009). Louisiana emerges as a leader in key funding indicators for STD prevention. Investments of $156.24 per capita in public health funding and $1.55 in per capita STD prevention funding are maximum

allocations far exceeding national averages of $43.14 and $0.23, respectively for the aforementioned indicators (ASHA, 2009).

Louisiana is at the maximum limit for all key indicators of state funding for STD prevention. Louisiana's ranking demonstrates the state government's contributions to STD prevention far exceed investments made by the remaining states (ASHA, 2009). At the national level, the percentage of state funding in STD prevention budget is 25.8%, while Louisiana is at 70.2% (ASHA, 2009). The second highest state in key indicators is not held by the same state, which suggests Louisiana's consistent high ranking is an anomaly in comparison to other states. Despite Louisiana's maximum level of investment to prevent STDs, new cases of these diseases continue to surface (Louisiana DHH, 2013). Although Louisiana assumes a heavy investment in STD prevention, the state may continue to experience the highest incidence rates for STDs if individuals do not protect themselves against STDs. Insights gained from this study could alert healthcare leaders and government officials to utilize healthcare providers in STD intervention programs.

Human costs. STDs cause women to bear immeasurable human costs and to slowly disclose their STD positive status. After acquiring an STD, women fear discrimination and social rejection (Jacobs & Kane, 2010; Smith, Mysak, & Michael, 2008). Pain, embarrassment, suffering, and shame are feelings infected women state they experience.

Women acknowledge they are uncertain about STDs, the at risk behaviors that may result in STDs, and the challenges they could face after acquiring STDs (Royer & Cerf, 2009). A few of the challenges women encounter are stress, a shortened life span,

and compromises to the quality of life. The time needed to spend with family and friends conflicts with time required for ongoing and progressive medical STD treatments (Royer & Cerf, 2009). For example, cervical cancer patients and HIV infected women require more frequent gynecological visits to adhere to recommended medical care (Tello et al., 2008).

Patient care. HIV infected women face high rates of gynecological problems (Tello et al., 2008). Data retrieved from John Hopkins HIV Clinical Cohort Database was analyzed to predict adherence to clinic visits by women in HIV primary care and gynecological clinics. The results of the analysis illustrated women were more likely to seek HIV primary care visits and less likely to seek HIV gynecological visits despite the fact both services were offered to HIV infected women at the urban clinic (Tello et al, 2008). The study period under review was January 2002 through April 2006. Completed primary care visits and gynecological visits were 55% and 36.2%, respectively. Factors associated with non-adherence to HIV gynecological visits were African American race and substance abuse.

Non-compliance of recommended HIV gynecological clinic visits results in a compromise to the quality of women's lives and an increase in health care costs (Tello, et al, 2008). A multivariate analysis employing a logistic regression and generalized estimating equations was used to identify clusters of multiple visits by the same patient. This study revealed HIV infected women have gynecological concerns. The design of interventions addressing barriers to receiving recommended gynecological care by this population of women is needed.

The study by Wilcher and Cates (2009) examined the significance of creating linkages between women's HIV status and their sexual health. Although women's health statuses are different, all women have the right to make choices driven by education and knowledge. Wilcher and Cates believed a linkage between HIV and sexual health may promote attention to the needs of HIV infected women.

Reproduction has become more of an issue in HIV infected women causing unmet needs to exist in this area (Finocchario-Kessler et al., 2010). A woman with an HIV positive status may desire to have children despite living with the disease. Since younger women are diagnosed at a higher rate than older women, addressing reproduction is a concern for providers who treat HIV infected women who wish to have children.

An HIV/AIDS diagnosis in women is an issue because of the damage the disease wreaks on their reproductive and health statuses (National Institutes of Health (NIH), 2010). HIV/AIDS infected women who become pregnant may vertically transmit the disease to their developing fetuses. STDs that go untreated in women could result in infertility, cancer, pelvic inflammatory disease (PID), and infection to other parts of the body. Logan, Khambaty, D'Souza, and Menezes (2010) determined women infected with HIV were more likely to develop cervical cancer than uninfected women. Cervical cancer may also result when a woman becomes infected with HPV (National Center for Biotechnology Information (NCBI), 2009), which will inevitably appear in most women at some point in their lives (Daley et al., 2008; Graziottin & Serafini, 2009).

Although providers are slow to discuss childbearing with women who have HIV, gynecologists must address all women who are of childbearing age. Counseling before conception may imply a woman's health status must improve before she conceives. HIV

infected women who try to conceive run the risk of transmitting the virus to their partner. Another reproductive health concern is the virus may pass from mother to child during childbirth (Finocchanrio-Kessler et al., 2010).

The CDC and the U.S. Preventive Services Task Force recommends women infected with HIV receive two Pap smear screenings within the first year of diagnosis (Logan, Khambaty, D'Souza, & Menezes, 2010). Researchers Logan et al. (2010) conducted a 200 patient study at a Florida local health department to examine adherence to the Pap smear screening guidelines and the demographic factors of those who test. The findings revealed 25% of HIV infected women adhered to the Pap smear guidelines (Logan et al., 2010).

Healthcare providers' are known to treat illnesses (CDC, 2012). Costs associated with treating diseases would lower if STDs were prevented (Chesson et al., 2004; "STD quarterly", 2009). This study could add needed information to previously written research about the STD phenomenon by investigating women's perceptions of the provider-patient consultation and provider influence in shaping their beliefs about protection against STDs.

Stigma. Stigma is defined as the devaluing of social identity in a social context (Clum, Chung, & Ellen, 2009). The stigma of having an STD perpetuates stronger feelings of guilt and failure to seek medical care to treat diseases (Jacobs & Kane, 2010). HIV related stigma may cause self-doubt in those who are infected. Discrimination may also take place if a woman disclosures her HIV positive status. In a study conducted by Clum, Chung, and Ellen (2009), the scholars examined the impact stigma has on HIV positive women. Clum et al. (2009) asserted HIV women face a magnitude of negative

sequelae such as depression and risky behaviors. HIV women are ostracized to the point of reduced support from family and friends.

Mortality rates. The presence of STDs is a growing public health concern because of their effect on women's morbidity rates (World Health Organization (WHO), 2009). In certain instances, women who acquire an STD may die as a result of the disease. In a study conducted on HIV related deaths, a plateau was reached during the 2001 – 2004 periods. Researchers purposively assessed deaths and their associated causes in HIV infected women who took part in the study (French et al., 2009). Death rates were examined over a 10 year time period using the National Death Index-Plus and the women's death certificates. Findings from the study purport further gains in reducing death rates for HIV infected women align with treatable conditions (French et al., 2009).

Although STDS are treatable, women stand to benefit if these diseases are prevented. This study explored women's perceptions of provider influence in shaping women's beliefs about protection against STDs. As supported by the HBM theory, behavior changes are likely to occur when individuals' beliefs change about an illness (Zak-Place & Stern, 2004). This study was needed because prior research of HCPs influence in shaping women's beliefs about protection against STDs was not available.

Leadership. The STD problem requires healthcare leaders to partner as cohorts to favorably impact the STD rate in women.

> STD prevention programs must develop, cultivate, and maintain effective working relationships with a growing network of public and private entities that work in both health and non-health sectors. Many STD prevention programs have

> recognized the need to expand their efforts and budgets to improve interaction and collaboration with various relevant partners. (CDC, 2011b, p. 8**,** para. 1)

Healthcare providers are major stakeholders and leaders in the continuum of care who regularly interact with women to maintain health and diagnose and treat disease (CDC, 2011b). HCPs are positioned to make a difference in the STD epidemic by expanding ongoing medical services to include STD prevention in women. Since STD prevention remains a growing public health concern, healthcare leaders must focus current and future collaborative efforts on women, the population most disproportionately affected by the STD epidemic (CDC, 2011b; Weeks et al., 2010).

Interventions. Findings from research addressing the STD phenomenon and the harmful effects of failing to use condoms during sexual activity are available in scholarly, peer-reviewed literature (Cavanaugh et al., 2011; Marcus et al., 2011; O'Leary et al., 2008; Squires et al. 2011). The focus of studies involving HIV/AIDS and other STD reductions in individuals primarily embodies the differences in social and demographic factors (Smith & Whiteside, 2010). STD intervention from a demographic or societal vantage point results in findings that identify at risk environments and the behaviors of those individuals within the targeted population (Smith & Whiteside, 2010).

Researcher Auerbach (2009) stated interests are growing in designing structural STD interventions. Empowering women through interventions aimed at diverse sexual behaviors is needed (Fathalla, Sinding, Rosenfield, & Fathalla, 2006). The "abstinence, be faithful, and use condoms (ABC)" (Fathalla et al., 2006, p. 2096) approach is indicative of the desire to design one intervention in support of different ideologies. Since acceptable interventions in one setting may fail if transferred to another setting, a

combination of integrative interventions is the only way to achieve success in STD prevention (Fathalla et al., 2006).

In a randomized controlled trial involving 564 women, Jemmott, Jemmott , and O'Leary (2007) evaluated the efficacy of interventions aimed to reduce risk in primary care settings. The authors asserted merely providing women with health information is insufficient (Jemmott et al., 2007). The study revealed skill building interventions was more successful in reducing women's STD behavioral risks by perpetuating condom use and negotiation skills. The authors theorized sexual behavior change in women is possible, so HCPs should exercise their influence during the provider – patient consultation to help women in adopting the correct understanding about STDs.

In the three decades since abstinence and safe sex programs were designed to reduce the number of reported HIV/AIDS cases in gay males by increasing awareness around safe sex practices, the media and other venues have continually omitted critical information about the sexual behaviors that lead to acquiring an STD (Cates, 2008). Findings from this research study are intended to assist Louisiana healthcare leaders, public health officials, and providers engaged in the continuum of care to invest budgeted costs for STD prevention in interventions targeting women. The reason for targeting women is they are the population most at risk in the area for contracting an STD.

A plethora of scholarly, peer reviewed information is available regarding STDs and the risky behaviors that may ultimately lead to acquiring a disease. In a study conducted by Akers, Gold, Coyne-Beasley, and Corbie-Smith (2012), researchers found women, particularly 15-24 year olds, were aware but not completely knowledgeable regarding this public health concern. One key finding is women rarely discuss STDs with their partners

or close friends (Friedman & Bloodgood, 2010). Healthcare providers are viable intermediaries and primary interpersonal resources who frequently miss opportunities to engage women in STD and sexual health discussions (Friedman & Bloodgood, 2010).

The possibility of a more heightened focus on designing interventions that help shape women's beliefs about STDs may help to prevent new incidences of STDs. Designing interventions addressing women's perceptions might also add new information and bridge the gap in literature between previously written research about women's beliefs regarding STDs and risky sexual behaviors. Health care providers may be the link to bridging the gap in knowledge between what women believe about STDs and the subsequent behavioral changes occurring after a shift in beliefs. Information was not found regarding women's perceptions about provider influence in shaping women's beliefs about STDs. In this study, successful attainment of pertinent information is intended to influence the implementation of newer interventions and to simultaneously embody the foundation of STD education and awareness efforts previously established.

Jemmott, Jemmott, Braverman, and Fong (2005) indicated most HIV sexual risk reduction studies focused on HIV facts and information. The researchers believed skilled behavior interventions aimed at preventing STDs have taken root in education and awareness programs involving condom use and fail to address health beliefs and the effect beliefs place on behaviors (Jemmott, Jemmott, Braverman, & Fong, 2005). Perceptions occurring in a woman's society and culture help to shape her beliefs and about HIV, yet the emphasis of STD programs remains on effective condom use and not the root cause of why condoms are needed (Medina, 2009). Since providing women

with STD information is important, STD prevention may occur as a result of collaborative strategies and interventions involving HCPs (Jemmott et al., 2007).

Healthcare providers must recognize women believe they are the primary resource to turn to for matters related to sexual health. Providers should be cognizant of the role they play in women's sexual health because women are not willing to reveal their concerns about STDs to friends and family. Since healthcare providers provide women with a private location to discuss confidential sexual health issues, healthcare providers may capitalize on the opportunity that exists during the provider to patient consultation to discuss STDs (Friedman & Bloodgood, 2010). These discussions could lead to a change in women's beliefs about these diseases, help to change women's at risk sexual behaviors, and result in fewer STD related deaths (Jemmott et al., 2007).

Researchers Emmers-Sommer et al. (2009) conducted a study focusing on communications between provider-patient based on age and gender. The study revealed women will engage in sex related discussions with providers. Although women may experience suffering on a personal and sexual level when their sexual health is compromised, Emmer-Sommers et al.'s study revealed women tend to be modest in discussing sex related matters.

Women need to describe how HCPs should couch STD related information regarding the prevention of potential disease resulting from sexual relations during the provider-patient consultation. Previous studies have not focused on women's perceptions of healthcare providers influence in shaping their beliefs about STDs. An investigation was needed to add knowledge about providers' consultations with women to determine if the information offered was effective in promoting change in the

behaviors placing women at risk for STDs. Women may not believe they are at risk and continue to engage in risky sexual behaviors because an association has not been made between the susceptibility to acquiring STDs and sexual behaviors (East, Jackson, Peters, & O'Brien, 2010; Royer & Cerf, 2009). HCPs should understand the power to meet women's needs in preventing STDs resides within their roles and responsibilities if they embrace all provider-patient discussions as teachable moments in shaping women's beliefs and sexual behaviors (Gollub, French, Latka, Rogers, & Stein, 2001).

