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THE ROLE OF THE BLACK CHURCH IN ADOLESCENT SEXUALITY EDUCATION

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Abstract

Objective: To identify pastors' and parents' opinions of the Black Church's role in promoting adolescent sexual health and preventing teen pregnancy. The Black Church institution is an important partner in preventing teen pregnancy. **Methods:** Semi-structured interviews were conducted with Black Church pastors (n=31) and parents (n=36) in two counties in a southwestern state. Interviews were conducted September 2014-July 2015 (pastors) and February-June 2017 (parents). The question paths were developed based on interviews with local leaders, literature searches, and key informant interviews. Questions included knowledge/beliefs about sexuality education, church's role in preventing teen pregnancy, and implementation obstacles. Interviews were transcribed and analyzed for themes. **Results:** Seven pastor themes emerged: 1) all pastors believed the Black Church should address teen pregnancy with parents/congregants; 2) two major obstacles emerged: a) all pastors perceived social consequences, including resistant parents; and b) many were uncomfortable discussing contraceptives/condoms; 3) all pastors were willing to partner with organizations, but most had reservations based on conflicting missions/values; 4) pastor response to teen sexual activity and teen pregnancy was grounded in patriarchal Black Church institution; 5) pastors discouraged teen sex based on biblical beliefs and complications of sex but used different ways; 6) many pastors perceived their church congregants' responses to teen pregnancy as loving and supportive, other pastors said congregants were judgmental and insisted on negative consequences for the pregnant/parenting female; 7) pastors' opinions of their leadership role and their response shifted when dealing with teen sexual activity to teen pregnancy. Five parent themes emerged: 1)

most parents said there should be no boundaries on the type of sexuality information shared by their church, but later changed their minds after reviewing a list of potential topics; 2) parents listed parent-child communication, goals and dreams, and relationships as the most important topics for a teen pregnancy prevention intervention; 3) parents said the information shared during workshops should be judgement-free and realistic; 4) parents most often said pastors and/or youth pastors/directors should deliver sexual health information; 5) parents believed older adults and other parents may oppose teen pregnancy prevention programs. **Conclusions:** These studies add to sexual health literature that explores the interrelationship between the Black Church and public health institutions and their roles in preventing teen pregnancy. Black Church pastors and parents were supportive of teen pregnancy prevention programs in the church. However, public health partners must be willing to compromise and overcome significant obstacles.

Chapter 1: Introduction

Introduction to the Problem

Adolescent sexual health remains a public health issue due to high teen birth and sexually transmitted disease (STD) rates. The United States has made significant strides over the past few decades to be intentional about reducing teen birth and STD rates. Although there have been historic declines in teen births, 61% since 1991, the United States still has the highest teen birth rate of any industrialized nation. [1] Moreover, even with these declines, racial/ethnic disparities persist, with particularly high teen birth and STD rates in the African American population.

Comprehensive sexuality education coupled with access to sexual health care has allowed adolescents to make more informed sexual health decisions.[2] However, sustaining sexual health behavior beyond the intervention has been challenging and highlights the potential importance of non-traditional efforts to reduce sexual risk behaviors. [3,4] There has been a concerted effort to understand antecedents of adolescent sexual behavior and to explore non-traditional, innovative approaches to not only changing outcomes immediately following an intervention, but also to sustain those outcomes.

One approach is church-based sexuality education. In general, church-based health promotion (CBHP) efforts have shown promising results (e.g. increased physical activity and weight reduction). However limited information in known about CBHP designed to promote adolescent sexual health and reduce sexual risk behaviors.[5,6] Exploring the utility of partnering with the faith community is certainly worth the time for the public and sexual health fields, particularly for populations and communities in

which the faith system is widely influential. This study endeavors to understand the potential role of predominately black churches in adolescent sexuality education, from the perspectives of pastors and parents.

Theoretical Foundation

Theoretical foundation helps to guide both qualitative and quantitative research. Patton referred to the theoretical foundations in qualitative research as qualitative inquiry frameworks.[7] Frameworks can be used to begin to understand an issue prior to data collection in order to help guide the data collection process.

The Systems Theory theoretical approach is particularly useful in guiding the development of a study exploring the interrelationship of adolescents, parents, and churches. The premise of Systems Theory is to understand how and why a system performs the way it does by understanding the interrelationships, restrictions, and perceptions within the system.[7] This approach would attempt to simultaneously understand multiple layers of relationships and phenomena. A systems thinking approach is arguably appropriate to understand human beings within interconnected systems. Behaviors, perspectives, relationships are all embedded in a particular context. Understanding that there are larger systems helps to guide research questions and understand data in context.[7]

The family system and the church system are two *whole* systems that are interconnected, particularly pertaining to the African American community. As noted in Cherlin, the roles of the church and the household often overlap in the functioning of the family. This is particularly the case in the African American culture, where the church is seen as a source of strength. [8] The Black Church has historically been a

trusted, influential staple in the African American community, empowering congregants and the community.[9] While exploring perceptions of the role of the church in adolescent sexuality education, it is important to understand that the family system influences perceptions and behaviors of the church, church leaders, and church congregants. This occurs while the church system influences the family's perceptions and behaviors. These interrelationships are important for health promotion program developers to consider in order to understand how these systems operate together and to develop appropriate and relevant interventions. There may be an opportunity for public health to fit into the natural intersection of the church and family system by developing appropriate and relevant interventions. However, it is vitally important to understand the interrelationships of these two systems and not discredit the power and influence of the parents.

Purpose of the Study

The purpose of this qualitative study is to examine the role of the predominately black church in preventing teen pregnancy and promoting sexual health through sexuality education. It is important to understand the role of the church from the perspective of both pastors and parents as they are the two major decision makers related to youth programming. This is especially important because this is such a divisive issue due to: conflicting religious beliefs, stigma related to sexuality, and misconceptions and biases related to content discussed in sexuality education programs. By highlighting pastor and parent perspectives researchers will better understand how they influence decisions made about sexuality education in the church.

Research Questions

There is one overarching research question:

- What is the Black Church's role in addressing adolescent sexuality education?

In order to examine this overarching research question (RQ), this study examined three main research questions, using two forms of data collection:

- RQ1: What are pastors' perceptions of the Black Church's role in promoting adolescent sexual health and preventing teen pregnancy?
- RQ2: What are pastors' perceptions of the Black Church's response to a teen pregnancy in the Black Church?
- RQ3: What are parents' expectations of the Black Church's (including expectations of the pastor and other leaders) role promoting adolescent sexual health and preventing teen pregnancy?

RQ1and RQ2 were addressed through semi-structured, in-depth interviews with pastors of predominately black churches. RQ3 was addressed through semi-structured, in-depth interviews with parents of adolescents 11 to 17 years old.

Hypotheses

A Grounded Theory approach was utilized to analyze data, allowing for themes to emerge rather than testing a priori assumptions. Therefore, stating hypotheses up front is not a requirement but if the researcher has already formulated expectations of the findings, they can be stated prior to conducting the study to increase study transparency. [7] There were four main hypotheses (H) based on related literature:

- H1: Pastors will report that sexuality education is important but feel limited in the type of information they can present.

- H2: Parents will report some discomfort discussing sexuality education topics.
- H3: Parents will report the need for additional information from clergy to better equip them to explain sexuality education to their children.
- H4: Parents will report the need for sexuality education that is relevant to their religious belief.

Significance of the Research

Teen births and STDs have significant social, physical, and economic consequences. Teen mothers are more likely to drop out of high school and live in poverty. In addition, children of teen parents are more likely to be: 1) less prepared for school, 2) a high school dropout, 3) incarcerated, 4) a teen parent themselves, and 5) subject to medical and behavioral complications. [10] Teens who are infected with STDs (such as syphilis, chlamydia, or gonorrhea) are also more likely to contract HIV, be infertile, and/or have an ectopic pregnancy. [11] Moreover, teen childbearing and STDs costs taxpayers billions in health care costs. [11,12]

Ideally adolescents would choose to abstain, use a condom, or use a condom and another contraceptive method when sexuality active to reduce the likelihood of these consequences. For decades, comprehensive sexuality education programs have provided essential information and skills to promote adolescent sexual health.[13] However, many adolescents do not have access to these comprehensive programs due to parental permission or geographic location (e.g. living in a more conservative state and/or city in which limited sexuality education programs are implemented). As of March 1, 2016, Guttmacher Institute reports that 24 states and the District of Columbia currently mandate sexuality education and 33 mandate HIV education.[14] Yet, based on the

2013Youth Risk Behavior Survey, 41% of sexually active adolescents did not use a condom at last sex.[15] Based on the 2006-2010 National Survey of Family Growth, 32% of females and 20% of males did not use a condom at first sex and 48% of females and 25% of males did not use a condom at last sex.[16] Consequently, adolescents remain at risk of contracting STDs and/or becoming pregnant. Thus, adolescents remain at risk for the social, medical, and economic issues associated with teen births and STDs which further highlights the importance of decreasing teen sexual activity and improving overall teen sexual health.

Notable declines in teen birth data should not result in a sense of complacency not only because of inconsistencies in contraceptive use among adolescents, but also due to the persistent racial/ethnic disparities. For adolescents 15-19 years old, birth rates were highest for Hispanic females (38.0 per 1000) and Non-Hispanic Black females (34.9 per 1000). Birth rates were lowest for Asian/Pacific Islander (7.7 per 1000) and Non-Hispanic White (17.3 per 1000) females.[17] African Americans are also more likely to be infected with chlamydia, gonorrhea, and syphilis than any other racial/ethnic group.[11] The high birth and STD rates, especially in minority populations, highlight the potential importance of non-traditional efforts, such as the utilization of churches, to reduce risky behavior.

The Black Church has been a safe haven and central hub for African Americans for decades. The Black Church is one of the most well-respected and trusted institutions in the African American community. Of Black Protestants, 89% believe that religious institutions bring people together and strengthen community bonds. [18] While the Black Church has been involved in health promotion efforts it is important to note that many

of these efforts have not been centered on sexual health issues. The few previous studies related to sexual health that have been implemented focused mainly on HIV prevention efforts with both adults and adolescents. [19,20] Understanding the role of the Black Church in implementing not only HIV education, but sexuality education that includes information on preventing pregnancy will help practitioners to further understand the complexities of working with this faith community. This study is significant because it will take one of the first steps in understanding the role of the Black Church in addressing teen pregnancy from the perspective of both pastors and parents, two important decision makers in the implementation of sexuality education in the church setting.

The Black Church may be seen as a plausible, trusted partner in the African American community. However it is important to take steps to understand the complexities of bringing such a sensitive health topic into an institution where this is not the most important issue. There is a need to understand the conflicting religious beliefs and stigma related to sexuality and misconceptions and/or biases related to content discussed in sexuality education programs. Understanding the perspectives of pastors and parents can lead to both buy-in from decision makers and the development (or tailoring) of sexual health interventions that are appropriate for the faith community. Once these strategies are developed there is the potential to reduce racial/ethnic disparities and significantly advance the sexual health field.

Delimitations of the Study

This study was delimited in several ways to help define the study parameters. First, only senior pastors of predominately black churches were recruited. The senior

pastor makes the final decision as it relates to the matters of the church; therefore a senior pastor's perspective may vary from an assistant pastor's perspective.

Second, the parent study was restricted to parents (biological or adoptive) of adolescents 11 to 17 years old. If the parent is the adoptive parent, he/she must have been the child's parent for at least a year to allow the parent and child some time to form a parent-child relationship.

Third, the study was delimited to Protestant, Christian, predominately black churches. In an effort to recruit a group that is similar enough to draw conclusions, the study was delimited to only this denominational group. However within the predominately black, Protestant group, there were several denominations included in this study including: Baptist, Methodist, Pentecostal, etc. Each of the denominations under this umbrella all have similar foundational principles, but have various ways of demonstrating those beliefs.

Lastly, this study was delimited to include pastors and parents. Adolescents were originally considered as another branch of this study; however the scope was limited to focus on the two important decision making groups first. Then, move to adolescent studies after the completion of the pastor and parent studies.

Limitations of the Study

Several possible limitations were considered. First, participants may want to censor their thoughts due to the stigma associated with talking about sex in the church and may be inclined to tell the researcher a desirable response instead of a true response. Therefore, the interviewer worked to establish trust with both pastors and parents during the data collection process.

Second, due to the qualitative nature of this study, the results are not generalizable to other populations. Conclusions were drawn from the data and suggestions have been made to further the sexual health field.

Third, [de-identified southwestern state] has historically been a conservative state, which may result in some difficulty recruiting for this study. Social activists have made many attempts to mandate comprehensive sexuality education, yet these efforts have been met with opposition from elected officials. [De-identified southwestern state] does not mandate health education at any grade level for all students, and certainly has not mandated sexuality education. [14] It is not apparent that due to the conservative nature of the state, that this would influence participation in the study. However, it was an important limitation to keep in mind during recruitment.

Assumptions of the Study

There were two main underlying assumptions of the study. First, there was an underlying assumption that the interview questions were clear. This is based on numerous edits and tests of the question path. Second, there was an underlying assumption that participants would give honest and accurate responses. While there was no way to guarantee participants would provide honest responses, participants were informed that their responses were de-identified when quoted and presented mostly in aggregate form.

Operational Definitions

- Church: gathering of people, typically for a Christian worship service (used interchangeably with congregation)

- Black Church: heterogeneous group of Protestant Christian churches that serve predominately black congregations
- Christian: a person who believes in and adheres to the teachings of Jesus Christ
- Congregant: a person that attends a church
- Religiosity: often a composite measure of the importance of religion, church attendance, belief in God, frequency of prayer, and/or frequency of mediation
- Teen pregnancy: typically refers to pregnancy to females 15 to 19 years old (unless otherwise specified)
- Teen birth: typically refers to births to females 15 to 19 years old (unless otherwise specified)
- Sexually transmitted disease: infection that can be contracted from having sex with someone who is infected
- Comprehensive sexuality education: provision of sexual health information that includes information about abstinence and contraceptive methods, and several additional topics such as sex, sexuality, healthy relationships, future aspirations, and communication
- Abstinence-only sexuality education: provision of sexual health information that includes information about abstinence and additional topics such as sex, sexuality, healthy relationships, but either omits or negates the effectiveness of contraceptive methods

Chapter 2: Literature Review

Importance of the Problem

Although teen birth rates have declined over 64% since 1991, preventing teen pregnancy remains one of the most preventable public health concerns.[21,22] Previous research in adolescent sexual behavior has been extensive, yet there is still a need to further understand several potential antecedents of sexual behavior that could reduce teen birth and sexually transmitted disease (STD) rates, and disparities in teen birth and STD rates for African American teens.[13,23]

Teen parenthood is one of the quickest pathways to poverty. Reducing teen births is important due to the significant short- and long-term social and economic effects on teen parents and their children: more likely to live in poverty, drop out of high school, and increased medical expenses. Also, children of teen parents are more likely to be teen parents.[10] Moreover, teen childbearing costs taxpayers billions in health care costs.[11,12] Reducing adolescent STD rates is important due to the social, economic, and medical consequences on the adolescent, including increased likelihood of ectopic pregnancy and increased medical care costs.[11] These social, medical, and economic issues associated with teen births and STDs highlight the importance of decreasing teen sexual activity and overall improving teen sexual health. [24]

Literature Related to the Research Problem

Early adolescence. The early adolescence time period, 10-14 years old, is of particular importance to both families and researchers because young people begin to experience puberty, notice changes in relationships and connections to others, and spend more time reflecting on self-worth. Cultural pressure and gender roles become

more prominent. Behavioral decisions and life choices become more important. Adolescents begin to ponder the use of alcohol, tobacco, and drugs, and engaging in sexual intercourse. [25] By eighth grade, about 20% of adolescents have gotten drunk, experimented with illegal drugs, or smoked cigarettes. By the end of high school, half of all students have participated in these behaviors. [26]

Early initiation of sex has been linked to early initiation of tobacco and substance use, relationships with peers who engage in risky behaviors, depression, and school disconnectedness and disruption. [24] Adolescents that have had sex by age 13 are at a higher risk of pregnancy and STDs.[24] Therefore, a focus on developmental outcomes to reduce the likelihood of initiating sexual activity could have a positive, long-term impact not only on sexual health, but also on many aspects of adolescents' lives.

Early adolescence is a prime opportunity to impact sexual health outcomes because most adolescents have not initiated sexual activity, nor have they been affected by the consequences of sexual activity. According to the 2013 Youth Risk Behavior Survey (YRBS), 6% of the high school students surveyed reported that they had sex before they were 13 years old.[27] In addition, a public opinion survey administered in 2002 by the National Campaign to Prevent Teen Pregnancy revealed that 81% of sexually active 12 to 14 year olds and 55% of sexually active 15 to 19 year olds reported that they wished they had waited until they were older to have sex.[24] By focusing sexual health efforts on young adolescents, there is the potential to delay onset of sexual activity and reduce the number of lifetime sexual partners, which also decreases the likelihood of becoming a teen parent or contacting an STD. [24]

Adolescent sexual health. High teen birth rates and STD rates in the United States remain to be a public health issue. A review of the literature related to sexual health outcomes and behavior is a helpful step in understanding the depth of the issue.

Teen births. Teen birth rates have significantly declined since the 1950s, with a rate of 22.3 births per 1000 females, 15-19 years old in 2015.[21] Teen births have declined 64% since 1991 and 8% since 2014.[21] From 2014 to 2015, birth rates declined for adolescents of all racial/ethnic origins. However, racial and ethnic disparities in adolescent sexual activity still remain a concern. For adolescents 15-19 years old, birth rates were highest for Hispanic females (34.9 per 1000) and Non-Hispanic Black females (32 per 1000). Birth rates were lowest for Asian/Pacific Islander (6.9 per 1000), Non-Hispanic White (21.3 per 1000), and American Indian/Alaska Native (25.7 per 1000) females.[21] For 10-14 year olds, birth rates were highest for Non-Hispanic Black females (0.5 per 1000), compared to American Indian/Alaska Native (0.3 per 1000), Hispanic (0.2 per 1000), Non-Hispanic White females (0.2 per 1000), Asian/Pacific Islander (0.1 per 1000).[21] Although rates have reached a record low, teen birth rates for 15-19 year olds remain high in many states, including Arkansas (38 per 1000), Oklahoma (34.8 per 1000), Mississippi (34.8 per 1000) Texas (34.6 per 1000), and New Mexico (34.6 per 1000).[21]

Teen births have significant short- and long-term social and economic effects on the teen parents and their children. Teen mothers are more likely to drop out of high school and live in poverty.[10] Most females (90%) who were not teen mothers receive their high school diplomas by age 22, compared to only half of teen mothers. [28] Moreover, children of teen parents are: less prepared for school and more likely to drop

out of high school, more likely to be incarcerated, exhibit increased behavioral and medical issues, and are more likely to give birth as a teen themselves. [10] Not only are these social costs substantial, but the economic costs are high as well. United States taxpayers pay approximately $10.9 billion annually towards teen pregnancies and births because of higher health care costs, increased foster care expenses, and expenses associated with a higher incarceration rate.[1]

Due to the social and economic costs of teen childbearing, teen parents are more likely to have a lower socioeconomic status (SES). SES describes a person's social class/standing, including education, income, and occupation. SES is relevant because those with lower SES are more likely to have poorer overall health compared to those of a higher SES.[29]

Intervening with teens before they become sexually active is crucial for teen pregnancy prevention due to the potential for long-term positive outcomes for the adolescent. Young adolescents who are not already sexually active should be encouraged to continue to delay sexual activity to decrease their likelihood of unplanned pregnancy and STDs.[24] Those few who are already sexually active should be encouraged to use condoms and another form or protection, if they choose to have sex.

Sexually transmitted diseases. In addition to the concern with high teen birth rates, high STD rates among young people highlight another sexuality issue plaguing adolescents. The most recent STD surveillance reports the first increase in STDs (namely chlamydia, gonorrhea, and syphilis) since 2006. Young people 15 to 24 years old still have the highest risk of contracting an STD, contracting half of all new cases of STDs annually.[11] For example, in 2014, 66% of all cases of chlamydia were among 15

to 24 year olds. Moreover, 25% of sexually active adolescent females have been diagnosed with an STD.[11]

In addition, racial/ethnic disparities persist. African Americans are more likely to be infected with chlamydia, gonorrhea, and syphilis than any other racial/ethnic group. For example, the rate of chlamydia among Black female adolescents (6,371.5 per 100,000) 15 to 19 years old was 4.9 times higher than White female adolescents (1,291.6 per 100,000). Among adolescent males 15 to 19 years old, the chlamydia rate was nine times the rate among White adolescents. [11]

In addition, there were 47,352 new diagnoses of Human Immunodeficiency Virus (HIV) in the United States in 2013. [30] Approximately 30% of all new cases of HIV are 25 to 34 years old and 26% are 13 to 24 years old. [31] Although there have been some declines in incidence of HIV diagnoses, notably from 2006 (56,000 new cases) to 2013 (47,352 new cases), HIV remains to be a serious public health concern.

Racial/ethnic disparities remain an issue. In 2010, African Americans represented 44% of all new cases of HIV, but only represent 12% of the United States' population. Additionally, Hispanics represented 21% of all new cases of HIV, but only represent 16% of the population. [30]

Why are the STD infection rates among adolescents relevant? STDs can lead to a host of consequences, including infertility and ectopic pregnancies. [11] The Centers for Disease Control and Prevention (CDC) estimates that undiagnosed STDs results in 20,000 women to become infertile per year. Therefore, the younger an adolescent, particularly a young woman, contracts an STD and the longer it is left untreated, the more her chances increase of becoming infertile. Although females are more susceptible

to contracting STDs, this should not only be a concern for young females but also for males. Whether male or female, having an STD increases a person's risk of contracting HIV. In particular, those who contract gonorrhea, syphilis, and/or herpes are at an increased risk of contracting HIV. [11]

STDs among young people also have financial implications. The CDC estimates that there are 20 million new STD cases per year, resulting in $16 billion in health care costs nationwide. [32]

The high birth and STD rates, especially in minority populations, highlight the potential importance of non-traditional efforts to reduce risky behavior, such as the utilization of churches. Church-based health promotion (CBHP) interventions have shown promising results in promoting healthy behaviors (e.g., increased physical activity and weight reduction). However limited information in known about CBHP designed to promote adolescent sexual health and reduce risky sexual behavior.[5,6]

Sexuality education. For decades, sexuality education curricula have primarily focused on adolescent sexuality knowledge, skills, beliefs, and attitudes.[13,23] Adolescents who receive this information are more likely to delay sex and use protection at first sex.[2] These efforts (coupled with increased access to sexual health medical services) have helped to reduce teen birth and STD rates. As of March 1, 2016, Guttmacher Institute reports that 24 states and the District of Columbia currently mandate sexuality education (which typically includes discussion of pregnancy and STD related content), and 21 of these states mandate sex education and HIV education.[14] When sexuality education is taught, 26 states mandate that practicing abstinence should be emphasized and 11 say it should be covered; 19 states and DC

require sexuality education curriculum to discuss the importance of sexual activity within the confines of marriage. Of the 33 states that require HIV education, 13 mandate only HIV education and do not require sexuality education as well. When HIV education is provided, 27 states require abstinence to be emphasized and 12 require abstinence to at least be covered. [14]

Why does it matter if a state teaches comprehensive sexuality education? Based on an analysis of 2005 state profiles on sexuality education policies, one study found that states that taught comprehensive sexuality education, teaching information about both abstinence and contraception (referred to as abstinence-plus or abstinence-based programs), had the lowest teen pregnancy rates.[33] Alternatively, states with abstinence-only sexuality education policies and stress abstinence until marriage had significantly higher teen pregnancy rates. [33] The more strongly states emphasize abstinence in their state policies, the higher the average teen pregnancy and teen birth rate. Although there have been individual differences in study-specific outcomes of sexuality education programs, abstinence-only programs have rarely successfully impacted adolescent sexual behavior and outcomes. [23,33] In fact, one of the few exceptions was an abstinence-only intervention implemented with black low-income middle school students that actually found that more intervention students were abstinent 24 months post-program compared to control students. [34] However, it is important to note that this program would technically not have met the criteria for federal funding because the program did not discuss sex with negative language, did not negate the effectiveness of condoms, debunked myths about sex and sexuality, and did necessarily encourage abstinence until marriage.[33,34] Therefore, while this was an abstinence-only program

that was successful, the results of this study cannot be generalized to other programs that address sexuality-related issues in a different way. Particularly with abstinence-only-until-marriage programs, these programs typically discuss sex only being morally appropriate in a heterosexual marriage, focus on failure rates of contraceptive methods, emphasize gender roles and stereotypes, and have been reported to contain medically-inaccurate information.[35] This cannot only be ineffective, but also detrimental to young people. Decades of research have found that comprehensive sexuality education programs have been widely more effective than abstinence-only programs.[13]

Based on research from the nationally-representative 2002 National Survey of Family Growth, researchers found that adolescents 15-19 years old who received comprehensive sexuality education prior to the first time they had sex were significantly less likely to report a teen pregnancy than adolescents who did not receive any formal sexuality education; there was no significant effect of the abstinence-only education programs.[16] Moreover, adolescents who received comprehensive sexuality education were 50% less likely to have experienced a pregnancy compared to the adolescents that received the abstinence-only-until marriage programs.[16] While neither the comprehensive nor abstinence-only program participation significantly reduced the likelihood of reporting an STD, there were significant, notable impacts on reducing the likelihood of experiencing teen pregnancy.[16]

Church-based sexuality education. Comprehensive sexuality education provides adolescents with the knowledge and skills to promote sexual health, including age-appropriate information on abstinence and protection from STDs and unintended pregnancy. [2] However, sustaining long-term effects have been indirect and significantly

mediated by the adolescents' age at first sex; for example, adolescents who were older at first sex were more likely to use a condom consistently. [4]

Church-based health promotion (CBHP) programs, albeit not a new concept, have experienced a revival and show promising results in promoting healthy behaviors, including programs designed to promote physical activity and weight reduction. [5,6,9] Based on a systematic review of health interventions in faith communities, 13 quasi-experimental or experimental interventions have been conducted since 1990.[5] Included studies focused almost exclusively on African American and adult populations. Behavioral changes included increased physical activity, increased fruit and vegetable consumption, weight loss, increased cancer screening, decreased smoking, and decreased cholesterol. Of the five studies with sufficient information to collect effect size information, effect sizes were in the small to moderate range. Moreover, a systematic review of physical activity interventions in faith-based organizations found that most interventions promoted an increase in physical activity (16 of 27 studies).[36] Interventions were most commonly implemented in predominately black churches and African American women were the most common population. Bopp, Baruth, Peterson, Webb recommended additional, longer studies, with larger sample sizes to further understand the utility of physical activity interventions in faith settings.[36] Although interventions have been implemented in faith settings and have seen promise, limited information is known about CBHP designed to promote sexual health and in adolescent populations. Conducting a literature search of sexual health interventions in faith settings unearthed only one systematic review, which focused specifically on HIV prevention programs.[37] Of the four studies discussed in the review, none of the studies

reported measurable outcome changes, making it difficult to truly understand the impact of these interventions.

Some predominately black churches have considered HIV ministries and conducted some presentations, but there have been challenges to addressing HIV prevention in churches, due to the stigma associated with the discussing the primary mode of transmission of HIV (anal sex). [38] In a study including 45 African American clergy (of three protestant denominations: Baptist, African Methodist Episcopalian, and Holiness) in North Carolina, Boyne-Beasley and Schoenbach found that the top five health issues for young adolescents (10-14 years old) in their congregation were: 1) HIV/AIDS, 2) drugs, 3) violence, 4) pregnancy, and 5) alcohol. Interestingly, although most clergy mentioned that topics such as abstinence, AIDS, and contraception are acceptable to discuss, topics such as anal sex, bisexuality, homosexuality, oral sex were unacceptable and should be discussed in school, not in the church. [38] Although it is apparent that there may still be stigma associated with discussing some of the topics and behaviors associated with HIV prevention, Coyne-Beasley and Schoenbach posit that churches are underutilized, influential institutions that could provide comprehensive sexuality education, particularly to young adolescents that may be more at risk for early sexual activity.

As outlined in a literature review conducted by Francis and Liverpool, many churches may struggle with key topics for HIV/AIDS prevention, namely openly discussing vaginal, anal, and oral sex. At times, topics that leaders deem inappropriate may be removed from the interventions; pastors and other leaders have hand selected which topics should be included in prevention programs.[37] Moreover, previously

conducted HIV/AIDS interventions have allowed time for pastors or other leaders to provide sermons or discuss information during workshops that were related to biblical teachings. Therefore, it is important to partner with the faith organization throughout the entire planning and implementation process. The following strategies were recommended: 1) public health organizations/professionals distributing resources to clergy or other leaders to help them begin conversations, 2) public health professionals partner with faith leaders and allow faith leaders to frame topics in a biblical frame, or 3) the public health professional/organization can provide both resources and the workshops to address the sexual health issue to allow the faith leader to focus on other services/programs related to the church's mission.[37]

With several limitations associated with partnering with faith organizations to implement sexual health interventions, one may question the benefit of sexuality education in a church setting. In fact, there are several reasons to support partnering with faith organizations to overcome obstacles and implement sexual health interventions. First, studies have shown that religious affiliation and attendance are associated with decreased likelihood of initiating or engaging in sexual intercourse and increased likelihood of delaying the onset of sex. Francis and Liverpool found that African American adolescents, a sub-population that is disproportionally affected by HIV infection and teen pregnancy, who reported church affiliation and attendance were less likely to have ever had sex and more likely to delay.[37] In addition, young adolescents 12 to 14 years old who report church attendance and affiliation also exhibit lower numbers of sexually active adolescence and higher rates of abstinence, compared to peers who did not. [39,40] Similarly, adolescents 15 to 17 who report church attendance

were also more likely to report being abstinent compared to peers. [40] Second, although there have been historic declines in teen birth data and declines in some STD categories, there remains to a persistent sexual health public health concern with teen births and STDs disproportionately affecting African American and Hispanic adolescents. Third, structured curricula and interventions designed to reduce negative sexual health outcomes have seen some success, particularly related to HIV-related outcomes. Since 2000, HIV interventions have been conducted in faith settings, primarily with African American congregations and primarily with adolescents. [19,41-44] Interventions found increases in HIV knowledge, perceived risk of HIV, self-efficacy in sexual situations, intention to be abstinent, and decreasing the number of current partners. [41,43,44] However, as previously mentioned, several studies have been implemented to address HIV concerns, yet little is known specifically about teen pregnancy prevention efforts in faith settings.

Religion and sexual behavior. Religiosity is often a composite measure of the importance of religion, church attendance, belief in God, frequency of prayer, and/or frequency of mediation. [45] The National Survey of Youth and Religion found that 87 % of high school students were affiliated with a religious organization. [46] As a young person, several aspects of the composite measure of religiosity are determined by parents, including church attendance, church affiliation, and potentially frequency of prayer. Therefore, parents have an influential role in the development of religiosity in young people, which could ultimately influence behavior as well.

Understanding the relationship of religiosity on sexual behavior is difficult due to the cross-sectional nature of most of the research studying this relationship. [47] For

example, one study found that young adolescents (12 to 14 years old) who constructively used their time in religious settings (e.g. church attendance at religious activities) were significantly less likely to have ever had sex and more likely to report being abstinent compared to adolescents who did not. [39,40] Teens 15 to 17 years old who participated in constructive use of time in a religious setting also were more likely to report being abstinent compared to their peers who did not. [40] Additionally, both males and females 12 to 19 years old, who constructively used their time in a religious setting were less likely to report ever having sex. [48] It is also important to note that although religiosity appears to have a protective effect on sexual activity, once adolescents become sexually active, the protective effect appears to diminish; studies have shown that religious adolescents were less likely to use contraceptive methods when they choose to have sex.[49]

Longitudinal data collected by the National Longitudinal Survey of Youth from 1997 to 2003 illustrated that family religiosity (measured by parental religious attendance, if the parent prays, religious activities, influence of religion on values, importance and influence of God on life) was indirectly, negatively associated with adolescent sexual activity through measures of family (e.g. family cohesion) and peer (positive, like-minded friends) influences.[50] Family religiosity was also indirectly associated with fewer sexual partners and consistent contraceptive use (mediated by positive peer behaviors and delayed initiation of sex). Direct associations between family religiosity and adolescent sexual behavior were limited, yet the study highlights the importance of both family and peer influences on adolescent sexual behavior regardless of family religiosity.

Rostosky, Wilcox, Wright, and Randall conducted a systematic literature review on the impact of religiosity on adolescent sexual behavior and found that the importance of religion varies across studies, with some studies indicating that older adolescents found religion to be less important and others did not find any differences in religious importance by age.[47] The lack of conclusive causal pathways between religiosity and adolescent sexual behaviors illustrates the importance of additional studies to understand the influence of religiosity, particularly as it relates to constructs that have had some associations with sexual health behaviors such as church attendance and affiliation.

The Black Church. The "Black Church" is a term used to describe a heterogeneous group of predominately black Protestant Christian churches. Some Protestant denominations are predominately black (such as African Methodist Episcopal). On the other hand, some predominately black churches are members of predominately white denominations (such as United Methodist). The historically black Protestant tradition, although not a homogenous group, has largely been shaped on experiences related to slavery and segregation, which places those who belong to this religious tradition in a unique category. Understanding the longstanding history of the Black Church is vitally important for any public health entity hoping to establish working relationships to reduce health disparities and promote health.

As Africans were transported to America, slave owners attempted to remove and disallow any association with their homeland. [51] White evangelical preachers attempted to "Christianize" slaves, teaching them messages from the Bible that justified actions of slave owners. Africans' expressions of their own, authentic and spiritual culture were

not allowed. Slaves conformed and found solace in Christianity. Over time, as freed slaves began worshipping alongside white churchgoers and were constantly ridiculed, they decided to form their own church. Several predominately black churches developed in the late 1700s and later organized as predominately black denominations (e.g. the African Methodist Episcopal Church) in 1794. Several additional denominations and many churches have developed since the 1700s.

The PEW Research Center categorizes the denominations of the historically black Protestant churches into six main categories: Baptist, Methodist, Pentecostal, Nondenominational, Holiness and Protestant non-specific/other Protestant Denominations.[52] Since all of the denominational categories represent Protestant traditions, the core doctrine are similar; each group subscribes to the teachings of Jesus Christ and believes the Bible should govern their actions. Differences exist in the interpretation of some aspects of the Bible or in the format of the worship service. For example, Baptist, Methodist and Nondenominational believe in and live by Biblical scriptures, but also subscribe to the understanding that some of the guidelines may not apply verbatim in society today. On the other hand, Holiness, Pentecostal, and Church of God in Christ (listed in Other Protestant Denominations) tend to subscribe to the belief that the guidelines in the Bible always apply and exceptions do not need to be made due to advances in society. These subtle differences can potentially alter how a denomination receives and interprets controversial information, such as sexuality education.

The Black Church was a safe haven and central hub for the black community. Due to the oppression of white slave owners during slavery, African Americans later

gravitated to the Black Church because they felt they could actually express cultural beliefs. By being able to express these cultural beliefs, a sense of loyalty was evoked towards the African culture, as well as a sense of pride and dignity. The Black Church was a safe place to handle difficulties and cope with the struggles of society. In addition to being a safe haven, the Black Church was also seen as a place where members of the black community could establish themselves as leaders within the church and their community. Several researchers have noted that the Black Church is the only institution in the United States that can claim this sense of loyalty and commitment within the black community.[51,53]

The Black Church is an institution with a longstanding history in the African American community. The Black Church is not only at the center of the spiritual wellbeing of its congregants, but also extends greatly beyond the traditional functions to also provide guidance and support in the economic, social, and political realm.[5] The Black Church is one of the most well-respected and trusted institutions in the African American community. Of Black Protestants, 89% believe that religious institutions "bring people together and strengthen community bonds." [18] Public health agencies that partner with these institutions have the opportunity to garner credibility from partnering with these agencies, especially with a group of people that has a general distrust of public health agencies and practitioners, due to strongly held beliefs of mistreatment of minority groups by the American government system.[5]

The Black Church has been involved in health promotion efforts since as early as the 1920s.[5] While the Black Church has historically been involved in health promotion efforts, it is important to note that many of these efforts have not been

centered on sexual health issues. Sexual health issues can be seen as controversial topics to discuss, particularly with a group that has a firm hold on their religious beliefs and values. According to the PEW Research Center, 85% of Black Church members report that religion is very important to them (only 2% report that religion is not important to them at all), 80% pray daily and 61% read scripture weekly. Although African Americans tend to vote Democratic, associating with more liberal values, Black Protestants tend to be socially conservative. As it relates to same-sex marriage, black Protestants have one of lowest rates (34%) of support for same-sex marriage, according to the PEW Research Center. Comparatively, 66% of Democrats reported favoring same-sex marriage and 79% of those who identify with a liberal ideology support same-sex marriage. [52] However, 51% of Black Protestants say that "homosexuality should be accepted by society." [18]

Pastors. The senior pastor of a predominately black church is in an influential, meaningful position to impact the implementation of sexuality education in churches. Decisions about sexual health interventions in churches are primarily regulated by pastors. Therefore, it is important to preface a decision to develop sexuality education interventions in faith communities with an in-depth understanding of pastoral perceptions. Several studies have been conducted with pastors to explore their perceptions of HIV education in the Black Church.[38,54-57] Perceptions related to pregnancy may vary from perceptions related to HIV.

Overall, clergy and lay leaders report the need for HIV education and expressed willingness to consider HIV education programs. Yet only between 11% and 39% of black congregations across these studies actually implemented some form of HIV

education.[57] The primary barrier to implementing HIV programming were attitudinal beliefs related to the church's/congregation's views of sexuality and homosexuality. Many clergy reported that it was most appropriate to teach about abstinence only, and specifically stated that discussing anal sex, homosexuality, and condom use were off limits.[38] Additional barriers were the lack of financial resources, community support, and lack of education surrounding HIV.

Since 2012, there have been few additional studies conducted to understand clergy and lay leaders' perceptions of HIV education. For example, Stewart focused on factors that could support clergy and lay leaders as they develop HIV-related ministries and implement HIV-related programs.[57] Semi-structured interviews were conducted with three clergy and two lay leaders from one predominately black church in the Midwest. Using a grounded theory approach, Stewart found that pastors primarily debunked myths surrounding HIV and gained congregational support. The primary barrier related to their views on sexuality and homosexuality and the primary support related to congregants they knew that have HIV/AIDS. [57]

Mendel et al. conducted a qualitative study with clergy and lay leaders of 14 various congregations (including Jewish and Christian denominations; and African American, Latino, White, and Asian participants).[58] Although this study was not specifically focused on African American Protestant congregations, there were some interesting findings across the participants (as reported by half of the participants). The most commonly emphasized facilitators and barriers were related to norms and attitudes. Attitudinal barriers related to HIV and/or homosexuality-related stigma and facilitators related to more inclusive and welcoming attitudes within congregations.

Attitudinal barriers were most often in Latino and African American congregations and particularly among the elderly and middle-class participants. Interestingly, barriers reported related to teaching and beliefs, rather than institutionalized denominational beliefs (except for Catholics and condom use). In addition, clergy support of HIV-related programs was most often a facilitator of programming within the congregation, illustrating to congregants the importance of implementing HIV interventions and potentially offering services. In addition to attitudinal factors, resources were also mentioned by the majority of participants, most often as a barrier. Lack of financial resources, space, supplies, and volunteers were the most often mentioned resource barriers. Lastly, organizational structure and process was the final barrier/facilitator category, with most participants reported external organizational connection as potential facilitators and opportunities for HIV interventions. However, the lack of established linkages between congregations and outside entities did not appear to hinder HIV prevention programs from developing.[58]

Although pastoral perceptions related to HIV have been studied, limited information is known about pastoral perceptions of comprehensive sexuality education programs that include teen pregnancy prevention information as well. Further exploration of pastoral perceptions of sexuality education and teen pregnancy should be studied to understand how those perceptions relate to views regarding HIV.

Parents. Parent-child communication regarding sexuality-related issues has been widely studied both quantitatively and qualitatively. Research related to parent-child communication has shown such communication decreases sexual risk behavior.[59-61]

There have been a few studies with parents who are members of predominately black churches to understand their opinions of adolescent sexuality education. However, these studies have focused mainly on parents' beliefs of their role as a parent in adolescent sexuality education, not necessarily the role of their church.[62-64]

Cornelius conducted a qualitative study of African American single mothers' views of faith-based sexuality education.[62] Focus groups were held at a predominately black Baptist church. A sign was posted at the church detailing the study and study contact information. A total of 21 African American mothers of adolescents 11 to 13 years old (active members of church, 31 to 52 years old) participated in the two focus groups. Focus groups lasted from 60 to 90 minutes and mothers were compensated for their participation. Four themes emerged from the focus groups: "consequences of risky sexual behaviors," "do what I say and not what I do," "it's in the Bible," and "strategies for program development." First, the mothers reflected on their own risky sexual behaviors and the risky behaviors they perceive their children are participating in. They also cite that the education their children receive in the home and at school is lacking and should happen in other venues as well. Second, mothers reflect on their own current dating behavior and expressed that they are not always the best role models for their children. Additionally, they expressed the need to be open and honest with their child but were uncomfortable talking about sexual health issues. Third, mothers expressed their desire for church leaders to discuss sexual health in the church; the Bible should be used as a tool to encourage parents to have conversations with their children. Parents were unable to name scripture references related to sexuality and expressed the need for more guidance. Fourth, the mothers shared that if faith-based sexuality education

programs were offered, they would need to reflect on their own sexual desires and needs. However, they would be supportive of the program and would invite others to attend. [62]

Cornelius, LeGrand and Jemmott conducted a qualitative study of African American grandparent caregivers' attitudes and feelings related to sexual health communications.[63] Grandparents who were the primary caregivers (legal guardians) of adolescents 11 to 13 years old were the focus of this study. Focus groups, held at black Protestant churches, were conducted with participants. Although conducted at churches, participants were recruited through flyers posted in laundromats and restaurants, in addition to the flyers posted in churches. A total of 40 grandparents (100% African American, 25 female, mean age of 64.5) participated in the four focus groups. Focus groups with grandchildren were held separately; only one grandparent and one child per household participated. Focus groups lasted from 90 to 120 minutes; grandparents and grandchildren were compensated. There were three main themes: knowledgeable of HIV but had conspiracy views on origins of the disease, conversations needed to happen but a lack of information prevented them from occurring, and grief and loss related to HIV. First, grandparents were knowledgeable about HIV transmission and prevention techniques but expressed concerns with governmental influence in the origin of HIV, citing the Tuskegee syphilis experiment. Second, grandparents felt the sexual health communication was important and felt positive about the communication, but felt they were not prepared to have those types of conversations, nor were they particularly comfortable having them. Interestingly, they cite that "sexuality education must start in the home."[63] Third, grandparents reflect on loved ones that have been impacted by HIV,

some were their own children. Because of their experiences with loss, grandparents expressed the importance of sexuality education in the home to "gain control" over HIV.

Williams, Pichon and Campbell conducted a qualitative study of parent-child sexual health communication among religious families (those who attended church weekly). The authors used family systems theory as the theoretical framework, citing that "families are influenced and determined by collective processes, structures, and values, such as those originating from religious participation." [64] Focus groups were conducted; participants were recruited from two predominately black churches. Focus groups lasted from 50 minutes to 115 minutes; participants were compensated for their time. There were both parent and adolescent focus groups; the parent focus groups (parents of adolescents 12 to 18 years old) are the focus of this review. A total of 19 (14 female, 18 African American, mean age of 47) adults participated in the two adult-only focus groups. There were three primary themes: "initiating sex talks," "using mistakes as teaching tools," and "clarifying prevention messages." [64] First, parents should be the primary sexuality educator for the adolescent; the parent should discuss religious values as well as sexuality facts with their child. Second, parents should allow teens to live their own lives and make mistakes. Families cited that they learn from the experiences of Bible characters and adolescents should be able to learn from their own experiences and the experiences of the parents and leaders. Utilize religious beliefs to learn from mistakes and move past them. Third, there were conflicting opinions about pregnancy and STD prevention messages that parents want to send to adolescents (abstinence until marriage or use contraceptive methods). Because of this, parent messages came across

as unclear. Parents reported that they knew they had to be clear in the delivery of their messages; parents thought they were clear and honest, but adolescents disagreed.

The existing qualitative literature of black parents' perceptions of the Black Church's role and their role in sexuality education is sparse and should not be generalized. However, there are four common themes to note across these three studies. First, parents report that they need to do more to educate their adolescents about sexual health topics; parents said sexuality education begins in the home.[62-64] Second, there is a need to discuss both religious values and factual sexual health information; parents need to express both to their children in order to have open and honest conversations.[62,64] Third, parents need guidance; parents said they were unclear and not prepared to present sexuality education information to their children.[62,63] Fourth, parents were uncomfortable talking about sexuality issues with their children, but felt it was necessary. [62,63] Interestingly, parents in one study expressed comfort and openness discussing sexuality topics with children, but their children disagreed and said parents were not forthcoming with sexual health information and that conversations were sparse.[64] Since these studies focused mainly on parent congregants' opinions of the discussing sexual health with their own children, it remains unclear if parents are comfortable with other church members discussing sexual health with their children (and which church members), what type of information should be shared with their children, and if parents believe their church is the appropriate place to discuss teen pregnancy prevention with their child.

Summary of Findings

Teen pregnancy prevention is a persistent public health concern. Public health efforts to address teen pregnancy have been overwhelming found in community and school settings. Efforts to address teen pregnancy with the assistance and through partnerships with the faith community are not as readily implemented. Knowing that African Americans have one of the highest rates in teen births and the importance of the Black Church in the African American community, it is not apparent that extensive efforts are being made to bridge the link between the public health community and the faith community to address teen pregnancy prevention. In fact, although the partnership appears to be promising, several questions remain unanswered and missing from available literature:

1. What can be done to reduce teen pregnancy in the African American community, from the perspective of leaders and congregants?
2. How do the perspectives of the leaders and congregants compare?
3. What are the barriers and supports for implementing teen pregnancy prevention efforts?
4. What has been done to understand the complexities and possibilities of working with the Black Church to reduce teen pregnancy?
5. What are detailed recommendations for public health professionals wishing to work with the African American faith community to implement sexuality education?

In order to address gaps remaining in the available literature and examine the reality of implementing teen pregnancy prevention efforts in the Black Church, this exploratory study will aim to unearth foundational issues related to implementing sexuality

education intervention in the Black Church by addressing the following three research questions:

- RQ1: What are pastors' perceptions of the Black Church's role in promoting adolescent sexual health and preventing teen pregnancy?
- RQ2: What are pastors' perceptions of the Black Church's response to a teen pregnancy in the Black Church?
- RQ3: What are parents' expectations of the Black Church's (including expectations of the pastor and other leaders) role promoting adolescent sexual health and preventing teen pregnancy?

The rationale for this study is that it will fill an important gap and highlight the perceptions of both pastors and parents about the role of the church in sexuality education in order to further advance the public health's efforts to reduce teen pregnancy.

Overview of Methods

In order to answer these research questions, realizing that limited information is currently available related to teen pregnancy prevention assumptions and efforts in the church, a qualitative approach was utilized to uncover foundational concepts related to teen pregnancy prevention efforts (which could ultimately lead to a larger scale, representative study of teen pregnancy prevention) in the Black Church. In order to uncover the realities and begin to understand the complexities of partnering with this faith community, semi-structured interviews were conducted with senior pastors of predominately black churches to understand perspectives from church leaders; and semi-structured interviews were conducted with parents of adolescents 11-17 years old

to understand perspectives from parents of adolescents. Understanding perspectives from both of these groups will help to inform the development or tailoring of sexuality education programs for young adolescents in the Black Church.

Value of Qualitative Research

Deciding to utilize a primarily qualitative approach was an intentional, deliberate process. Based on the limited research available to understand the complexities surrounding teen pregnancy prevention programs in the Black Church and the resulting gaps remaining in the research, a qualitative approach was deemed most appropriate to uncover closely held attitudes, beliefs, perceptions related to teen pregnancy prevention. By applying a qualitative approach first, this will allow researchers to further understand the depth and complexities of this issue and allow for a foundational understanding of this understudied topic and could allow for a quantitative study to later be implemented to help evaluate and generalize results in this qualitative study.[65]

In comparison, a primarily quantitative study to understand this issue may strive to understand how many churches are implementing sexuality education programs, how many churches would like to implement sexuality education program, what is the relationship between sexuality education programs in the Black Church and prevention of teen births or delayed initiation of sex or increased condom use. While these questions would be valuable to answer, the next step in filling the gaps left in the literature is to truly understand this population, without making assumptions about the capacity of the Black Church in implementing sexuality education There are certainly many ways to address this issue but for the information the researchers want to know,

the best method is a qualitative approach. Several questions can be answered utilizing a qualitative approach: 1) What role does the church play in addressing adolescent sexual health and why? and 2) What gaps are currently left in the implementation of sexuality education in the Black Church? These types of questions require the use of in-depth qualitative analysis.

Chapter 3: Methodology

Study 1

Pastors Study Methodology (Manuscripts 1 & 2)

Introduction. Study 1 examined pastors' perceptions of the Black Church's role in sexuality education by conducting semi-structured, in-depth interviews. The purpose of Study 1 was two- fold: 1) to examine pastors' perceptions of the role of predominately black churches in promoting sexual health by providing sexuality education and 2) to examine pastors' perceptions of predominately black churches' responses to a teen pregnancy within the church. Study 1 will address RQ1 and RQ2.

Thirty-one interviews were conducted by the researcher with senior pastors of predominately black churches in two counties in [de-identified southwestern state]. Interviews were transcribed, checked for consistency in transcriptions with the recordings, and analyzed using NVivo software. These findings were also incorporated into Chapter 5 (discussion and conclusions for all 3 studies).

Sample.

Description of sample. Senior pastors of predominately black churches were the target sample for Study 1. Pastors are the leaders of the congregation and have a great deal of influence in the lives of the congregants. Senior pastors are seen as the visionaries and ultimately make the final decision in the church. Pastors are trusted to provide not only leadership to the church about spiritual issues, but also clear guidance in delivering social, political, economic, and health issues as well.[5] Pastors of black churches are in unique positions, different from any other role in the American culture. They have the unique responsibility of guiding the congregation, holding true to

traditional (often times conservative) religious beliefs and values, while also standing up and speaking out against discrimination and marginalization of the African American community.

Through emotive words and often close-knit relationships, the pastor conveys to congregants that the struggles of today can be overcome through Jesus and their faith.[66] The role of a Black Church pastor is intricate and intriguing. Arnold notes that some of the main responsibilities of a Black Church pastor includes leading/guiding the congregation during difficult times, individually counseling congregants, spiritually guiding congregants to understand and have faith in God, and being a community organizer, activist, and mentor.[66]

The role of the pastor has been explained using Biblical perspectives and confirmations as well. For example, Apostle Peter, who was one of Jesus's disciples, provides advice for pastors (also known as elders/overseers in the Bible) in this passage. "Care for the flock that God has entrusted to you. Watch over it willingly, not grudgingly - not for what you will get out of it, but because you are eager to serve God. Don't lord it over the people assigned to your care, but lead them by your own good example" (I Peter 5:2-3, New Living Translation). Another example can be found in I Timothy (I Timothy 3:2-7, New Living Translation), where the qualifications of the pastors (elder/overseer) are outlined:

> *So an elder must be a man whose life is above reproach. He must be faithful to his wife. He must exercise self-control, live wisely, and have a good reputation. He must enjoy having guests in his home, and he must be able to teach. He must not be a heavy drinker or be violent. He must be gentle, not quarrelsome, and not love money. He must manage his own family well, having children who respect and obey him. For if a man cannot manage his own household, how can he take care of God's church? An elder must not be a new believer, because he might become proud, and the devil would cause him to fall. Also, people outside*

> *the church must speak well of him so that he will not be disgraced and fall into the devil's trap.*

The Bible is used as an instruction manual for pastors, other leaders, and congregants. It is highly important to the Protestant faith. Instructions presented in the Bible are respected and the pastors are charged with providing direction and guidance in deciphering the instructions laid out in the Bible. Although there are other leaders in the church, such as deacons, the pastor's opinion is revered higher than others.

The office of the deacon was created to provide assistance to the pastor. The deacon ultimately follows the leadership of the pastor and helps him/her with the functioning of the church. As with the pastor, the role of and characteristics of deacons are also found in the Bible. For example, in the book of Acts (Acts 6: 2-4, New Living Translation), the apostles (who can be likened to pastors of today), decided to appoint seven deacons to help them with the needs of the church so they could focus on teaching the Bible:

> *So the Twelve called a meeting of all the believers. They said, "We apostles should spend our time teaching the word of God, not running a food program. And so, brothers, select seven men who are well respected and are full of the Spirit and wisdom. We will give them this responsibility. Then we apostles can spend our time in prayer and teaching the word."*

It is clear that while the deacon holds a respected office in the church, their task is to follow the leadership of the pastor and provide support in carrying out the missions of the church.

Just as deacons are expected to follow the leadership of the pastors, congregants are also expected to follow the leadership and guidance of the pastors. The instructions provided by the pastors are respected and the expectations of the congregants are also found in the Bible. One example can be found in the book of Hebrews: "Obey your

spiritual leaders, and do what they say. Their work is to watch over your souls, and they are accountable to God" (Hebrews 13:17, New Living Translation).

Based on the review of positions and responsibilities in the Black Church, it is evident that there are levels of leadership in churches. Depending on the church, the levels could include the senior pastor, associate ministers/pastors, deacons and deaconesses (typically wives of deacons), ministry leaders, and congregants.[51] Ultimately the vision and overarching guidance and leadership funnels down from the senior pastor. It is important to understand the offices, roles, and responsibilities of people in the church to understand the importance of the pastor as the target sample for Study 1. The pastor has a great deal of influence on the programs that occur within their churches and the messages that are delivered to congregants. Pastors have one of the most influential voices in the church and it is essential to receive the pastor's approval for a church-sponsored program prior to implementation.[9,36] The senior pastor was the target for Study 1 in order to gain an understanding of their perceptions of the role of the church in 1) sexuality education and 2) the church's response to pregnant teen congregants.

Historically black Protestant denominations are the target denominations for this study sample. In southern states in America, the historically black Protestant denomination is widely prevalent and relevant. Approximately 62% of those identifying with this tradition live in the south (which includes the de-identified southwestern state). [52]

Moreover, the primary focus of this study was to include pastors within the Baptist and Methodist categories. These denominations represent a large proportion of

historically black Protestant churches (nearly 70%) and the researcher hypothesized this would provide a fair representation of the landscape of sexuality education in the Black Church.[18] The Pentecostal denomination also represents approximately 16% of the historically black Protestant churches and will also be contacted for inclusion in this study. [52]

The sample included pastors of churches in two counties in the [de-identified state]. Sampling occurred across these two large counties to help protect the pastors' identities. A total sample of 31 pastors (19 Baptist, 6 Methodist, and 6 other [Christian Church, Church of Christ, Non-denominational]) were interviewed and included in the analysis related to RQ1 and RQ 2.

Recruitment. Recruitment through purposive sampling took place in two counties in [de-identified state]. Purposive sampling is a technique used to select meaningful, information rich people to allow for a deeper understanding of an issue. [7] The purpose is not to identify a large sample for generalization but to identify information rich sources of information to discuss their perceptions about the role of the church and the pastor in addressing sexuality education. Based on the most recent report of the PEW Research center senior pastors of predominately black churches are overwhelmingly male.[52] This may be related to both Biblical references to the qualifications of the pastor and/or traditional, patriarchal values of congregants. However, it is important to note that targeted sampling strategies were used to include both male and female pastors in the sample of senior pastors in order to gain perspectives from both male and female pastors.

A list of predominately black churches were compiled based on local newspapers, telephone book, and internet listings. Two local newspapers (one in each county) were used as the primary source to identify churches. Once a list of churches and pastors were obtained, pastors were contacted to ask if they would be interested in participating in the study. A recruitment script was used to describe the study to the administrative assistant and/or the pastor (See Appendix A). Based on a purposive sampling approach, the principal investigator began the process by contacting pastors listed in one of the two newspapers, ensuring that pastors of the two primary denominations of interest (Baptist and Methodist) were included.

At the conclusion of each interview, a snowball sampling approach was incorporated to recruit additional pastors, as utilized in previous studies within this population.[67] Snowball sampling has particularly been utilized in social science research to study topics that are heavily influenced by or typically discussed amongst tight knit social networks and those that are sensitive topics.[38,51] Pastors were asked to provide a list of other pastors they believed would like to participate in this study. The pastors were asked if they would like for the researcher to share with the potential participant that he/she provided the potential participants name. If they would rather their name not be shared, the potential participant was told that another pastor recommended that he/she participate.

The minimum recruitment target was 20 pastors, with a maximum recruitment target of 50 pastors. A minimum of 20 was selected based on the faculty mentor's experience with previous studies that found that a minimum of 20 was needed before the authors noticed enough patterns across subjects.[68,69] However, there is no minimum

number or limit recommended for interviews.[7] The 20 to 50 interview range is the suggested range. However, recruitment continued until saturation was reached, meaning no new ideas were emerging from the field and there was a range of ideas already presented.[7] Since this is an understudied population, it was not clear if the target number was likely to reach saturation, hence the need to establish a wide range to ensure saturation could be reached.

Delimitations to the sample. First, Study 1 was limited to the senior pastor of the church. Youth pastors, assistant pastors, other ministers, or other leaders were not included in this study. Senior pastors represent the leadership of the church and serve in a revered position in the church. Understanding their perspective of the church's role in sexuality education and their role in sexuality education may be very different from the perspective of other ministers on staff or youth leaders. It is important to mention that one senior pastor invited the youth pastor to join the interview; the interviewer was not aware that he would be joining the interview until the interview began and the youth pastor walked in the room. The interviewer did not dismiss the youth pastor but instead decided to allow the youth pastor to jointly participate in the interview, as long as the senior pastor answered the questions first. This was a unique occurrence and it did not happen with any of the other senior pastors.

Second, Study 1 is primarily a qualitative study. A brief questionnaire was utilized to collect demographic information. Qualitative methodology (semi-structured, in-depth interviews) was utilized to provoke an in-depth understanding of the perceptions of pastors in a one-on-one setting. By scheduling face-to-face interviews this also made the research experience more personal compared to a quantitative tool,

encouraging a more open dialogue between the principal investigator and the participant.

Literature related to study sample. Historically, pastors of predominately black churches have been seen as not only a minister, but also a teacher, political activist, community organizer.[67] Since predominately black churches have been involved in public health issues, the pastor has been seen as a change agent for health and key community partner in the black community. Health issues range from diabetes, heart disease, prostate cancer, and others. However, these programs historically have focused on adults and have not focused on sexual health issues, for adults or adolescents.

In the past 10 to 15 years, pastors have conveyed a need for additional health initiatives, especially for adolescents centering on topics such as violence, alcohol, pregnancy, and drugs.[38,67] Generally, church leaders seem to be open to discussing sexuality-related topics in the church setting, if they are knowledgeable and able to discuss what they are comfortable discussing.[67]

In two feasibility studies conducted in African American church settings, leaders report being uncomfortable discussing sexuality and HIV transmission with adolescents due to their discomfort with discussing oral and anal sex, masturbation, homosexuality, and bisexuality.[67,70] Since the focus of this study is on teen pregnancy, these concepts that caused the most discomfort for church leaders will not be the main focus. However, it is important to point out issues concerning perceptions of teenagers having sex and becoming pregnant may vary from perceptions about HIV transmission and certainly should be explored in more detail. Literature exploring pastor perceptions of teen

pregnancy in particular is lacking. Consequently, this study aimed to further understand those opinions.