Interventions focusing on women's beliefs regarding STDs are needed in Louisiana because individuals' beliefs are posited from research to drive behavior. This type of intervention, particularly in high prevalence areas such as Louisiana, may be successful in reducing the new number of STDs occurring annually. Jemmott et al. (2007) concluded sexual behavior change in women is possible, yet interventions must go beyond providing information about effective condom use.

Women in Louisiana are rooted in southern culture and religious beliefs. Although southern women state they are knowledgeable and aware about STDS and their consequences, their beliefs about STDs place them at greater risks for these diseases (Annang, Johnson, & Pepper-Washington, 2009). Women's beliefs are non-behavioral factors influencing at risk sexual behaviors and health outcomes. Healthcare providers must exercise their influence in shaping women's beliefs about STDs to improve health among women and to eradicate their risky sexual behaviors (Annang et al., 2009).

A major focus of health improvement efforts is to address the STD epidemic (CDC, 2012). Efforts to prevent new cases of STDs in women require a "better understanding of the epidemic, including the behaviours that drive it and the impact of

various prevention interventions" (WHO, 2010, p. 105). The services offered by healthcare providers align with diagnosis and treatment of illnesses. Increases in the number of STD cases in women should influence healthcare providers to adopt medical services to prevent these diseases. Much like the great smoking cessation efforts underway in the United States where all patients are asked if they smoke, providers must ask patients about sexual beliefs and behaviors. Provider to patient consultations should involve discussions about STDs regardless of the nature of women's visits and the number of visits made because women's beliefs ultimately influence their behaviors (Bailey & Hutter, 2008).

Conclusions

Sexually transmitted diseases in women continue to prevail in the United States. The literature review presented significant evidence that risky sexual behavior is a precursor to STDs. Past intervention programs omit information regarding the sexual behaviors that place individuals at risk for these diseases (Cates, 2008) and fail to address the gender shift in STDS. The main focus of STD prevention is to promote awareness on consistent condom use through the media and printed material, yet this approach does not appear effective in reducing the number of new cases of STDs. Healthcare providers represent a viable resource to assist in preventing new cases of STDs in women by exercising their influence during the provider-patient consultation. The problem of STDs in women requires a new approach because interventions should be tailored to address the population most at risk (Fathalla et al., 2006). Women's health statuses are in jeopardy because of preventable diseases.

Summary

Chapter two provided a detailed literature review of the risky behaviors, which may lead to sexually transmitted diseases in women. Risky sexual behaviors were defined as inconsistent condom use, alcohol consumption before sexual encounters, sex with multiple partners, unprotected sex, sex with men who have sex with men, women who have sex with women, violent relationships, substance abuse, and the sharing of partners. Health care providers are the link to bridging the gap between what women believe about STDs and the subsequent behavioral changes occurring after a shift in beliefs. Information was not found regarding women's perceptions about provider influence in shaping women's beliefs about STDs. Given the fact the CDC continues to report millions of new cases of STDs each year, more work is needed to implement newer preventive strategies for STDs in women. Chapter two also addressed the interventions used to reduce the spread of sexually transmitted diseases. Chapter three will provide the research method, design, population, instrumentation, validity, and reliability for the research study.

Chapter 3

Method

The purpose of this qualitative multiple case study was to gain a better understanding of women's perceptions of provider influence in shaping women's beliefs about protection against sexually transmitted diseases during provider-patient consultations. The study focused on adult women in Louisiana because of the state's high prevalence of STDs in women. The number of reported cases of women living with HIV, an incurable STD, increased steadily in Baton Rouge, Louisiana between 2001 and 2010 (Louisiana DHH, 2011; Louisiana DHH, 2013). Study participants were solicited from professional organizations and associations for women in the Baton Rouge area to which the researcher belongs. Since member email addresses are available to members, the researcher sent emails to more than 100 women requesting their participation in the study. Individuals selected for inclusive in the study were telephone interviewed for approximately one hour using open-ended questions regarding provider influence in the STD phenomenon. Yin (2003) indicated using interviews as a research instrument is invaluable for gaining new insights when participants grant their input in a qualitative study regarding a phenomenon. A pilot study was performed to validate the research instrument by testing the interview questions before data were collected.

Qualitative research reveals findings associated with social behaviors and a phenomenon (Bansal & Corley, 2012). Through the qualitative research method, new information may emerge as to why women continue to acquire STDs despite programs aimed at promoting safe sex practices through consistent and effective condom use. Insights derived from qualitative case studies attempt to address research questions

involving social behaviors (Power, 2002). The knowledge gleaned from this qualitative multiple case study is intended to help improve previous interventions involving a phenomenon because the data collected is based on the understanding and described perceptions of study participants (Bansal & Corley, 2012).

Chapter three will detail the research method and design appropriateness, followed by the study's research questions. The population, geographic location, and sampling frame, along with a discussion about ethics, consent, and confidentiality are also discussed. The chapter concludes with discussions about instrumentation, data collection, data analysis, [design] validity, and [design] reliability for the research study of adult women in the Baton Rouge, Louisiana area.

Research Method and Design Appropriateness

Quantitative, qualitative, and mixed are three methods found in research studies.. Researchers adopt a quantitative method to explain the relationship between variables (Patterson & Morin, 2012). Qualitative research is used to better understand a phenomenon (Yin, 2003). The mixed method is a combination of the quantitative and qualitative methods and is used when the emergence of more knowledge is expected than either individual method would produce (Creswell, 2005). Since this study was used to better understand information associated with a phenomenon, the qualitative method was appropriate.

In qualitative research, data is explored and discovered, which "often indicates that there is not much written about the participants or the topic of study" (Campbell, 2014). Qualitative research is interpretive, interactive, and humanistic. Data emerges rather than the researcher using data that is prefigured (Campbell, 2014).

The case study is a qualitative research design. Yin (1981) defined the case study as an empirical inquiry, which investigates a contemporary or current phenomenon in the context of real life. Case studies are typically categorized as exploratory, explanatory or descriptive and may involve one case or multiple cases (Yin, 1981). Research studies employing a case study design derive their contexts from an understanding of processes or procedures, describing a phenomenon within its contextual framework, and focusing on events to explain how situations occurred and their effect on a particular situation (Yin, 2003).

The case study was selected because the objective of this study was to understand women's perceptions of healthcare providers influence in the STD phenomenon within the context of the Health Belief Model. Women interviewed made visits to healthcare providers between years 2012 - 2014, so their responses to questions about the provider-patient consultation were based on personal perceptions. By means of responses to open-ended questions obtained from telephone interviews, adult women described how healthcare providers could motivate changes in risky sexual behaviors during provider-patient consultations.

Atieno (2009) indicated qualitative research arrives at discoveries based on how participants perceive their experiences. A qualitative multiple case study solicited testimonials from participants to examine women's perceptions of healthcare providers influence in shaping women's beliefs about the causes and long-term effects of sexually transmitted diseases. This research study reveals how women perceive sexual health information could be offered by providers during provider-patient consultations. Using the multiple case study approach was substantive in the research conducted of women's

perceptions of healthcare providers influence in shaping women's beliefs about protection against STDs during routine, follow-up, or other health related patient visits. Women revealed how they believe healthcare providers could couch STD related information to lower women's resistance to changing risky sexual behaviors.

The case study design was appropriate for studying women's perceptions of HCPs influence in the STD phenomenon. Women were granted an opportunity to verbalize their perceptions of the provider-patient consultation. The case study design arrives at new knowledge by unveiling the perceptions of study participants (Mohammadpour, Yekta, & Nasrabadi, 2010; Yin 2003).

Other qualitative design methods include ethnography, phenomenology, and grounded theory. Ethnography was not selected because this type of design requires studying the intermingling of individuals within society and culture (Goulding 2005; Merriam, 2009). As revealed by Merriam (2009), ethnography originated through work performed by anthropologists and requires the researcher's observations as a participant to the study, along with the researcher's diaries and experiences. Collecting data using an ethnographic technique involves research over an extended time period and could result in higher costs.

Phenomenology focuses on individual's lived experiences and the manner in which they interpret meaning about a phenomenon (Merriam, 2009). The phenomenological design focuses on individuals lived experiences of a particular phenomenon arising in human and social sciences and examines a phenomenon's shared meaning as experienced by several individuals (McCaslin & Scott, 2003). "The understanding of meaningful concrete relations implicit in the original description of

experience in the context of a particular situation is the primary target of phenomenological knowledge" (Moustakas, 1994, p. 14). In qualitative studies, the phenomenological research design embraces research from the study's participants' points of view and grants input of their lived experiences to arrive at new insights (Zahavi, 2003). Study participants in a phenomenological study are allowed to voice their realities regarding the phenomenon (Moerrer-Urdahl & Creswell, 2004). Since the purpose of this research study was to explore women's perceptions and not their lived experiences, the phenomenological inquiry was not appropriate for this study. Findings from this study were intended to gain a better understanding of women's perceptions of provider influence in shaping their beliefs about protection against sexually transmitted diseases.

Grounded theory was considered as a possible qualitative research design to explore women's perceptions of provider influence in the STD phenomenon. The main concept behind grounded theory research is a theory, which is grounded in the data, emerges over time from the information collected through iterative processes (Charmaz, 2006; Merriam, 2009; Moustakas, 1994; Strauss & Corbin, 1998). The implication behind grounded theory is the researcher works backwards to arrive at a theory behind the phenomenon.

Grounded theory research is in opposition to other research designs that begin with theoretical frameworks and result in logical conclusions. The grounded theory is intended to explain interactions, actions, and processes of a phenomenon (Moustakas, 1994). Although the theories currently in existence may not appear adequate to understand HCPs influence in shaping women's beliefs about STDs, grounded theory was not selected as the research design. Grounded theory was not appropriate for this

study because research was not conducted to generate a new theory regarding healthcare providers' influence in shaping women's beliefs about STDs.

The quantitative research method was not appropriate for the study because quantitative research involves variables and numerical comparisons. Findings resulting from quantitative research are precise and limited to statistical measurements (Patterson & Morin, 2012). Quantitative research was not appropriate for this study because it may have failed to produce comprehensive, contextual detail (Patterson & Morin, 2012).

Since consistent commitment over time is needed to capture data in quantitative studies, attrition bias is an issue because the researcher may incur additional costs to keep track of participants in the event they relocate (Patterson & Morin, 2012). Quantitative research cannot delve into women's perceptions of healthcare providers' influences in the STD phenomenon to arrive at new meaning. Findings from quantitative research are narrow and fail to produce holistic results found with qualitative studies (Patterson & Morin, 2012). A quantitative methodology did not align with the essence of the study, which was to explore women's perceptions of healthcare providers influence in shaping women's beliefs about protection against STDs.

Research Questions

The study's purpose was to explore women's perceptions of the provider-patient consultation to better understand provider influence in shaping women's beliefs about protection against STDs. Based on the study's purpose, three research questions underpinned the qualitative study.

RQ1: How do women perceive provider-patient consultations regarding the prevention of potential disease resulting from sexual relations?

RQ2: How might healthcare providers couch STD related information to lower resistance and motivate women to change risky sexual behaviors?

RQ3: How do women perceive the information received from healthcare providers regarding method and concept of use of contraceptives in the prevention of sexual transmission of disease during sexual relations?

Responses to these research questions specifically included input from women and revealed information from the perspectives of the at risk population in the STD epidemic. Knowledge gleaned from this body of research is intended to bridge the gap in voluminous information written about women's beliefs and behaviors regarding STDs and exemplify women's perceptions of HCPs influence in the STD phenomenon. By focusing on women's perceptions of the provider-patient consultations, new information was introduced into the STD phenomenon from the vantage point of the population most at risk.

Population and Geographic Location

Adult women in the state of Louisiana continue to experience the highest incidence rates for sexually transmitted diseases in the United States (Louisiana Department of Health & Hospitals (DHH, 2013). In comparison to its neighboring southern states, sexually transmitted disease rates are disproportionately higher for Louisiana than other parts of the southern region. Given the fact Louisiana leads the United States in the allocation of budgeted dollars for STD prevention, the presence and emergence of new STD cases in Louisiana is inconsistent with the state's investment in STD preventive measures (American Social Health Association (ASHA), 2009).

Sampling Frame

Sampling is a subset of individuals within a larger population (Neuman, 2006). The selection of qualitative research may result in obtaining data through purposive sampling, which is the intentional selection of participants possessing knowledge of a phenomenon (Neuman, 2006). Purposive sampling is useful when conducting small sample studies and aligns with the small number of participants found in qualitative studies that use interviews for data collection (Gledhill, Abbey, & Schweitzer, 2008). In this qualitative multiple case study, sampling was more manageable because the goal was to conduct an in-depth study as opposed to generalizing findings of a larger population (Yin, 2003). Since constraints associated with time and money are possible when dealing with larger populations, a purposeful sampling was used in this research study.