Instrumentation/measurement protocols.

Description of measurement instruments. There were two primary data collection tools utilized in Study 1. First, a demographic questionnaire was developed to obtain demographic information about the pastor and the church, e.g. pastoral tenure, number of adolescents in the church, church size, and church denomination. The questionnaire was administered after the completion of the informed consent form and prior to the interview. Second, the interview question path was developed in a series of steps. Initially, informal informational interviews were conducted with local community leaders about sexuality education in predominately Black churches. Next, a literature search was conducted on sexuality education in predominately black churches. An initial question path was developed and presented to the faculty advisor. An iterative process ensued, sending the question path through many rounds of changes. The initial, updated question path was then tested with a local pastor of a predominately black church who was not a part of the study. The pastor participated in a mock interview with the principal investigator (including completion of the demographic questionnaire). Suggestions/modifications to the demographic questionnaire or the question path were addressed, which included omitting questions that may be offensive to or unanswered by a pastor (e.g. the relationship status option of unmarried and living with someone). The final demographic questionnaire (see Appendix E) and question path (see Appendix B) was utilized for the pastor interviews in Study 1.

Research design.

Type of data to be collected. Participants participated in in-depth interviews, allowing for a rich exchange between the researcher and participant. The information received from the participants was used to better understand the relationship between the Black Church and sexuality education.

Data collection and management. The pastors who agreed to participate in the study were interviewed in a private location of their choice that was not a private residence. Care was taken to be sure that the interview was guided, but not restrictive. As suggested in Ulin, Robinson, and Tolley, the interviewer should create an encouraging environment, promoting a natural flow of information and minimizing any sense of participant fear. The interviewer should also obtain answers to the questions and asked the difficult questions toward the end of the interview after trust and comfort had been established.[65]

Pastors' names were not linked to the interview. Pastors were identified by code number only. For record-keeping purposes, a key was kept during the participant recruitment containing pastor name and code number. The key was kept in a password-protected file and the key was destroyed at the conclusion of the data collection and transcription process. Prior to beginning the interview, pastors completed an informed consent form and a brief demographic questionnaire. The brief questionnaire was not linked to the interview. The researcher did not know which questionnaire was completed by which pastor. The researcher asked (on the informed consent form) for consent to contact these pastors again about future studies. However, these consent forms were not linked to the actual interviews. Only a list of pastors who provided consent was kept in a password-protected file and in a locked cabinet. Both the

informed consent forms and the questionnaires were kept in a locked cabinet in a locked office.

Literature related to data collection and management procedures. Data collection procedures were selected based on suggestions from experienced qualitative researchers and their guides to conducting in-depth interviews. [7,65] Literature focusing particularly on teen pregnancy was not readily available. However, several studies have focused on perceptions related to HIV education, pastoral and congregational responses to the intervention/church ministry.

Mendel et al. conducted in-depth interviews with clergy and lay leaders (57 participants across 14 congregations, at least one clergy and one lay leader) in Los Angeles, CA. researchers sampled through purposive sampling, sampling based on the outcomes of interest (e.g. recruit congregations both with and without current HIV education).[15] It is important to note that approximately 39% of the participants were African American and the same percentage of participants were clergy (however it is not clear how many African American clergy specifically were included in the study). In addition, denominations included both Jewish and Christian denominations (including Catholic, Protestant, and Pentecostal). Clergy and lay leaders were interviewed about congregational dynamics related to HIV/AIDS education, current and previous HIV/AIDS education participation, interactions with outside organizations. They also asked participants to complete a congregational demographic form that inquired about membership size, resources, and programs, number of religious services, health and HIV-related programs, and facility availability. Interviews typically lasted 1.5 hours, but ranged from 1-4 hours each. Since this particular paper focused on

internal and external facilitators and barriers to HIV-related activities in congregations, data was coded using these main categories. Concepts were considered a theme if reported by more than half of the 14 congregations, not necessarily the number of participants. There was no direct mention of utilization of NVivo or other qualitative software to analyze data.

Stewart conducted semi-structured interviews with five clergy and lay leaders from one predominately black church. Researchers were focused on development and maintenance of the HIV ministry at this one church.[57] In addition, the manuscript does not specify which denomination the church belonged to within the historically black Protestant tradition but specified that it was one that was "open and affirming to homosexuality." Interviews lasted 30 minutes to 2 hours each. Interviews were recorded, transcribed verbatim, and checked for accuracy. Data were analyzed using a grounded theory approach, consisting of 5 primary tasks which included transcribing the interview, narrow text down to related research interests, search for repeating ideas or similar words, group repeating ideas, and group themes (groupings of repeated ideas) into theoretical constructs. The manuscript of the study did not specific that an a priori limit was set prior to data analysis and also recognized that this was a study with a considerably small sample size. Similar to previously conducted studies, Stewart also found that barriers and supports for HIV ministry/intervention emerged as major themes, in addition to the clergy and lay leaders' perception of their role in the development of HIV programming.[57]

Based on a review of the literature related to this population, the researcher decided to conduct semi-structured, in-depth interviews, incorporating many of the

topics asked of clergy and lay leaders previously about HIV-related activities (perceptions of the role of the pastor, barriers and supports of sexuality education) but tailored the question path to be more specifically related to teen pregnancy related activities (including specific questions related to pregnancy, response to pregnancy, additional sexuality related topics beyond focusing specifically on HIV prevention). In addition, although interviews were designed to last on average 45 minutes to an hour, the researcher prepared for lengthy interviews, based on lengths reported in previously studies conducted with clergy. When scheduling interviews, she prepared to be available a minimum of 2 hours, including completion of the informed consent, demographic form, interview, and post-interview casual discussion.

Data analysis.

Data analysis software and procedures. Interviews were transcribed verbatim. Transcriptions were checked for errors, and then analyzed for themes. De-identified interviews will be analyzed using NVivo software. A grounded theory approach will be used to analyze the data for themes.[7] A grounded theory approach posits that researchers should allow the theory to emerge from the field-work to explain the phenomenon being studied, instead of confining results to a particular theory. Researchers who use a grounded theory approach focus on the process and remain open to emerging theories when exploring an understudied topic. For example, grounded theorists analyze data in an iterative process, look for new concepts in the data, develop thematic categories through data analysis, and develop a theory based on the results.[7]

Two independent coders (the researcher and faculty advisor) analyzed the transcripts for themes in order to promote investigator triangulation of coding, which

brings different perspectives to the analysis of the data in order to allow for similarities and differences to be discussed.[7] Investigator triangulation strengthened the findings of this study by combining the efforts of two researchers and minimizing the potential risk of bias. There should be some agreement in the themes, but conversations about differences in themes were also valuable. In order to ensure consistent coding, the coders developed codes and coded the first three interviews together. The codebook was revised and definitions were clarified based on their questions and differences in coding. The two researchers coded the remaining transcripts independently and met to confirm final coding; the team experienced high agreement between coders.

The researchers next met to discuss and identify themes. An a priori threshold of 25% was set as the threshold for including a code as a final theme.[68,69] There is no true consensus across qualitative researchers about the a priori threshold, but experienced researchers have stressed the importance of selecting the threshold prior to data collection.[65] Selecting the threshold prior to data collection establishes trustworthiness of the data. There are four criteria for assessing the trustworthiness of qualitative data, one of which is confirmability. Setting the threshold allows the researchers to contribute systematically to a detailed audit trail and track the process of the data analysis process.

After themes were identified, transcripts were reviewed again for disconfirming evidence that contradicted themes to ensure that the themes are representative of the participants.[7] Next quotes were selected to represent each theme. The findings were grounded in the narrative data to ensure that participants' opinions in their own words were conveyed in the results.

Study 2

Parents Study Methodology (Manuscript 3)

Introduction. The purpose of Study 2 was to examine parents' perceptions and expectations of the role of the Black Church in promoting sexual health and preventing teen pregnancy through sexuality education. Interviews were conducted with parents of adolescents 11 to 17 years old who are members of predominately black churches, Interviews were designed to elicit their opinions regarding sexuality education in the Black Church. Study 2 focused on answering RQ3: What are parents' expectations of the Black Church in implementing sexuality education to adolescents in the church?

Sample.

Description of sample. Parents (mother or father) of adolescents 11 to 17 years old were recruited for Study 2. Parents of young adolescents were the primary target for this study in order to understand the specific influences and perceptions of these parents on church programming for young adolescents. Targeting parents of young adolescents allows for development of programs to curtail behavior and influence sexual health choices prior to adolescents engaging in sexual health behaviors. Perceptions of parents of young adolescents (who tend to be more dependent on their parents and are not as developed) may vary greatly from parents of older adolescents (who tend to be less dependent and more developed). Parents of adolescents 15-17 years old were included to compare opinions of the parents of younger adolescents with those of the parents of older adolescents, allowing for a foundational understanding of the differences in opinions about appropriate topics and situations based on the age of the child.

One parent per household was able to participate in the study in order to reduce the likelihood that parents would hear of or know about the topics discussed. Mothers or fathers could both participate in the study. Parents were an important group to study because the roles of the church and the family are often interrelated, with parents yearning for education, support, and guidance from the church leaders.

Historically black Protestant denominations were the target denominations for this study sample. The same denominations targeted for Study 1 were the same as those targeted for Study 2: Baptist, Methodist, and Pentecostal. Parents had to be members of a church congregation to participate, as the interview was centered on the dynamics between the church and the family and the influence of the Black Church on effective sexuality education. Lastly, parents who were in leadership positions in their church were allowed to participate except for parents who were: 1) in paid positions, 2) senior pastors, 3) youth pastors, 4) associate/assistant pastors, or 5) deacons. This was an intentional effort to separate the opinions of major church leaders in the church from parent congregants and to understand parents' opinions as parents, not as church leaders.

Recruitment. Initially, the plan was to utilize focus groups as the primary data collection method. All of the focus group materials (recruitment materials, procedures, focus group question path, questionnaires, etc.) were approved and recruitment initially took place for the focus groups. Connections already established with pastors in Study 1 were used to recruit for the focus groups. All pastors that provided consent to be contacted again for a future study during Study 1 were contacted about Study 2. The senior pastors' only involvement in Study 2 was to approve the posting of a flyer in

their church and make a single announcement that information was available in a designated area. Flyers were posted at churches to allow for parents to voluntarily and confidentially call the number listed. Churches were also asked to include a copy of the flyer in the church bulletin/newsletter (electronic and/or hard copy). Pastors were asked to send an electronic copy of the flyer to church congregants. Pastors were asked not to directly contact parents to decrease the risk for parents feeling coerced to participate.

A minimum of 20 churches were targeted for participant recruitment in order to allow for a diverse group of participants to be recruited. Churches were going to be recruited in segments, in order to include at least one church per denomination. However, very few parents signed up to participate via church recruitment.

After five months of recruiting (e.g. posting flyers in churches, distributing flyers to congregants, running advertisements in local newspapers and posting on Craigslist) for focus groups, it was decided that the data collection method should be changed to interviews. Over the five month period, only one focus group (with five participants) had been conducted with four groups rescheduled multiple times without completion. Although parents did not directly say their reason for not participating in focus groups or for cancelling days/hours prior to the focus group, it is possible that parents were not comfortable discussing sexual health content in a group setting, particularly based on the taboo nature of discussing sexual health in the Black Church. Based on previously conducted research, discussing more sensitive, emotion-provoking topics (such as sexuality education and safer sex practices) may be best explored in one-on-one settings.[71] Researchers have found that discussing emotion-provoking topics in a group setting may actually promote a bond over shared experiences. However, parents

cancelling or no-showing for focus groups in this study demonstrated the importance of discussing emotion-provoking, sensitive topics in a one-on-one setting, rather than focus group.[72,73]

With this change to interviews, the recruitment flyer was updated (and the focus group question path was changed to an interview question path). The 20 parents who originally signed up to participate in focus groups but were unable to do so (or did not show up to their focus group) were contacted again to inform them of the change from focus groups to interviews; only nine of the original 20 parents participated in an interview. At the conclusion of each interview, the interviewer asked participants to refer additional parents that may participate in the study. Most of the parents that signed up for interviews were recruited by referral from another participant. Also, if a parent signed up to participate in the study but was not eligible to participate, the researcher asked them to refer additional parents. Sampling continued until saturation was reached, meaning no new ideas were emerging from the interviews and there was a range of ideas already presented.[74]

Delimitations to the sample. First, Study 2 was limited to one parent per household to ensure that participants were not provided information by spouses or caregivers prior to their interview. Second, the study was limited to the biological or adoptive parent. If a parent was an adoptive parent, the adoptive parent had to be the legal guardian for at least one year. Foster parents were not included in this study to ensure that the perspectives of parents involved represented those of parents that intended to raise the child for the duration of their childhood. Grandparents (even if they are the legal guardian) were not included in this study to maintain consistency in

the sample of participants. The dynamics and perceptions of grandparents raising grandchildren may be different from those of the parent/adoptive parent. Exploring those perceptions was beyond the scope of this study. Third, Study 2 was a qualitative study and did not include quantitative methodology. Qualitative methodology (interviews) was the focus of this study in order to evoke an in-depth understanding of the perceptions of parents in a face-to-face setting.

Literature related to study sample. In order to explore black parents' perceptions of the role of the church in adolescent sexuality education it is important to understand that the family system influences perceptions and behaviors of the church, church leaders, and church congregants in conjunction with the church system influencing the family's perceptions and behaviors. These interrelationships are important for health promotion program developers to consider in order to understand how these systems operate together and to develop appropriate, relevant interventions.

The existing literature related to black parents' perceptions of the Black Church institution's role and their own role in sexuality education is sparse and should not be generalized. Across these studies, researchers found that parents want to educate their own adolescents about sexual health and include religious information in these discussions but most are ill-prepared and uncomfortable presenting sexual health information with their own children.[62-64] Parents in one study expressed comfort and openness discussing sexuality topics with children, but their children disagreed and said parents were not forthcoming with sexual health information and that conversations were sparse.[64] Since these studies focused mainly on parent congregants' opinions of the discussing sexual health with their own children, it remains unclear if parents are

comfortable with other church members discussing sexual health with their children (and which church members), what type of information should be shared with their children, and if parents believe their church is the appropriate place to discuss teen pregnancy prevention with their child.

The emergent themes from the available research were both relevant and insightful. However two main gaps still persist in the research related to this specific sample. First, it is unclear if parents prefer to learn the content themselves through parent sexuality education interventions in the churches (which would allow for parents to be the educators of their own adolescents) or if they would prefer that adolescents receive some instruction from church leaders or those brought into their church to administer programming by church leaders, or a combination of the two educational approaches. Second, it is not clear if parents (particularly referring to parents within the church system) would prefer abstinence-only education or more comprehensive sexuality education. As noted, parents in two studies expressed a desire to include both factual sexual health information and religious information.[62,64] Understanding these two concepts in more detail, in addition to other factors related to sexuality education implementation in predominately black churches will allow researchers to have a more holistic picture of the complexity of this issue.

Instrumentation/measurement protocols.

Description of measurement instruments. There were two primary data collection tools utilized in Study 2: questionnaires and an interview question path. First, the questionnaires included a demographic and psychographic questionnaire. The demographic questionnaire collected basic demographic information about the parent

and the church, e.g. number of adolescents in the home, church denomination, health programs offered at the church (see Appendices F & H). The demographic questionnaire was administered prior to the interview. The psychographic questionnaire asked questions that focused on understanding barriers and supports of sexuality education in the church related to the parent, clergy, other congregants, and outside forces (see Appendices G & I). The psychographic questionnaire was administered after the interview. Each questionnaire was completed in approximately 10 minutes.

This technique of separating demographic and psychographic questions, asking basic demographic questions first then the more specific psychographic questions after was adapted from another study.[75] Although not explicitly stated in the published manuscript, asking psychographic questions after the interview was beneficial in two ways: 1) participants were not inadvertently swayed to answer interview questions based on the psychographic questions, which could bias their responses and 2) this allowed the researcher to ask information not covered in the interview that shed a light on issues that may be important in understanding issues surrounding sexuality education.

Second, the interview question path was developed through a series of steps. Initially, information from informal informational interviews conducted with three local community leaders prior to Study 1 was reviewed. Next, a literature search was conducted on sexuality education in the predominately black faith community, including parental involvement in sexuality education in churches.

Since the original data collection method was focus groups, the original question path was a focus group question path that was tested with a parental advisory group

composed of five parents who attend predominately black churches (they did not participate in the study). The question path was revised based on parent recommendations. After changing the data collection method to interviews, none of the questions were changed from the original intent; questions were only changed to reflect it being in a one-on-one rather than group setting. The final demographic and psychographic questionnaires and interview question path (see Appendix C) were used for the participants in Study 2.

Research design.

Type of data to be collected. Qualitative, information rich data was collected from the parents participating in in-depth interviews. The information received from the participants was used to better understand the relationship between the parent congregants and leadership in predominately black churches regarding the church's responsibility and role in adolescent sexuality education.

Data collection and management procedures. Informed consent was obtained prior to the interview. Interviews were conducted using a semi-structured question path, which was informed by the previously conducted study with pastors, based on a review of literature about the influence of the Black Church, and feedback from the parent advisory group.

Parents were interviewed at a time and public location of their choice. The most common location choice was a local restaurant or coffee shop and after work was the most common time chosen. The researcher conducted all interviews. Participant documents were identified by code number only; no names were written on any questionnaire or other materials. Prior to the interview, participants completed the

informed consent and brief demographic questionnaire. Interviews were audio-recorded, lasting on average 40 minutes.

At the end of the interview, parents completed the psychographic questionnaire and received a $20 store gift card. Some gift cards were purchased by the faculty advisor with faculty start-up funds and the rest of the gift cards were purchased using a graduate research award through the University of Oklahoma, Robberson Research Grant. Participants completed the incentive receipt document, submitted the form, and then received their gift card. Qualitative researchers (when resources are available) utilize nominal, reasonable incentives to show appreciation to participants for their time.[74] The most common incentive utilized in interview or focus group research is a store or movie theatre gift card.[74]

Prior to leaving, participants were asked if they would also be willing to contact other parents to inform them of the study and if so if they would be willing to distribute the researcher's information to these parents (snowball sampling). Recruitment continued until saturation was reached, meaning no new ideas were heard.[7] Interviews were conducted from February 2017 to June 2017.

Interviews were recorded on two devices to ensure that there were no recording errors. Recordings were transcribed by trained undergraduate students, under the direction of the researcher. Transcripts were de-identified (e.g. names of people, churches, or other identifying information) prior to analysis. Recordings and transcripts were kept on a password protected computer. The researcher also kept a participant list on a password protected computer. Participants were identified by code number only.

The participant list was deleted at the conclusion of the study. Informed consent forms and demographic sheets were kept in a locked cabinet in a locked office.

Literature related to data collection procedures. In order to encourage meaningful discussion, particular attention was given to the development of the question path. The question path was structured in a way that would likely establish trust and comfort with discussing sexuality education and promote meaningful, reflexive comments. Participants may be inclined to portray themselves in the best light or may even genuinely not be aware of the depth of their emotions about this topic or how those emotions influenced behavior.

Krueger and Casey outlined two key ways to evoke meaningful comments.[74] First, ask questions about feelings and emotions, instead of thoughts and perceptions. Second, facilitate activities involving sorting and arranging that provide a glimpse into their emotions. Since this study wanted to understand the emotions surrounding sexuality education in the Black Church, these approaches were used to structure the interview process and question path.

High-involvement topics, such as sexuality education and safer sex practices, typically evoke emotions that are more sensitive and more involved. Focus groups have been conducted to explore "low-involvement topics" that may evoke few emotions, while interviews have been utilized to explore "high-involvement topics."[71] Researchers have found that focus groups can be used to study high-involvement topics for various populations that may find it meaningful to bond and share experiences in a group setting (e.g. adolescent drug users, drug dependent and HIV infected mothers and social services) and that focus groups also allow for a more dynamic, deeper understanding of

the issues among some groups.[72,73] In addition, whether or not a topic is considered high-involvement may depend on the participants. As mentioned by Overlien, Aronsson, and Hyden, discussing sexuality with staff of a gynecological clinic may be low-involvement but discussing the same topic with teenagers that attend the clinic may be high-involvement.[17] Due to the limited research in the Black Church institution, there was no true way to know if discussing sexuality education would be a high or low involvement topic. Focus groups were originally the preferred method to allow parents to share experiences in this group setting, but due to low recruitment and participation the method changed to interviews. There is no way of knowing why recruitment was so low for focus groups, but when the method changed to interviews the recruitment and participation numbers drastically increased. Discussing sexuality education with parents may be a high-involvement topic that requires a one-on-one conversation in order for parents to truly feel comfortable sharing their feelings and opinions.

Data analysis.

Data analysis software and procedures. Interviews were transcribed verbatim and checked for accuracy. NVivo (v.11; QSR International) was used for coding. Codes were ideas that were mentioned in the question path and/or emerged from the participants that centered on the parent's opinions of their church's role in preventing teen pregnancy.[65] Two researchers (LH, MC) created the codebook, coded six transcripts together, and made revisions to the codebook. During coding of these six transcripts, a parent interview was excluded due to the questionable cognitive ability of the parent to answer questions and the limited unusable information shared; with this exclusion, 36 parent interviews were included in the final data analysis process.

Next, the two researchers coded three transcripts independently, met to review coding and clarified any differences in coding. Two additional transcripts were then coded independently to ensure coding was still consistent and to clarify any additional questions; the researchers continued to experience high agreement. At this point, the researchers coded the remaining 26 transcripts. The intercoder reliability for coding was 94.5%

The interviews were then analyzed for themes. The researchers used thematic analysis to investigate the coded transcripts for emerging patterns across codes and parent participants.[65] Twenty-five percent was set as the a priori threshold for including a concept as a final theme. Although there is no consensus across qualitative researchers, experienced researchers have recommended setting a threshold to establish transparency and trustworthiness in theme identification.[65,68,69] Themes included subthemes which represented multiple parent beliefs related to their church's role in preventing teen pregnancy and response to teen pregnancy. After identifying themes, transcripts were reviewed again for disconfirming evidence of the themes.[7] Finally, coded transcripts were reviewed again for quotes to represent each theme.

Chapter 4: Results

Manuscript 1: Pastors' Opinions of the Role of the Black Church Institution in Preventing Teen Pregnancy

Abstract

Objective: To identify pastors' perceptions of the Black Church's role in promoting adolescent sexual health and preventing teen pregnancy. The Black Church and pastor are important partners in addressing health disparities in the black community, especially sensitive issues such as teen pregnancy. **Methods:** Semi-structured interviews (n=31) were conducted with Black Church pastors in two southwestern US cities, September 2014-July 2015. The question path was developed based on interviews with local leaders, literature searches, and key informant interviews. Questions included knowledge/beliefs about sexuality education, church's role in preventing teen pregnancy, and implementation obstacles. Interviews were transcribed and analyzed for themes. **Results:** All pastors believed the Black Church should address teen pregnancy with parents/congregants. Two major obstacles emerged: (1) all pastors perceived social consequences, including resistant parents; and (2) many were uncomfortable discussing contraceptives/condoms. All pastors were willing to partner with organizations, but most had reservations based on conflicting missions/values. **Conclusions:** Black Church pastors support teen pregnancy prevention programs in the church. However public health partners must be willing to compromise and overcome significant obstacles.

Introduction

Adolescent sexual health is a significant public health issue due to high teen birth and sexually transmitted disease (STD) rates. Inconsistencies in contraceptive use, and racial/ethnic disparities have been shown to contribute to these high teen birth and STD rates. Teen parenthood is highly predictive of poverty, resulting in increased medical expenses, high rates of high school dropout, and lower school achievement.[76] Births to black teens have decreased nearly 50% since 2007; Still black teens have the second highest teen birth rate among 15-19 year olds (34.9 per 1000) and highest among 10-14 year olds (0.6 per 1000).[76] In addition, black adolescents (10-19 years) have the highest HIV/AIDS, chlamydia, gonorrhea, and syphilis rates when compared to other racial/ethnic groups.[11] More black high school students (48.5%) have engaged in sex compared to white (39.9%) students.[77] By eighth grade, 20% of all adolescents have engaged in sex.[26] More black adolescents report having engaged in sex before they were 13 years old (8.3%) than Hispanic (5.0%) and white (2.5%) adolescents.[77] Adolescents who have had sex by 13 are at higher risk of becoming pregnant and contracting STDs.[24]

Access to early sexual health education, coupled with increased access to sexual health medical services for adolescents delays the onset of sexual activity, increases use of protection during sex, and reduces the number of lifetime sexual partners, which decreases the likelihood of teen parenthood and STDs.[2,24]

In the black community, religious institutions are important resources for education and programs,[18] and the Black Church is one of the most trusted institutions in the black community.[9] Pastors are trusted to provide not only leadership to the church

about spiritual issues, but also guidance in social, political, economic, and health issues.[5] In the Black Church, senior pastors are gatekeepers, since programming decisions are filtered through them and only implemented with their permission.

Public health practitioners have successfully partnered with the Black Church to provide health promotion interventions that have improved health behaviors and outcomes. Past efforts have promoted physical activity, increased nutritional food options at church, and increased fruit and vegetable consumption. These efforts have led to positive health outcomes such as decreased blood pressure, decreased cholesterol, decreased weight, and increased breast self-examination.[5,6] Most research in this area has targeted cardiovascular and cancer related issues, rather than sexual health. Reports of sexual health promotion in the Black Church are limited to HIV/AIDS. Across several studies, black clergy and lay leaders reported a need within their congregations and expressed willingness to implement HIV programs, yet only 11-39% of these congregations implemented some form of HIV education.[38,54-57] The primary barrier was the church's views on sexuality and homosexuality. Many clergy reported that it was most appropriate to teach abstinence only, and discussion of sexual practices such as anal/oral sex and condom use were off limits.[38,54] However, HIV interventions that have been implemented in black churches have resulted in increased HIV knowledge, perceived risk of HIV, self-efficacy in sexual situations, abstinence intentions, and decreased sexual partners.[41,43,44]

While research has documented the Black Church's experiences with HIV education and awareness among adults, little to no research has focused on teen pregnancy and adolescent sexual health. The objective of this qualitative study was to

identify pastors' perceptions of the Black Church's role in promoting adolescent sexual health and preventing teen pregnancy.

Methods

An interview question path was developed based on informational interviews with local community leaders and a literature search of previously conducted sexual health interventions in the Black Church. The question path was tested with a local pastor, from a predominately black church, who did not participate in the study. The question path was then revised based on his recommendations.

Purposive sampling was used to recruit senior pastors of predominately black churches.[7] The primary focus was on understanding perceptions of pastors within Methodist and Baptist denominations, since these denominations represent nearly 70% of black churches.[18] However, all pastors of predominantly black churches listed in newspapers serving the black community, phonebooks, and internet were contacted by telephone. Pastors were eligible to participate if they were the senior pastor (male/female) of a predominately Black protestant church located in two large metropolitan areas in the target southwestern state. Seventy-seven pastors were identified and contacted and 31 (40%) agreed to participate.

Interviews lasting approximately 1 hour were audio-recorded and usually took place in the pastor's office. At the end of the interview, pastors were also asked to suggest other senior pastors to contact (snowball sampling). Pastors did not receive incentives to participate in the study because the key informant pastor suggested no incentives be given to pastors because in their role as pastor they are unlikely to need an incentive to participate in a study for a student. Recruitment continued until saturation

was reached, meaning no new ideas were heard during the interviews.[7] Interviews were conducted from September 2014 to July 2015. The University of Oklahoma Institutional Review Board approved all aspects of this study.

Interviews were transcribed verbatim. NVivo (v.11; QSR International) was used for thematic coding. Two researchers (LH, MC) initially created the codebook, and coded 3 transcripts together. After this process, the codebook was revisited and revisions were made according to the initial findings. The two researchers coded the remaining transcripts independently and met to confirm final coding; the team experienced high agreement between coders. The interviews were then analyzed for themes. An a priori limit of 25% was set as the threshold for including a code as a final theme to establish transparency and trustworthiness in theme identification.[65,68,69] After identifying themes, transcripts were reviewed again for disconfirming evidence.[7] Finally, quotes were selected to represent each theme.

Results

Pastor characteristics. A total sample of 31 pastors (19 Baptist, 6 Methodist, and 6 other [Christian Church, Church of Christ, Non-denominational]) were interviewed (see Table 1). A little over half of the pastors were 46-55 years old (54%), most were male (87%), and most served at their church for 10 years or less (67%). Over half of the pastors lead congregations of 200 or less (54%), and most congregations included 50 or fewer adolescents under 18 (60%).

Table 1: Manuscript 1 Pastor Characteristics (n=31)

Characteristic	**No. (%)**
Age	
35 and younger	2 (6%)
36-45	2 (6%)
46-55	17 (54%)
56-65	8 (25%)
66 or older	2 (6%)
Gender	
Male	27 (87%)
Female	4 (12%)
Pastoral Tenure	
0-10 years	21 (67%)
11-20 years	4 (12%)
21-30 years	4 (12%)
31 years or greater	2 (6%)
Denomination	
Baptist	19 (61%)
Methodist	6 (19%)
African Methodist Episcopal	*2 (6%)*
United Methodist	*1 (3%)*
Christian Methodist Episcopal	*3 (10%)*
Disciples of Christ/Christian Church	2 (6%)
Non-denominational	3 (10%)
Church of Christ	1 (3%)

Participant themes. Three themes were identified, with multiple subthemes. Each theme is accompanied by supporting quotes.