The study was conducted on a purposive sample of adult women in Baton Rouge, Louisiana. Women located in Baton Rouge, Louisiana were invited to participate in the study because women in this area of Louisiana are disproportionately affected by STDs and more likely to live with an incurable STD (Louisiana DHH. 2011). Individuals privy to an experience, reflect the sample of individuals who are needed to obtain pertinent information (Maxwell, 2005). Adult women aged 18-45 living in Baton Rouge, Louisiana were chosen to participate. Sandelowski 1995 indicated researchers may experience difficulty in obtaining data saturation when the sample size is too small. Sandelowski asserted researchers may also experience difficulty in conducting a qualitative "deep, case-oriented analysis" (p. 183) when the sample size is too large. A sample size ranging from 11 - 20 is not too small or too large to obtain rich and

meaningful data regarding women's perceptions of provider influence in shaping their beliefs about protection against STDs.

The researcher recruited a purposive sample of adult women from professional associations and organizations to which the researcher belonged. These associations and organizations consisted of professional women from various educational and professional backgrounds who sought networking opportunities in the Baton Rouge area. The researcher had no relationship to other women in the group other than member affiliation.

Each member had access to other members' email addresses for the purpose of requesting network connections. Since members' email addresses were available, an invitation to participate (Appendix B) was emailed to approximately 100 adult women in the Baton Rouge area. Questions included in the invitation to participate pertained to demographic information such as gender, age range, and the number range of patient visits women made to providers spanning from years 2012 – 2014.

The returned invitation to participate forms, which will be kept for three years, were printed out and stored in a fire-safe, locked, and undisclosed location. Forms returned within one week of the email sent dates constituted women's willingness to be interviewed for the study. Researchers Anseel, Lievens, Schollaert, and Choragwicka (2010) determined advance notice, follow-up, monetary incentives, and topics relevant to the population increase response rates. Since a purposeful sample was targeted, the researcher increased the response rate by contacting women through follow-up emails within five days of the initial email sent dates of the invitation to participate documents. Although monetary incentives tend to produce more responses (Furse, Stewart, & Rados, 1981), incentivizing women using money or gift cards did not occur.

Reeder (1960) stated motivating potential participants is the key to increasing response rates to questionnaires used in health studies. Higher response rates are produced when social utility of the questionnaire is explained in terms of the value society and the general population will receive from the data collected. Reeder further stated potential participants, who feel they possess a special role in maximizing the utility of the research instrument, are more likely to respond. Women were informed of the STD statistics in Louisiana and may have chosen to participate in the body of information collected about the diseases because of the significance to the general population and to women.

The number range of visits made by women to healthcare providers during 2012 - 2014 was the selection criterion used. The woman with the highest number range of visits made during the time period was selected first. The woman with the second highest number of visits made was selected second. If there were women with the same number range of visits made to providers, then women were selected in the order their signed invitations to participate forms were received. The process continued in this manner, with the exception of participant 12, who volunteered after the selection period ended. Excluding participant 12, the last three women chosen from the returned invitation to participate forms were asked to validate the research instrument and agreed to participate in a pilot study.

Baton Rouge is a large metropolitan area and the capitol of the state of Louisiana. Reports illustrate Baton Rouge is a leader in Louisiana's prevalence and incidence rates for STDs (Louisiana DHH, 2011). Healthcare providers in the Baton Rouge area are aware of the STD epidemic plaguing the city (CDC, 2012) and could serve as a catalyst

in preventing new STD cases in women. An investigation was needed to better comprehend women's perceptions of healthcare providers influence in shaping women's beliefs about protection against STDs during provider-patient consultations.

Ethics, Consent, and Confidentiality

Researchers of case studies involving human subjects are guided by standards of ethics such as those presented in the Belmont Report. The three basic principles set forth by the Belmont Report are intended to establish ethical standards and protect human subjects participating in behavioral research (Maleson, 2010). To ensure respect, beneficence, and justice, which are the three ethical principles found in the Belmont Report, researchers must obtain an informed consent from study participants (Maleson, 2010).

The Institutional Review Board (IRB) must approve studies involving human subjects to ensure individuals are informed properly (Cottrell & McKenzie, 2011). The proposal and all required supporting documents such as the invitation to participate, informed consent, the interview questions, and the confidentiality statement were submitted with the IRB application. Women, as stated in the Belmont Report, are a protected class in research studies and must receive additional safeguarding. According to the University of Phoenix IRB guidelines, studies involving women must receive full IRB approval before data is collected. Full IRB approval was received on January 12, 2015.

Since research involving human subjects requires voluntary participation, informed consent indicates individuals comprehend the study and agree to be included. Informed consent is needed when a study involves human subjects such as women

(Salkind, 2003). The informed consent document serves to eradicate the emergence of ethical and moral concerns associated with qualitative studies (Salkind, 2003). In the body of the informed consent document, the significance and nature of the study is explained.

Signed informed consent documents were intended to record women's cognizance of the research study. Women who were selected to participate were required to provide their electronic signatures on an informed consent document (Appendix A) if they wanted to participate in a face to face or telephone interview. The return of electronically signed informed consent documents was required before interviews began. Upon receipt of the electronically signed informed consent documents, the researcher emailed each participant a final copy of her document with the researcher's inked signature and date to keep for her records. Electronically signed documents will remain in the researcher's email inbox for three years. The documents were also printed out and will be stored in a fire-safe, locked, and undisclosed location for the same three years.

Although face to face interviews were an option, women elected to be interviewed telephonically. At the start of the telephone interviews, the researcher reviewed the informed consent documents with participants. Efforts were made to keep participants' signed documents away from public disclosure by storing all data collected such as signed consent forms in a fire-safe, locked, and undisclosed location. Voice recorded interviews and handwritten notes were stored with the signed consent forms to maintain confidentiality and to protect the privacy of the study's participants. The signed documents are confidential and private (Shank, 2006). After the three years retention

period expires, all collected data will be destroyed by shredding, burning, or deleting of electronic data to maintain confidentiality and privacy.

Participants were told they should notify the researcher during face to face encounters or by email or telephone if a decision was made to withdraw. Women were reassured no further obligations pertaining to the research study would be warranted. The informed consents remained in force because none of the study's participants chose to withdraw from the study. Participants were made fully aware they were under no obligation for inclusion in the study and all opted to remain in the research.

Ethical research studies are conducted in a manner that protects private and confidential information obtained from participants involved in the study. Privacy and confidentiality are major concerns in research because infringements on an individual's personal information could cause harm to the individual involved (Shank, 2006). In qualitative studies, codes are utilized to secure private and confidential data. Women who participated in this study were assigned a code and a number. The codes begin with AW1, which represents *adult woman one.* Coding follows this pattern and was assigned through the last adult woman participating in the study. A range of 11 - 20 participants was pre-established because this number of participants was sufficient to arrive at rich meaning in qualitative studies (Sandelowski, 1995; Yin, 2003). Applicable codes were assigned to all information obtained from women to ensure confidentiality. Handwritten notes taken, interviews recorded, and transcription of data collected were coded and remain in the sole possession of the researcher.

Instrumentation

The instrument used in this qualitative multiple case study was the in-depth interview. Face to face interviews were preferred for this study and planned to take place at the researcher's home office location. Since face to face interviews were difficult to schedule because of personal or professional conflicts on the part of the researcher or participants, telephone interviews were used and were an acceptable protocol. Women were contacted to schedule telephone interviews through electronic mailings.

The interviews took approximately one hour. A set of interview questions were used to solicit responses from participants (Appendix C). The interview questions were designed to answer the research questions using the theoretical framework of the Health Belief Model. Three research questions drove this qualitative multiple case study.

First, how do women perceive the provider-patient consultations regarding the prevention of potential disease resulting from sexual relations? Allowing women, who are disproportionately affected by STDs, to state their perceptions of healthcare providers' influence in shaping women's beliefs regarding the prevention of STDs during provider-patient consultations may prove beneficial to women. Society and the health care industry stand to benefit because of the economic and personal burdens STDs place on everyone involved (Daley et al., 2008)

Second, how could healthcare providers couch STD related information during the provider-patient consultation to lower resistance and motivate women to change risky sexual behaviors? The intent of this question was to unveil findings that will help women to feel comfortable discussing STDS with their providers and act upon the information they receive from HCPs because they place credence in the information offered.

Concepts associated with the HBM purport behavior change is not likely to occur unless individuals believe a disease is severe and they are susceptible to acquiring it (Zak-Place & Stern, 2004).

Third, how do women perceive the information they receive from healthcare providers regarding method and concept of use of contraceptives in the prevention of sexual transmission of disease during sexual relations? The intent of this question was to investigate if the information women receive during consultations is specific enough to change or shift women's beliefs about STDs. Women should obtain adequate information to protect themselves against STDs. Since beliefs drive behavior (Medina, 2009), women need to receive evidence based information that causes women to change or shift their attitudes, which ultimately will lead to behavior changes.

In addition to the three research questions, participants were asked questions about their perceptions in the STD phenomenon. Inquiries into women's perceptions of the barriers that keep them from adhering to provider influence were made. Women were also asked to describe how they stand to benefit from receiving STD related information during the provider-patient consultation.

In qualitative studies, the researcher is an instrument (Pezalla, Pettigrew, & Miller-Day, 2012). "The depth and complexity of the interpretation [of data] is determined by the effectiveness of the researcher as instrument" (Xu & Storr, 2012, p. 15). Since qualitative interviews were used to solicit information from participants, the researcher played "a central role in generating and interpreting data (Xu & Storr, 2012, p. 1).

Pilot study. Testing of the interview questions occurred during a pilot study to ensure the interview questions were clear. Fifteen women returned signed invitation to participate documents demonstrating their willingness to be a part of the study. A pilot study was conducted with three women excluded from the fifteen who emailed their completed invitation to participate forms to the researcher. Women who were asked to participate in the pilot study received emailed Informed Consent forms requiring electronic signatures. Upon the researcher's receipt of the signed Informed Consent forms, the interview questions were sent by email to women for testing. Neuman (2006) indicated testing of interview questions helps in designing questions that are engaging and encouraging to the interviewees. Effective questioning should cause study participants to share their perceptions through in-depth, meaningful discussions. The premise behind the pilot study was to reveal possible misgivings in the design of the interview questions that could cause bias in the study's outcome (Maxwell, 2005). Appropriately structured pilot studies are instrumental in adding concise understanding and meaning to the phenomenon under investigation (Maxwell, 2005).

Data Collection

After testing of the interview questions occurred by pilot study participants, the researcher added rating scales to questions one, two, and six based on the feedback provided. The researcher then scheduled one hour interviews for the selected purposive sample of 12 adult women who indicated their willingness to be part of the study by signing and returning invitation to participate documents containing demographic information (Appendix B). Participants self-reported their gender, age range, and the number of visits made to healthcare providers between years 2012 and 2014.

Informed consent documents (Appendix A) were emailed to the 12 study participants prior to the start of their scheduled interviews. All of the selected participants returned signed informed consent forms. Upon receipt of the informed consent documents by participants, the researcher signed and emailed the forms back to the 12 women for their records. Participants were reassured their confidential information and anonymity were protected.

Data collection from the purposeful sample of women involved telephone interviews of women using open-ended questions (Appendix C). Women participating in the study were advised frequently of their right to withdraw from inclusion in this body of research at any point in time. Reassuring participants of the confidentiality and anonymity associated with their responses helped to minimize stress so women felt free to reveal information about the STD phenomenon (Walker, 2007). The in-depth telephone interviews sought to collect data on women's perceptions of provider influence in shaping their beliefs about protection against sexually transmitted diseases.

Interviews were digitally voice recorded and handwritten notes were taken. The collection of data continued until saturation occurred. Saturation happens when new data fails to provide new meaning or insights (Shank, 2006).

The interviews were transcribed into Word documents. Transcribed interviews were returned to women for review and to enhance the validity of the study's findings (Dearnley, 2005). Women who participated in telephone interviews were also asked to validate their documented information.

Since codes were assigned to participants' transcribed information, participants' data and privacy were protected. Documents collected were stored in an undisclosed,

locked and fire-safe location. Handwritten notes taken during the interviews and printed out copies of the informed consent documents were also stored and secured with the participants' transcriptions.

Information obtained from the participants added to the data collected about the STD phenomenon in women. Peer-reviewed journal articles on STD prevention, STDs in women, and healthcare provider roles in the STD phenomenon were collected. These literary sources were used to compare to the data collected from participants' interviews.

Data Analysis

NVivo 10 software was used to analyze the transcribed data collected from the 12 adult women. Information obtained from women during data collection was analyzed until new categories of information failed to emerge. Data collected from the interview process was analyzed to determine themes of women's perceptions of healthcare providers' influence on women's beliefs about protection against sexually transmitted diseases during patient-provider consultations.

Qualitative research requires the researcher to engage in approaches that deconstruct or induce themes from the data collected. Qualitative research is interactive because the participants help to facilitate new learning and meaning. As a result of the social nature found in qualitative studies, the analysis of collected data consists of coding and developing concepts (Neuman, 2006).

In case studies, findings are less generalizable because of the small sampling size. The case study design focuses more on meaning and unveiling deeper knowledge. Yin 2003 indicated the case study design is effective to explore human experiences and contribute to social realities.

Bradley, Curry, and Devers (2007) indicated the researcher should strive to find meaning in the collected data. NVivo software was used to help analyze the information collected from interviews. Before beginning a new project in the NVivo software, the collected interviews were read and reviewed in the initial phase of the data analysis. After the initial analysis was complete, coding the data began by arriving at themes found in the collected data and forming concepts. Participants' responses to the interview questions were analyzed in stages.