Beliefs about the role of the church. Pastors expressed several strong beliefs about the role of the church in teen pregnancy prevention. All pastors expressed that the Black Church should acknowledge teen pregnancy as a problem and address this problem in the black community. However, their beliefs about the role of their church in addressing teen pregnancy varied greatly based on past personal experience with a teen pregnancy, relationships with church leadership, and longevity at their current church. Most said it was the role of the church to address teen pregnancy prevention by partnering with families, but that parents were the primary educators.

Education efforts in the church. The boundaries for the type of sexual health educational content for youth were different for different groups of pastors, which did not fall along conservative or denominational lines. About one-third said the church should only discuss the biblical teachings on abstinence until marriage so young people understand God's expectations. Nearly half said that they would provide a more comprehensive approach, answering all questions and providing any information needed to the young person, including information regarding contraceptive methods. However, these pastors also admitted that addressing biblical and practical principles regarding sex and sexuality put them in a precarious position with their congregation.

> *I think the most important part is that we need to educate our young people um not on the subject of acceptance but on abstinence and I think what has happened is that a lot of, I don't want to say churches but the society has begun to accept this as to say a necessary evil that is going on because kids are wiser now and more interested in things and you have so many other tools available to them now that we didn't have as kids and so now it is more accepted but I think that the church's role it has to get back to educating our kids that this is not an*

acceptable lifestyle and you can be a teen, you can be a Christian you can have fun and not adopt this type of lifestyle. –P12

I think the African American community has to talk about the dilemma of teen pregnancy and talk about teenagers that are having sex outside a marriage. I think we have kind of kept it in the closet and want to pretend that it is not happening but it is happening at a high percentage and it is happening at a younger age than even when I was young and so I think the more we begin to bring it out the closet and begin to talk about it and deal with it and talk about how do we talk to teenagers that if they are going to have sex outside a marriage what type of preventive measures do they use, because you are going to still have some that have it regardless of the Biblical standpoint and so we have to deal with it and be honest about dealing with it. –P13

I do believe we have a role in raising awareness about the scope of the problem. I do believe we have a responsibility to empower parents and teenagers with information about preventing pregnancy and I think we have a responsibility to be honest with parents and teens about sex and sexuality and what we know about how often teens are actually engaged in sexual activity so that we can help even those young people who are engaged in sexual activity to prevent you know not only unwanted or unplanned pregnancies but you know the spreading of sexually transmitted diseases. –P25

Pastors' expectations of parents. Pastors expect parents to be involved in teen pregnancy prevention (e.g. approve of their child's participation, review the curriculum, and offer input). One-third of pastors said the Black Church needs to work alongside families to reduce teen pregnancy, instead of the church dictating the needs of all of the children to parents. Some pastors stated that parents should be included during sexuality education programs/lessons. Separate parent workshops should also be offered to cover their questions and inform them of the information provided to their adolescents.

When I think in the African American church I think more of an overall responsibility so I don't think of just teen pregnancy but I think of the entire development of the whole person and really to deal with the African American teen pregnancy rate you have to deal with the family structure of the church so there should be programs that benefit, edify and build every part of the family not just the teen, but then you have to have ministries of focus on just the teen because as you know they will speak to people outside of the family that they won't speak to other family about the same things. So I think it is a whole approach of edifying and building the entire family unit. –P6

The church has got to work in concert with, with families, parents and I don't know exactly what they're doing in schools, even talk about this now but I've always talked about it from the biblical point of view and, and I, and I would even say it now, ok, I'll say that cause that that's what I do, however, you all are gonna you know you all that are having sex, please, please, please use protection and not necessarily just, I mean, used to be that pregnancy was the worst thing that could happen to you. But now you know you know you have diseases that would actually kill you and that's, that's a concern and in this age in the 21st century where those no stigma attached to buying condoms like it was when I was a young man, I mean, cause I have to go into the pharmacy where I would go pick up my momma's medicine. You know, gal, you get condoms, they give them away. There is no excuse right now. I mean, it's no excuse and so I talk about it. –P10

Pastors' expectations of congregants. One-fourth of pastors expressed that non-parental adults should serve as mentors, or caring role models to young people. A few pastors mentioned specifically that congregants who have experienced teen pregnancy should share their testimony. Pastors said congregants should highlight their mistakes and consequences of teen pregnancy and that they can empathize with adolescents.

One is mentorship. Um we have a lot of parents who are already parents, married parents, or even single parents. Maybe just connecting them up and doing some mentoring and talking with teens about sex and some of those issues I think are really um a part of our teen problems so to speak as far as their pressures and things they have to deal with on a daily basis. So I think if we have more mentorship it would work. - P11

Stay with the scripture. The scripture says that the older women should teach the younger women and if we stay with the scripture will always work that is a theme that we have here stay with what works don't try to invent anything new stay with what works and if we will just stay with the scripture. The scripture says that the older women teach the younger. –P12

Beliefs about obstacles to implementation. Pastors saw the need for teen pregnancy prevention programs, but also saw obstacles to implementation. All pastors perceived social consequences of implementing teen pregnancy prevention programs at their churches, such as congregants and parents who are unhappy with the program and decide to either leave the church or not support the programs. The most consistent

perceived obstacle for pastors and congregants (based on pastors' beliefs) was discussing contraceptives and condoms. Several pastors stated that parents would not like the church to discuss anything related to teen pregnancy.

Pastors' personal obstacles to implementation. Half of the pastors expressed personal reservations about implementing teen pregnancy prevention programs. One-third stated that they were personally uncomfortable discussing condoms and contraceptives. Some pastors stated that parents should teach condom use skills, instead of relying on the church, and it was not the church's place teach this skill. Few pastors feared reactions of parents and congregants that do not want frank conversations about sex with their young people.

> *I think the only thing that makes me uncomfortable is that probably some of the parents reaction and some of the church members not wanting a frank conversation about it and that is probably the only thing that makes me uncomfortable that again that we are in such denial about the topic, that makes me uncomfortable because you, I don't care what church you go to on Sunday, it is in there, whether somebody is pregnant somebody is having sex it is in there. –P13*

> *The only one that I think, I kind of shrink back on is the condom use. Simply because of the church's stance on premarital sex. Now that doesn't mean it doesn't happen, it doesn't mean we don't know it's happening, but you know I kind of shrink back when I look at that to say you know what does that say. I think that is a individual program. If anything, I think that that's a program for parents versus begin a program for the teens. –P20*

> *Um the last two contraceptive methods and condom use um I think it will probably be controversial within a ministry. Personally I believe they need to be taught, as a parent I taught them to my children um but I don't know if I would… I would have to wrestle with that one, because people might say that you are promoting to having sex but you know I think we have to teach our kids everything they need to protect themselves. – P23*

Pastors' perceptions of parental obstacles to implementation. Nearly two-thirds of pastors expressed strong beliefs that parents could be an obstacle to implementation.

Nearly half of these pastors said that parents did not want to have any conversations about sexuality and did not want anyone talking to their children about sexuality at church.

> *A lot of parents believe that if you talk about contraceptives, birth control, you're encouraging them to, you know it's like, well they handing out condoms and I'm sure you've heard that as a lament in a lot of school base sex education program, they go picket. -P14*

> *Uh the parents. Church people and I don't mean any harm by that but church people can be so heavenly, so heavenly consumed that they are not earthly good. You know sometimes we just got to be practical and I think there are some things that if church people got into it, if they were apart of it, they would make it really difficult and uncomfortable to really share. –P16*

> *They don't want they kids hearing about sex at the church, which is the craziest thing 'cause they will sit down and watch movies and sitcom's and TV and have them in a room while they talk about it umm you know but then I want them talking about that in church like God doesn't (laughter) doesn't know or I don't know like God doesn't want us talking about sex. – P1*

Pastors' perceptions of congregational obstacles to implementation. A third of pastors said congregants would say that discussing contraceptives/condoms would be inappropriate in the church. Some pastors stated that congregational opposition to teen pregnancy prevention programs would likely come from middle-aged/older congregants. Some pastors expressed logistical obstacles, stating they would have to find knowledgeable, acceptable facilitators to teach the content, because they do not have congregants to implement teen pregnancy prevention programs.

One-quarter of the pastors stated that they do not foresee any congregational obstacles because of the progressive nature of the congregation. As the leader of the church, if the pastor is committed, congregants would commit to these programs.

> *Contraceptive methods, I'm just picturing a couple of senior saints saying oh, no pastor. –P14*

> *A part of our struggle with sometimes getting volunteers in our congregation is that people don't realize what they have to offer. Or they feel like they have nothing to offer when that's not true. –P3*

> *I really don't think at this particular church we really have any obstacles I think from the foundation we have set forth and also the commitment of the pastor who is the leader of this church and knowing his position that it makes it easier to follow the position of the pastor yea so I don't think we have really any obstacles. –P27*

Pastors' perceptions of adolescent obstacles to implementation. Half of pastors said adolescents would be embarrassed to discuss teen pregnancy prevention with anyone at the church. Pastors said adolescents may feel guilt/judgement if they are already sexually active or worry that discussions would not remain confidential and parents/grandparents would find out.

> *That's what I think their reservations, even if they have experienced sex before you know I don't think, most of them won't, probably not at church, now they will among their peers but I think that's the reservation. That's why I say it's big, it's important for them to understand that and know this is a safe place to share. It's ok, you know. Now how to convey that and get them to share is tough. That's been my experience. –P18*

> *I guess teens you just you never know… I guess sometimes they might not want you to pry into certain areas just in case they get caught or get exposed. You know what I'm saying. So I think that, that would be the reservation that they might have is the potential being caught up into something of being exposed that they were doing something. That would, that would probably be, but I think, but you have to, you have to address it, you have to address it. You have to. –P26*

Beliefs about partnerships. All pastors expressed their willingness to partner with organizations to host programs designed to prevent teen pregnancy, however pastors diverged on which organizations were acceptable partners.

Willing to partner with specific reservations. Over one-third of pastors expressed that while they are open to partnering with agencies to provide sexual health education, there are certain organizations and ideals that would not be appropriate for

their church. Planned Parenthood was the only organization mentioned by name that some pastors said they would not be willing to partner with because they were against abortions and would not partner with an organization that condoned abortions.

One-fourth of pastors stated ideological concerns instead of concerns about specific organizations, such as not partnering with organizations that serve gay/lesbian individuals, provide abortions, or would not allow Biblical teachings to be incorporated in a teen pregnancy prevention program at their church. Pastors stated these ideals do not align with their Biblical teachings and would be in direct conflict with their values.

> *I don't think we could partner with those agencies that promote abortion because that's not where we stand and it would be crushing to refer them to an agency that leads them to that place of abortion and as a church we gave them that avenue so we couldn't necessarily deal with those kinds of agencies and I guess Planned Parenthood is that, I guess I don't know I think they provide that kind of thing. Now am I against contraception no on the front end, but the other opposite end I'm not for abortion. –P4*

> *I wouldn't be opposed to that as long it was within the understanding that we've got to use the gospel in along with it. I don't want a program that is void of the gospel message. Okay meaning the fact that the word of God still has to be prevalent and we have to use it in the training process also. I wouldn't be opposed to that. –P8*

> *Ok so here's the thing. I would love to partner, if in fact they present it from a Christian perspective, ok. So the conflict would be if they want to bring condoms. I can't become the church that gives out condoms but other than that, I would love to. –P9*

Willing to partner, without specific reservations. Over half of pastors expressed they did not believe any specific organizations would be inappropriate partners. Some of these pastors stated they would like to have more sexual health professionals come to the church to teach content related to teen pregnancy prevention to their young people, while others discussed previous experiences with organizations that went well. About a quarter of pastors expressed that they would take each organization and individual on a

case-by-case basis to ensure that organizations' ideals and programs are appropriate for their church.

> *We're always open to hear what programs have to offer. I mean you know and like I think we'll kind of work from that standpoint. We can always sit down and at least engage each other to see what's being offered and talk through it, but I wouldn't say that there is just anybody off hand that we would just say completely no to. –P16*

> *I want to say yes but I want to also know these people you know. I want to know, I would really want to know who these people are before I invite them to come in and spend this time with our kids but that is just the parent in me so yes but I would really want to make sure they are who they say they are. –P29*

> *No I can't think of one group that has a bad reputation that I wouldn't want to deal with no but anything that is brought to my attention, I'm going to ask questions about whether it be the organization or the people if I don't already know about them. I'm going to do some research on them or ask questions so that I can be sure that that's the right or the best person to come. –P2*

Discussion

High teen birth rates among black teens presents an intersecting health issue for public health and the Black Church.[9,76] In the Black Church, congregational vision funnels down from senior pastors and pastor approval is essential for any church-sponsored program.[9,36,51] Public health practitioners have seen success in partnering with the Black Church to target cardiovascular health, cancer, and HIV related issues, typically among adults.[5,6,41,43,44] Based on available literature, it is not apparent that teen pregnancy prevention interventions among adolescent congregants have occurred in this setting. However, pastors in this study were supportive of partnering with professionals to implement teen pregnancy prevention programs. Despite their expressed support there were several broad limitations and roles to consider prior to implementation.

In addition to spirituality, the Black Church has a number of roles within black communities including: bringing communities together and providing

linkages/resources to congregants regarding social issues such as politics, health and health care, voting, criminal justice.[9,18] All the pastors in this study recognized the Black Church's responsibility to acknowledge teen pregnancy as an issue and provide education and resources.[18] Public health professionals must recognize that although pastors acknowledge that addressing teen pregnancy is the Black Church's responsibility, overcoming pastoral and congregational obstacles will need to be a priority prior to implementing any teen pregnancy prevention program.

Pastoral perceived obstacles with parents appeared to be the most likely barrier to implementation of programs while other congregants/adolescents were not perceived to be as big of a barrier. Nearly two-thirds of pastors expressed strong perceived parental obstacles, such as not discussing contraceptives/condoms. Pastoral perceptions of parental obstacles present an opportunity for public health professionals to aid in addressing this barrier. One way to do this would be to include parents along with pastors in the planning process. The parental obstacles presented here are perceived and may or may not be actual obstacles. Instead pastors could report parental obstacles as a way to avoid topics they are personally uncomfortable discussing. An important next step is to obtain information directly from parents to determine the obstacles they perceive and establish an understanding of parental beliefs about the role of the Black Church.

While most pastors saw the need for teen pregnancy prevention program, many also had strong personal reservations about teen pregnancy prevention programs. Several stated personal reservations to discussing contraceptives/condoms, with some expressing that it was the parents' place to discuss contraceptives/condoms instead of

the church. Although some expressed discomfort discussing condoms and fear of parental backlash, a few pastors also said that no topics should be off limits.

Although church leaders in previous studies were interested in providing HIV education and resources, very few had actually implemented programs.[57] Also, interest in HIV education focused on adults, not adolescents. A clear understanding of previous public health and Black Church collaborations to address teen pregnancy was not evident in the literature. However in this study, all pastors expressed willingness to partner with organizations to provide teen pregnancy prevention programs and resources to their congregation. Similar to Black Church leaders expressing HIV education interest with few actually implementing programs, very few pastors in this study had any previous experience with implementing any sexual health programming at their church. Public health practitioners must prepare to bridge the gap from interest in addressing teen pregnancy to actual implementation of programs by overcoming perceived and actual obstacles, along with partnering with pastors and congregants to develop interventions.

All pastors expressed willingness to educate youth about sexual health; yet most also expressed the need to add biblical principles to any curriculum presented in their church. Biblical principles and scriptures that need to be included from the church perspective are different from what is typically included in an evidence-based program from the public health perspective (i.e. medically accurate information regarding the body and sexuality, not including spirituality). Public health professionals need to be aware that this is the expectation of the pastors and prepare to compromise to include biblical scriptures and principles.

This study has several limitations. This study involves a relatively small number of pastors. While efforts were made to recruit from multiple denominations and both male and female pastors, study results may not be representative of all Black Church pastors' views of teen pregnancy prevention programs. There is also no way of knowing if the perceptions of pastors who participated differ from those who did not participate. The study was also limited to two southwest geographic locations. Cultural norms and religious beliefs/practices may vary by region, particularly related to sexual health. Lastly, there is a level of pastoral social vulnerability related to discussing sexual health, which could limit what pastors' said during the interview due to social and financial consequences if people knew which participant they were.

Public Health Implications

Public health entities have successfully partnered with the Black Church to implement programs such as cardiovascular disease and healthy eating habits.[5,6] Yet, partnering to address teen pregnancy prevention has not occurred. While the Black Church may be a traditional, resourceful partner in the black community, it is imperative that public health professionals understand that teen pregnancy cannot be discussed the same way as other topics or discussed the same way as in other venues, such as schools or community centers.

First, public health practitioners must understand and meet the needs of the Black Church. The Black Church has many responsibilities beyond teen pregnancy prevention; understanding pastoral beliefs about the church's role in preventing teen pregnancy, perceived obstacles to implementing teen pregnancy prevention programs, and founded and unfounded perceptions about partnering with outside agencies are all

important to understand prior to implementation. Practitioners must first meet with senior pastors to discuss and address their church's needs and obstacles, then include pastors (and designated leaders) in the planning and implementation of a teen pregnancy prevention program, and modification of evidence-based teen pregnancy prevention programs to include biblical teachings, if necessary. Incorporating biblical teachings and scriptures is not common practice in evidence-based teen pregnancy prevention programs (no current evidence-based program includes this).[78] Incorporating biblical teachings could overcome pastoral obstacles, but also create a complicated issue of determining how to regulate the types of biblical teachings to include and how this information effects program effectiveness.

Pastors are accustomed to having programmatic control in their church. Public health professionals should converse with pastors prior to making any decisions, and designate pastor/designee times to insert biblical teachings. This would allow public health professionals to remain non-biased and non-religious during implementation, which would be particularly important if the program was a federally funded project that did not allow professionals to interject biblical teachings. The fate of the program depends on the inclusion of pastors during the planning and implementation process.

Second, public health practitioners must understand that although the end result to prevent teen pregnancy may be a common goal among all stakeholders (practitioners, pastors, and congregants), the way the result is accomplished is likely not the same. Although grants and organizations may have certain goals and objectives, the Black Church may have other goals and objectives that must first be met. While the health and well-being of congregants may be a part of the church's mission, it may not be the

church's primary mission. Public health professionals must approach conversations with pastors and churches recognizing and respecting the missions and beliefs of the church and find common ground among the practitioner's and church's goals/objectives. Finding this common ground will take considerable time and conversations prior to actual implementation. Although timelines are helpful to practitioners and the church, practitioners must be prepared to be flexible with pastors and congregants and make modifications to schedules as needed.

Lastly, understanding parental expectations and obstacles is a necessary next step. Pastors expressed strong beliefs about parental opposition to teen pregnancy prevention programs, but this should be understood directly from the parents' perspectives. With the pastor's permission, practitioners should host parent meetings, asking specific questions about their support for and reservations about their child participating in a teen pregnancy prevention program.

In sum, teenage pregnancy rates are a major public health disparity in the black community.[17,76] Partnering with black churches provides an opportunity to decrease teen birth rates and reduce health disparities, as long as public health professionals include pastors in the planning and implementation of teen pregnancy prevention programs. Public health practitioners must understand needs, missions, and goals of the Black Church, and expect to overcome pastoral and parental obstacles prior to implementing teen pregnancy prevention programs.

Manuscript 2: Pastors' Opinions of the Black Church's Response to Teen Pregnancy

Abstract

Objective: The objective of this qualitative study was to identify pastors' opinions of the Black Church's response to teen sexual activity and teen pregnancy. **Methods:** Black Church pastors (n=31) in two southwestern US cities participated in semi-structured interviews, September 2014-July 2015. A question path was developed based on literature searches, and interviews with key informants (e.g. leader of local faith initiative). Questions focused on adolescents' readiness to have sex, engage in sexual activity, the church's response to adolescents who become pregnant. Interviews were conducted in community locations, transcribed verbatim, coded using NVivo, and thematically analyzed by investigating the coded transcripts for patterns across codes and participants. Themes identified multiple pastors' beliefs of their church's response to teen sexual activity and pregnancy. Coded transcripts were reviewed again for quotes to represent each theme. **Results:** Four themes were identified, with multiple subthemes. First, pastors' responses to teen sexual activity and teen pregnancy were grounded in the patriarchal Black Church system; most pastors perceive teen pregnancy as a female issue. Second, all pastors would discourage teen sex, but used two different approaches to discuss with adolescents. Third, while many pastors perceived their church congregants' responses to teen pregnancy as loving and supportive, other pastors said congregants were judgmental and insisted on negative consequences for the pregnant/parenting female. Fourth, pastors' opinions of their leadership role and their response shifted when dealing with teen sexual activity to teen pregnancy.

Conclusions: By understanding pastors' beliefs regarding teen sexual activity, pregnancy, and balancing pastors' beliefs and social consequences, public health practitioners will have a deeper understanding of how to discuss adolescent sexual health in predominately black churches.

Introduction

Teen parenthood is one of the quickest pathways to poverty.[76] Teen parents have higher rates of high school dropout, lower school achievement, and increased medical expenses compared to non-parenting teenagers.[76]

Although there has been a historic 60% decline in teen births since 1991, the United States still has the highest teen birth rate (22.3 per 1000 15-19 year olds) of any industrialized nation.[79] Furthermore, despite these reported declines, racial/ethnic disparities persist, with high teen birth rates in the black community (black: 34.9 per 1000; white: 21.3 per 1000).[77] Since 2007, births to black teens have declined almost 50%; however, among 15-19 year olds, black teens still have the second highest teen birth rate (34.9 per 1000), compared to other racial/ethnic groups: Hispanic (34.9 per 1000), Asian/Pacific Islander (6.9 per 1000), Non-Hispanic White (21.3 per 1000), and American Indian/Alaska Native (25.7 per 1000).[21,76] Based on the 2015 Youth Risk Behavior Surveillance Survey, 8% of black youth report having sexual intercourse before the age of 13, 31% of black high school students have had sex by the 9th grade and 63% of all black high school students have ever had sex by the end of high school, more than any other racial/ethnic group.[77] Consequently, black teens are disproportionately more likely to be at risk of early sexual debut, early pregnancy, and sexually transmitted diseases.[24,77]

Sexually active black adolescents are at an increased risk of pregnancy, high number of lifetime sexual partners than black adolescents who choose not have sex; they are also less likely to use protection.[24] Comprehensive adolescent sexual health interventions delay the onset of sexual activity, increase the likelihood of using protection during sex, and reduce the number of lifetime sexual partners, which all decrease the likelihood of teen pregnancy.[2,24] Additional comprehensive adolescent sexual health interventions in the black community could help to reduce the disproportionately high rates of sexual acitivity and teen pregnancy among black adolescents. To reach large groups of black adolescents, public health practitioners need to partner with trusted institutions in the black community.

Religious institutions are important, trusted resources for education and health promotion interventions in the black community.[18] The "Black Church" is a term used to describe an institution of heterogeneous predominately black Protestant churches, which includes Baptist, Methodist, and Pentecostal denominations.[52] The historically black Protestant institution has largely been shaped by experiences related to slavery and segregation, which places those belonging to the Black Church institution in a unique category, not similar to other racial/ethnic groups.[53,80] Pastors are trusted to lead Black Church congregants through spiritual, emotional, social, political, and health concerns and provide clear instruction on how to handle such concerns. [5] Pastors of black churches are in unique positions, different from any other role in American culture. They have the unique responsibility of guiding a congregation, holding true to traditional religious beliefs and values, while also standing up and speaking out against discrimination and marginalization of the black community.[66] In black churches,

decisions to provide educational programs and health interventions are almost always made by the senior pastor.

In the past, public health practitioners have successfully partnered with the Black Church institution to provide health promotion interventions that have improved health behaviors and outcomes, such as increased physical activity, healthier food options during church events, decreased blood pressure, decreased cholesterol, decreased weight, increased fruit and vegetable consumption, and increased breast self-examination.[5,6] Discussing cardiovascular and cancer related issues are not controversial and do not conflict with biblical teachings. However, sexual health topics could conflict with biblical teachings, such as teaching the use of contraceptive methods among unmarried adolescents rather than solely teaching the biblical stance of abstinence until marriage.

Typically, when addressing sexual health, black churches have focused on HIV education and awareness among adults, rather than pregnancy prevention among adolescents. HIV interventions in black churches have shown promising results: increased HIV knowledge, perceived risk of HIV, self-efficacy in sexual situations, abstinence intentions, and decreased sexual partners.[41,43,44] In previously conducted studies, many black clergy have objected to openly discussing vaginal, anal, and oral sex, bisexuality, and homosexuality in their church due to the stigma associated with discussing these topics, even if they find it necessary to prevent HIV/AIDS; but would allow discussion of abstinence, contraception, and explanation of HIV/AIDS.[37,70] Many black pastors have been supportive of HIV interventions in their church with mainly

adult participants, with restrictions on which topics would be acceptable for their congregation.[37,70]

Shifting the focus from adults to adolescents, and from HIV prevention to teen pregnancy prevention, would be a completely different way of addressing a sexual health issues in the Black Church institution. Discussing teen pregnancy means churches may have to recognize that adolescent congregants are having sex before marriage. Discussions regarding sexual health between clergy or other congregant members and adolescents may result in social consequences for the church, including some congregants disagreeing with leaders that such discussions should take place at all, which could lead to congregants leaving the church or discontinuing to financially support the church. Public health practitioners must understand how to implement teen pregnancy prevention programs in an institution that is rooted in steep, historical, and religious standards. Pastors are instrumental decision makers in implementing teen pregnancy prevention programs, but could pose as barriers if they do not support the program. One way to understand whether they will support implementation is to understand the social pressure they may feel from their congregants, if they decide to implement sexual health programs.

The objective of this qualitative study was to identify pastors' opinions of the Black Church's response to teen sexual activity and teen pregnancy.

Methods

Tool development. Semi-structured, one-on-one interviewed will be conducted to elicit free responses from pastors, understand underlying motives and beliefs. Interview questions were created based on informational interviews with 3 local

community leaders who had experience working with faith-based organizations and a literature search of previously conducted sexual health interventions in black churches. An initial draft of the question path (along with the brief demographic questionnaire) was first tested with a local pastor of a predominately black church who was not a part of the study. The question path was revised based on pastor recommendations, such as not asking pastors too many personal questions such as if they were single and living with a partner (see Appendix B). The University of Oklahoma Institutional Review Board approved this study.

Sampling. Under the supervision of a faculty member with extensive training in qualitative data collection methods, the first author of this study contacted all pastors, and conducted all interviews. Purposive sampling was used to recruit senior pastors of predominately black churches.[7] The purposive sampling method was utilized to recruit participants who would provide information-rich and relevant responses to the interview questions about the Black Church's role in teen pregnancy prevention. All pastors of predominantly black churches (in two target southwester metropolitan areas) listed in newspapers, phonebooks, and the internet serving the black community were contacted by telephone. Inclusion criteria included: (1) senior pastor (male/female) of a predominately black protestant church, (2) church must be in one of two large metropolitan areas in the target southwestern state (see Appendix A). The pastors were screened by utilizing the publically available information listed on the church website and by confirming the name of the senior pastor by phone. Based on advice provided during the key informant pastor interview, pastors were contacted directly by calling the church, rather than indirectly by sending recruitment flyers. The first author called all of

the churches by utilizing the publically available church number. A recruitment script was used to explain the purpose of the study and schedule the interview.

Data collection. Seventy-seven pastors were identified and contacted and 31 agreed to participate (40% participation rate). Pastors were interviewed at a location of their choice, which was most commonly the pastor's office during his/her office hours. Pastors were identified by code number only. Prior to the interview, participants completed the informed consent form and a brief demographic questionnaire. Interviews were audio-recorded and lasted approximately 1 hour. At the end of the interview, pastors were also asked to suggest other senior pastors to contact (snowball sampling), with most pastors providing several pastor and church names. Recruitment continued until saturation was reached, meaning no new ideas were heard.[7] Based on the suggestions of the key informant pastor and the position of the pastor in the church, pastors received no incentives to participate. Interviews were conducted from September 2014 to July 2015.

Data analysis. Interviews were transcribed verbatim and checked for accuracy. NVivo (v.11; QSR International) was used for coding. Codes were ideas that were mentioned in the question path and/or emerged from the participants that centered on the pastor's opinions of their church's response to a teen pregnancy. Two researchers (LH, MC) created the codebook, coded 3 transcripts together, and made revisions to the codebook. The remaining transcripts were independently coded, and afterwards the two researchers met to confirm final coding. Overall, there was a high level of agreement in coding between the researchers, and any differing opinions were discussed until the researchers came to a consensus. The interviews were then analyzed for themes. The

researchers used thematic analysis to investigate the coded transcripts for emerging patterns across codes and participants. To establish transparency and trustworthiness in theme identification, an a priori threshold of 25% was set as the threshold for including a concept as a final theme.[65,68,69] While there is no consensus across qualitative researchers pertaining to any a priori limit, experienced researchers have stressed the importance of selecting a limit prior to data collection.[65] Themes included subthemes which identified multiple pastoral beliefs related to their church's response to teen sexual activity and pregnancy. After identifying themes, transcripts were reviewed again for disconfirming evidence of the themes.[7] Finally, coded transcripts were reviewed again for quotes to represent each theme.

Results

Pastor characteristics. Thirty-one pastors participated in the study (see Table 2). Over half of pastors were between the ages of 46 and 55 (54%), most were male (87%), most served at their church for 10 years or less (67%), and most had congregations with less than 200 congregants (54%) and smaller youth groups with less than 50 children under 18 (60%). The researchers decided not to collect or report too many identifying characteristics about pastors in order to maintain anonymity, reducing the likelihood that anyone could determine pastors' identities.