In qualitative studies, coding involves a code structure, which may or may not embody predetermined codes. A deductive approach uses a list of predetermined codes and the inductive approach does not. The data collected for this study was analyzed using an inductive approach to explore themes emerging from women's interviews.

A preliminary analysis of the data was the first phase in the coding process (Neuman, 2006). An analysis of the text obtained from participants was consolidated into codes, which is also known as open coding. Responses received from each participant were coded using nodes found in NVivo. Duplication in responses resulted when a study participant provided a response to an interview question matching a response previously obtained and formed the master headings or first level concepts. Subheadings or second level categories resulted from other unmatched information obtained to a particular research question.

Axial coding is the second phase in the coding process (Neuman, 2006). During this stage of coding, the discovery of key categories found in the data was made by organizing and linking codes. Concepts and categories were confirmed to the corresponding interview questions. Axial coding is different than the open coding level

because the concepts and categories formed from the first level are reviewed for accuracy and their contextual relationship during second level coding.

The third phase of coding is selective coding (Neuman, 2006). During this level of coding, previous codes were identified and selected to support the conceptual code categories previously developed. Code categories were also connected using an inductive approach to the analysis.

The analysis culminated with the identification of similar codes, which resulted in the emergence of major ideas (Leedy & Ormrod, 2010; Shank 2006). NVivo 10 assisted in forming clusters from the presenting themes of the women's perceptions and helped with management of the data. Research findings were described, reported, and validated. A summary of the patterns and themes found in the data was created. The analysis revealed how women believe healthcare providers could couch STD related information to lower resistance and motivate women to change risky sexual behaviors. This study used a qualitative multiple case study design and inductive reasoning to understand how women perceive healthcare providers influence in shaping their beliefs about STDs.

In qualitative studies, the researcher gives meaning to the data (Neuman, 2006). The researcher is also involved in the translation or interpretation of data. First-order interpretation reveals meaning in the data for the participants involved in the study. Based on first-order interpretation, the researcher reconstructs the interpretation to arrive at the significance of study participants' actions, which is also known as second-order interpretation (Neuman, 2006). Second-order interpretation of the data may confirm the obvious or what is already known from the data, eliminate or reduce misconceptions, or reveal meaning that was not previously known (Patton 2002). Based on this multiple

case study, the researcher engaged in second-order interpretation to link meaning to the study's findings. The results of the data analysis were verified by double-checking the results and reporting accurate findings based on the data collected to comply with the principles of ethical reporting (Cottrell & McKenzie, 2011).

Moustakas (1994) described the Epoche process to minimize preconceived bias when conducting research involving a phenomenon. Researchers must refrain from prejudgments and strive to discover new information (Moustakas, 1994). Using an Epoche process, women's perceptions are described as they were presented to the researcher.

Validity

The concept of external and internal validity is immeasurable in qualitative research, yet validity is obtained using triangulation of data (Guion, Diehl, & McDonald, 2011). Authors Leedy and Ormond (2009) indicated external validity considers the generalization of research results. Qualitative research focuses on exploring, explaining, or describing a phenomenon. Generalizing results is not an objective of qualitative studies (Christensen, Johnson, & Turner, 2011).

Elo et al. (2014) determined creditability, rigor, authenticity, and trustworthiness are terms associated with qualitative studies. In qualitative studies, trustworthiness involves collecting data and reporting findings linked to the data. "From the perspective of validity, it is important to report how the results were created" to disclose meaningful findings that warrant attention (p. 1).

Internal validity considers the credibility of participants and the information provided (Leedy & Ormond, 2009). Since each interview was conducted separately,

triangulation was achievable as a result of collecting independent sets of data. Peer-reviewed literature helped to increase the validity of the study. Statistics and reports obtained from the Center for Disease Control and Prevention in conjunction with published records from the Louisiana Department of Health and Hospitals also helped to increase the validity of the research study. A pilot study was conducted on the interview protocol by women whose information was not used in this body of research. The pilot study helped to validate the information obtained. The inclusion of individual interviews from different participants in the study, peer-reviewed literature, and statistics obtained from the Center for Disease Control and Prevention and published records from the Louisiana Department of Health and Hospitals are all independent data sources used to achieve triangulation.

An additional method to ensure validity of the study's findings was to return transcribed interview data to study participants for verification. Member checking involves asking study participants to validate information for accuracy by reviewing and verifying the data. Member checking is critical to establishing credibility in qualitative studies (Lincoln & Guba, 1985).

The goals of research are to achieve thoroughness and purposive completeness (Richards, 2002). These outcomes are regarded as rigor in qualitative studies. Rigor is achieved through scoping the inquiry, which is an ongoing analysis of the study's scope, assessing the themes for completeness, and achieving data saturation (Richards, 2002). The triangulation of data and member checking are also methods to ensure rigor in qualitative studies. Triangulation and member checking establishes creditability of the study's findings. Members were asked to verify information for accuracy of reporting.

Reliability

In qualitative studies, reliability of the research design is not easily determined as with quantitative studies (Neuman, 2006). The case study is an effective qualitative design to collect dependable data from study participants, which is consistent with the reliability found in quantitative studies. Since a pilot study was conducted of the survey instrument, revelations obtained from this study are dependable. A research assistant was not used for this study. The researcher assumed sole responsibility for designing the research instrument and collecting and analyzing the data to help maintain the dependability of data contained in the study. Neuman (2006) indicated reliability in qualitative studies pertains to the dependability of collected data. In qualitative studies, researchers Lincoln and Guba (1985) recommended replacing the term reliability with dependability.

The researcher of a qualitative study must ensure conformity of participants' information. Conformity means data is provided accurately as presented by the participants and not the product of misinterpretations by the inquirer (Elo et al., 2014). In this study, conformity was achieved by allowing participants to confirm the information provided in their interviews was captured correctly through member checking of their transcribed interviews.

Summary

Chapter 3 discussed the research method and design of the research study. The qualitative multiple case study was selected because of its appropriateness for investigating women's perceptions of health care providers influence in shaping their beliefs regarding protection against STDs. In chapter 3, the research questions,

population and sampling, informed consent, confidentiality, and the geographic location were addressed. Face-to-face and telephone interviews will be selected as the research instrument to assist in the collection of data because gaining new insights is achievable when participants of a qualitative study are granted input regarding a phenomenon (Yin, 2003). The chapter included information pertaining to the manner in which data will be analyzed. Chapter 4 will focus on the findings of this qualitative multiple case study.

Chapter 4

Results

The purpose of this qualitative multiple case study was to explore women's perceptions of provider influence in shaping their beliefs about protection against sexually transmitted diseases during the provider-patient consultation. Three research questions formed the basis of the inquiry used to solicit responses from women and were as follows: (a) How do women perceive provider-patient consultations regarding the prevention of potential disease resulting from sexual relations? (b) How could healthcare providers couch STD related information to lower resistance and motivate women to change risky sexual behaviors? (c) How do women perceive the information received from healthcare providers regarding method and concept of use of contraceptives in the prevention of sexual transmission of disease during sexual relations?

"Invitation to Participate" documents, as displayed in Appendix B, were sent to approximately 100 women who were members of the researcher's professional women's association located in Baton Rouge, Louisiana. Fifteen signed documents were returned indicating women's willingness to participate in the study. Twelve women were selected from this purposive sampling of women who met three criterions. For inclusion in the study, the participant had to be a woman, aged 18-45, who made visits to healthcare providers between years 2012 - 2014. Research and interview questions were tested for clarity by the three women who were not selected to participate, but agreed to be part of a pilot study.

Chapter 4 includes reviews of the problem and research questions, results from the pilot study, and a detailed description of the information collected. The analytical

procedures performed and the emergent themes found in the data using NVivo 10 are also presented. Emergent themes resulted from recurring themes obtained from women's responses to the 10 interview questions found in Appendix C.

Review of the Problem

In the aftermath of safe sex education and awareness interventions designed to increase knowledge of the importance of condom use during sexual relations, the problem is women are disproportionately contracting STDs by engaging in risky sexual behaviors. Healthcare providers are entrusted with preventing diseases and improving patients' health statuses and outcomes, yet there is a gap in knowledge regarding HCPs' effectiveness in influencing women's beliefs about STDs and their ability to compel women to use protection to prevent them. Based on information obtained from the Louisiana Department of Health and Hospitals (DHH, 2013), Louisiana is a national leader in reported STD case rates, causing women in this population to be at a greater risk for contracting a disease if their beliefs about STDs are based on outdated or inaccurate information.

A qualitative multiple case study was designed to explore women's perceptions about the provider-patient consultation in helping women to prevent contracting an STD and changing associated risky sexual behaviors. Friedman and Bloodgood (2010) indicated women's preference is to receive sexual health information from HCPs. To better understand how women perceive HCPs and the information obtained during the provider-patient consultation, research questions were designed to solicit meaningful information from women, who are the population disproportionately affected by STDs.

Review and Basis of the Research Questions

The three research questions answered by 12 women participants recruited for the study were: 1) How do women perceive provider-patient consultations regarding the prevention of potential disease resulting from sexual relations? 2) How could healthcare providers couch STD related information to lower resistance and motivate women to change risky sexual behaviors? 3) How do women perceive the information received from healthcare providers regarding method and concept of use of contraceptives in the prevention of sexual transmission of disease during sexual relations? The interview questions included these three questions and other questions intended to elicit responses that addressed the constructs of the Health Belief Model.

Guided by the constructs of the Health Belief Model, women responded to questions about STD severity and susceptibility in women, along with the perceived benefits of receiving information from providers that could change risky sexual behaviors. Women were also questioned about the perceived barriers that would keep them from taking providers' recommendations to change at risk behaviors. Insight gleaned from this research study involved questioning women about the STD phenomenon and the risky sexual behaviors that place women at risk for contracting a disease.

The interview questions used to arrive at findings for this study were:

1. How severe do you believe STDs are in women?

   5) extremely severe 4) very severe 3) neutral 2) somewhat severe 1) not severe

2. How susceptible do you believe women are to contracting an STD?

   5) extremely severe 4) very severe 3) neutral 2) somewhat severe 1) not severe

3. What is your perception of the provider patient-consultation regarding the prevention

of potential disease resulting from sexual relations?

4. How would you describe risky sexual behavior?
5. What is your perception of healthcare providers willingness to routinely initiate discussions about STDs?
6. Based on your experience, how effective are healthcare providers in influencing you to adhere to prescribed recommendations?

   5) extremely effective 4) very effective 3) neutral 2) somewhat effective 1) not effective
7. How do you believe healthcare providers could couch STD related information to motivate a change in risky sexual behaviors?
8. What is your perception of the information you receive from healthcare providers regarding method and concept of use of contraceptives in the prevention of sexual transmission of disease during sexual relations?
9. How do you believe you stand to benefit from receiving STD related information during the provider-patient consultation?
10. What barriers do you believe would keep you from adhering to provider influence?

Women were not asked to answer personal or sensitive questions about their health statuses. Participants were given an opportunity to describe openly and freely their perceptions of the provider-patient consultation.

Pilot Study

Three women who emailed their invitation to participate forms to the researcher, but were excluded from participating in the study, were asked to test the research questions for clarity. Informed Consent forms were delivered via email and required

electronic signatures from pilot study participants before testing of the research questions began. After the researcher received the signed Informed Consent forms, the interview questions as shown in Appendix D were sent by email to the three women participating in the pilot study. Based on the comments received, the original interview questions were revised. Rating scales were added to questions one, two, and six. Since the participants in the pilot study believed the interview questions, which included the three research questions, were clear and contextual, no other changes were made.

Demographics

Study participants were recruited from the researcher's professional association of women in Baton Rouge, Louisiana. The 12 participants responded to an "Invitation to Participate" document emailed to approximately 100 professional women in the Baton Rouge, Louisiana area. The criteria for selection involved women between the ages of 18 – 45 who visited healthcare providers between years 2012 - 2014. The demographics of the adult women participants were as follows:

1. Participant AW1 is an adult female in the 36-40 age range. She made more than four visits to HCPs between 2012 through 2014.
2. Participant AW2 is an adult female in the 31-35 age range. She made more than four visits to HCPs between 2012 through 2014.
3. Participant AW3 is an adult female in the 31-35 age range. She made more than four visits to HCPs between 2012 through 2014.
4. Participant AW4 is an adult female in the 20-25 age range. She made more than four visits to HCPs between 2012 through 2014.

5. Participant AW5 is an adult female in the 41-45 age range. She made more than four visits to HCPs between 2012 through 2014.
6. Participant AW6 is an adult female in the 31-35 age range. She made more than four visits to HCPs between 2012 through 2014.
7. Participant AW7 is an adult female in the 41-45 age range. She made one to two visits to HCPs between 2012 through 2014.
8. Participant AW8 is an adult female in the 36-40 age range. She made one to two visits to HCPs between 2012 through 2014.
9. Participant AW9 is an adult female in the 36-40 age range. She made one to two four visits to HCPs between 2012 through 2014.
10. Participant AW10 is an adult female in the 31-45 age range. She made one to two visits to HCPs between 2012 through 2014.
11. Participant AW11 is an adult female in the 41-45 age range. She made one to two visits to HCPs between 2012 through 2014.
12. Participant AW12 is an adult female in the 26-30 age range. She made more than four visits to HCPs between 2012 through 2014.

The purpose of the qualitative multiple case study was to increase knowledge within the parameters of the problem under investigation (Merriam, 2009). As illustrated in Table 1, the demographics consisted of 58 % of study participants with more than four visits made to healthcare providers during the time period used for the research. The remaining 42% visited HCPs one to two times during the designated time period.

Table 1

Participants' Demographic Information

Participant	Gender	Age Range	Visits to HCPs Between 2012 - 2014
AW1	Female	36-40	4+
AW2	Female	31-35	4+
AW3	Female	31-35	4+
AW4	Female	20-25	4+
AW5	Female	41-45	4+
AW6	Female	31-35	4+
AW7	Female	41-45	1 - 2
AW8	Female	36-40	1 - 2
AW9	Female	36-40	1 - 2
AW10	Female	31-35	1 - 2
AW11	Female	41-45	1 - 2
AW12	Female	26-30	4+

Data Collected

As presented in Table 1, the demographic information collected from each participant included self-reported gender, age ranges, and the number range of patient visits made to healthcare providers between the 2012-2014 time periods. Women were selected from a purposive sampling of adult women in the Baton Rouge, Louisiana area and asked to respond to the 10 interview questions found in Appendix C. Twelve

participants were telephone interviewed and digitally voice recorded by the researcher between January 18, 2015 and May 20, 2015 to seek women's perceptions of provider influence in shaping their beliefs about using protection against sexually transmitted diseases during the provider-patient consultation. The voice recordings were transcribed into Word documents and sent to participants for member checking.

Data Analysis Process

NVivo 10 qualitative software was used to analyze the data collected from study participants' interviews. In NVivo 10, a new project titled "Qualitative Multiple Case Study" was created with the word "Dissertation" entered as a description. The Word documents from participants' interviews were imported into the software and saved as internal sources labeled "Interviews". NVivo 10 was checked to verify data were imported correctly and contained participants' full interviews in compliance with the standards established for ethical reporting. Data were also reviewed to gain an understanding of the information contained in the interviews.

After data were reviewed and verified, an inductive approach to analysis was adopted to create the node structure. Since an inductive approach was used, pre-determined themes and patterns were not selected. The node structure was built and formed a list using each interview question. Women's responses to each interview question were open coded under the applicable interview node, which was the first phase of the coding process.

Responses from study participants resulted in major themes and patterns emerging from the analyzed data. As themes and patterns developed, sub-nodes were created and

listed below the corresponding interview question node. The sub-nodes were used to group the themes or patterns together.

In the second phase of the coding process, major categories and concepts of information were discovered in the data from organizing the codes. This step is known as axial coding. The major concepts and categories were confirmed to the associated interview questions and relationships were identified.

Through an inductive analysis approach, the next phase of coding was accomplished through selective coding. During this third phase, the researcher identified and selected previous codes. These codes resulted in the emergence of major themes and patterns.

Findings of the Study

Coded data of 12 interviews imported into NVivo 10 were queried to reveal themes or patterns associated with women's perceptions of the provider-patient consultation in influencing women to use protection during sexual relations. Queries were run using the query wizard, content analysis, and matrix queries. All 12 women participants acknowledged visits to healthcare providers between 2012 and 2014. During the timeframe used for the research study, 58% of the participants confirmed they visited HCPs more than four times and 42% reported healthcare visits were made to HCPs one to two times.

NVivo 10 allowed for a qualitative analysis of women's perceptions about how they believed information should be presented during the provider - patient consultation to motivate changes in women's risky sexual behaviors. An analysis of women's perceptions of the information presented during the provider-patient consultation also led

to the discovery of information that culminated in emergent themes. The NVivo 10 Qualitative Multiple Case Study project produced three major themes. As displayed in Table 2, one subtheme presented from theme 1 and four subthemes presented from theme 3. A discussion of these themes follows Table 2, which displays major theme numbers and their descriptions, along with the subthemes associated with the major themes.

Table 2

Major Themes and Subthemes

Major Theme	Description	Subtheme
Theme 1	Providers did not initiate discussions about preventing STDs	
Theme 2	No information received about preventing STDs during consultations	1) Negative perceptions about STDs
Theme 3	Visuals could motivate change in risky sexual behaviors	1) Unprotected sex and multiple partners were described as RSBs 2) Sharing knowledge is a benefit of receiving STD related information 3) HCPs are highly effective in influencing women to take recommendations 4) No barriers would keep women from adhering to provider influence

Theme 1: Providers did not initiate discussions about preventing STDs.

Research question one and interview question three was "What is your perception of the

provider patient-consultation regarding the prevention of potential disease resulting from sexual relations"? Information obtained by asking this question revealed 67% of the participants perceived HCPs did not initiate discussions about preventing STDS during their consultations with women. AW1 stated these discussions were not initiated and believed provider discussions were dependent on women's reasons for visiting HCPs. AW4 responded

> In my experience, they won't tell you anything about it unless you ask. So, many people don't really think to ask about things like that for one reason or another. I believe it should be maybe a routine thing that should be done especially when between uh 2012, 2014, 2015, I had two kids within that timeframe. I had to ask, hey is everything ok? Let me make sure if anything is off. They won't test you just because. They won't give you that information just because. You have to actually ask for it.

AW7's comment was

> I think it's a conversation that unless you bring it up, it is not brought up. From personal experience, if you were to ask something, I think you get very limited, very concise about whatever the specific question you are asking about information. So, I don't think there's a lot of hey this is the time I can educate. So, let me tell them about more. They kind of keep it to the direct question that you might have asked, or the direct problem that you are dealing with.

AW4 and AW7 opined providers do not have these types of discussions unless the patient initiates it.

AW5 and AW9 asserted their perceptions of the provider-patient consultation as it pertains to preventing STDs, which was providers will have these discussions only if a woman patient comes in with a health concern or contracted disease. AW5's perception caused her to state "I don't think they discuss it a lot unless someone has contracted a disease". AW9 commented "the patient typically would have to present some type of concern or problem".

AW2, AW6, and AW10 stated providers had never had these types of discussions with them. AW1, AW2, AW4, AW5, and AW6 visited HCPs more than four times between the 2012 – 2014 time period. Responses obtained to research question one and interview question three revealed providers did not initiate discussions about preventing STDs during provider-patient consultations. Women believed the patient must inquire about or present with a health concern before HCPs engage in discussions about preventing STDs.

Interview question five was "What is your perception of healthcare providers' willingness to routinely initiate discussions about STDs"? Responses to this question did not reveal new information. AW1 asserted

> They don't really initiate it unless you initiate it. I think they go through the motions of having their routine questionnaire so to speak. But unless you come to them with an issue, I don't think it is an open discussion item.

AW5 declared "I don't think they initiate it very often unless they are running a test or something. Or, the patient has symptoms of something. I don't think they routinely discuss it at all". AW8 described "I don't think that most healthcare providers initiate the conversation unless they see certain things".

Women's comments were similar to the responses provided when asked "What is your perception of the provider patient-consultation regarding the prevention of potential disease resulting from sexual relations"? Most women had no perception of providers' willingness to engage in routine discussions about STDs because this type of discussion was never initiated by study participants' HCPs between 2012 and 2014. The only participant who expressed new information was AW12. Although her providers never initiated conversations about STDs, which made her provider-patient consultation experiences similar to other participants, she stated "I think healthcare providers are willing to do it. I just don't think that there is always enough time or staff on hand to assist the patient with education".

Table 3

Discussions Not Initiated By Providers

Major Theme	Description	Sources
Theme 1	Providers did not initiate discussions about preventing STDs	AW1, AW2, AW4, AW5, AW6, AW7, AW9, AW10

Theme 2: No information received about STD prevention. Women indicated no information was received from providers about STD prevention during the provider-patient consultation, yet they held negative perceptions about the severity of STDs in women and women's susceptibility to acquiring them. Research question three and interview question eight was "What is your perception of the information you receive from healthcare providers regarding method of contraceptives to use in the prevention of sexual transmission of disease during sexual relations"? The reason for this question was

to determine if women were given any information about using protection to prevent STDs. In the event discussions did not occur, providers may have used cues or chosen other ways to inform patients of the ramifications involving the diseases while remaining cognizant of time constraints. Other options involved referring women to online resources or opting to provide women patients with handouts, yet 67% of participants indicated they did not receive information in any form about preventing STDs during provider-patient consultations.

AW1 responded "I really haven't received anything". In AW3s' and AW10s' visits to HCPs, the discussion focused on birth control and nothing was mentioned about preventing STDs. AW10 described "The method of contraceptives they are talking about more so with the women is using birth control as contraceptives, but never really anything to prevent [STDs]". AW4 stated "I haven't been presented with any information about that, honestly". AW6 indicated "I can't remember if a provider ever told me to use a barrier". AW7 expressed "I don't think that it [information] comes from physician to client". AW11's response concurred with AW1's response and was "I haven't really received any information on it". AW12 stated "to be honest with you, when I go to a doctor's office or anytime I've gone to the doctor, we've never even talked about like safe sex". Responses received from eight out of 12 participants revealed no form of information to prevent STDs was presented during their provider-patient consultations.

Subtheme 1: Negative perceptions about STDs. Based on the constructs of the Health Belief Model, individuals must believe a health condition is severe and they are susceptible to presenting with the illness to change behaviors (Montgomery & Bloch,

2010). Given these constructs, the researcher attempted to arrive at participants' perceptions about the severity of STDs in women and women's susceptibility to these diseases. Interview question one asked women to rate the severity of STDs in women using the following scale: 5) extremely severe, 4) very severe, 3) neutral, 2) somewhat severe and 1) not severe. AW3 and AW9 indicated STDs were extremely severe in women, while AW2, AW4, AW5, AW8, AW10, and AW12 believed STDs were very severe in women. None of the participants believed STDs were not severe in women. Based on responses from 67% of participants, women believed STDS were highly severe in women.

Interview question two asked women to rate women's susceptibility to contracting an STD using the same scale to rate the severity of STDs in women, which was: 5) extremely severe, 4) very severe, 3) neutral, 2) somewhat severe and 1) not severe. AW2, AW5, AW7, AW8, AW10, AW12 believed women were extremely susceptible to contracting an STD, while AW1, AW3, AW4, AW6, AW9, and AW11 believed women were very susceptible to contracting an STD. None of the participants were neutral or believed women were not susceptible to contracting an STD. Based on responses from 100% or all 12 participants, women believed women were highly susceptible to contracting an STD.

Women indicated they did not receive any information about STDs during their provider-patient consultations. Individuals participating in the study revealed their perceptions about the severity of STDs and women's susceptibility to contracting them. Through inductive analysis, the researcher discovered women held negative perceptions about STDs. Women understood that contracting an STD was a health risk for women.

Table 4

No Information Received about Preventing STDs

Theme 2 and Subtheme	Sources
No information received about preventing STDs during consultations	AW1, AW3, AW4, AW6, AW7, AW10, AW11, AW12
Negative perceptions about STDs	AW1, AW2, AW3, AW4, AW5, AW6 AW7, AW8, AW9, AW10, AW11, AW12

Theme 3: Visuals could motivate changes in risky sexual behaviors. Risky sexual behaviors cause women to contract sexually transmitted diseases (Bolton, McKay, & Schneider, 2010). Participants in the study described risky sexual behaviors as unprotected sex and sex with multiple partners. Based on the constructs of the Health Belief Model, individuals must believe a disease is severe and they are susceptible to it before they decide to change behaviors that place them at risk for the disease (Zak-Place & Stern, 2004). Individuals must also recognize benefits of making changes and believe there are no barriers to making these changes (Zak-Place & Stern, 2004). Since women believed HCPs are highly effective in influencing them to take providers' recommendations, no barriers were identified as preventing them from changing behaviors based on provider influence. Women discussed a major benefit of receiving STD related information from providers is the ability to share knowledge with other women who may not be as informed about at risk sexual behaviors that could lead to an STD.

In order to address RSBs, research question two and interview question seven was "How do you believe healthcare providers should couch STD related information to

motivate a change in risky sexual behaviors"? AW1, AW3, AW4, AW5, AW6, AW8, AW11, and AW12 indicated visuals could motivate changes in risky sexual behavior. AW1 said she wanted to see visuals before engaging in discussions with her provider. The study participant affirmed "I am more of a visual person and then, you know after the visual, let's talk". AW3 indicated she was a reader and would like to receive printed information to read later. AW4 avowed she was "definitely visual and loved handouts". AW5 declared

> I think definitely having the information visual in the room. I know when I go into the room, because you are sitting there waiting, you tend to read things on the walls. Even if that's not what you're there for, you tend to read them. So, if they have posters or signs or something you know, even if the sign just said STDs in women is rising, is 30%. I think you would catch people's attention. I do believe at the visit they could give people something to read about it.

AW6 mentioned showing photographs. AW8 expressed that visuals were effective the majority of the time because "you can see the outcome". AW11 stated providers should use whatever information they have readily available to "physically show their patients what could happen if they contract STDs". AW12 believed women should be shown the most graphic pictures their HCPs have available. She stated "you know for me, seeing the pictures freaks me out".