Table 2: Manuscript 2 Pastor Characteristics (n=31)

Characteristic	**No. (%)**
Age	
45 and younger	4 (13%)
46-55	17 (54%)
56 and older	10 (32%)
Gender	
Male	27 (87%)
Pastoral Tenure	
0-10 years	21 (67%)
11-20 years	4 (12%)
12 or greater	6 (19%)
Denomination	
Baptist	19 (61%)
Methodist	6 (19%)
African Methodist Episcopal	1 (6%)
United Methodist	1 (3%)
Christian Methodist Episcopal	3 (10%)
Disciples of Christ/Christian Church	2 (6%)
Non-denominational	3 (10%)
Church of Christ	1 (3%)
Members	
Less than 200	17 (54%)
200-599	10 (32%)
600 or greater	5 (16%)
Children Under 18 (n=30)	
Less than 50	18 (60%)

50-100	8 (26%)
101-200	2 (7%)
201 or greater	3 (10%)

Participant themes. Four themes were identified, with multiple subthemes. Each theme is accompanied by supporting quotes.

Pastors' response to teen sexual activity and teen pregnancy was grounded in a patriarchal Black Church institution. Most pastors perceive teen pregnancy as a female problem. Pastors focused conversations on leadership and financial responsibility for adolescent males, and purity/self-worth and the devastation of a teen pregnancy for females.

Different messages based on gender. Many pastors framed said they would frame their messages in response to readiness to have sex differently based on the audience (male/female adolescent). Several pastors focused more on the consequences of unprotected sex with the male adolescent and their financial responsibility as a man if those consequences were to occur, such as providing for the partner and child. Some pastors conveyed they would have a "gentle and loving approach" with female adolescents, focusing on the girl's lifelong goals, her self-worth and value of purity, and purpose in life. Pastors directly linked early sex and pregnancy as a deterrent from reaching lifelong goals and fulfilling the pastors' definition of the adolescent's purpose in life to females, which was different from the focus on financial responsibility to provide for a family with male adolescents.

> *Oh yea. I would say more to him than her. Because I still feel, and I still believe and I always casually mention the role of a young man as it relates to how God put us, now you are responsible for her, if she's your girlfriend, it's your role to be the leader, not just to get your desires wanted so I talk to him about that. I*

talk to him about I talk to him about my personal experience as a young man and urges. Nothing wrong with that. It's normal. God designed it that way. And I try to use some illustrative pictures to try to help them really get it. One comes to mind, the fireplace. The fire in the fireplace is safe but if it gets outside the fireplace, it can burn the house down. So the fire is intended to stay in the fireplace.-P18

Um in reality, keep it in your pants. Um there's a responsibility that goes with having sex and you're not ready for that type of responsibility um um mentally, emotionally, uh even age wise, if you're not able to realize that no matter how safe you are that pregnancy can occur, then you're going to be, you can still be a father, you need to wait, you need to wait until you are actually mature to handle that. Um of course you know of course speak to the word of God in regards to that situation that you should just wait until you are married. That's the most responsible way to do it. Yea. –P11

[…] the biblical beliefs, I always say that. That's one of the first things we talk about that and then I talk about the relationship with the boy you know do you love him that much, does he love you that much you know. Do you think about that your body, and how precious it is, do you think he's going to be there? Or is it just for the moment? Does he want to use you for the moment? He loves you, he's saying that right now. But once it's over, will he say that again? Will he be there? I've seen too many cases where all they want is the sex and you need to really seriously think about that you know because once that moment is over you know, he's feeling his libido right now but when it's gone, his testosterone is rising and I say that, when it's gone, when that feeling is over, is he going to be there. You're going to be there, and you don't know what's going to happen and how that's going to impact you. So yea that's what I say. Your biblical beliefs, you know, you need to really take into consideration, the boy's intent, what he's really, you need to really consider that. I know you say I love him and he loves me but you need to really think about will he be there. You need to really think about that. Talk with some other girls and see what happened. There's girls out there that experienced that. Talk to them, you know. – P17

Similar messages with boys and girls. In contrast, fewer pastors said they would share similar messages with boys and girls who told them they were ready to have sex, but the message content across these pastors ranged from using scare tactics to scare adolescents into not having sex to discussing the adolescent's value and responsibility. Most pastors that mentioned they would share the same messages with both boys and

girls stated they would share messages of responsibility and biblical values, regardless of gender.

> *Well same thing, boy or girl. I need to know what brought you to this. Why do you feel you are ready to have sex and with who? –P19*

> *Pretty much the same thing. That you know according to God's Word that we should be married before we be intimate in those types of relationships and then I would talk, I guess with a boy I probably, with both, I would talk about the responsibility that comes with that especially if things don't go the way they anticipate them going, the damage that can be done if the relationships does not work out the way that they think. Just try to educate them more about not doing it and then the consequences that come with it as well. –P2*

> *It may not be as bad but it wouldn't be good either. It would be pretty much the same. Pretty similar. I would tell them the same thing about the Bible, fornication. If I had the chance to do it over knowing what I know now, I would've waited. –P5*

Pastor's response to teen pregnancy directed to the female. In response to a teen pregnancy at their church, most pastors focused their response on the pregnant female, which included messages of support and counsel, resources for the pregnant/parenting female, or criticism about teen sex and that it should not happen again. Nearly half of pastors said their role as the leader of their church was to be a supporter of the adolescent, by loving and counseling a teen girl, encouraging a teen girl that she can still reach her goals, and that God still loves her. Some pastors responded by focusing on non-biblical messages and providing tangible, parenting resources to the parenting teen, such as information about parenting classes and contraceptive methods. However, some pastors said their role as the leader was to convey the burden the pregnancy and having child at an early age will have on the teen's life, condemning having sex prior to marriage and the resulting unplanned pregnancy, and discussing biblical reasons why a teen pregnancy should not occur again after having a child.

Only one pastor specifically mentioned both the pregnant female and teen father in their response to teen pregnancy; in which case both partners were removed from their leadership roles in the church but were also assigned mentors. It was unclear if other teen fathers also attended the same church; however, most conversations about how the teen pregnancy would impact the adolescent's life was geared towards the pregnant teen only.

> *What we could have done collectively other than, if we've had these conversations before, maybe in the back of her mind she could have said you know this is not something I want to do […] Well ok, even if I'm not planning to do it, if something happens and I had this and again I think the responsibility is on both sides but ultimately I mean the responsibility becomes the woman, a woman's issue and preventing her pregnancy you know. Don't trust a guy. –P14*

> *…they wanted to hold a baby shower at the church for her and I told them no, you can't do that here and the reason you couldn't do it is because I don't want to condone what she's doing as good, or right. You can go hold it anywhere else but no you can't hold it here because I don't want to stamp approval to that. She's a baby. She don't need to be doing that but because it's been done I'm not going hold it against her but I'm not going to condone it either. –P8*

Pastors discourage teen sex based on biblical beliefs and complications of sex but used 2 different ways in their approach. When asked what they would say to a teen that said they were ready to have sex, nearly two thirds of pastors said they would discourage adolescents from having sex.

Ask why they are ready, then discourage sex. Nearly half of pastors said they would first respond by *asking* why the teen was ready to have sex. Next they would discourage the teen from having sex by focusing on the complications of sex: having sex and becoming pregnant would deter the teen from accomplishing goals and dreams, sex would result in either the financial responsibility of taking care of a child or the lifelong emotional attachment to the partner after having sex with them. Pastors said

they would want to ask why the teen wants to have sex because they wondered why a teen would mention readiness to have sex to them as the pastor, which could be a sign of a deeper issue such as coercion or sexual abuse.

> *I would ask them the question, why, what makes them think they are ready. And then depending on what they would say, then we would talk about it. –P2*

> *I would ask them to share with me what is the definition of ready that is the first thing I would ask and I would ask them were they ready for the responsibility that sex brings. Are they ready for the emotional attachment the spiritual attachment, the financial responsibility of having a child? –P24*

> *Well baby, how do you know that you're ready? How do you, you're ready to have, well what's causing you to feel that urge of readiness? That you ready to, to really take all that emotion psychologically and to be able to handle that emotion because the difference between women and guys, men or women are different. Where men will hit it and quit it, where women become emotionally attached and want to build something that's not there. Are you ready for that? Are you ready for that? Are you sure that after you give yourself then he doesn't call you anymore and he'll go home, then he has this long belt he put another slash in it as in he's now up to number 25. Are you ready for that? That would be my approach, along with what trying to keep Romans 12 before them. – P26*

Don't ask, just tell. Several of pastors said they would *tell* adolescents that they were not ready to have sex because of the pastors' belief that the Bible instructs people to wait until marriage, and God expects them abstain from sex. After telling the adolescents they are not ready to have sex until they are married, very few of these pastors would ask for reasons why he/she wanted to have sex, while the remaining would not ask questions but would continue to convey that it is more appropriate to wait until marriage.

> *I would tell [them] that they are not. I wouldn't give them any indication that I was okay in it I would tell them that they are not. –P12*

> *You're not ready for the responsibility. You're not ready for that responsibly you know and again sharing them with the big picture, the big picture and how you know uh these things that you're starting to feel now they have a proper place in your life and so then now you are learning about how to manage you*

> *know your emotions and your drives and all those kinds of things like that. This is the part about becoming an adult and so that now that you begin to see and feel those kinds of things, how then do you manage them so they don't manage you. That's important to be able to get them to thinking about those things in that perspective. –P7*

Church's response to a teen pregnancy. Although many pastors perceived their church and themselves to be loving and supportive of adolescents, many other pastors said their congregants were judgmental, shared criticizing comments about the teen pregnancy to other congregants, and the teen pregnancy resulted in negative consequences for adolescents who experience a teen pregnancy within their church.

Over a third of pastors said their congregation was mostly loving and supportive in response to a teen pregnancy, offering to assist the teen parent without criticizing them for having sex before marriage. Some pastors said young adults were the most supportive in their church; some pastors also said they did not agree with the young adult view point, stating that the young adults were too supportive and accepting, which pastors felt condoned/celebrated the teen pregnancy.

In contrast, some pastors said their congregation responded mostly with shame and judgment. Sometimes, pastors knew of shame and judgment due to conversations between other members in the church about the teen, rather than any direct conversations with the pregnant teen or family. Several pastors said older adults were more disapproving and judgmental of teen pregnancy, compared to the more supportive young adults. Several pastors specifically mentioned openly negative consequences that the pregnant teen and/or partner experienced as a result of the pregnancy. Several pastors said the pregnant teen was asked to come to the front of the church to publically confess that she was pregnant and ask the church forgive her for becoming pregnant.

The pregnant teen was also removed from leadership roles and prevented from participating in any activities with the other teens of the church.

> *Embraced her and the baby. In fact every one of them that we've had in here, that's what they've done. And you know I don't know if that's a cultural thing, I think it is more or less for us. We don't throw away our babies. We don't discard our children. We don't care how they come here. Once they get here, we love them and because we think they have the potential to be somebody and that's the way this church is. –P15*

> *She really would not allow me to pastor her because she felt so ashamed and I think the shame came from some of the other members. They made her feel that way and so it basically ended up, I would have to send communication through her aunt and she would respond back to me but she would never respond directly to me. […] I got word that there were members talking about the young lady instead of helping her… -P16*

> *I am trying not to say what I hope happens I am trying to tell you realistically we are taught to love each other. We are taught to love people through that stuff. Now there will be some who will you know ostracize or say ugly things but we are taught that you know all of us are susceptible to that kind of, any father raising daughters is susceptible to that. –P31*

Pastors' responses shift when responding to a teen wanting to have sex compared to responding to a teen pregnancy.

Pastors feel marriage is necessary prior to sexual activity but not after a teen pregnancy. Nearly half of pastors said they would respond to an adolescent's readiness to have sex by telling them the Bible says sex is appropriate only when partners are married. Very few pastors also explained their belief that God has a specific purpose for sex: to create a union between the married couple and to have children.

Although many pastors would encourage adolescents to marry prior to sex, almost all pastors said they would discourage a teen couple from marrying if the female partner is pregnant. Many of these pastors said marriage would complicate the teen couple's relationships further, not solving any problems nor providing a remedy to the

teen pregnancy. They would also not want them to add to their existing stress of taking care of a child by marrying someone they do not love. Several pastors also said they would encourage the couple to concentrate on being parents to their child, rather than marrying at an early age.

> *I would ask them are you ready to be married? And then it's like, I mean here's the thing and not just dismiss it and says well why are ready? I mean do you, I mean you're in love with this person? Well yeah. It's like oh well I mean you know what are you all going to do together? Are you gonna spend the rest of your life with him? And I would impress upon them that that encounter is a life encounter. I mean no matter what you know society says is that you want to look at it as a life encounter so you gonna, this is the person you're choosing to be with for the rest of your life? Ok, alright, so when y'all gonna come for premarital counseling? I would tell them that. –P14*

> *No. Sex doesn't equal love. Sometimes they don't even know why they are just having sex they are just having sex because that is the trend to have sex so it is you know that trend when I was young and they saying well you got to marry her uh huh I wouldn't want to force that on anyone because again sex does not equal true love. That is a decision that if they have to come to it I am not going to force them into it. –P13*

> *Oh hell no, I mean oh no. Huh uh, nope. No need to be miserable for the rest of your life you know you're already gonna have to you know have to take care of this baby and depending on who it is, if it's a man, uh, no, if it's a woman, no, um, no. Absolutely not. That is covenant between you and God. That is a vow and you gone no, absolutely, huh uh. –P30*

Pastors feel education is necessary in response to teen pregnancy, rather than in response to teen sexual activity. Very few pastors said they would want adolescents in their church to have as much information about sex as possible, prior to them engaging in sex. Although several pastors expressed a sense of responsibility for preventing teen sexual activity, pastors either did not know or did not explain how they should discuss delaying sexual activity with the teen, nor did they state how their church should be involved to delay sex.

Although pastors did not know/did not state how they should delay adolescent sex, the majority of pastors recognize that some adolescents in their church are having sex. About half of pastors said adolescents start having sex when they are 14 or younger, while several pastors said adolescents were 15 to 18 years old at first sex. Compared to national estimates (see Table 3) pastors likely overestimated the number of adolescents who actually had sex. While pastors believe adolescents are sexually active, most pastors did not find it necessary to provide sexuality education until a teen pregnancy had already occurred.

Table 3: Pastors' Perceptions of Adolescent Congregants' Age of Thinking about Dating and Age at Initiation of Sexual Intercourse (n=31)

	National Estimate for African American teens	Pastor Estimate of Age 14 or younger	Pastor Estimate of Age 15-18	Don't Know or No Response
Age Thinking about Dating		23 (74%)	2 (6%)	6 (19%)
Age at Initiation of Sexual Intercourse	Sex by 9th grade: 31.4% Sex by 12th grade: 63.3%	15 (48%)	10 (42%)	6 (19%)

However, *after* a teen pregnancy, nearly half of pastors said they should have provided more education and resources directly to the pregnant or parenting teen. Pastors conveyed different focuses for these conversations. A minority focused on biblical messages such as abstaining from sex again until they are married but most pastors focused on non-biblical, practical resource-based messages such as information

about parenting classes and contraceptive methods. This second group of pastors acknowledged they should have provided more information to the pregnant/parenting teen after the teen pregnancy. However, they did not offer (or did not discuss that they would offer) any additional sexual health information to other teens in their church to prevent them from becoming pregnant.

Although half of all pastors focused on providing direct education with the pregnant/parenting adolescent, several other pastors said they should have provided more education and resources to all of the adolescents of their church after a teen pregnancy occurred, rather than focus efforts on the pregnant/parenting teen. Most of these pastors spoke more broadly and vaguely about offering more education to the youth ministry of their church. They did not speak to the specific education they would allow but said it would be appropriate to have additional discussions about teen pregnancy with their adolescents. Also, none of these pastors said they actually provided additional sexual health education to the youth ministry.

> *Okay you have got a thin line. Okay you don't want to condemn her and then you don't want to condone her either. So you have a very very thin line. I believe that it depends on the maturity of a girl, whether not that you allow to communicate with her through her parents, which that is out. What you have to do from that point um develop a program at her age group and she becomes a part of that age group and she will be the only one who has experience and I think that you would use her as a positive tool for the others. –P24*

> *I think one of the things we are going to being that it is there is a current teen pregnancy being taken place, now that we know I think we really going to have to really kind of continue to for lack of better terms kind of cliché, double our efforts to talk with this individual about you know what the circumstances the place of circumstances that they happened, perhaps some more counseling in all of that they recognize, perhaps the mistake let me put it that way they had to be a mistake that they had made and share with them ways preventing that because to my knowledge most clinics and things would provide birth control products and definitely when this person become more so for herself and now her family to utilize these products. –P27*

> *It takes me back to what we've always, we already talked about the church's responsibility, value to kid to show them that we care, and then to prepare the kid. Are we doing that and is it working? It's not in that case. And it's also about the power of the church. You have to think about it, we have the youth here maybe 1.5 hours on Wednesdays an hour or two on Sunday, and then the rest of the week they are left to their own devices of the family, friends, school, so on and so forth so just makes you wonder if those times that we have are powerful enough to hold them through all of that other until they get back next week. –P4*

Discussion

Black adolescents experience disproportionately high rates of early sexual activity and teen births compared to their white adolescent counterparts.[77] Due to high rates of early sexual activity and teen pregnancy, black adolescents are at an increased risk for dealing with consequences of teen pregnancy, including lower school achievement, high school dropout, increased medical expenses, and poverty.[76]

In this study, pastors believe adolescents are sexually active, yet most pastors did not find it necessary to provide sexual health education until a teen pregnancy had already occurred. As one of the most trusted institutions in the black community, the Black Church institution is in a unique position to help reduce teen birth rates among black adolescents by proving sexual health education prior to occurrence of a teen pregnancy.[5,18,66]

Public health agencies and predominately black churches have been successful in improving HIV outcomes with adults.[41,43,44] While pastors have been supportive of HIV prevention interventions with adults as long as they could influence the types of topics discussed, it is not apparent, based on available research, if the same level of support will persist for teen pregnancy prevention interventions.[37,70] In this study, pastors had a reactive rather than proactive/preventive mindset, focusing heavily on

how they would prevent a pregnant/parenting teen from becoming pregnant again and providing parenting resources, rather than providing education to adolescents they suspected were sexually active. There was a shift in what pastors perceived as necessary once a tangible consequence, such as a pregnant teen, was present in their church rather than the nonvisible and uncomfortable issue of early teen sexual activity. The response to the tangible consequence of a teen pregnancy rather than sexual activity illustrates the disconnect between pastors knowing teen pregnancy is a problem and actively addressing teen pregnancy through sexuality education. Pastors appear to favor of tertiary prevention (discussing prevention methods after a teen pregnancy has occurred) rather than primary prevention methods (discussing prevention methods before a teen pregnancy has occurred).

Moreover, most pastors in this study perceive teen pregnancy as more of the female's responsibility rather than the male; female adolescents will have to deal with the heavy burden of caring for a child at a young age. Overall, pastors' responses were grounded in a patriarchal church system that focuses on the leadership and responsibility of the man, and the purity/self-worth and purpose of the female.[66] Even as pastors discussed the financial responsibility of the teen father, they consistently reiterated that females would have to carry the heavier burden of raising the child, rather than the teen father.

In addition, the manner in which most pastors would discuss preventing teen pregnancy with adolescents would focus more on the adolescent's life goals and spiritual value rather than the specific education lessons and public health outcomes addressed in evidence-based public health interventions. This educational approach in

addressing teen pregnancy was very different from the approach of HIV prevention interventions conducted in black churches, which was more skills-based focusing directly on how HIV is transmitted and how someone can prevent the transmission through HIV testing, condom use, knowing the partner's status, and limiting partners.[37,44] Based on pastors' responses, addressing teen pregnancy prevention would preferably be a more indirect, attitudinally-based discussion (such as discussing adolescents' spiritual value) rather than the direct approach used in previous studies addressing HIV prevention (such as preventing HIV by using condoms).

Lastly, pastors preferred to discuss abstaining from sex with adolescents, rather than how to prevent teen pregnancy if sexual activity does continue. This was also a shift from addressing HIV education, as those discussions rarely, if ever, included information on abstaining from sex. HIV prevention messages with adults focus on reducing the risk while sexually active, rather than preventing the sexual activity. Based on this study, it is apparent that pastors expect and want adolescents to remain abstinent as teenagers and until marriage. Pastors would respond to readiness to have sex by either asking why adolescents would want to be sexually active or telling adolescents they do not need to be sexually active due to the consequences. However, based on previous studies related to HIV prevention, pastors do not expect adults to remain abstinent until married, or they acknowledge adults are having sex.[37] In addition, several pastors and/or churches in this study required pregnant/parenting females (and very rarely males) to apologize to the church for the unplanned pregnancy. This same expectation was not apparent as a consequence for adults who were unmarried and pregnant, nor was this discussed in previous studies as a consequence for contracting

HIV.[37] The different expectation levels highlight the difficulty of discussing sexual health with adolescents and the potential contradictory sexual health information that is provided to adolescents compared to adults about waiting to have sex until marriage.

This study has several limitations. Due to the limited geographic location, cultural norms and/or religious practices could be different in this location compared to other regions. This study included a relatively small group of pastors from two southwest geographic locations and is not generalizable to other populations. Although, extensive recruiting was done to recruit both male and female senior pastors from multiple denominations, few female pastors participated, and not all Black Church denominations were presented; thus, study results may not represent all Black Church pastors' beliefs regarding teen sexual activity and teen pregnancy. In addition, due to the sensitive nature of discussing adolescent sexual health, there is no way of knowing if the viewpoints of participants are similar or different from pastors who did not participate in interviews. Lastly, there is a level of social vulnerability related to pastors discussing adolescent sexual health, which may have limited what pastors' said due to both financial and social consequences if their congregants or community members knew their identity.

Public Health Implications

First, public health practitioners must recognize the difficulty of discussing adolescent sexual health in an institution where sex prior to marriage is highly discouraged. Although pastors recognize that some adolescents are having sex, most pastors failed to address reducing sexual activity and teen pregnancy rates publicly. There is a need to bridge the gap from acknowledging that teen sexual activity occurs to

delivering sexual health information that will reduce the risk for teen pregnancy and/or sexually transmitted diseases. Therefore, public health professionals should schedule multiple, one-on-one meetings with senior pastors (and youth pastors/directors and/or other leader) to discuss their reservations about implementation of teen pregnancy prevention programs. Meeting with the pastor privately will alleviate anxiety associated with being challenged/corrected in front of congregants and allow for an open discussion between the practitioner and pastor regarding how information should be conveyed to adolescents. Focus on building relationships with pastors prior to asking about program implementation. In addition to individual meetings, public health practitioners could host community trainings for pastors (and other designated lay leaders) to deliver sexual health information directly to the leaders, answer questions and devise solutions in a group setting, and allow for information sharing across pastors, lay leaders, and practitioners prior to disseminating sexual health information to adolescents. However, practitioners must be aware that there is no guarantee that pastors or lay leaders will be responsive to community trainings. Without any prior relationship building or gate-keepers publicizing the training to local pastors and lay leaders, there may be low participation.

Second, although public health practitioners will not be able to quickly change strongly held patriarchal views of teen pregnancy, practitioners should discuss with pastors in a one-on-one meeting why it is important to share teen pregnancy prevention information with both adolescent females and males. Although the practitioner may not change patriarchal views, he/she could advocate for the instruction of prevention information to both males and females. Practitioners should provide information (i.e.

pamphlet, one-page document) to pastors explaining why male adolescents should be involved in preventing teen pregnancy along with females. Reasons include that gender norms of black male masculinity have created a norm for black male adolescents having sex early, more sexual partners than other racial/ethnic groups, low condom use, placing responsibility on female adolescents to prevent pregnancy, and that impregnating a girl/woman proves his manhood.[81] Practitioners should also say openly to the pastor that these norms are further perpetuated in churches that only focus on preventing pregnancy by discussing ways to prevent pregnancy with adolescent females and only publicly address the pregnant female during a pregnancy rather than the teen father as well. A public health practitioner explaining why prevention information should be provided to both males and females could help to change pastors' opinions that teen pregnancy is mostly a female problem, although it is certainly not a guarantee. After disseminating information to the pastor, allow him/her time to review this information privately; schedule a follow-up meeting with the pastor to discuss his/her response to the information and questions.

In order to convey effective prevention information to adolescents, pastors must first recognize that teen pregnancy involves both males and females, then demonstrate this mindset to adolescents. In order to change the patriarchal nature of discussing teen pregnancy prevention in black churches, the change must happen from the senior pastor down to the congregant. Meeting with the pastor once will likely not change strongly held beliefs. However, public health practitioners should establish relationships with pastors through continuous meetings and information sharing to promote a more holistic

view of teen pregnancy prevention, including the roles of adolescent males and females in preventing pregnancy.

In sum, partnering with the Black Church to implement teen pregnancy prevention programs provides an opportunity to reduce teen birth rates. By knowing pastors responses to teen sexual activity and teen pregnancy, and how to deal with their beliefs and the social consequences, public health practitioners will have a deeper understanding of how to discuss adolescent sexual health, in predominately black churches.

Manuscript 3: Parents' Opinions of the Role of the Black Church Institution in Preventing Teen Pregnancy

Abstract

Objective: Parents are important decision makers in black churches. The objective of this qualitative study was to identify parents' opinions of the Black Church's role in preventing teen pregnancy and promoting healthy teen relationships. **Methods:** Parent members (n=36) of 27 predominately black churches in two southwestern US cities participated in semi-structured interviews from February- June 2017. The question path was developed based on literature searches, key informant interviews, and a previous study with local pastors. Questions focused on parents' knowledge/beliefs about sexuality education, church's role in preventing teen pregnancy, and implementation obstacles. Interviews were conducted in community locations, transcribed verbatim, coded using NVivo, and analyzed for themes by investigating the coded transcripts for patterns across codes and participants. Coded transcripts were reviewed again for quotes to represent each theme. **Results:** Five themes were identified, with multiple subthemes. Most parents said there should be no boundaries on the type of sexuality information shared by their church, but later changed their minds after reviewing a list of potential topics. Parents listed parent-child communication, goals and dreams, and relationships as the most important topics for a teen pregnancy prevention intervention. Parents said the information shared during workshops should be judgement-free and realistic. Parents most often said pastors and/or youth pastors/directors should deliver sexual health information. Parents believed older adults and other parents may oppose teen pregnancy prevention programs. **Conclusions:** By understanding parents' opinions of

teen pregnancy prevention programs, public health practitioners will better understand concerns, be able to modify recruitment and implementation strategies, and utilize parental support to gain buy-in for implementing programs in predominately black churches.

Introduction

Teen parenthood is one of the quickest pathways to poverty, yet one of the most preventable public health concerns.[22,76] Teen parents are more likely to drop out of high school, live in poverty, and have increased medical expenses compared to non-parenting teens; concurrently, the children of teen parents are less prepared for school, more likely to drop out of high school, be incarcerated, have more medical and behavioral complications compared to children of non-teenage parents, and be a teen parent themselves.[10] Moreover, teen childbearing costs taxpayers billions in health care costs.[11,12]

In 2015, teen birth rates fell 8% below the record low set in 2014 (24.2 per 1000) to 22.3 per 1000 females 15-19 years old. This drops represents an overall decline of 64% since 1991.[21] From 2014-2015, teen birth rates declined for all race/ethnic groups: Asian/Pacific Islander (10%), black (9%), white (8%), Hispanic (8%), American Indian/Alaska Native (6%).[21] However, there are still significant racial/ethnic disparities. Teen birth rates remained highest for Hispanic (34.9 per 1000) and black (32 per 1000) females, and lowest for Asian/Pacific Islander (6.9 per 1000), non-Hispanic White (21.3 per 1000), and American Indian/Alaska Native (25.7 per 1000) females.[21] Moreover, more black high school students (48.5%) have engaged in sex compared to white students (39.9%).[77] More black adolescents report having engaged in sex before

they were 13 years old (8.3%), compared to Hispanic (5.0%) and white (2.5%) adolescents.[77] Ideally, to continue the trend of reduction in teen birth rates and reduce racial/ethnic disparities, if adolescents choose to have sex, they would use multiple birth control methods, such as using a condom in tandem with another contraceptive method when sexuality active. Another effective method to reduce the likelihood of pregnancy and/or STDs is abstinence.[22] For decades, comprehensive sexuality education programs have provided prevention information and skills to promote adolescent sexual health. [13] However, many adolescents do not have access to comprehensive sexuality education programs due to lack of parental permission or their geographic location (e.g. living in a more conservative state and/or city in which limited sexuality education programs are implemented).[14] As of March 1, 2016, only 24 states and the District of Columbia required sexuality education and 33 required HIV education to be taught in school settings.[14] However, sexuality education programs can be voluntarily implemented in schools, and public health institutions can partner with other community-based institutions to provide sustainable sexuality education programs to adolescents. In the black community, the most trusted, yet most underutilized community partner is the Black Church.

The "Black Church" is a term used to describe an institution of heterogeneous predominately black Protestant churches, which includes for example Baptist, Methodist, and Pentecostal denominations.[52] Historically black Protestant churches have largely been shaped by experiences related to slavery and segregation, which places those belonging to the Black Church institution in a unique category compared to other racial/ethnic groups.[53,80] The Black Church was a safe haven and central hub for

black Americans and remains a central institution in the black community today.[52] Black churches are important resources for education and programs, with leaders (particularly pastors), trusted to provide leadership and instruction regarding spiritual, social, political, and economic issues to their congregants.[5]

However, it is important for public health institutions to understand the interrelationships between black church congregants, and its leadership, to plan appropriate teen pregnancy prevention interventions. Although public health institutions have successfully partnered with black churches in other health promotion efforts (e.g. increasing fruit and vegetable consumption, increasing breast cancer screening rates), many of these efforts have not been centered on sexual health issues.[5,6] Sexual health issues are different from cardiovascular and cancer related public health issues because topics related to sexual health can be controversial, conflict with biblical teachings, and be an uncomfortable, emotion-provoking topic for parents, adolescents, and other church members. Of the previous studies related to sexual health in the black church, most have focused on HIV prevention efforts with adults and fewer included adolescents; none have included unplanned pregnancy prevention efforts with adolescents.[19,20]

In order to partner with black churches to address teen pregnancy, public health professional must start by understanding the facilitating factors and barriers to gain buy-in from the two most important decision makers in the church: pastors and parents. A previous study focused on pastors' opinions of teen pregnancy prevention, during which pastors said parents would be the most significant barrier to implementing teen

pregnancy prevention programs at their churches because parents would not want their church to discuss sexuality related topics with their adolescents.[82]

There have been a few studies with parents who are members of predominately black churches to understand their opinions of adolescent sexuality education; however, these studies have focused mainly on parents' beliefs of their role as a parent in adolescent sexuality education, not necessarily the role of their church.[62-64] Across these studies, researchers found that parents want to educate their adolescents about sexual health and include religious information in these discussions, however most are ill-prepared and uncomfortable presenting sexual health information. Since these studies focused mainly on parent congregants' opinions of discussing sexual health with their own children, it remains unclear if parents are comfortable with other church members discussing sexual health with their children (and which church members), what type of information should be shared with their children, and if parents believe their church is the appropriate place to discuss teen pregnancy prevention with their child.

The objective of this qualitative study was to identify parents' opinions of the Black Church's role in preventing teen pregnancy and promoting healthy teen relationships.

Methods

Tool development. Initially, researchers determined that focus groups would be the most appropriate data collection method for this study, based on the literature review process and previously conducted studies. Focus group questions were developed based on informal information interviews with local leaders, literature search of previously conducted sexual health interventions in the Black Church that included

parental involvement, and previously conducted interviews with local pastors of predominately black churches. Two brief questionnaires, a demographic and psychographic questionnaire, were also created based on the previously conducted pastor study and literature review.

The demographic questionnaire collected basic demographic information about the parent and the church, e.g. number of adolescents in the home, church denomination, and health programs offered at the church (see Appendices F & H). The demographic questionnaire was administered after completion of the informed consent form and prior to the focus group. The psychographic questionnaire asked questions that focused on understanding barriers and supports of sexuality education in the church related to the parent, clergy, other congregants, and outside forces (see Appendices G & I). The psychographic questionnaire was administered after the focus group. This technique of asking basic demographic questions prior to the focus group and more psychographic questions after the focus group was adapted from a previously conducted study.[75] Asking psychographic questions after the focus group is beneficial in two ways: 1) participants are not inadvertently swayed to answer focus group questions based on the psychographic questions, which could bias their responses and 2) this allows researchers to ask information not covered in the focus group that may shed light on important issues surrounding sexuality education. Disadvantages to asking psychographic questions after the focus group are that 1) participants may be ready to leave or need to leave immediately following the interview or 2) participants may feel the researcher wants a certain response based on the types of questions asked during the focus group and not answer honestly.

An initial draft of the focus group question path (along with both questionnaires) was tested with a parental advisory group composed of five parents who attend predominately black churches (who did not participate in the study). The question path was revised based on parent recommendations. The University of Oklahoma Institutional Review Board approved this study.

After five months of recruiting (e.g. posting flyers in churches and distributing flyers to congregants, running advertisements in local newspapers, posting on Craig's List) for focus groups in the two target metropolitan areas, the researchers decided to change the data collection method to interviews. Over the five month period, only one focus group had been conducted, with four groups rescheduled multiple times without completion. Although parents did not directly say their reason for not participating in focus groups or for cancelling days/hours prior to the focus group, the researchers theorize that parents were not comfortable discussing sexual health content in a group setting, particularly based on the taboo nature of discussing sexual health in the Black Church. Also, based on previously conducted research, discussing more sensitive, emotion-provoking topics (such as sexuality education and safer sex practices) may be best explored in one-on-one settings.[71] Researchers have found that discussing emotion-provoking topics in a group setting may actually promote a bond over shared experiences; however, parents cancelling or no-showing for focus groups shortly in this study demonstrated the importance of discussing emotion-provoking, sensitive topics in a one-on-one setting, rather than focus group.[72,73]

With this change to interviews, the focus group question path was updated, not changing the content asked but changing the way in which questions were asked to be

more appropriate for a one-on-one interview rather than a group discussion (see Appendix C). Demographic and psychographic questionnaires were not changed. The University of Oklahoma Institutional Review Board approved the revisions to this study.

Sampling. The first author was the primary contact for all parents and conducted all interviews; she was supervised by a faculty member with extensive training in qualitative data collection methods. A combination of purposive sampling and snowball sampling was utilized to recruit participants. The purposive sampling method was utilized to recruit parents who would provide information-rich responses to the interview questions about the Black Church's role in teen pregnancy prevention, based on their experiences as parents, members of their churches for numerous years, and relationships with leaders in churches. Recruitment flyers were sent electronically and hand delivered to pastors that participated in the previously conducted pastors' study (and additional recommended pastors), distributed to church congregants, posted on Craig's list, sent via email to predominately black sorority and fraternity alumni email lists. The snowball sampling method was also utilized by asking each parent participant to refer other parents that may also provide information-rich responses that either may be different or similar to their viewpoints.

Once parents contacted the first author to sign up, the first author used a screener to determine eligibility to participate (see Appendix D). Inclusion criteria were: 1) African American, 2) member of a predominately black church in one of the two target metropolitan areas, 3) biological or adoptive parent of an adolescent 11-17 years old that attends the same church, 4) joint or primary custody of child 11-17 years old, 5)

does not hold a paid position in the church, 6) not the pastor, deacon, elder, or youth director of the church. Once eligibility was determined, the interview was scheduled.

Data collection. Fifty-six parents were identified as potential participants, either by calling the first author directly after seeing a recruitment flyer, by referral from another parent participant, or based on previous registration for a focus group. Of those 56, two parents were ineligible to participate based on membership at nondenominational, predominately white churches. Thirty-nine parents agreed and were deemed eligible to participate in an interview. During the interview, two parents were deemed ineligible due to one parent recently changing their membership to a nondenominational, predominately white church and the other disclosing that she was the youth director at her church (which was not disclosed during the screening process). Thirty-seven parents agreed and participated in interviews (66% participation rate)

Parents were interviewed at a public location of their choice, which was most commonly a local restaurant or coffee shop after work. Parents were identified by code number only. Prior to the interview, participants completed the informed consent form and brief demographic questionnaire. Interviews were audio-recorded, lasting on average 40 minutes. At the end of the interview, parents completed the psychographic questionnaire and received a $20 Target gift card. Participants were asked if they would also be willing to contact other parents to inform them of the study and if so if they would be willing to distribute the researcher's information to these parents (snowball sampling). Recruitment continued until saturation was reached, meaning no new ideas were heard.[7] Interviews were conducted from February 2017 to June 2017.

Data analysis. Interviews were transcribed verbatim and checked for accuracy. NVivo (v.11; QSR International) was used for coding. Codes were ideas that were mentioned in the question path and/or emerged from the participants that centered on the parent's opinions of their church's role in preventing teen pregnancy.[65] Two researchers (LH, MC) created the codebook, coded six transcripts together, and made revisions to the codebook. During coding of these six transcripts, a third parent interview was excluded due to the questionable cognitive ability of the parent to answer questions and unusable information shared, leaving 36 parent interviews in the final data analysis process.

Next, the two researchers coded three transcripts independently, met to review coding and clarify any differences in coding. Two additional transcripts were then coded independently to ensure coding was still consistent and to clarify any additional questions; the researchers continued to experience high agreement. At this point, the researchers coded the remaining 26 transcripts. The intercoder reliability for coding was 94.5%. After examination of the transcripts, the researchers felt that there were not substantial differences in responses of the parents of 11-14 year olds compared to parents of 15-17 year olds, so the results were presented together as one group, rather than in separate categories.

The interviews were then analyzed for themes. The researchers used thematic analysis to investigate the coded transcripts for emerging patterns across codes and parent participants.[65] Twenty-five percent was set as the a priori threshold for including a concept as a final theme. Although there is no consensus across qualitative researchers, experienced researchers have recommended setting a threshold is used to

establish transparency and trustworthiness in theme identification.[65,68,69] Themes included subthemes which represented multiple parent beliefs related to their church's role in preventing teen pregnancy and response to teen pregnancy. After identifying themes, transcripts were reviewed again for disconfirming evidence of the themes.[7] Finally, coded transcripts were reviewed again for quotes to represent each theme.

Results

Parent characteristics. Thirty-six parents participated in the study (see Table 4). Sixty-one percent of parents were between the ages of 40 and 49, most were female (94%), and married (58%). Most parents were also college graduates (61%), employed full-time (81%), and have money left over at the end of the month (64%). There were only 2 more parents of 15-17 year olds (n=19) than parents of 11-14 year olds (n=17) included in this study.

Most parents were members of a predominately black Baptist church (67%). Most parents have been members of their church for 11 or more years (66%), attend church multiple times per week (53%), and most said their children attend multiple times per week as well (53%).

There was consistency across both age groups regarding psychographic questions, with slight differences on most questions (Table 5). All parents (across both age groups) said it was important their child learns about sexual health. All parents (both age groups) said they were comfortable talking to their own child(ren) about sexual health information and preventing teen pregnancy. Most parents also said they want to be the main person that teaches their child(ren) about sexual health (89% across both groups). However, most parents (64%) said they were not concerned that their

child is thinking of having sex. Less parents of 15-17 year olds (47%) were concerned that their child was having sex than parents of 11-14 year olds (82%).

Table 4: Manuscript 3 Parent Characteristics (n=36)

Characteristic	**No. (%)**	**Characteristics**	**No. (%)**
Age		**Parent Was a Teen Parent**	
39 and younger	11 (31%)	Yes	9* (25%)
40-49	22 (61%)	No	27 (75%)
50-59	3 (8%)	**Parent Category**	
Gender		Parent of 11-14 year old	17 (47%)
Female	34 (94%)	Parent of 15-17 year old	19 (53%)
Male	2 (6%)	**Denomination**	
Marital Status		Baptist	24 (67%)
Married	21 (58%)	Christian Methodist Episcopal	2 (6%)
Widowed	0	Pentecostal	7 (19%)
Divorced	8 (22%)	Non-denominational	1 (3%)
Separated	1 (3%)	Church of God in Christ	2 (6%)
Never married	6 (17%)	**Frequency of Parent Attendance at Church**	
Highest Level of School		Multiple times per week	19 (53%)
Some high school	1 (3%)	At least once a week	12 (33%)
High school diploma	1 (3%)	Less than once a week	2 (6%)
Technical school	1 (3%)	Less than once a month	3 (8%)
Some college	11 (31%)	**Frequency of Child Attendance at Church**	
College graduate	22 (61%)	Multiple times per week	19 (53%)
Employment Status		At least once a week	13 (36%)
Full-time	29 (81%)	Less than once a week	1 (3%)
Part-time	0	Less than once a month	3 (8%)
Temporary	0	**Years as Member of Church**	

Seasonal	0	0-5 years	6 (17%)
Not currently employed	4 (11%)	6-10 years	6 (17%)
Stay at home mom/homemaker	*2 (6%)*	11-20	12 (33%)
Student	1 (3%)	21 or more	12 (33%)
Financial Status at the End of the Month			
I have enough money left over	23 (64%)		
I have just enough money to get by	8 (22%)		
I still have bills to pay	5 (14%)		

Table 5: Manuscript 3 Parent Psychographics (n=36)

	Parent of 11-14 Year Old (n=17)			*Parent of 15-17 Year Old (n=19)*		
Question	**Yes***	**No**	**Other**	**Yes**	**No**	**Other**
1. It is important that my child learns about sexual heath.	17 (100%)			19 (100%)		
2. Teen pregnancy is a serious health issue.	17 (100%)			17 (89%)	2 (11%)	
3. Teen pregnancy should be a serious concern at my church.	13 (76%)	3 (18%)	1 (6%)	16 (84%)	3 (16%)	
4. Teen pregnancy is a serious concern for my community.	16 (94%)		1 (6%)	15 (79%)	4 (21%)	
5. I am comfortable talking to my child about sexual health information.	17 (100%)			19 (100%)		

6. I want to be the main person that teaches my child about sexual health.	15 (88%)	2 (12%)		17 (89%)	2 (11%)	
7. I am comfortable talking to my child about preventing teen pregnancy.	17 (100%)			19 (100%)		
8. I want my pastor to provide me with information I can use to discuss sexual health with my child.	6 (35%)	11 (65%)		8 (42%)	10 (53%)	1 (5%)
9. I would prefer a church leader to provide my child with sexual health information.	2 (12%)	15 (88%)		3 (16%)	13 (68%)	3 (16%)
10. I would like for my church to discuss only abstinence with my child (excluding contraceptive method information).	5 (29%)	11 (65%)	1 (6%)	4 (21%)	15 (79%)	
11. I would allow my child to participate in an abstinence-only sexuality education program at my church.	10 (59%)	5 (29%)	2 (12%)	13 (68%)	5 (26%)	1 (5%)
12. I would prefer for church leader to discuss both abstinence and contraceptive method information with my child.	14 (82%)	3 (18%)		14 (74%)	4 (21%)	1 (5%)
13. I would allow my child to participate in a comprehensive sexuality education program that discusses abstinence and contraception at my church.	13 (76%)	3 (18%)	1 (6%)	17 (89%)	1 (5%)	1 (5%)
14. I'm concerned that my [11-14 or 15-17 based on the age of the child] year old child may be thinking of having sex.	3 (18%)	14 (82%)		9 (47%)	9 (47%)	1 (5%)

* Number and within age category percentages provided.

Most parents (80%) said teen pregnancy should be a serious concern at their church (parents of 11-14: 75%; parents of 15-17: 84%). However, more than half of parents (58%) did not want their pastor to provide them with sexual health information to discuss with their child(ren) (parents of 11-14: 65%; parents of 15-17: 53%). In

addition, more parents (83%) would allow their child to participate in a comprehensive sexuality education program that included both abstinence and contraceptive methods (parents of 11-14: 76%; parents of 15-17: 89%) compared to an abstinence-only program (64%) that excluded contraceptive method information (parents of 11-14: 59%; parents of 15-17: 68%)

Participant themes. Five themes were identified, with multiple subthemes. Each theme is accompanied by supporting quotes.

Parents' beliefs about the boundaries of their church.

It takes a village. Nearly half of parents said there were no boundaries/limitations on what their church should share with their children to prevent teen pregnancy. When discussing boundaries, many parents discussed their trusting relationship either with the pastor or other members, rather than specific limitations on sexual health content. Parents said there were no limitations because they trusted those working with adolescents of their church to provide appropriate information. Although parents did not explicitly state what was appropriate, these parents did convey a sense of trust that leaders would make appropriate decisions for the adolescents because they have similar values and their church members were like family. Although several parents said they should be informed and provide consent before any sexual health content is provided to their children, parents said once consent was provided, their church should not be limited in the type of sexual health information that is shared.

> *I don't think there should be boundaries. It's just so many things out there. I'm a firm believer. It's not what you say it's how you say it. And I don't believe there should be any boundaries. I believe it should be a conversation because how you gone get to the younger generation if you keep putting boundaries on things. – P22*

I don't feel like there are any boundaries. It takes a village to raise these kids, so there are no boundaries or limits. –P23

Reality strikes. After learning of specific topics (see Appendix J) that could be included in a teen pregnancy prevention program, only six of the 16 parents that originally stated there were no boundaries/limitations on their church maintained this belief. After continued discussion and seeing possible sexual health topics, three parents changed their opinion and said it was not the church's role to discuss any sexual health information with their child; most other parents wanted their church to discuss information to prevent teen pregnancy but wanted to limit the type and how information is shared with their children.

Like I said, I don't think when it comes to that, I don't think anything is not appropriate. It just depends on the way that you bring it out there. I just think it depends on who is giving the information. […] I would have to trust that person. And if I trust that person there shouldn't be nothing- a boundary that you can't talk to my child about. If I trust you I know you're not there to harm my child. –P17

I just don't think that sex… that type of stuff- people need to handle it that type of business with their children in home or in the doctor's office. You know maybe in school because you know like we had the sex education course and that type of stuff, but I just don't think that churches is the place for sex education. That's just my opinion. –P16

Mmmm, I don't think they should share any of that. Just go read what's out of the bible. And the bible does talk somewhat about sexuality, mentions it but I don't think it's something the church should just harp on 24/7. Uh uh. –P12

Parents' beliefs about sexual health information shared in the Black Church institution.

What information should be shared. Without reviewing a list of potential topics or learning in detail what type of information could be shared in a teen pregnancy prevention program, parents already had strong opinions about the type of sexual health

information their church should share with adolescents. Many parents said information should include discussion of sexually transmitted diseases (STDs), with some parents specifically mentioning AIDS. Parents said there was a high prevalence of STDs in the black community, and some STDs are not curable. In addition, several parents said their church should share information about preventing pregnancy and STDs through safer sex practices (including condoms and birth control methods); these parents said they would rather their child have the skills/information necessary to prevent pregnancy and/or STDs than be ill-prepared if they decide to have sex. Lastly, several parents said any information presented by their church should relate to biblical principles, such as what the Bible says about abstaining from sex until marriage and that the body should be treated as a temple/with respect. Of the parents that said their church should discuss abstinence with their child, nearly all of these parents (except one) said it was not realistic to believe adolescents would remain abstinent until marriage so their church should still discuss specific ways to prevent pregnancy and STDs.

> *Well they should share abstinence and uh safe sex and if they do decide to do it you need to practice safe sex because you don't want to be a teen parent at all. So that's what they should, yes. They should have those topics with children. And then maybe they would be a little bit more comfortable because sometimes you can't come to your family and talk about it. -P1*

> *I think they strictly preach abstinence or from what I've heard every time I go. And so, I get it, yes, I certainly don't want my 12 year old to be having sex but I feel she should be armed with knowledge about it um so I would like preliminary conversations about relationships and honesty with your parents and with someone that you trust within the church. –P3*

> *I feel like, um, definitely churches should preach abstinence. Um just based on you know what the bible tells us. However, with our society and how sexualized, I do think that it's important that um the churches don't do what my mother did to me. Um and make the kids feel bad about it because they're living in a different day and time. It's out there, you know, they're going to see things, they're going to be curious about things and I feel like the church should be a*

place where they should be able to come and feel comfortable and get guidance in that area without being made to feel ashamed. –P11

I feel that it should be discussed. So one uh sexually transmitted diseases because they can be passed on in more than one way. But in order to prevent that from happening you need to first be able to identify that whatever is going on is not normal. And what I mean by that is I'm going to say so maybe someone that may have sexually transmitted disease. And let's say if it's orally or whatever you, you need to be cautious of who you interact with and things to that nature. –P18

Most important topics to include. After reviewing a list of potential topics (topics that are most included in evidence-based teen pregnancy prevention programs (see Appendix J) parents selected the three most important topics to include in a teen pregnancy prevention program at their church. This allowed parents to narrow down from their more broad responses regarding information their church should share to specific topics they would most prefer their church share with their child to prevent teen pregnancy. Although there was no explanation by the interviewer of how each topic related to teen pregnancy prevention, the majority of parents explained their opinion about why each of their top three topics was most important to include in a teen pregnancy prevention program at their church and how it related to teen pregnancy prevention. The overwhelming majority of parents selected the first three topics on the list: parent-child communication, goals and dreams, and/or healthy relationships. Parents that selected parent-child communication said if parents and children were able to trust and communicate openly with each other, they would establish a healthy parent-child relationship, allow for conversations regarding teen pregnancy prevention to occur at home, dispel misinformation, and provide correct information regarding pregnancy prevention. Parents that selected goals and dreams said adolescents should focus on their aspirations instead of having sex as teenagers and know that a teen pregnancy

could change their path towards their goals. Lastly, most parents that selected healthy relationships in their top three focused on the importance of teaching adolescents about healthy relationships with a boyfriend/girlfriend (such as what is not healthy or what could be considered abuse, parents/other adults modeling healthy relationships for adolescents, discussing how to communicate with a boyfriend/girlfriend, and building a friendship with a boyfriend/girlfriend first). Several parents that selected healthy relationships said they want their church to teach adolescents how to have healthy relationships with their friends to avoid being peer pressured to have sex, and healthy relationships with parents/other adults to have adults with whom they can discuss sexual health questions.

Because the majority of parents selected the first three topics on the list as the most important to include in a teen pregnancy prevention program at their church, it is important to note that there could be a potential confound based on the topic list order; parents may have selected these topics because they were listed first, and these topics may have seemed appropriate for their church. However, it is also important to recognize parents' responses to questions throughout interview and on the post-interview psychographic questionnaire overall were consistent with their selection of most important topics. For example, parent-child communication was chosen as a top three topic by 70% of parents; after the interview when parents were asked on the psychographic form if they wanted to be the main person that taught their child about sexual health, nearly all parents said yes (see table 5, question 7).

In addition to the first three topics on the list, one-third of parents also selected contraceptive methods/birth control methods in their top three topics that should be

included in a program at their church. These parents said it was important for adolescents to know all their options to prevent unplanned pregnancy whenever they decide to have sex. The selection of contraceptive methods in the top three for a large number of parents was also consistent with more parents selecting they would allow their child to participate in a comprehensive sexuality education program at their church, compared to an abstinence-only sexuality education program at their church (see table 5, questions 11 and 13).

> *The parent child communication I feel like is number one is because if the parent and child have a clear open communication the rest of these topics will be easy to combine. So, if my child feel comfortable enough to me to communicate with… with me with how she's feeling if she's thinking about taking that um necessary step with her partner if she's thinking about sex have questions about if we have a clear open line of communication she's going to come talk to me about it and so she'll talk to me about condom usage um contraceptives all of these things she'll come and talk to me about it. –P10*
>
> *Ok my number 1 is goals and dreams and I chose that because I think if that is a primary focus that will put other things into perspective about how your choices may effect your goals and dreams.-P20*
>
> *And then contraceptive methods definitely want that to be what I consider my number two because we all know with the internet, sexual promiscuity and then because kids think it's all about my appearance and not necessarily their self-image and being confident in them. I think they tend to feel like oh well if they tell me like for instance if a boy is telling my daughter "Oh well you don't need that" if she has all the knowledge that she needs as far as how to protect herself then she will be more confident in who she is and going to say I'm going to make a conscious decision to either use this birth control, this particular method or not even interact as far as sexual promiscuity. –P2*

Some topics should only be discussed between parent and child. Nearly all parents stated several specific topics they would rather discuss with their own children, rather than their church; some topics were on the list of potential topics provided to participants and some topics were not. The most commonly stated topics parents said would be inappropriate were condom use skills, homosexuality, and sexual positions.

One-third of parents said discussing condom use skills in their church would not be appropriate (with many of these same parents also including contraceptive methods) because discussing condoms would condone and encourage sex, rather than prevent it; these parents said their church should be discussing abstinence instead of these prevention methods. Several of these parents also said discussing condoms is an intimate conversation that should only occur between parent and child. This was in contrast to the over 80% of parents that said they would allow their child to participate in a comprehensive sexuality education program at their church, including both abstinence and contraceptive methods. Therefore, it was unclear if parents were not comfortable with perceived program facilitators discussing how to use condoms or if some parents' opinions changed over the course of the interview after exposure to more specific questions and topics.

Several parents also stated that sexual positions should not be discussed because it could also condone sexual behavior and create curiosity for adolescents to want to experiment with these positions. In addition, several parents said homosexuality should not be discussed either because they did not agree with their church's stance on same-sex relationships being wrong, or because they would rather explain homosexuality directly to their own child to avoid any bias in the way the information is presented to them. Lastly, several parents also said it would not be appropriate to discuss if adolescents have had sex, reproduction, or puberty (about the same number of parents for each topic); parents said these topics are personal and may be different from to child to child, and should be discussed between a parent and child, not by church members. Information that is appropriate or relevant for some adolescents in their church may not

be appropriate for others, based on adolescents' previous experiences/exposure to sexuality topics and their maturity level.

> *I just don't feel like it would be my pastor's responsibility or any other youth leader's in the church to try to tell children how to use condoms. Because we're in church. When we're in church, everything correlates to the bible, and this doesn't- the bible doesn't mention these things- the bible wants us to abstain. –P15*

> *Um and that probably goes along with how I feel probably about um homosexuality. Um my thoughts are it's not something that I agree with. It's not something that I think is right. However, it is not for me to judge you on that because I gotta make sure I get myself to heaven. And I won't let that stop me from that. –P12*

> *I wrote sexual positions, that's not important. Um for the group of kids that's in- that's intimate between the two ma- I mean people, you and your mate, in my opinion. Um places where you should have it… shouldn't talk about that, that goes down a different road and I think it creates temptation, it makes- it creates temptations with others people that talk about that. –P13*

Parents' beliefs about how sexual health information should be shared in the Black Church institution. All parents had strong beliefs about how (and if) their church should share sexual health information with their children. Only three parents said it was not the role of the church to provide sexual health information, providing three different explanations for their opinion: 1) church members will gossip/spread information adolescents share, 2) anyone can read what the Bible says about sexuality, and 3) this should strictly be a parent-child conversation; it is too personal for the church. However, among the remaining parents, there were three main ways parents wanted their church to discuss sexual health information with their child. First, one-third of parents said they would want their church to have multiple workshops/classes focused on sexual health information to allow adolescents to have dedicated time and space to discuss information to prevent teen pregnancy with a trusted adult. Second,

many parents said their church should discuss sexual health information in a stigma- and judgement-free way, free of personal opinion (including the appropriate age to have sex and if it is appropriate to have sex before marriage), and full of factual information. Parents said they wanted their children to feel safe and comfortable discussing sexuality information at their own church and not feel judged by past behavior (if adolescents have had sex) or feel that church leaders would judge them for asking questions. Parents also wanted their church to provide realistic sexual health information to adolescents instead of trusting that they will find out trustworthy information from other people (namely friends or school).

> *Probably doing more forums and youth forums or rallies with the kids, you know giving them some place to come and giving them something to think about other than you know…a lot of times when kids are pregnant they have a lot of free-time and sometimes some kids you have to fill their day up… the church can be an alternative. This goes on in the church on this day, have things going on like two to three times a week for them to come and you know participate in. Nothing is full-proof though. –P15*

> *I would like to see more churches move away from that whole stigma you know mouth covering of surprise and you know disappointment and all that, get it-it's not about you. It's not about the child, it's about Christ that's what the church is about. And so it doesn't matter what your opinion is, this is what our job is to be and just acknowledging for that all have sinned and come short you know whatever that means and how that is defined for each and every one of us. We know it is defined for each and every one of us, so provide our children with a safe and loving place, that you know for us acknowledging that's what our goal should be. –P4*

> *[…]Just identifying those that are willing to be real and to be non-judgmental to mentor and pair up with them. […] I think that every church needs to have a safe place and that's a place where kids can just be kids and they can laugh and talk. –P7*

> *I think we need to have real open dialogue for them, like I said earlier. I think we have to be realistic about uh what we, what children face in society and what teenagers face in society, and I think that only comes through open dialogue like real. Not like, like I said do as I say, not as I do. I think we have to have those*

real, tough conversations and allow our children to feel comfortable with talking to us about it […] –P24

Parents' beliefs about who should deliver sexual health information in the Black Church. Overall, all parents said they would be comfortable with church leaders (such as pastors, assistant pastors or ministers, and youth leaders who are adult congregants leading the youth ministry) discussing their selected top three topics with their children. Many parents were more skeptical about allowing *any* church leader to discuss sexual health information; most parents said they would have to trust the person providing this information to their child before allowing them to participate. Some parents explained they would be most comfortable with church leaders that already worked with their children in the church's youth ministry/department or their pastor because of their established relationship with the pastor and their trust in their pastor to convey appropriate information to their children. Based on this explanation, it was not surprising that most parents later said, after being asked which church leader they would be comfortable discussing these topics, they would be most comfortable with either their pastor or youth leader/youth pastor.

However, based on comments and explanations about why pastors would be the chosen leader to discuss teen pregnancy prevention topics, it was observed that many parents selected their pastor not because they wanted them to explain sexual health topics in great detail with their child, but because the pastor is the natural leader of their church and they trusted information presented by the pastor. When discussing pastors, several parents were referring to pastors speaking about sexual health content during sermons rather than a separate teen pregnancy prevention program. Because of their explanations, it remained unclear if parents would truly want their pastor to be the

primary educator during a teen pregnancy prevention program or if they said their pastor as a reflex because he/she is the natural, trusted leader. In addition, on the post-interview survey, most parents said they would *not* want their pastor to provide them with sexual health information to share with their child (see Table 5, question 8). There was a disconnect from general comfort/trust in the pastor as the natural leader of the church and comfort in the pastor to deliver sexual health information to adolescents.

However, when parents referred to either the youth leaders (youth director, youth pastor, or other adult volunteers working with adolescents) parents discussed their comfort with those leaders discussing sexual health topics because of their experience working with adolescents in their church on a consistent basis. Parents said youth leaders have an established relationship with the adolescents. Parents explanations of comfort with youth leaders was more often directly related to established relationships with adolescents and discussion of sexual health topics compared to explanations of comfort with pastors, which was more often related to the pastor being the natural, trusted leader.

Interestingly, three parents who originally said discussing sexual health information was not the role of the church (prior to reviewing a list of potential topics), all said they would be comfortable with specific church leaders discussing their top three most important topics with their child. These parents said they would be comfortable with either the pastor or youth leader/youth pastor discussing their top three topics with their child because of their trust in that leader to provide appropriate information. However, it is important to note that these parents were referring to their comfort with the pastor/youth leader discussing their chosen topics, not all topics on the

list nor did they select any of the more targeted sexual health topics- such as puberty, reproduction, myths and facts about pregnancy, contraceptive methods, or condom use skills. These same three parents also selected they would not allow their child to participate (or were not comfortable answering the question) in neither an abstinence-only nor a comprehensive sexuality education program on the post-interview questionnaire (see Table 5, questions 11 and 13).