Women acknowledged people learn in different ways, yet 67% of participants responded that visuals could help motivate changes in risky sexual behavior. Responses included having information in the patient rooms available so patients could read while

they waited for their HCP, providing patients with handouts, and illustrating through graphic pictures how an STD affects the woman's body.

Subtheme 1: Unprotected sex and multiple partners were described as risky sexual behaviors. Interview question four inquired about RSBs and was "How would you describe risky sexual behaviors"? The reason for this question was to determine which behaviors women believed placed them at risk for STDs. AW1 and AW11 stated "Multiple partners. Unprotected sex with multiple partners". AW2 described "picking up strangers in bars" and having one night stands with strangers. AW3's response "becoming intimate with someone you don't have enough information on" and "it could be a one night stand or it could be a long-term relationship not being informed both ways" was similar to AW2's response. She also included unprotected sex in her description of risky sexual behaviors. AW4 responded "unprotected sex pretty much with multiple partners". AW6 indicated having unprotected sex and expounded

> First of all, not asking questions initially like straight up just asking "Do you have any sexually transmitted diseases"? I think that's risky. I think that's one thing that's risky. The other thing is not using any type of protection and that means like a barrier you know, like a condom. Or, something else that would protect you. That's two big ones right there.

AW6 reflected further and expressed

> [sex] without any barrier method; without actually asking your partner that you are going to be with you know whether or not they know their status or not. Also, not being aware of your own status. That's also a part of it as well. Not just the

> partner, but you need to know what is going on with your body, so that all encompasses unprotected sex to me.

AW5 described RSBs as unprotected sex, sex with someone whose sexual habits were not known to the woman, and unprotected sex with multiple partners. AW7 was consistent with other women's descriptions and declared "casual encounters, multiple partners, and the lack of protection" were all RSBs. AW8 and AW9 believed sex with multiple partners was risky. AW10 described anal sex, men having sex with men, women having sex with women, and kissing areas that are not considered as the cleanest parts of the body. AW12 indicated sex without a condom was risky sexual behavior. Based on responses received to interview question four, the majority of women believed unprotected sex and sex with multiple partners were risky sexual behaviors.

Subtheme 2: Sharing knowledge is a benefit of receiving STD related information. The third construct of the Health Belief Model is perceived benefits (Zak-Place & Stern, 2004). Changes in behavior are driven by an individual's belief that there is a benefit in changing behavior. Interview question nine was "How do you believe you stand to benefit from receiving STD related information during the provider-patient consultation"? AW1 indicated if she received more STD related information, she believed she could benefit by watching others benefit if she passed information along to them. The response from AW1 was

> I think how I can benefit is through watching others benefit. And I think knowing some people I may think are engaging in risky conversations probably passing information along to them. I think that's how I can benefit just by passing information to others I think can benefit from it.

AW2 stated “I might take the information he gives me and share it with my friends and family”. AW3 discussed she “could share information with other females” if she knew more. AW4 also mentioned she would share information if it was made available to her. AW11 would share information with her daughter. AW12 believed she would benefit a lot and “would share the information”. Fifty percent of women interviewed expressed they would share new knowledge with other women and alert them of possible new viruses afflicting women.

Subtheme 3: HCPs are highly effective in influencing women to take recommendations. Interview question six was “Based on your experience, how effective are healthcare providers in influencing you to adhere to prescribed recommendations”? Women were asked to use the following rating scale: 5) extremely effective, 4) very effective, 3) neutral, 2) somewhat effective and 1) not effective. Seven out of the 12 women interviewed believed HCPs were highly effective in influencing them to adhere to their recommendations.

Although AW8 did not expound on the reasons for rating her providers extremely effective, the responses given by AW6, AW7, and AW9 indicated trust and women’s individual experiences were main drivers of the extremely effective rating. AW6 observed her provider conducting searches on various topics and trusted the recommendations made. She commented

> I try to screen my healthcare providers very carefully. For example, when I picked my obstetrician, I made sure she had the same values I did. She was informed about all of her decisions she was making whenever I was in the office

with her. I watched her search on a lot of things. So, I really trusted her opinion; therefore, she really influenced me on any type of recommendation she had.

AW7 stated she relied on medical opinion and trusted her provider's expertise. She disclosed

> When I go to my doctor for a medical opinion, I am looking to them as an expert. I am looking for their wisdom. It's not an emotional um request, it is a fact. And I look to my doctor to give me facts. And so, if my doctor says you know "A" is the best thing for you because of blah blah blah, then if I trust my doctor and I have a relationship with my doctor, then why would I say "oh, no. I think I know better".

AW9 explained she cared about her health and based her rating of extremely effective on her personal experience with her provider.

A rating of very effective was driven by trust and women's beliefs about physicians. AW2 explained she had a good relationship with her doctor of many years and trusted him because

> I have a relationship or been going to my like gynecologist for years now. So, I trust that um, his opinion or it would be in my best interest. Plus, all those years he went to medical school, I would think he would know what he's talking about.

AW5's rating was based on the belief that people listened to advice given by medical professionals.

> For the most part, if your providers are telling you, then you would probably try to do what it is they are telling you to do and not to do. Not that it would be

100%, but you would probably try because they are medical professionals. So, people usually trust their medical professionals.

AW11 opined "I believe in taking care of myself and my doctor is much more knowledgeable about my medical needs than what I am. I'm not a doctor. So, I do follow what she says and what her instructions are".

AW6, AW7, AW8, and AW9 rated providers as extremely effective, while AW2, AW5, and AW11 rated providers as very effective. These seven participants comprised 58% of women interviewed for this study. Medical expertise, trust, and women's personal experiences with their providers caused women to provide high ratings of their providers' effectiveness.

Subtheme 4: No barriers would keep women from adhering to provider influence. Interview question 10 was "What barriers do you believe would keep you from adhering to provider influence"? AW2 could not think of any barriers that would keep her from adhering to the recommendations made by her provider. AW3 stated "I can't think of anything that would be a barrier". AW4 responded "I wouldn't have any barriers". She further added "But, I have to be presented with the information". AW8 responded with "For me personally, there is nothing that would stop me or hinder me from actually taking the advice of my provider". AW9 declared "I can't see any barriers for me personally, just because of my own personal attitude". AW12 indicated nothing would keep her from adhering to her provider's influence because she trusted him. Participants AW2, AW3, AW4, AW8, AW9, and AW12 represented 50% of the total number of women included in this study and expressed there were no barriers that would keep them from adhering to provider influence.

Table 5

Visuals Could Motivate Changes in Risky Sexual Behaviors

Theme 3 and Subthemes	Sources
Visuals could be used to motivate changes in risky sexual behaviors	AW1, AW3, AW4, AW5, AW6, AW8, AW11, AW12
Unprotected sex and multiple partners are risky behaviors	AW1, AW3, AW4, AW5, AW6, AW7, AW8, AW9, AW11, AW12
Sharing knowledge is a benefit of receiving STD related information	AW1, AW2, AW3, AW4, AW11, AW12
HCPs are highly effective in influencing women to take recommendations	AW2, AW5, AW6, AW7, AW8, AW9, AW11
No barriers would keep women from adhering to provider influence	AW2, AW3, AW4, AW8, AW9, AW12

Summary

The purpose of this qualitative multiple case study was to explore women's perceptions about the provider-patient consultation. The reader was provided with reviews of the problem and the research questions driving the study to cause them to remember the significance behind the research. Three women validated the research questions. Based on the feedback given, rating scales were added to interview questions one, two, and six.

Chapter 4 disclosed the research findings resulting from the 12 women who gave their consent to be interviewed for the study. A detailed description of the data collected and imported into NVivo 10 for analysis was presented. Three significant themes emerged after women's responses to the interview questions were examined and verified:

1. Providers did not initiate discussion about preventing STDs.

2. No information received about preventing STDs during consultations.
3. Visuals could motivate change in risky sexual behaviors.

In Chapter 5, the emerging themes regarding how women perceive the provider-patient consultation form the basis for the study's conclusions and implications, as well as establish and explain the need for future research.

Chapter 5

Conclusions and Recommendations

The purpose of this qualitative multiple case study was to explore women's perceptions of the provider-patient consultation regarding providers influence in shaping women's beliefs to use protection to prevent STDs. The three research questions the study was designed to answer were: (a) How do women perceive provider-patient consultations regarding the prevention of potential disease resulting from sexual relations? (b) How could healthcare providers couch STD related information to lower resistance and motivate women to change risky sexual behaviors? (c) How do women perceive the information received from healthcare providers regarding method and concept of use of contraceptives in the prevention of sexual transmission of disease during sexual relations?

A purposive sample of women was recruited and selected from the researcher's professional organizations and associations to participate in this study, resulting in telephone interviews scheduled and conducted on 12 participants who gave their consent to be interviewed. Since individual interviews were scheduled and conducted, the data provided by each participant were independent of those acquired from remaining participants. The inclusion of interviews, scholarly, peer-reviewed literature, and statistics retrieved from the Center for Disease Control and Prevention were the sources of independent data collected and used for this study. Published records were also obtained from the Louisiana Department of Health and Hospitals. Triangulation was achieved through different sources of independent data (Guion, Diehl, & McDonald, 2011).

The participants' responses to open-ended questions pertaining to the study were collected using digital voice recordings, transcribed into Word documents, and entered in NVivo 10 data analysis software. Based on the results from the data analysis, recurring themes presented in participants' responses to the interview questions. The three emergent themes revealed in chapter four were:

1. Provider did not initiate discussion about preventing STDs.
2. No information received about preventing STDs during consultations.
3. Visuals could motivate change in risky sexual behaviors.

In chapter five, the emerging themes regarding how women perceive the provider-patient consultation form the basis for the study's conclusions and implications, as well as establish and explain the need for future research. The study's limitations will also be discussed. Chapter five will summarize the chapters in the research study before concluding.

Results of the Data Analyses

As previously stated, women's responses to the 10 interview questions were analyzed in NVivo 10 qualitative software. NVivo 10 allowed for a contextual analysis of the data collected from women to arrive at major themes. The three emergent themes gleaned from the interview questions were: (a) Providers did not initiate discussions about preventing STDs. **(**b) No information received about preventing STDs during consultations. (c) Visuals could motivate changes in risky sexual behaviors.

Theme 1: Providers did not initiate discussions about preventing STDs. Research question one and interview question three asked women to discuss their perceptions of the provider-patient consultation. Responses to this question revealed

healthcare providers did not initiate discussions about preventing STDs. Sixty seven percent of the study's participants (AW1, AW2, AW4, AW5, AW6, AW7, AW9, and AW10) expressed consultations embodying STD prevention were not part of the protocol experienced during visits to providers. This result aligns with the discovery made by Friedman and Blood (2010), which was HCPs were possibly not engaging in teachable moments to prevent STDs when consulting with women. Women believed discussions about using protection against STDs take place if a patient presents with an illness, brings up the subject of STDs, or contracts an STD.

Participants in the study duplicated responses when asked question five about their perceptions of healthcare providers' willingness to routinely initiate discussions about STDs. Women's responses to the question were consistent with the responses given when they were asked about their perceptions of the provider- patient consultation influencing STD prevention. Study participants iterated they were never counseled about STD prevention or using protection to safeguard against STDs during patient visits, so they were unable to express if providers were willing to routinely have these types of discussions. One participant (AW12) out of 12 opined her belief that providers were willing to have routine STD prevention discussions, but other factors such as lack of time or staff caused providers to omit them during consultations.

Theme 2: No information received about preventing STDs during consultations. Research question three and interview question eight asked participants about their perceptions of the STD prevention information received during provider-patient consultations. Women declared no information was disseminated about preventing STDS during the provider-patient consultations. Healthcare providers could

use opportune time afforded during patient consultations to convey information that might help women protect their overall health, yet HCPs failed in providing women with information to prevent STDs during patient visits (Friedman & Blood, 2010). Sixty seven percent of study participants (AW1, AW3, AW4, AW6, AW7, AW10, AW11, and AW12) asserted providers did not circulate or exhibit STD prevention information. Participants were not referred to online resources or reference materials emphasizing the importance of STD prevention. Women who participated in the study reported visits were made to healthcare providers between the 2012-2014 timeframe, yet eight out of 12 of the purposive sample of women indicated they were not given information that could help prevent STDs by changing at risk sexual behaviors.

Subtheme 1: Negative perceptions about STDs. Based on the Health Belief Model, individuals change behaviors if they believe a disease is severe and susceptibility is impending. Severity and susceptibility are two of the four constructs of the HBM (Montgomery & Bloch, 2010). Interview question one asked women about the severity of STDs in women, while interview question two inquired about women's susceptibility to contracting an STD. Even though no information was received during consultations, women expressed negative perceptions about STDs. Six out of 12 participants (AW2, AW4, AW5, AW8, A10, and AW12), which was 50% of the women interviewed, rated STDs as very severe in women. Two out of 12 women (AW3 and AW9) believed STDs were extremely severe in women. Participants also indicated women were highly susceptible to contracting an STD. Fifty percent of women (AW1, AW3, AW4, AW6, AW9, and AW11) rated STDs as very susceptible, while 50% of women (AW2, AW5, AW7, AW8, AW10, and AW12) rated STDs as extremely severe.