> *Like our pastor is so down to earth I would be comfortable with him. –P29*
>
> *My pastor. I would be comfortable with him. […]Um, because I've had conversations before, not about this particular topic but just general conversations. And I know how he communicates and then like on Sundays I know how he is in the pulpit and how he relates to people. You know, he's very down to earth and I feel like he would relate to my daughter on a positive level, you know. I think he would do a good job, I think he would. –P15*
>
> *Um, our youth director, which her name is [youth director name] and she's always engaged in our youth. Their health, education, you know uh spiritually, emotionally she's always there. She really has a true passion for the kids. So I can trust her and trust God that he would lead her to be able to have that discussion with my child and my child is not second guessing. –P18*
>
> *Um, [youth pastor name], that's our youth leader, Pastor [name], he's great with kids and I believe he would do very good with something like this. So I'm going to share it with him and see what he thinks about it. –P1*

Parents' beliefs about opposition to implementing a teen pregnancy prevention program.

Older adults. Nearly 80% of parents identified church members who would be opposed to a teen pregnancy prevention program at their church, with only a few parents saying no one would be opposed. More than half of parents said older members of their church would be opposed. Of the parents who said older members, twice as many said specifically that older women (rather than all older members) because older women were more involved in the operation of the church, had been at their church for

an extended period of time, and would say discussing sexual health would be inappropriate. Of all the parents that said older members (including women and men), parents generally said this opinion was based on assumptions that older members are more conservative, would consider discussion of sexual health as taboo and inappropriate to discuss in the church; parents believed older members would want parents to discuss this at home. For the most part, these beliefs were most not based on previous experiences with these older adults (or previous experiences were not shared).

> *Probably like an older member. You know they still set in their ways. They don't think you should be condoning stuff like that so probably the older members. - P35*

> *Um you know the older people in the church like… they have that mentality that this is something that happens at home, that needs to be taken care of at home. - P29*

> *Probably all them old women sitting on the front rows. The mother boards. Those types of folks would probably have an issue. […] No. They just being old folks in the church and they probably think those discussions shouldn't be had in church. –P16*

Parents. Several participants said other parents would be opposed to a teen pregnancy prevention program because parents have their own set of standards and do not want other people telling their children something different from what they have taught them. One parent based this opinion on a previous attempt to host an adolescent program at her church that included not only sexual health, but also suicide, school dropout, and running away from home; she was met with significant resistance from parents that did not want other people telling their children how to behave and ultimately was unable to implement the program.

> *If anybody, it would be some of the parents of the children and it's because um they think that they're dealing with it on their own by saying don't do it and we'll discuss it later. So, they have their own set of standards and they don't*

want anybody to taint what they already created and I've heard people say, I don't need her to um have any examples of stuff to do. –P7

Probably the parents because [they] don't want anybody telling [their] kids about what uh they need to be doing and if we ask them to lead the subject they would be like yea. It would be the parents. –P27

I probably would. If it you know if it wasn't… cause I you know I do believe that parents should be informed first. And if the parents are not informed first, then yes I would probably not agree with it. –P25

Discussion

Due to high rates of early sexual activity and low rates of contraceptive use, black adolescents experience disproportionately high rates of teen births compared to white adolescents.[21,77] Reducing teen birth rates among black teens is an intersecting health issue for public health and the Black Church, one of the most trusted institutions in the black community.[9,76] Based on available literature, it is not apparent that teen pregnancy prevention interventions among adolescent congregants have occurred in black churches.

In a previous study, Black Church pastors were supportive of partnering with public health professionals to implement teen pregnancy prevention programs; yet explained several broad barriers to consider prior to implementation, one of which was that parents will be the most significant barrier.[82] Interesting, the overwhelming majority of parents in this study said teen pregnancy should be a serious concern at their church and they would allow their child to participate in a comprehensive sexuality education program at their church (that includes information about abstinence and contraceptive methods). Although seemingly supportive, most parents wanted to have control of the dissemination of sexual health information to their children.

Several parents said it was necessary to include biblical principles in a teen pregnancy prevention program at their church. However, fewer parents stated this need than the authors originally expected. Based on previous studies conducted with parent members of black churches, most parents said it was necessary to include biblical principles in any sexual health information they provided to their own children.[62-64] However, strong conclusions cannot be made that parents do or do not require biblical principles. Parents were not asked directly if they would or would not want biblical principles included in a teen pregnancy prevention program. Since most parents did not mention the need for biblical principles (such as waiting until marriage to have sex), this recognizes the importance of building relationships with each Black Church congregation separately.

The overwhelming majority of parents said parent-child communication, goals and dreams, and/or healthy relationships were the most important topics to include in a teen pregnancy prevention program at their church. However, since these topics were the first three on the prepared list provided to parents, it is important to recognize the potential that parents may have simply selected the first three topics they found to be appropriate. These three topics may not actually be the most important topics out of all of the topics on the list. To avoid order effect, each topic could have been provided on notecards and participants could have put the cards in order. Also, the list could have been alphabetized or a different ordering or topics could have been provided to each participant.

Also, it is important to recognize that parents' opinions may change over time. Several parents' opinions appeared to change over the course of the interview. Parents

were exposed to multiple topics and had time to consider sexual health information over the duration of the interview, which may have resulted in a change of opinion by the end. For example, although several parents listed condoms as inappropriate about midway through the interview, the majority of parents said they would allow their child to participate in a comprehensive sexuality education program on the post-interview questionnaire, which included several parents who originally said condoms were off-limits. These inconsistencies likely show that parents may not have strongly established opinions on sexuality education, may not have considered sexuality education being implemented in their church, or may change their opinions over time. Since opinions could change over time, parents within each congregation should be asked about their opinions, including appropriate topics, barriers and supports of sexuality education in their church, immediately prior to potential program implementation.

Next, trust was a major issue for parents. Most of the parents' hesitation regarding the delivery of sexual health information in their church was about their trust/distrust in church leaders (usually the pastor and/or youth pastor/director). Parents who were more trusting that their church leaders would provide appropriate information to their child were more supportive of having teen pregnancy prevention programs. Parents who were less trusting or did not have established relationships with certain leaders were not as supportive of having a teen pregnancy prevention program. This further highlights the importance of understanding each congregation's parents separately, rather than assuming all parents will approve/disapprove of the same information and have the same level of trust/distrust for their church leaders.

Lastly, although pastors in a previous study said parents would be the most significant barrier to implementing teen pregnancy prevention programs in black churches, more than half of parents in this study said older members would cause the most opposition; much fewer parents said other parents would be opposed.[82] This finding raised an interesting point that parents and pastors may have different beliefs about the barriers to implementing teen pregnancy prevention programs at their churches, or may be placing blame on other groups within their church because they are uncomfortable with sexual health programs themselves. Pastors and parents opinions should be shared with each other to ensure that both groups know the true opinions of the other. Both parents and pastors beliefs within a congregation should be considered prior to implementation to ensure that public health practitioners have an accurate understanding of barriers (and supports) to implementation.

This study had several limitations to consider. First, this study involves a relatively small number of parents, and mostly mothers, although significant efforts were made to recruit mothers and fathers. Also, efforts were made to recruit across multiple denominations, although mostly Baptist congregants participated. Study results may not be representative of all black parent congregants of all predominately black churches. Second, this study was limited to two southwest metropolitan areas. Cultural norms and religious practices may be different by region, particularly related to adolescent sexual health. Third, there is a level of social vulnerability. Parents may have limited what they said based on relationships with pastors and other church congregants due to potential social consequences if other congregants knew they were talking negatively about their own church. They also may not want other church leaders to

know their opinions regarding sexual health. Fourth, parents may have provided socially desirable responses; parents may want to be seen as more comfortable with church leaders discussing sexual health with their child than they actually are. Fifth, there is also no way of knowing if opinions of parents who did participate differed from those who not. It is important to consider that there may still be opinions of parents that were not captured by the study.

Public Health Implications

Public health practitioners must spend considerable time establishing relationships and building trust with parents (and other influential decision makers) prior to recruiting for any teen pregnancy prevention program. This can be done several ways.

First, public health practitioners must meet with church decision makers (pastors, youth pastors/directors) to determine what would be appropriate to discuss in that particular church, discuss several curricula with pastors and youth pastors, and designate pastor/designee times to insert biblical teachings within the instruction of the curriculum (which may have to be pre-approved if a local or federal public health agency is governing implementation of the program). None of the current evidence-based curricula include biblical teachings, which was an relevant aspect for parents in the study and pastors in the authors' previous study.[82]

If they gain the support from church decision makers, pastors or youth pastors/directors should inform parents of their approval of the implementation of a teen pregnancy prevention program in their church. Establishing this level of support from the leadership in the church will likely allow for a smoother transition for practitioners

to explain the type of information that can be shared in a teen pregnancy prevention program in a later parent meeting. Although parents are an influential group within the Black Church institution, pastors have ultimate programmatic control of what is implemented in their church. Gaining pastor buy-in first will not only secure pastoral support, but will help to gain parent and other congregant buy-in.

Second, involve parents in the planning process by hosting multiple parent preview nights. Parent preview night could include a detailed discussion of the type of information that would be shared with adolescents of the church and answer any questions parents have about specific content. If possible, public health practitioners could provide parents with 2-3 options for curricula that could be taught to their children; parents could discuss questions and concerns about each curriculum and provide their choice for the program they would want implemented at their church. It was evident in this study that most parents were simply not aware of the type of information that is typically presented in an evidence-based teen pregnancy prevention program. Many of the topics parents listed as inappropriate would not be discussed in an evidence-based teen pregnancy prevention program. Educating parents about specific topics and content that will be presented to their children could help to ease some anxiety about inappropriate information being presented and enlighten parents about the type of information that could be presented to their children, if they approve. However, public health practitioners should be aware that if they ask parents for their opinion and offer them the opportunity to select a curriculum, they should actually use the information provided by parents. If they do not utilize information provided by parents after saying they would, they will hurt their chances of building relationships and trust

with parents before the program is implemented. If practitioners are unable to include parent feedback in the selection of the curriculum, practitioners (alongside pastors and youth pastors/directors) should still explain to parents which curriculum was chosen and why it was chosen.

Third, public health practitioners should consider disseminating the same teen pregnancy prevention information that will be presented to adolescents to the adults. This can be done by either implementing the same curriculum to parents prior to implementation with adolescents or by implementing a parent and adolescent sexuality education program, which includes separate and joint sessions for parents and adolescents. Moreover, by having joint sessions, parents may feel more comfortable discussing topics that some parents said should only be discussed between the parent and child (such as condom use skills) and feel better equipped to have continued conversations with their child(ren) after the intervention is complete. By intentionally including parents in the program, this could likely lead to program buy-in to encourage parents to allow their children to participate in the adolescent-focused intervention. However, it is important to note that none of the approved, evidence-based teen pregnancy prevention programs utilize this parent-child education model, which could be an issue with federally funded programs required to implement programs from the approved program list.[78] Practitioners would need to plan how to integrate parents and pilot-test a modified parent-child program prior to widespread implementation.

In sum, parent members of predominately black churches are influential decision makers when deciding to implement teen pregnancy prevention programs in the Black Church institution. Without parents support and approval, teen pregnancy

prevention programs will not be implemented. By understanding parents' opinions of teen pregnancy prevention programs, public health practitioners will better understand concerns, be able to modify recruitment and implementation strategies, and utilize parental support to gain buy-in for implementing programs in predominately black churches.

Chapter 5: Global Discussion

The Black Church is one of the most trusted institutions in the black community that brings communities together and provides resources to congregants regarding social, emotional, political, criminal justice, health, and spirituality related issues.[9,18] However, sexual health issues have not been as widely addressed as other health-related issues due to conflicting religious beliefs and stigma related to sexuality and the misconceptions related to content discussed in sexuality education programs. Moreover, although teen pregnancy prevention programs may be effective, these programs may not always be appropriate, as designed, to be implemented in predominately black churches. Decision makers within the Black Church institution are in a unique position to influence the design and implementation of teen pregnancy prevention programs. Because of this potential influence, this study aimed to understand the role of the Black Church in adolescent sexuality education, according to two influential decision makers: pastors and parents. This chapter focuses on the global findings, limitations, conclusions, and recommendations for research and practice.

Global Summary of Findings

Overall, findings from these three studies can inform public health professionals who wish to partner with predominately black churches to implement teen pregnancy prevention programs. The results highlight the barriers and supports to program implementation, key personnel, boundaries, and church culture. Several themes emerged from the studies.

Main themes from the pastors were: 1) beliefs about the role of the church, 2) beliefs about obstacles to implementation, 3) beliefs about partnerships, 4) response to

teen sexual activity and teen pregnancy grounded in patriarchal Black Church institution, 5) pastors discouraged teen sex based on biblical beliefs and complications of sex but used 2 different ways in their approach, 6) church's response to teen pregnancy, and 7) pastors' responses shift when dealing with perceptions of sexual activity to responding to a teen pregnancy.

Main themes from the parents were: 1) parents' beliefs about the boundaries of black churches, 2) parents' beliefs about sexual health information shared in black churches, 3) parents' beliefs about how sexual health information should be shared in black churches, 4) parents' beliefs about who should deliver sexual health information in black churches, 5) parents' beliefs about opposition to implementing a teen pregnancy prevention program.

Similarities across Studies

Overall, pastors and parents both recognize the need to prevent teen pregnancy in the black community and the need for predominately black churches to be more involved in teen pregnancy prevention. Very few parents said preventing teen pregnancy was not the role of the Black Church institution. Most pastors and parents said their churches have not implemented sexuality education in their church. However, both groups stated the need and desire for predominately black churches to be more involved in adolescent sexual health.

Moreover, both pastors and parents were supportive of implementation of teen pregnancy prevention programs in their specific churches. Along with the pastor and parent support of teen pregnancy prevention programs was their need to control the dissemination of sexual health information to adolescent congregants. Both pastors and

parents wanted to be actively involved in deciding the type of information, how information would be disseminated, and who would be disseminating information in their church.

Lastly, both pastors and parents were vocal about their personal reservations about having sexuality education programs in their church (and other congregants' reservations as well). Both pastors and parents expressed strong personal reservations about the taboo nature of discussing sexual health in their church and the difficulty with discussing information adolescents need that may conflict with biblical teachings. However, this was not a deterrent from program implementation for either group.

Differences across Studies

Across the studies, there were several notable differences. First, most pastors said parents were the most likely obstacle to teen pregnancy prevention programs being implemented in their churches, compared to other congregants/adolescents. Pastors said parents would be strongly against discussion of contraceptives/condoms. However, parents most often said older adults were the most likely obstacle to teen pregnancy prevention programs being implemented in their churches, stating older congregants were more conservative and would view sexual health as an inappropriate topic to be discussed in the church (although it is unclear if these older adults would actually oppose). Also, although several parents said condom use skills would not be appropriate for their church, nearly 80% of parents said they would allow their child to participate in a comprehensive sexuality education program that included discussion of both abstinence and contraceptives. However, it was unclear if parents were aware that condoms would be included in a contraceptive methods lesson during a comprehensive

sexuality education program; it was also unclear if parents were against actual condom demonstrations but would want the condom discussion to be included in a program.

Second, pastors and parents had differing opinions about discussing abstinence and/or contraceptive methods within a teen pregnancy prevention program at their church. Most pastors wanted to focus on abstinence with adolescents, even after a teen pregnancy had occurred; most pastors did not want to include contraceptive methods in a teen pregnancy prevention program at their church. However, most parents said they wanted their child to participate in a comprehensive program. Pastors may have assumed that parents would not approve of a contraceptive methods discussion or may not want to discuss because it would not coincide with their biblical beliefs of abstinence until marriage. Also, parents may have provided more socially desirable answers, saying they were more comfortable discussing contraceptive methods than they actually were. It would be crucial to discuss these differences with both pastors and pastors together to reconcile potential differences in including biblical beliefs or not.

Third, much fewer parents than pastors stated the need to include biblical principles in a teen pregnancy prevention program. Biblical principles were the foundation of the responses for the pastors, but credible information and trust was the foundation of the responses for the parents. Parents most often wanted to not only focus on what was in the Bible, but also on establishing/building relationships, particularly parent-child relationships and relationships with the person facilitating the program.

Global Limitations

This study has several limitations. First, this study involves a relatively small number of pastors and parents. While efforts were made to recruit from multiple

denominations and both genders, study results may not be representative of all Black Church pastors' and parents' views of teen pregnancy prevention programs. There is also no way of knowing if the perceptions of pastors and parents who participated differ from those who did not participate.

Second, the study was also limited to two southwest geographic locations. Cultural norms and religious beliefs/practices may vary by region, particularly related to sexual health. Also all of the churches in this study were in urban areas. There is no way of knowing if perceptions of pastors and parents in urban areas vary from those of more rural areas. These study results may not be representative of predominately black churches in other geographic areas.

Third, there is a level of social vulnerability related to discussing adolescent sexual health with pastors and parents. Pastors may have limited what they said during the interviews due to social and financial consequences if people knew which participant they were. Parents may have limited what they said based on relationships with pastors and other church congregants due to potential social consequences if other congregants knew they were talking negatively about their own church. They also may not want other church leaders to know their opinions regarding sexual health. Social vulnerability may have influenced the type of responses or the level of detail provided by participants.

Fourth, both pastors and parents may have provided socially desirable answers. Pastors may want to be seen as more comfortable allowing discussions of sexual health in their church than they actually are. Parents may want to be seen as more comfortable allowing church leaders to discuss sexual health with their child than they actually are.

Global Conclusions

In sum, partnering with predominately black churches provides an opportunity to decrease teen birth rates and reduce health disparities, as long as public health professionals include pastors and parents in the planning and implementation of teen pregnancy prevention programs. These studies add to sexual health literature that explores the interrelationship between the Black Church and public health institutions and their roles in preventing teen pregnancy. Findings from these studies have deepened the understanding of both pastor and parent opinions of the role of predominately black churches in preventing teen pregnancy. Multiple identified barriers and supports can work to promote or obstruct implementation of teen pregnancy prevention programs.

These studies had the following conclusions. First, both pastors and parents are influential in the promotion or hindrance of implementing teen pregnancy prevention programs in predominately black churches. Without support of both of these key decision makers, program implementation will not occur. However, support does not end with gaining approval to have a program. Pastors and parents want to be involved in the program development and implementation process as well. In order to involve these key decision makers, public health practitioners will need to consider practical ways to include them, such as hosting parent preview nights to allow parents to review the curriculum.

Second, pastors and parents are not the only key decision makers in the church. Youth pastors/directors and older congregants are other influential members that could either support or hinder the planning and/or implementation process. According to participants, youth pastors/directors are the most likely to be directly involved and

trusted by parents and pastors to be involved with the facilitation of teen pregnancy prevention programs in churches. Moreover, older congregants were named as the second most likely group to be opposed to program implementation; including at least a few older congregants in the planning process could help to foster support among other older congregants.

Third, every predominately black church is not the same. Study findings provided a deeper understanding of both pastors' and parents' beliefs, but these findings should be used as catalysts for additional research and practical application. It is necessary for public health professionals to understand the needs, missions, and goals of each individual church. What is appropriate for one church may not be for another, such as the inclusion/exclusion of contraceptive methods from a teen pregnancy prevention program in that church.

Although there were multiple barriers to implementation, there were multiple supports as well. Partnering with predominately black churches remains an appropriate way to reach a large number of black adolescents and potentially reduce health disparities, as long as the needs of the church are the forefront of the intervention.

Recommendations for Research

This qualitative research study provided a deeper level of understanding and guidance for future research of the Black Church institution's role in adolescent sexual health. Additional qualitative studies are recommended to further understand the complex nature of partnering with predominately black churches to reduce teen pregnancy, with the following qualitative research recommendations:

- Replicate both the pastor and parent studies across the United States to provide comparison data, including both rural and urban churches.
- Conduct focus groups or interviews with youth directors/pastors to understand their perceived role in preventing teen pregnancy and their opinions of the role of their churches.
- Conduct focus groups with adolescents of multiple congregations to learn more about their beliefs about their church's role in preventing teen pregnancy. Based on current research, it is not apparent if adolescents would want church leaders to discuss sexual health information with them.

In addition to qualitative research studies, the following quantitative research studies are also recommended:

- Survey pastors in multiple congregations across the United States to gain a more holistic, generalizable understanding of pastors' opinions of their role and their church's role in preventing teen pregnancy.
- Survey parents in multiple congregations across the United States to gain a more holistic, generalizable understanding of parents' opinions of their church's role in preventing teen pregnancy.
- Survey adolescents in multiple congregations across the United States to understand their opinions about what their churches should do to prevent teen pregnancy, their barriers and supports to implementation.
- Evaluate any existing sexual health curricula being taught in predominately black churches that may not be known to public health practitioners, or on evidence-based curricula lists.

Recommendations for Public Health Practice

Public health institutions should make an intentional effort to partner with decision makers of predominately black churches to implement both appropriate and evidence-based teen pregnancy prevention programs. The following steps are recommended for public health practitioners:

- Prior to meeting with pastors, schedule meetings either with curriculum developers or those responsible for any adaptations to curricula to receive guidance regarding inclusion of biblical principles, through a designated church leader. Know the limitations and opportunities prior to contacting churches.
- Schedule introductory meetings with pastors and youth pastors/directors in local communities to learn more about their church's needs, missions, and values; and to explain the intent for partnering with their church to host a teen pregnancy prevention program.
- Include pastors and youth pastors/directors in the planning and implementation process. Practitioners should explain to pastors and youth pastors/directors the need to utilize evidence-based, medically accurate teen pregnancy prevention curricula to disseminate accurate information to adolescents but also ask for their opinion about which of these curricula may work best for their congregation.
- Allow for inclusion of biblical teachings in curriculum. Although none of the current evidence-based teen pregnancy prevention programs include biblical teachings, both pastors and parents (albeit fewer than pastors) said this was important to them.

- Allow time for pastors and youth pastors/director to review potential curricula options without the public health practitioner present. Decision makers may need some time to review this information with other church leaders or may want to include parents in their decision making process.
- Host parent preview nights. Parents want to be involved in the planning and implementation process and want to know that they can trust those disseminating information to their children. Parent preview nights should atleast allow parents to review and ask any questions pertaining to the curriculum. Address reluctant parents by partnering with trusted church leaders to discuss the curriculum during the preview night. Although all parents may not agree to implementation, partnering with trusted leaders and providing parents with as much information as they need may reduce some of their concerns.
- Train a designated church leader (such as the youth pastor/director) to co-facilitate the program at that church. Allow time for this leader to write down how exactly they would want to insert biblical teachings into the curriculum. This information should be reviewed prior to implementation to allow the practitioner time to consider any conflicting messages that may be provided and how to answer follow-up questions.
- Host community trainings for pastors, youth pastors/directors, parents, and other congregants to learn more about the potential impact of the Black Church in preventing teen pregnancy, answer questions, devise solutions, and recruit for program implementation.

References

1. Hamilton BE, Ventura SJ. Birth rates for U.S. teenagers reach historic historic lows for all age and ethnic groups (NCHS data brief No. 89). *National Center for Health Statistics.* 2012(89).

2. Lindberg LD, Maddow-Zimet I. Consequences of sex education on teen and young adult sexual behaviors and outcomes. *Journal of Adolescent Health* 2012;51:332-338.

3. Catalano RF, Berglund ML, Ryan JM, Lonczak HS, Hawkins JD. Positive youth development in the United States: Research findings on evaluations of positive youth development programs. *The Annals of the American Academy of Political and Social Science* 2004;591:98-124.

4. Gavin LE, Catalano RF, Markham CM. Positive youth development as a strategy to promote adolescent sexual and reproductive health *Journal of Adolescent Health.* 2010;46:S1-S6.

5. Campbell MK, Hudson MA, Resnicow K, Blakeney N, Paxton A, Baskin M. Church-based health promotion interventions: Evidence and lessons learned *Annual Review of Public Health* 2007;28:213-234.

6. DeHaven MJ, Hunter IB, Wilder L, Walton JW, Berry J. Health promotion programs in faith-based organizations: Are they effective? . *Research and Practice* 2004;94(6):1030-1036.

7. Patton M. *Qualitative Research and Evaluation Methods.* Thousand Oaks, CA: Sage 2015.

8. Cherlin AJ. *The Marriage-go-round: The state of marriage and the family in America today.* New York, NY: Alfred A. Knopf; 2009

9. Peterson J, Atwood JR, Yates B. Key elements for church-based health promotion programs: Outcome-based literature review. *Public health nursing.* 2002 19(6):401-411.

10. Centers for Disease Control and Prevention. Improving the lives of young people and strengthening communities by reducing teen pregnancy: At a glance 2011. 2011; http://www.cdc.gov/chronicdisease/resources/publications/aag/teen-preg.htm.

11. Centers for Disease Control and Prevention. Sexually transmitted disease surveillance 2014. 2015.

12. Centers for Disease Control and Prevention. Teen pregnancy in the United States. 2015; http://www.cdc.gov/teenpregnancy/about/index.htm. Accessed June 23, 2015.

13. Kirby D. Effective approaches to reducing adolescent unprotected sex, pregnancy, and childbearing. *Journal of Sex Research.* 2002;39(1):51-57.

14. Guttmacher Institute. State policies in brief: Sex and HIV education 2016; https://www.guttmacher.org/sites/default/files/pdfs/spibs/spib_SE.pdf.

15. Centers for Disease Control and Prevention. Trends in the prevalence of sexual behaviors and HIV testing, National YRBS: 1991-2013. In: Health DoAaS, ed2014.

16. Kohler PK, Manhart LE, Lafferty WE. Abstinence-only education and comprehensive sex education and the initiation of sexual activity and teen pregnancy. *Journal of Adolescent Health.* 2008;42(4):344-351.

17. Hamilton BE, Martin JA, Osterman MJK, Curtin SC, Matthews TJ. Births: Final data for 2014. In: Services USDoHaH, ed. Vol 642015:1-63.

18. PEW Research Center. US public becoming less religious. 2015; http://www.pewforum.org/2015/11/03/u-s-public-becoming-less-religious/.

19. Griffith DM, Picon LC, Campbell B, Allen JO. YOUR Blessed Health: A faith-based CBPR approach to addressing HIV/AIDS among African Americans. *AIDS Education and Prevention* 2010;22(3):203-217.

20. Lightfoot M, Rotheram-Borus MJea. Religious groups as diffusers of HIV anitbody testing and prevention messages. *Journal of Community Psychology* 2001;29(4):459-472.

21. Martin JA, Hamilton BE, Osterman MJK, Driscoll AK, Mathews TJ. Births: Final data for 2015. In: Services USDoHaH, ed. Vol 66. Hyattsvill, MD2017:1-69.

22. Centers for Disease Control and Prevention. Winnable Battles. 2017; https://www.cdc.gov/winnablebattles/index.html. Accessed July 19, 2017.

23. Kirby D. Reflection on two decades of research on teen sexual behavior and pregnancy. *Journal of School Health* 1999;69(3):89-94.

24. Albert B, Brown S, Flanigan C, eds. *14 and younger: The sexual behavior of young adolescents (summary).* Washington, DC: National Campaign to Prevent Teen Pregnancy; 2003.

25. Bolognini M, Plancherel B, Bettschart W, Halfon O. Self-esteem and mental health in early adolescence: Development and gender differences. *Journal of Adolescence.* 1996;19(233-245).

26. Gottfredson DC, Cross A, Wilson D, Rorie M, Connell N. An experimental evaluation of the All Stars prevention curriculum in a community after school setting. *Prevention Science* 2010;11(142-154).

27. Centers for Disease Control and Prevention. Teen pregnancy and United States students In: Health DoAaS, ed. Atlanta, GA 2014

28. Kost K, Henshaw S, Carlin L. U.S. teenage pregnancies,births, and abortions: National and state trends and trends by race and ethnicity. 2010; http://www.guttmacher.org/pubs/USTPtrends.pdf.

29. Wilkinson R, Marmot M. Social determinants of health: The solid facts In: Organization WH, ed. 2nd ed2003.

30. Centers for Disease Control and Prevention. HIV in the United States: At a glance 2015; http://www.cdc.gov/hiv/pdf/statistics_basics_ataglance_factsheet.pdf. Accessed April 26, 2016.

31. Centers for Disease Control and Prevention. Estimated HIV incidence among adults and adolescents in the United States, 2007-2010 HIV Surveillance Supplemental Report 2012. 2012; http://www.cdc.gov/hiv/topics/surveillance/resources/reports/#supplemental. Accessed November 27, 2014.

32. Centers for Disease Control and Prevention. Reported STDs in the United States: 2014 national data for chlamydia, gonorrhea, and syphilis 2015; http://www.cdc.gov/std/stats14/std-trends-508.pdf.

33. Stanger-Hall KF, Hall DW. Abstinence-only education and teen pregnancy rates: Why we need comprehensive sex education in the U.S. *PLOS ONE.* 2011;6(10).

34. Jemmott JB, Jemmott LS, Fong GT. Efficacy of a theory-based abstinence-only intervention over 24 months: A randomized controlled trial with young adolescents *Archives of Pediatrics and Adolescent Medicine* 2010;164(2):152-159.

35. Advocates for Youth. Sexuality education: Building an evidence- and rights-based approach to healthy decision-making 2015; http://www.advocatesforyouth.org/storage/advfy/documents/Factsheets/sexuality-education-2015.pdf.

36. Bopp M, Baruth M, Peterson JA, Webb BL. Leading their flocks to health? Clergy health and the role of clergy in faith-based health promotion interventions. *Family & community health.* 2013;36(3):182-192.

37. Francis SA, Liverpool J. A review of faith-based HIV prevention programs. *Journal of Religion and Health* 2009;48:6-15.

38. Coyne-Beasley T, Schoenbach VJ. The African-American church: A potential forum for adolescent comprehensive sexuality education *Journal of Adolescent Health.* 2000;26:289-294.

39. Doss JR, Vesely SK, Oman RF, et al. A matched case-control study: Investigating the relationship between youth assets and sexual intercourse among 13- to 14-year olds. *Child: Care, Health, and Development.* 2006;33:40-44.

40. Aspy CB, Vesely SK, Tolma E, et al. Youth assets and delayed coitarche across developmental age groups. *Journal of Early Adolescence.* 2010;30(2):277-304.

41. Baldwin JA, Daley E, Brown EJ, et al. Knowledge and perception of STI/HIV risk among rural African-American youth: Lessons learned in a faith-based pilot program. *Journal of HIV/AIDS Prevention in Children & Youth* 2008;9(1):97-114.

42. Marcus MT, Walker T, Swint M, et al. Community-based participatory research to prevent substance abuse and HIV/AIDS in African American adolescents *Journal of Interprofessional Care* 2004;18(4):347-359.

43. Sherr ME, Dyer PM. Evaluating a comprehensive abstinence-based program for minority youth: Comparing church and public school outcomes. *Social Work and Christianity* 2010;37(1):28-44.

44. Wingood GM, Robinson LR, Braxton ND, et al. Comparative effectiveness of a faith-based HIV intervention for African American women: Importance of enhancing religious social capital *American Journal of Public Health* 2013;103(12):2226-2233.

45. Cotton S, Zebracki K, Rosenthal SL, Tsevat J, Drotar D. Religion/spirituality and adolescent health outcomes: a review. *Journal of Adolesent Health* 2006;38:472-480.

46. Smith C, Faris R. Religion and the American adolescent delinquency, risk behaviors, and constructive social activities. *National Study of Youth & Religion.* 2002(1).

47. Rostosky SS, Wilcox BL, Wright MLC, Randall BA. The impact of religiosity on adolescent sexual behavior: A review of the evidence. *Journal of Adolescent Research* 2004;19(6):677-697.

48. Mueller R, Gavin L, Oman RF, et al. Youth assets and sexual risk behavior: Differences between male and female adolescents. *Health Education Behavior* 2010;37(3):343-356.

49. Amadczyk A, Fellson J. Fetal positions: Unraveling the influence of religion on pregnancy resolution *Social Science Quarterly.* 2008;89(1):17-38.

50. Manlove J, Logan C, Moore KA, Ikramulla E. Pathways from family religiosity to adolescent sexual activity and contraceptive use. *Perspectives on Sexual and Reproductive Health* 2008;40(2):105-117.

51. Allen AJ, Davey MP, Davey A. Being examples to the flock: The role of the church leaders and African American families seeking mental health care services. *Contemporary Family Therapy* 2010;32:117-134.

52. PEW Research Center. America's Changing Religious Landscape. 2015; http://www.pewforum.org/2015/05/12/americas-changing-religious-landscape/

53. Taylor RJ, Ellison CG, Chatters LM, Levin JS, Lincoln KD. Mental health services in faith communities: The role of clergy in Black Churches. *Social Work.* 2000;45(1):73-87.

54. Brown EJ, Williams SE. Southern rural African-American faith communities' role in STI/HIV prevention within two countries: An exploration. *Journal of HIV/AIDS & Social Sciences* 2005;4(3):47-62.

55. Cunningham S, Kerrigan D, McNeely C, Ellen J. The role of structure versus individual agency in churches' response to HIV/AIDS: A case study of Baltimore city churches. *Journal of Religion and Health.* 2011;50(2):407-421.

56. Harris AC. Sex, stigma, and the Holy Ghost: The Black church and the construction of AIDS in New York City. *Journal of African American Studies* 2010;14(21):21-43.

57. Stewart JM. Pastor and lay leader perceptions of barriers and supports to HIV ministry maintenance in an African American church *Journal of Religion and Health.* 2014;53:317-325.

58. Mendel P, Derose KP, Werber L, Palar K, Kanouse DE, Mata M. Facilitators and barriers to HIV activities in religious congregations: Perspectives of clergy and lay leaders from a diverse urban sample. *Journal of Religion and Health.* 2014;53:1472-1486.

59. Bettinger JA, Celetano DD, Curriero FC, Adler NE, Millstein SG, Ellen JM. Does parental involvement predict new sexually transmitted diseases in female adolescents? . *Archives of Pediatrics and Adolescent Medicine.* 2004;158:666-670.

60. Blake SM, Simkin L, Ledsky R, Perkins C, Calabrese JM. Effects of a parent-child communications intervention on young adolescents' risk for early onset of sexual intercourse. *Family Planning Perspectives* 2001;33:52-61.

61. DiClemente RJ, Wingood GM, Crosby R, Sionean C, Cobb BK, Harrington K. Parental monitoring: Associations with adolescents' risk behaviors. *Pediatrics* 2001;107:1363-1368.

62. Cornelius JB. The birds, the bees, and the Bible: Single African American mothers' perceptions of a faith-based sexuality education program. *Journal of Cultural Diversity* 2009;16(1):21-25.

63. Cornelius JB, LeGrand S, Jemmott LS. African American Grandfamilies attitudes and feelings about sexual communication: Focus group results. *Journal of the Association of Nurses in AIDS Care.* 2009;20:133-140.

64. Williams T, Pichon LC, Campbell B. Sexual health communication within religious African American families. *Health Communication* 2015;30(4):328-338.

65. Ulin PR, Robinson ET, Tolley EE. *Qualitative methods in public health: A field guide for applied research.* San Francisco, CA Jossey-Bass; 2005.

66. Arnold BM. Shepherding a flock of different fleece: A historical and social analysis of the unique attributes of the African American pastoral caregiver. *Journal of Pastoral Care & Counseling.* 2012;66(2):1-14.

67. Francis SA, Lam WK, Cance JD, Hogan V. What's the 411? Assessing the feasibility of providing African American adolescents that HIV/AIDS prevention education in a faith-based settings. *Journal of Religion and Health.* 2009;48(2):164-177.

68. Cheney MK, Gowin MJ, Wann TF. Marketing practices of vapor store owners. *American Journal of Public Health.* 2015;105(6):16-21.

69. Cheney MK, Mansker J. African American young adult smoking initiation: Identifying intervention points and prevention opportunities. *American Journal of Health Education.* 2014;45:86-96.

70. Coyne-Beasley T, Schoenbach VJ. The African-American church: A potential forum for adolescent comprehensive sexuality education. *Journal of Adolescent Health.* 2000;26:289-294.

71. Overlien C, Aronsson K, Hyden M. The focus group interview as an in-depth method? Young women talking about sexuality *International Journal of Social Research Methodology* 2005;8(4):331-344.

72. Seals BF, Sowell RL, Demi AS, Moneyham L, Cohen L, Guillory J. Falling through the cracks: Social service concerns of women infected with HIV. *Qualitative Health Research.* 1995;5(4):496-515.

73. Agar M, MacDonald J. Focus groups and ethnography *Human Organization* 1995;54(1):78-86.

74. Krueger RA, Casey MA. *Focus groups: A practical guide for applied research* Thousand Oaks, CA: SAGE Publications 2015.

75. John R, Cheney MK. Resistance to influenza vaccination: Psychographis, audience segments, and potential promotions to increase vaccination. *Social Marketing Quarterly.* 2008;12(2):67-90.

76. The National Campaign to Prevent Teen and Unplanned Pregnancy. The Black Church and teen and unplanned pregnancy: What are the facts and why does it matter? 2017; https://thenationalcampaign.org/sites/default/files/resource-supporting-download/the_black_church_and_teen_and_unplanned_pregnancy-what_are_the_facts_and_why_does_it_matter.pdf.

77. Kann L, McManus T, Harris WA, et al. Youth Risk Behavior Surveillance-United States, 2015. *Morbidity and Mortality Weekly Report Surveillance Summaries.* 2016;65(6):1-174.

78. U.S. Department of Health & Human Services. Evidence-based TPP programs. 2017; https://www.hhs.gov/ash/oah/sites/default/files/ebp-table.pdf.

79. Advocates for Youth. *Science and success: Sex education and other programs that work to prevent teen pregnancy, HIV, and sexually transmitted infections (executive summary).* Washington, D.C. 2012.

80. Allen AJ, Davey MP, Davey A. Being examples to the flock: The role of the church leaders and African American families seeking mental health care services. *Contemporary Family Therapy* 2010(32):117-134.

81. Wilchins R. Gender norms and teen pregnancy *Pregnancy Pause Blog.* Vol 2017: The National Campaign to Prevent Teen and Unplanned Pregnancy; 2012.

82. Harris LW, Maness S, Branscum PB, et al. Pastors' perceptions of the Black Church's role in teen pregnancy prevention. 2017.

Appendices

Appendix A: Interview Request Script

Hello, my name is LaNita Harris and I am a doctoral student at the University of Oklahoma. I asked to speak with you today because you are the Pastor of _____. I am interested in learning more about the church's role in promoting healthy teen relationships and preventing teen pregnancy. I'm also interested in learning from Pastors like you about the role of the Pastor in the lives of the youth in the congregation. I am conducting interviews and this interview would take between 45 minutes and 1 hour. This interview is confidential and your name and the name of your church will not be shared with others. I can do the interview when it is convenient for you and in a private location you are comfortable with that is not a private residence. Would you be interested in participating in this interview?

Appendix B: Pastor Interview Question Path

Thank you for agreeing to take part in this discussion about healthy teen relationships and preventing teen pregnancy.

My name is LaNita Harris and I work with the University of Oklahoma.

(If necessary) With me today is _____, who will be assisting me during the session.

We are interested in learning more about the church's role in promoting healthy teen relationships and preventing teen pregnancies. We've asked you to participate today because as the Pastor and leader of your congregation, you have an influential role in the lives of the youth in your congregation, so we want to understand your role in this effort.

I am aware that as pastor, you are prone to promote your church in the best light. However, I want to stress that it is less helpful to me if you paint things in a better light than what they actually are. Everything that you say will remain confidential. When publishing this information, I will not say the city where this study took place, nor will I name churches or pastors. I am interviewing at least 30 people so no one will know who I interviewed and who I did not. No pastor will know for sure if you did or did not participate.

I will report aggregate data (such as large, medium, small church), not personal data. I realize that this is sensitive material. So I appreciate your honesty and willingness to share.

I'm here today to ask questions and listen to you. There are no right or wrong answers. I simply want to hear your point of view.

I would like to record the discussion today because it would be impossible to listen and effectively take notes. I want to be sure I don't miss anything you say. Again no names or personal information will be shared, and the recordings will be deleted after the interview is transcribed. Is this ok with you?

At this time I'd like to ask that you keep your phone on silent and not answer phone calls or text messages during this discussion.

Are you ready to begin?

1. What do you think the African American church should be doing to prevent teen pregnancy?

   Probes:

   - What programs do you know of that are designed to prevent teen pregnancy?
   - How well do teen pregnancy prevention programs in this neighborhood work?
   - Are teen pregnancy prevention programs needed in your congregation?
     - Tell me how you came to that conclusion.

2. Tell me about the types of programs you provide for teens to be successful outside of the church?

   Probes:

   - Do any of these programs include information on healthy relationships?

3. Not everyone has to everything, but everyone can do something. What do you think is the church's "something" that they can do to prevent teen pregnancy?

4. Teen pregnancy prevention programs could include all of the following concepts. Which would you prefer to incorporate in a ministry at your church? (Note: circle all that apply)

   Parent-Child Communication (*this involves educational and interactive components that encourage parents and their children to talk to one another)*

   Goals and Dreams

   Healthy Relationships

   Effective Communication with Romantic Partner (*romantic partner is someone who is in a relationships with someone else)*

   Problem Solving Skills

   Negotiation Skills with Romantic Partner *(how to express concerns confidently with a partner and getting out of uncomfortable situations confidently)*

   Puberty *(lessons on puberty would describe the physical and emotional changes the males and females go through during the pre-teen and teenage years)*

   Reproduction *(this outlines the biological processes necessary to create a baby)*

   Myths and Facts about Pregnancy

   Contraceptive Methods/Birth Control Methods Lesson

   Condom Use Skills *(learning how to properly use a condom)*

   Probes:

   - Tell me about your choices
   - Tell me about church leadership decisions to include some of these topics but not others.
   - Are there any topics that are off limits for you and your congregation?

- Tell me about that.

5. Who do the adolescents of your church look up to?

   Probes:

   - Tell me about that person.
     - What is their role in the church?
   - Would a trusted adult, such as this person, be able to convey messages that help prevent teen pregnancy?

6. At what age do teens at your church start thinking about dating and relationships?

   Probes:

   - Do you think they are mature enough to handle relationships at that time?

7. At what age should teens start receiving education about sexual health and pregnancy prevention?

   Probes:

   - Tell me about that.

8. At what age do you think teens at your church start having sex?

   Probes:

   - Tell me a little about how you came to that conclusion.
   - How does that make you feel?
   - What would you say to a teen that told you they were ready to have sex?
     - Tell me what you would say to a girl
     - Tell me what you would say to a boy

- Has that ever happened to you?
    - Tell me about it
    - Did you have other conversations with the teen about it later?
    - When do you think you are overstepping your bounds?

9. Tell me about a time when a young person in your congregation got pregnant.

   Probes:

   - How did the congregation respond?
   - What did you feel was your role?
   - Were there different responses amongst different groups?
   - What did you think the church needed to do after she gave birth to prevent it from happening again?

10. If a teen got pregnant or got someone else pregnant, would you expect them to marry the partner?

    Probes:

    - Tell me more about that.

11. What would you want to say to the teens of your church to prevent pregnancy?

    Probes:

    - Do you say that now?
        - Tell me what keeps you from saying it.
    - How would you convey your messages to them?
    - Is anything off limits?

12. Are there things you wish you could say to the teens or programs you wish you could have at your church that you have not done because of the feedback from the church?

    Please give me an example of this experience.

    How about another time?

13. Tell me about anything that makes you uncomfortable about this topic.

    Probes:

    - What reservations do you think parents may have about a teen pregnancy prevention program at your church?
    - What reservations would the teens have?
    - What obstacles would someone face if they are trying to gain support for a teen pregnancy prevention program at your church?

14. Do you have any of the following resources necessary to implement a teen pregnancy prevention program?

    Potential program facilitators

    Funds to provide snacks

    Funds to purchase a curriculum (lessons)

    Location to host program

    Capacity to make copies

    TV and DVD player or laptop and projector

    Probes:

- Would you be willing to partner with an agency or individual to host a program designed to promote healthy teen relationships and prevent teen pregnancy?
    - Tell me about why they are acceptable
- Any organizations or individuals that your church would not be willing to partner with?
    - Tell me about that

Is there anything else you would like to share with me today?

Thank you again for agreeing to meet with me and for participating in this discussion.

Appendix C: Parent Interview Question Path

Thank you for agreeing to participate in this discussion about the role of the church in adolescent sexuality education.

My name is LaNita Harris and I am a doctoral student at the University of Oklahoma. I want to learn more about your perceptions of the church's role in promoting healthy teen relationships, sexuality education, and preventing teen pregnancy.

I am here today simply to listen to you provide your perspectives on sexual health and sexuality education in the church. There are no right or wrong answers. So please feel free to share your beliefs and opinions and know that I am listening to you judgement free. Lastly, I will be recording our session today because it would be impossible to write down everything you say and I want to be sure that I capture all of your comments. I will not report any names or personal information that you may share.

I understand that this may be a sensitive topic so I truly appreciate your participation and willingness to share. Before we begin, I'd like to ask that you keep your phone on silent and not answer phone calls or texts during this discussion, as best you can. Ok, let's get started.

Note: Questions listed in bullet points are probes. They will be asked as needed if parents do not address the topic in their answer.

1. Briefly share with me how old you were the first time your parents talked to you sex.
2. *(For those of that had that conversation with their parents before they were 20)* Tell me about that conversation. What information was shared?
    - How old were you when they discussed this with you?

- Please share some of the topics that you discussed.
- Tell us about any misinformation that you heard from your parents.
- What did you want to know that you did not hear from them?

3. *(For those of that did not have that conversation with their parents before they were 20)* How did you find out sexual health information?
    - Who did you hear this information from?
    - What type of information did you hear?
    - Did you hear any misinformation?

Thank you for sharing your experiences. Now I would like to switch topics a bit and ask you about your children.

4. On a scale of 1 to 5, with 1 being very uncomfortable and 5 being very comfortable, how would you rate your comfort level in discussing sexual health topics with your children? Write down your number and the most important 1 to 2 reasons why you picked that number on the index card.
    - Share with me one or two reasons why you picked that number
5. Now let's talk about information discussed in your church. What type of sexuality information should your church share with your children?
    - Have those conversations already happened?
    - If not, tell me why you think those types of conversations have not happened yet.
    - What are the boundaries or limits on what the church should share with your children?

6. Teen pregnancy programs could include many different concepts. If the church were going to have a program such as this, what should they include? I've written a few options here on the sheet of paper in front of you (topics on board: Parent child communication, goals and dreams, healthy relationships, effective communication with a romantic partner, problem solving skills, negotiation skills with a romantic partner, puberty, reproduction, myths and facts about pregnancy, contraceptive methods/birth control methods lesson and condom use skills).
    - Looking at the following list, find your top 3 choices. Write down on the sheet of paper in front of you. Circle your top choice. (pause) Place a check by your second choice, (pause) and now star your third choice.
    - Share with me your choices.
    - How comfortable would you be with a church leader discussing these topics with your child?
    - When answering the previous question, what church leader came to mind, specifically their role in the church?
    - Now draw a line under your top 3 choices. Under that line, list the topics that are not appropriate for the church.
    - Share with me the topics that you consider to be inappropriate for the church to discuss.
    - Which topics are only ok for parents to discuss with their own child?
7. At what age should teens of your church receive sexual health information?
    - What made you come to that conclusion?

- At what age do teens of your church start thinking about dating and relationships?
- At what age do you think teens at your church start having sex?

8. Has there been a teen pregnancy at your church?
    - How did the church respond?
9. What do you think the African American church should be doing to prevent teen pregnancy?
    - What influence does the church have in the information you choose to share with your children?
10. If it were up to you, what would you suggest that church leaders say to the teens of your church to prevent pregnancy?
11. Who would you go to first in your church if you want to have a teen pregnancy prevention program?
    - Who would throw up road blocks to having a teen pregnancy prevention program?
12. *(Note: Question only for parents of 15-17 year olds)* What advice would you give a parent of an 11 to 14 year old child related to conversations they have with their children about preventing teen pregnancy?
    - How have your beliefs related to sexuality education changed since your child was 11 to 14 years old?
13. Are there any other topics we should have talked about today but did not?
    - How would you answer that?
14. Of all the topics we discussed today, which is the most important to you?

15. Suppose you had one minute to talk to your pastor about teen pregnancy prevention, what would you say?

Thank you all for participating in this discussion today. The information you all provided was meaningful and enlightening. Have a wonderful evening.

Appendix D: Parent Interview Screener

Hello_____, my name is LaNita Harris and I am a doctoral student at the University of Oklahoma. Thank you for calling to sign up for the interview. I appreciate your flexibility. I am conducting interviews with parents like you to learn more about the role of the church in preventing teen pregnancy and promoting healthy teen relationships. I just have a few questions for you to see if you are eligible for the study. Please pardon these questions; I simply need to be sure the people included in the study are the primary decision makers for their child.

1. Please state the race with which you most identify?
    - If not African American: This study is specific to African American parents that are members of predominately African American churches. May I please keep your contact information and contact you should I have conduct additional studies with parents?
    - Please share with me how you heard about this study.
2. Where do you go to church?
3. What is the denomination of your church?
4. What race represents the majority of members in your church?
5. How did you hear about the study?
6. Are you the biological parent of an 11-17 year old that lives with you?
    - If no: are you the adoptive parent?
    - If yes to adoptive parent: how long has your 11-17 year old child been living with you?
    - Are you the grandparent of the 11-17 year old?

7. Does your child attend the same church as you?
    - How often do you and your child attend church?
    - Parent and child must attend church at least once per month. If not, parent will be excluded from the study.
8. Do you hold a paid position and/or leadership position in your church?
    - If yes, ask which position?
    - If a pastor, deacon, elder, or youth director cannot participate in the study because their perceptions should be included in a separate leader's study
9. What is your home address?
10. What is your cell phone number?
11. The interview will last approximately 1 hour and can take place at a time when we are both available. Is there a public location where you would feel comfortable meeting for the interview?

Thank you again for your interest in the study. I will send you a follow-up text or email with confirmation of the interview. Do you have an email address you can share with me? I look forward to meeting you. Your insights will be greatly appreciated.

Appendix E: Pastor Demographic Sheet

What is your age? _____

Are you ☐ male ☐ female

Are you: ☐ Single ☐ Married

☐ Divorced/Separated

# of children under 18 living at home with you _____ **OR** ☐ **none**

How far did you go in school?
- ☐ Did not finish high school
- ☐ High school graduate
- ☐ Technical school or some college
- ☐ College degree or higher

Where?_____

☐ I am still in school

Where?_____

I work as a Pastor:

☐ Full-time ☐ Part-time _____ hours a week

How long have you served as Pastor of this church? _____

On average, how many congregation members do you have?

- ☐ Less than 200
- ☐ 200-399
- ☐ 400-599
- ☐ 600-799
- ☐ 800-999
- ☐ 1000 or greater

Approximately how many children under 18 attend your church? _____

Approximately how many children 11-14 attend your church?

Which of the following activities do you have for children youth 11-14 years old?
- ☐ Bible Study
- ☐ Children's church apart from the traditional morning worship service
- ☐ Summer Camp
- ☐ Sunday School
- ☐ Vacation Bible School
- ☐ Youth and Children's Ministry
- ☐ Youth Retreat

How often does your church have events outside of the regular weekly worship service on Sunday mornings and weekly Bible Study?

☐ at least once a week ☐ less than once a week

☐ Less than once a month ☐ Almost never

What is your church's average monthly income?
- ☐ Less than $16,000
- ☐ $16,000-$32,000
- ☐ $32,001-$48,000
- ☐ $48,001-64,000
- ☐ $64,001-$80,000
- ☐ Greater than $80,000

Which of the following health and wellness activities do you have at your church?
- ☐ Blood pressure screenings
- ☐ Health fairs
- ☐ Blood drives
- ☐ Seminars
- ☐ Workshops

Do your health and wellness activities ever focus on teens?

☐ Yes ☐ No

If yes, what kinds of activities?

_____

Appendix F: Parents of 11-14 Year Olds Demographic Sheet

What is your gender? _____

What is your age? _____

What is your race/ethnicity? _____

What is your marital status?
- ☐ Married
- ☐ Widowed
- ☐ Divorced
- ☐ Separated
- ☐ Never married

# of children living at home with you
_____ # under 18
_____ # 11-14 years old

How old are your children? _____

What is the gender of your 15-17 year old?
- ☐ Boy
- ☐ Girl

What is your relationship to the 11-14 year old that lives with you?

_____

Were you a teen parent?
- ☐ Yes
- ☐ No

Is your 11-14 year old sexually active?
- ☐ Yes
- ☐ No

Has your 11-14 year old been teen parents?
- ☐ Yes
- ☐ No

What is the highest level of school you have completed?
- ☐ Some High School
- ☐ High School Diploma or GED
- ☐ Technical School
- ☐ Some College

Where? _____
- ☐ College Graduate

Where? _____

What is your current employment status?
- ☐ Employed Full-Time
- ☐ Employed Part-Time
- ☐ Employed Temporary
- ☐ Employed Seasonal
- ☐ Not Currently Employed
- ☐ Student
- ☐ Other _____

At the end of the month which of the following best describes your situation?
- ☐ I have money left over
- ☐ I have just enough money to get by
- ☐ I still have bills to pay

What denomination is your church?
- ☐ Baptist
- ☐ Methodist
- ☐ Other _____

How often do you attend church?
- ☐ Multiple times per week
- ☐ At least once a week
- ☐ Less than once a week
- ☐ Less than once a month
- ☐ Almost never

How long have you been a member of your church?

_____

How often does your 11 to 14 year old child attend church?
- ☐ Multiple times per week
- ☐ At least once a week
- ☐ Less than once a week
- ☐ Less than once a month
- ☐ Almost never

Which of the following does your church have for youth 11 to 14 years old? Check all that apply.
- ☐ Bible Study
- ☐ Children's church apart from traditional Sunday morning worship
- ☐ Summer camp
- ☐ Sunday school
- ☐ Vacation Bible school
- ☐ Youth and children's ministry
- ☐ Youth retreat
- ☐ Other youth events

_____
- ☐ Don't really know

Appendix G: Parents of 11-14 Year Olds Psychographic Sheet

Thank you for participating in the interview. We have a few brief questions for you before you leave. Please completely fill in your response in the box using the pencil provided. → ■

	Yes	No	Not comfortable answering
1. It is important that my child learns about sexual health.	☐	☐	☐
2. Teen pregnancy is a serious health issue.	☐	☐	☐
3. Teen pregnancy should be a serious concern at my church.	☐	☐	☐
4. Teen pregnancy is a serious concern for my community.	☐	☐	☐
5. I am comfortable talking to my child about sexual health information.	☐	☐	☐
6. I want to be the main person that teaches my child about sexual health.	☐	☐	☐
7. I am comfortable talking to my child about preventing teen pregnancy.	☐	☐	☐
8. I want my pastor to provide me with information I can use to discuss sexual health with my child.	☐	☐	☐
9. I would prefer a church leader to provide my child with sexual health information.	☐	☐	☐
10. I would like for my church to discuss only abstinence with my child (excluding contraceptive method information).	☐	☐	☐
11. I would allow my child to participate in an abstinence-only sexuality education program at my church.	☐	☐	☐
12. I would prefer for church leaders to discuss both abstinence and contraceptive method information with my child.	☐	☐	☐
13. I would allow my child to participate in a comprehensive sexuality education program that discusses abstinence and contraception at my church.	☐	☐	☐
14. I'm concerned that my 11-14 year old child may be thinking of having sex.	☐	☐	☐

Appendix H: Parents of 15-17 Year Olds Demographic Sheet

What is your gender? _____

What is your age? _____

What is your race/ethnicity? _____

What is your marital status?
- ☐ Married
- ☐ Widowed
- ☐ Divorced
- ☐ Separated
- ☐ Never married

# of children living at home with you
_____ # 15-17 years old
_____ # 11-14 years old

How old are your children? _____

What is the gender of your 15-17 year old?
- ☐ Boy
- ☐ Girl

What is your relationship to the 15-17 year old that lives with you?

_____

Were you a teen parent?
- ☐ Yes
- ☐ No

Is your 15-17 year old sexually active?
- ☐ Yes
- ☐ No

Has your 15-17 year old been a teen parent?
- ☐ Yes
- ☐ No

What is the highest level of school you have completed?
- ☐ Some High School
- ☐ High School Diploma or GED
- ☐ Technical School
- ☐ Some College

Where? _____
- ☐ College Graduate

Where? _____

What is your current employment status?
- ☐ Employed Full-Time
- ☐ Employed Part-Time
- ☐ Employed Temporary
- ☐ Employed Seasonal
- ☐ Not Currently Employed
- ☐ Student
- ☐ Other _____

At the end of the month which of the following best describes your situation?
- ☐ I have money left over
- ☐ I have just enough money to get by
- ☐ I still have bills to pay

What denomination is your church?
- ☐ Baptist
- ☐ Methodist
- ☐ Other _____

How often do you attend church?
- ☐ Multiple times per week
- ☐ At least once a week
- ☐ Less than once a week
- ☐ Less than once a month
- ☐ Almost never

How long have you been a member of your church?

_____

How often does your 15-17 year old child attend church?
- ☐ Multiple times per week
- ☐ At least once a week
- ☐ Less than once a week
- ☐ Less than once a month
- ☐ Almost never

Which of the following does your church have for youth 15-17 years old? Check all that apply.
- ☐ Bible Study
- ☐ Children's church apart from traditional Sunday morning worship
- ☐ Summer camp
- ☐ Sunday school
- ☐ Vacation Bible school
- ☐ Youth and children's ministry
- ☐ Youth retreat
- ☐ Other youth events

_____
- ☐ Don't really know

Appendix I: Parents of 15-17 Year Olds Psychographic Sheet

Thank you for participating in the interview. We have a few brief questions for you before you leave.
Please completely fill in your response in the box using the pencil provided. → ■

	Yes	No	Not comfortable answering
1. It is important that my child learns about sexual health.	☐	☐	☐
2. Teen pregnancy is a serious health issue.	☐	☐	☐
3. Teen pregnancy should be a serious concern at my church.	☐	☐	☐
4. Teen pregnancy is a serious concern for my community.	☐	☐	☐
5. I am comfortable talking to my child about sexual health information.	☐	☐	☐
6. I want to be the main person that teaches my child about sexual health.	☐	☐	☐
7. I am comfortable talking to my child about preventing teen pregnancy.	☐	☐	☐
8. I want my pastor to provide me with information I can use to discuss sexual health with my child.	☐	☐	☐
9. I would prefer a church leader to provide my child with sexual health information.	☐	☐	☐
10. I would like for my church to discuss only abstinence with my child (excluding contraceptive method information).	☐	☐	☐
11. I would allow my child to participate in an abstinence-only sexuality education program at my church.	☐	☐	☐
12. I would prefer for church leaders to discuss both abstinence and contraceptive method information with my child.	☐	☐	☐
13. I would allow my child to participate in a comprehensive sexuality education program that discusses abstinence and contraception at my church.	☐	☐	☐
14. I'm concerned that my 15-17 year old child may be thinking of having sex.	☐	☐	☐

Appendix J: Teen Pregnancy Prevention Program Sample Topics

- Parent-child communication
- Goals and dreams
- Healthy relationships
- Effective communication with a romantic partner
- Problem solving skills
- Negotiation skills with a romantic partner
- Puberty
- Reproduction
- Myths and facts about pregnancy
- Contraceptive methods/birth control methods
- Condom use skills