Theme 3: Visuals could motivate changes in risky sexual behaviors. Research question two and interview question seven asked women how they believed STD related information should be couched to motivate women to change risky sexual behaviors. Eight out of 12 study participants (AW1, AW3, AW4, AW5, AW6, AW8, AW11, and AW12) believed visuals could motivate women to change at risk sexual behaviors. Women were aware the same technique would not work for everyone, but 67% of participants expressed visuals were best to motivate behavioral changes in risky sexual behavior because women could see the disastrous, long-term effects of STDs in women. Garcia-Retamero and Cokely (2011) discovered that including visual aids with health information about STDs helped increase the messages about effective sexual health behaviors.

Subtheme 1: Unprotected sex and multiple partners were described as risky sexual behaviors. Interview question four asked women to describe risky sexual behaviors to determine women's knowledge of the behaviors that could lead to STDs. As described by Bolton, McKay, and Schneider (2010) and Marcus, Fulton, and Turchik (2011), unprotected sex and sex with multiple partners are risky sexual behaviors that could lead to contracting an STD. Eighty three percent of women (AW1, AW3, AW4, AW5, AW6, AW7, AW8, AW9, AW11, and AW12) concurred with findings from Bolton et al. (2010) and Marcus et al. (2011) by expressing unprotected sex and sex with multiple partners were risky sexual behaviors in response to interview question four. Alcohol and drug use, sex in non-committed relationships, partner violence, as well as other risky behaviors determined by researchers Barban and Craciun (2007), Cole,

Logan, and Shannon (2007), Furman and Shaffer (2011), and Marcus et al., (2011) were not mentioned by the majority of the 12 women interviewed.

Subtheme 2: Sharing knowledge is a benefit of receiving STD related information. Findings from the interview conducted on 12 adult women revealed 50% of participants (AW1, AW2, AW3, AW4, AW11, and AW12) believed a derived future benefit of receiving STD related information during the provider- patient consultation is the ability to share information with other women, which could lead to women changing risky sexual behaviors. One of the constructs of the Health Belief Model pertains to the benefits an individual perceives will occur after making behavioral changes (Zak-Place & Stern, 2004). Even though the Affordable Care Act (ACA) was enacted in 2010 to allow individuals affordable healthcare, disparities in healthcare services could still cause some women to not visit their healthcare providers for regular check-ups (Abdus, Mistry, & Selden, 2015). Conveying information informally and impersonally through conversations held with women who lack knowledge about RSBs, or who exhibit or engage in risky sexual behaviors, is a benefit to the at risk population, some of whom may not visit healthcare providers regularly.

Subtheme 3: HCPs are highly effective in influencing women to take recommendations. Women were asked to rate their providers effectiveness in influencing them to take recommendations. Seven of the 12 participants (AW2, AW5, AW6, AW7, AW8, AW9, and AW11), which was more than half of the women interviewed, indicated HCPs are highly effective in influencing women to take recommendations. Women's personal experiences with and beliefs about medical doctors resulted in high ratings of extremely effective for healthcare provider

effectiveness. By exercising their influence and effectiveness during the provider-patient consultation (Alexander, Hearld, Mittler, & Harvey, 2012), HCPs could change women's risky sexual behaviors by driving patient activation. The status of women's overall health might improve if providers address these at risk sexual behaviors.

Subtheme 4: No barriers would keep women from adhering to provider influence. Interview question 10 asked women "What barriers do you believe would keep you from adhering to provider influence"? Fifty percent of women (AW2, AW3, AW4, AW8, AW9, and AW12) asserted no barriers would keep them from adhering to provider influence. The reasons women gave for indicating there were no barriers to taking the advice of providers were attributed to trust and providers' knowledge. Communications specifically addressing STD prevention in women require health care providers to build trust in their patient relationships and prescribe recommendations in an effort to deliver successful healthcare outcomes (Brincks, Feaster, Burns, & Mitrani, 2010). Based on a construct associated with the Health Belief Model, behavioral changes might occur if there are no known barriers perceived by an individual (Zak-Place & Stern, 2004).

Implications to Leadership

The implications to leadership of the study's findings include a more heightened focus of healthcare provider involvement in the STD phenomenon. HCPs could utilize the provider-patient consultation as a teachable moment to advise women to use protection against STDs when engaging in sexual relations. The implication of the current study to leadership is that more collaboration is needed between public healthcare

leaders and healthcare providers to increase STD awareness by addressing women's risky sexual behaviors.

Findings from the current study may cause healthcare leaders to enhance earlier or form new interventions specifically for women to promote STD prevention. As researchers Fathalla, Sinding, Rosenfield, and Fathalla (2006) indicated, the previous ABC approach of "abstinence, be faithful, and use condoms" was one attempt at designing an intervention in support of a social movement to prevent STDs (p. 2096). The integration of a combination of interventions to lessen or eradicate new incidences of STDs may help in preventing STDs (Fathalla, Sinding, Rosenfield, & Fathalla, 2006) Public healthcare leaders and officials might recognize measures may be undertaken in the general population to educate women of other risky behaviors associated with contracting STDs.

Health initiatives could involve HCPs because women believe they have more expert knowledge about diseases and illnesses. Since healthcare providers are not required to discuss STD prevention and at risk behaviors with women, government officials may determine a mandate is needed, which would force healthcare providers in different settings to have discussions and/or provide meaningful STD prevention information. STDs are and may continue to be a public health concern in the age of casual relationships, such as friends with benefits, if a different approach to STD prevention is not adopted.

Theoretical Framework

Based on the social cognitive theory and the constructs of the Health Belief Model, an individual must hold certain beliefs about illness before deciding to change

health behaviors. This research was founded on literature involving the social cognitive theory and the Health Belief Model. STDs are a health concern affecting women negatively and disproportionately as a result of women's engagement in risky sexual behaviors. It was imperative to gain a better understanding of how women perceived STDs and healthcare providers' influence in the STD phenomenon. Researchers Baban and Craciun (2007) ascertained the Health Belief Model is motivational because individuals must perceive consequences of and susceptibility to an illness, as well as barriers to and benefits of changing behaviors.

Previous studies about the STD phenomenon in women did not reveal if women received adequate and up to date information required to motivate changes in risky sexual behaviors from healthcare providers during provider-patient consultations. The lack of ample information about women's perceptions about provider-patient consultations revealed the need for further research and prompted a qualitative multiple case research study. The social cognitive theory and the Health Belief Model formed the framework for the study and helped in yielding new insights about how women perceive the problem of STDs in women and healthcare providers' efforts to motivate women to change risky sexual behaviors. Women expressed behaviors might change if HCPs presented women with visuals to illustrate the outcomes of contracting an STD.

Limitations of the Study

There were limitations or weaknesses associated with the focus of the study, which was to examine women's perceptions of the provider-patient consultation in influencing the use of protection against STDs. Based on 15 women volunteering out of 100 solicited to participate in the study, the response rate was 15% and limited the

examination by the 12 women who were included in the study. The purposive sample of 12 adult women limited the study because the entire population of women was not represented by the sampling.

Findings obtained from the purposive sample of adult women further limited the study because women located in Baton Rouge, Louisiana women may not generalize to women living in other jurisdictions. Since women were asked questions about their perceptions of provider-patient consultations that occurred between years 2012 through 2014, the study was limited because women's recollections of the provider-patient discussions may not have been accurate. The limitation of bias may have been introduced based on women's inability to recall the counseling provided by HCPs

The researcher's selection of the qualitative multiple case study rather than a quantitative methodology to further understand women's perceptions of the provider-patient consultation could have limited the study. In quantitative research, comparisons are made using variables and numbers (Patterson & Morin, 2012). Researchers use statistics and measurements to reject or fail to reject hypotheses (Lewis, McGrath, & Seidel, 2009). In qualitative research, the researcher is allowed to collect data using open-ended inquiries. Findings and contextual detail that resulted from this qualitative research of participants' perceptions of the provider-patient consultation could be limited because they were subjected to interpretation by the researcher.

Recommendations

Based on the research findings revealed and the conclusions drawn from this study, opportunities exist to help women, healthcare providers, healthcare leaders, and the general population with STD prevention. Recommendations involving ways to

leverage staff in healthcare providers' settings, illuminate cues to action, and develop STD awareness programs specifically for women, could trigger changes in women's at risk behaviors, ultimately leading to fewer newly reported cases of STDs in women. Recommendations for future research to add new knowledge about healthcare providers' influence in preventing STDs in women also exist.

Leverage staff. Women interviewed for the study were informed that healthcare providers include doctors, nurses, nurse practitioners (NPs), physician assistants (PAs), pharmacists and other individuals and facilities licensed to identify, treat, or prevent illness, yet women associated the term of provider with physician or medical doctor. Given the fact that nurses usually spend time collecting and reviewing information prior to patients being seen by a doctor, NP, or PA, physicians could leverage the time nurses spend with patients. The nurse becomes a valued liaison during the patient's visit and could help open up the lines of communication between patients and doctors.

Since Jacobs and Kane (2010) found there was a stigma associated with STDs, the health screening questionnaires could be updated to include a few key questions about STDs to put patients at ease if they are concerned about how their providers might perceive them if they initiated the discussions. AW7 expressed

> I think if doctors would do that for people who may be a little more reserved or shy or hesitant to ask embarrassing or difficult questions, it may give them some prompting to open that subject up. Otherwise they may come in and walk out and never ask.

Using the health screening questionnaire as a prompt, nurses could inquire about women's sexual health statuses and apprise women of the current state and new

developments associated with the STD phenomenon prior to women visiting with the physician.

Cues to action. Findings from this research indicate healthcare providers are missing teachable moments to engage in STD prevention discussions during consultations with women. Jozkowski, Geshnizjani, and Middlestadt (2013) revealed healthcare providers' discussions about STD prevention are limited by time restraints because other health matters take precedence. In the research conducted by Dyer and das Nair (2013), several themes emerged as to why healthcare providers do not talk about sex issues. The researchers' study revealed barriers to providers initiating sex discussions were "the lack of time, resources, and training, knowledge and abilities, worry about causing offense, personal discomfort, and a lack of awareness" (p. 2658). It was also determined by Dyer and das Nair (2013) that providers feared initiating these discussions because it could be like opening Pandora's Box.

Visuals in the form of printed material placed in waiting areas, patient rooms, and/or at the check-out desk at providers' locations could serve as cues to action (Manika & Goldman, 2011). Signs or posters on walls are also cues to action because they are visuals, which is how women believe healthcare providers could present STD related information to lower resistance to or motivate changes in women's at risk sexual behaviors. Visuals could trigger and increase women's awareness to the harmful effects caused by STDs.

Intervention programs. Women should be the focus of STD interventions because they are the population disproportionately affected by the STD phenomenon (East, Jackson, Peters, & O'Brien, 2010; Logan, Khambaty, D'Souza, & Menezes, 2010).

Interventions designed to address the risky sexual behaviors placing women at risk for contracting STDS, as well as the consequences women suffer when living with an incurable STD, might result in women engaging in safer sex practices. Education and awareness about using condoms during sexual activity are insufficient in preventing STDs as evidenced by women continuing to contract STDS because of their engagement in other risky behaviors. In addition to effective and consistent condom use, other risky behaviors to consider include, but are not limited to, alcohol and/or drug use, violent partners, oral sex, anal sex, sex in non-committed relationships, women's perception's about their relationships, unknown sexual histories, women having sex with women, and women having sex with men who are having sex with men (Barban & Craciun, 2007; Bolton, McKay, & Schneider, 2010; Furman & Shaffer, 2011; Marcus, Fulton, & Turchik, 2011; Maynard, Carballo-Diéguez, Ventuneac, Exner, & Mayer, 2009). Women engaging in these risky behaviors may not knowingly realize these behaviors could lead to an STD. Programs and interventions embodying communications about safe sex practices should continue to address condoms, but expand to include women and other at risk behaviors.

Future research. Participants in this study disclosed their perceptions of the provider-patient consultation and expressed providers did not initiate discussions about STDs. Based on the findings from the study conducted by Dyer and das Nair (2013), healthcare providers may believe it is not in the best interest of providers or patients to engage in discussions about sexual matters. Future research using a qualitative multiple case study to examine the barriers and obstacles healthcare providers believe impede sex related discussions is needed because "efforts to improve this aspect of healthcare will require a greater in-depth understanding of how these barriers operate, as well as how HCPs think these [barriers] could be overcome" (Dyer & das Nair, 2013, p. 2659).

Interviews conducted on HCPs might add to information written about healthcare provider roles in the STD phenomenon. Since women believe HCPs are highly effective in influencing them to adhere to recommendations, there is a need for providers to discuss STDs during consultations with women to change or shift women's perceptions about risky sexual behaviors and STDs. As a participant in the study implied, changes in behavior are not likely to occur if an individual does not believe he/she is doing anything wrong.

Macleod-Downes, Albertyn, and Mayers, (2008) asserted a person's beliefs about illness are a product of certain socio-demographic factors. Age and education are two of the influential factors that drive individuals' beliefs and perceptions about illness (Macleod-Downes, Albertyn, & Mayers, 2008). The veracity of this study's findings may require additional research involving women's age and education factors.

Research could be conducted to reveal if women under 30 years have the same perceptions of provider-patient consultations. Eighty-three percent of the women participating in this study were over 30 years of age. Since the majority of women were not in their twenties, research conducted on younger aged women may help to strengthen the knowledge gleaned from this study. Further explorations of younger aged women could add new knowledge and thematic labels if their perceptions of the provider-patient consultations differ from this study's findings. Revelations may indicate providers target younger aged women for STD prevention.

Although education levels were not collected from study participants, it could have factored into the responses the women provided. Healthcare providers may assume women who present themselves in a professional manner are educated and already know about risky sexual behaviors and how to protect themselves from STDs. Future research could be

designed to determine if the nature of provider-patient consultations is perceived differently based on women's education levels.

A qualitative case study was chosen to evaluate how women perceived the provider-patient consultation. Future research exploring healthcare provider's involvement in the STD phenomenon might use a mixed method approach. Research involving mixed methods employs both quantitative and qualitative methods. In the quantitative phase, researchers could determine if socio-demographic factors correlate with women's knowledge of risky sexual behaviors and condom use. In the qualitative phase, researchers could use a case study design to collect data from adult women's perspectives regarding risky sexual behaviors and condom use. Information obtained in the qualitative phase may enhance the knowledge obtained from the quantitative phase.

Warren (2010) determined the dissemination of information and the discussions that occur in a healthcare provider's setting were strategic approaches to an intervention that may prove effective. Since a major finding of Cates' (2008) analysis was responsible choices involving sexual activities were dependent upon individuals receiving pertinent information, researchers may gather information to better understand why HCPs do not believe it is the provider's responsibility to prevent STDs (Warren, 2010). A qualitative multiple case study analysis designed to answer why HCPs believe STD prevention is not the responsibility of an HCP could guide the study. The general population and women in particular stand to benefit if HCPs adopt preventive measures in an integrative manner along with diagnosis and treatment of illness protocols (Manika & Goldman, 2011). HCPs may make STD discussions part of the standard of care practices (Cates, 2008).

This research study culminated with answers to how adult women located in Baton Rouge, Louisiana perceived the provider-patient consultation influenced STD prevention. Women explained there were no discussions or references pertaining to using protection against STDs or explaining the behaviors placing them at risk. Future research might use the current methodology and explore women's perceptions in other areas of Louisiana and the United States to arrive at findings.

Summary

The purpose of this qualitative multiple case study was to explore women's perceptions of the provider-patient consultation regarding the prevention of STDs by analyzing 12 women's responses to 10 interview questions (see Appendix C). In chapter one, the background of the problem was presented. The information presented in chapter one discussed the need for STD prevention in women and the scarcity of research involving provider influence in shaping women's belief's about STD prevention during the provider-patient consultation.

Chapter two was comprised with information from the literature review. Seven major sections included in chapter two were: (a) literature search and documentation, (b) overview of sexually transmitted diseases, (c) women' s beliefs regarding sexually transmitted diseases, (d) risky sexual behavior, (e) alcohol and sexual behavior, (f) the role of healthcare providers, and (g) concerns regarding sexually transmitted diseases. The discussion provided in chapter two embodied information found about STDs and women's beliefs about STDs, but lacked evidence of women's perceptions of healthcare providers influence in preventing STDs during the provider-patient consultation.

Chapter three included the research method and data analyses used to explore women's perceptions of the provider-patient consultation. Triangulation and member checking were discussed to establish credibility of the data collected from independent sources. The research method and data analyses techniques were described in detail to guarantee the legitimation of the study.

Chapter four encompassed the results of the research study. Reviews of the problem and research questions were followed by discussions about data collection and the analysis process. The three emergent themes revealed by the analyzed data were: (a) Provider did not initiate discussion about preventing STDs; (b) No information received about preventing STDs during consultations; and (c) Visuals could motivate change in risky sexual behaviors.

Chapter five summarized the results of the analysis conducted on the data collected. Three major themes were identified from how women perceived the provider-patient consultation influenced the use of protection in preventing STDs. The three significant themes yielding from the analysis of the data collected were: (a) Provider did not initiate discussion about preventing STDs; (b) No information received about preventing STDs during consultations; (c) Visuals could motivate change in risky sexual behaviors. The implications to leadership and the need for further research were also explained.

Conclusions

The research study involving provider influence in shaping women's beliefs to use protection against STDs concludes with Chapter five. Three major themes emerged in providing insights as to how women perceived the provider-patient consultations in

helping to prevent STDs: a) providers did not initiate discussions about preventing STDs, 2) no information received about preventing STDs during consultations, and 3) visuals could motivate change in risky sexual behaviors. The implications of these findings indicate HCPs, in partnership with other healthcare leaders, should work collaboratively to design interventions at the provider setting, focusing on women and raising awareness and knowledge levels to the risky behaviors that could lead to an STD.

The fact that women are the population disproportionately affected by STDs indicates a shift should occur in STD interventions (Hall, Espinoza, Benbow, & Hu, 2010; Smith & Whiteside, 2010). The earlier approach promoting abstinence, be faithful, and condom use should be intertwined with newer interventions targeting the gender shift from gay males to women. Based on this study's findings, women understood that failing to use condoms and sex with multiple partners were risky behaviors, but in most cases, women did not reveal they had knowledge of other risky behaviors that could lead to an STD.

Future studies should focus on the provider-patient consultation to determine: (1) if socio-demographic factors of age and education factor into women's perceptions of the provider-patient consultation; (2) women's perceptions of the provider-patient consultation in other jurisdictions of Louisiana and the United States; (3) findings using a mixed methodology; and (4) healthcare providers' perceptions of provider's responsibility in initiating STD discussions and safe sex talks during provider-patient consultations to prevent future STD cases in women.

The current study may be of interest to the study participants, healthcare providers, public health leaders, and stakeholders in the healthcare industry. The

researcher will provide a written summary to the participants who were included in the study. Through professional associations, the researcher's colleagues in the healthcare industry will also receive a written summary of the study's findings. The study will be submitted for publication in a dissertation database and journals of medicine.

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Appendix A

Informed Consent Form

Informed Consent: Participants 18 Years of Age and Older

Dear Participant,

My name is Trina Green Armstrong and I am a student at the University of Phoenix working on a Doctor in Health Administration degree. I am doing a research study entitled "Provider Influence In Shaping Women's Beliefs About Protection Against Sexually Transmitted Diseases: Case Study". The purpose of the research study is to explore women's perceptions of the provider-patient consultation regarding the prevention of potential disease resulting from sexual relations.

By agreeing to participate in this study, you will be asked to answer 10 open-ended interview questions. Interviews are expected to last approximately one hour. Although it is preferred that you participate in a face to face interview, telephone interviews are acceptable. The interviews will be tape recorded and later transcribed. Your participation is voluntary, so you may withdraw from the study at any point in time by notifying me in person, via email, or contacting me by telephone. Although the results of this study may be published, your name and other personal identifiable information will not appear in this study because a special code will be assigned to identify you and your information. Collected information will remain solely with the researcher and stored in a locked fire proof cabinet.

There are no foreseeable risks to you. Although there may be no direct benefit to you, a possible benefit from your being part of this study is your input will add to the body of knowledge available about the sexually transmitted diseases phenomenon. The information collected from you may also help providers and other healthcare leaders to design interventions that motivate women to use protection against sexually transmitted diseases. Findings from this study will benefit women by contributing information that may help healthcare providers to change risky sexual behaviors associated with women contracting sexually transmitted diseases. Women, healthcare providers, and society will benefit from insights gleaned from this study because new information may help to lower the incidence and prevalence rates of sexually transmitted diseases, which continues to be a public health concern.

If you have any questions about the research study, please call me at 000-000-0000 or email me at xxxxx@email.phoenix.edu. For questions about your rights as a study participant, or any concerns or complaints, please contact the University of Phoenix Institutional Review Board via email at xxxxx@phoenix.edu.

As a participant in this study, you should understand the following:

1. You may decide not to be part of this study or you may want to withdraw from the study at any time. If you want to withdraw, you can do so without any problems.
2. Your identity will be kept confidential.
3. Trina Green Armstrong, the researcher, has fully explained the nature of the research study and has answered all of your questions and concerns.
4. If interviews are done, they may be recorded. If they are recorded, you must give permission for the researcher, Trina Green Armstrong, to record the interviews. You understand that the information from the recorded interviews may be transcribed. The researcher will develop a way to code the data to assure that your name is protected.
5. Data will be kept in a secure and locked area. The data will be kept for three years, and then destroyed.
6. The results of this study may be published.

Please electronically sign the document and send to my email address, which is xxxxx@email.phoenix.edu. This form must be returned prior to your telephone or face to face interview. Upon receipt of your electronic signature, I will email a final copy of this document with my inked signature and date for you to keep for your records. "By signing this form, you agree that you understand the nature of the study, the possible risks to you as a participant, and how your identity will be kept confidential. When you sign this form, this means that you are 18 years old or older and that you give your permission to volunteer as a participant in the study that is described here."

(☐) I accept the above terms. (☐) I do not accept the above terms. (CHECK ONE)

Signature of the interviewee _____ Date _____

Signature of the researcher _____ Date _____

Appendix B

Invitation to Participate Email

Dear Members,

I, Trina Green Armstrong, am writing this email to notify you that I am a doctoral student at the University of Phoenix. Since you may not be aware, I wish to inform you that Louisiana is one of the states leading the nation in sexually transmitted diseases (STDs) and Baton Rouge is a leader in Louisiana for incidence and prevalence rates of sexually transmitted diseases (STDs). In the Baton Rouge area, women are the population most at risk for acquiring an incurable STD. I am currently conducting a research study entitled "Provider Influence in Shaping Women's Beliefs About Protection Against Sexually Transmitted Diseases: Case Study." The intended focus of the research study is to investigate women's perceptions of the provider influence in shaping their beliefs about protection against sexually transmitted diseases during the provider-patient consultation.

Women stand to benefit from this study because findings from the viewpoints of those most at risk should address gaps in knowledge about the STD phenomenon, serve to empower women to engage in safe sexual behaviors, and potentially minimize the onset of new cases of preventable diseases. Insights gained from the research involving your perceptions could lead to interventions involving healthcare providers addressing women's sexual health beliefs during provider-patient consultations. The face to face interview, which should take approximately an hour, is the selected instrument for data collection. Although face to face interviews are planned, telephone interviews will be accepted if you or I experience a scheduling conflict. During face to face interviews, handwritten notes will be taken in addition to tape recordings to ensure all information is captured. Telephone interviews will be treated in the same manner as face to face interviews.

Your anonymity will be protected by assigning codes to your data transcription to avoid unwanted exposure. Further security measures will be taken by placing hard copies and tapes of the interview in locked fire-safe, file cabinets to safeguard the information for three years. After three years, handwritten data collected will be destroyed and tape recordings will be erased.

If you want to volunteer to be an integral part of this study, please return this form to my email address after answering the questions included in this document. Feel free to contact me with any questions you may have by emailing xxxxx@email.phoenix.edu or calling 000-000-0000. You have the right to change your mind and completely withdraw from this study at any time.

The selection of study participants is based on the following criterion:

Criterion:

1. Female
2. Aged 18 – 45
3. Visits made to healthcare providers between 2012 and 2014

Questions:

1. What is your gender?
2. What is your age range? Place an x by one of the following.

   18-19
   20-25
   26-30
   31-35
   36-40
   41-45
   45+

3. How many visits did you make to healthcare providers between 2012 and 2014? Place an x by one of the following.

   0
   1-2
   3-4
   4+

Appendix C

Interview Questions

1. How severe do you believe STDs are in women?

   5) extremely severe 4) very severe 3) neutral 2) somewhat severe 1) not severe

2. How susceptible do you believe women are to contracting an STD?

   5) extremely severe 4) very severe 3) neutral 2) somewhat severe 1) not severe

3. What is your perception of the provider patient-consultation regarding the prevention of potential disease resulting from sexual relations?

4. How would you describe risky sexual behavior?

5. What is your perception of healthcare providers willingness to routinely initiate discussions about STDs?

6. Based on your experience, how effective are healthcare providers in influencing you to adhere to prescribed recommendations?

   5) extremely effective 4) very effective 3) neutral 2) somewhat effective 1) not effective

7. How do you believe healthcare providers should couch STD related information to motivate a change in risky sexual behaviors?

8. What is your perception of the information you receive from healthcare providers regarding method and concept of use of contraceptives in the prevention of sexual transmission of disease during sexual relations?

9. How do you believe you stand to benefit from receiving STD related information during the provider-patient consultation?

10. What barriers do you believe would keep you from adhering to provider influence?

Appendix D

Original Interview Questions

1. How severe do you believe STDs are in women?
2. How susceptible do you believe women are to contracting an STD?
3. What is your perception of the provider patient-consultation regarding the prevention of potential disease resulting from sexual relations?
4. How would you describe risky sexual behavior?
5. What is your perception of healthcare providers willingness to routinely initiate discussions about STDs?
6. Based on your experience, how effective are healthcare providers in influencing you to adhere to prescribed recommendations?
7. How do you believe healthcare providers should couch STD related information to motivate a change in risky sexual behaviors?
8. What is your perception of the information you receive from healthcare providers regarding method and concept of use of contraceptives in the prevention of sexual transmission of disease during sexual relations?
9. How do you believe you stand to benefit from receiving STD related information during the provider-patient consultation?
10. What barriers do you believe would keep you from adhering to provider influence?