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Facilitators and Barriers to Implementing Church-Based Adolescent Sexual Health Programs in Baltimore City

Terrinieka W. Powell, Ph.D. [a,*], Fiona H. Weeks, M.S.P.H. [a], Samantha Illangasekare, Ph.D. [a], Eric Rice, Ed.D. [b], James Wilson [c], Debra Hickman, M.Div. [c], and Robert W. Blum, M.D., M.P.H., Ph.D. [a]

[a] *Department of Population, Family and Reproductive Health, Johns Hopkins Bloomberg School of Public Health, Baltimore, Maryland*
[b] *Johns Hopkins School of Education, Baltimore, Maryland*
[c] *Sisters Together and Reaching (STAR), Baltimore, Maryland*

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A B S T R A C T

Purpose: Black churches are an important community resource and a potentially powerful actor in adolescent health promotion. However, limited research exists describing the factors that may influence the successful implementation of evidence-based adolescent sexual health programs in churches. In the present study, a multi-informant approach was used to identify facilitators and barriers to implementing adolescent sexual health programs in black churches.
Methods: Nine Black churches located in Baltimore, MD, were recruited to participate in this study. The senior pastor and youth minster from each congregation participated in an in-depth interview (N = 18). A total of 45 youth (ages 13–19 years) and 38 parents participated in 15 focus groups. Qualitative data were transcribed verbatim and analyzed using a qualitative content analytic approach.
Results: Participants agreed that comprehensive adolescent sexual health education should be available for youth in black churches. They also believed that abstaining from sex should be discussed in all adolescent sexual health programs. Three facilitators were discussed: widespread endorsement of church-based adolescent sexual health education, positive influence of youth ministers on youth, and life lessons as teaching tools. Four barriers are described: perceived resistance from congregants, discomfort among youth, lack of financial resources, and competing messages at home about sexual health.
Conclusions: Our findings suggest that churches are a preferred place for adolescent sexual health education among some parents and youth. Study findings also reinforce the feasibility and desirably of church-based adolescent sexual health programs.

IMPLICATIONS AND CONTRIBUTION

Black churches can play an important role in reducing racial disparities in sexual health among adolescents in the United States. This study considers the perspectives of faith leaders, parents, and youth in the context of adolescent sexual health programs in churches.

Reducing incidences of pregnancy and HIV among adolescents are two of the goals outlined by the Healthy People 2020 initiative [1]. Resources must be allocated toward prevention efforts targeting those who have the highest risk of becoming pregnant and/or contracting HIV. In Maryland, African-Americans have the highest HIV rate of any group and account for 76% of living cases of HIV among adults and adolescents [2]. In Baltimore, MD, 52% of African-American high school students have had sexual intercourse at least once, and 13% have had sexual intercourse before the age of 13 years [3]. In 2014, 38% of African-American high school students reported current sexual activity; 37.7% of this group did not use a condom at the last sex, and 16.6% did not use any other method to prevent pregnancy [3].

Conflicts of Interest: The authors have no conflicts of interest to disclose.

* Address correspondence to: Terrinieka W. Powell, Ph.D., Department of Population, Family and Reproductive Health, Johns Hopkins University, Bloomberg School of Public Health, 615 N. Wolfe Street, E4614, Baltimore, MD 21205.
E-mail address: terri.powell@jhu.edu (T.W. Powell).

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Tremendous potential exists to involve black churches in adolescent sexual health promotion. First, the strong social infrastructure of churches makes them a feasible and desirable context for the implementation of sexual health programs [4–6]. Second, African-American families believe that churches can and should be a resource for sexual health [7]. Third, some faith leaders are willing to be trained and believe that addressing sexual health is consistent with their congregation's mission [8,9]. Fourth, some black church leaders and families believe that much of the content in existing evidence-based adolescent sexual health programs should be offered to their youth in a church setting [10]. Finally, black churches that are physically located in African-American neighborhoods share knowledge and experience of the challenges residents face [11].

Still, few evidence-based adolescent sexual health programs have been implemented in churches because of persistent barriers [12]. For example, there continues to be considerable stigma around sexual health topics in some faith settings [13–15]. In addition, many faith leaders lack the skills and knowledge to effectively address these issues in their congregations, especially for youth [8,16]. Funding and coordinating change among multiple constituencies also limit the ability of some churches to implement HIV prevention interventions [17,18].

Previous studies describing the facilitators and barriers to addressing adolescent sexual health programs in churches have been limited in their scope [4,6,19]. In particular, they have largely focused on the perspectives of church leadership. Other studies have solicited youth and parents' perspectives on faith-based sexual education, but not faith leaders [20,21]. To be successful, a program should have buy-in from the entire church community. The goal of the present study was to use a multi-informant approach to identify the facilitators and barriers to implementing adolescent sexual health programming in black churches. We engaged a range of the stakeholders within the same church communities to garner a more holistic picture of the community landscape and feasibility of faith-based sexual education.

Methods

Data analyzed for this study were drawn from the Faith-based Adolescents Involved in Total Health (FAITH) project, an exploratory qualitative study that sought to understand the influence of youth ministers on adolescent sexual health. The Johns Hopkins Urban Health Institute and Sisters Together and Reaching, Inc. partnered to conduct the FAITH project. All components of the project adhered to the principles of community-based participatory research. [22] The university and community partners jointly identified this need, secured funding, developed instruments, collected and analyzed data, and generated manuscripts. Regular meetings were scheduled for all partners to discuss updates, lessons learned, and dissemination of findings. Adolescent sexual health programs were defined as activities tailored to the developmental needs of adolescents and explicitly discussed sexual and reproductive health topics (e.g., relationships, sexual intercourse, sexually transmitted diseases, and pregnancy). Faith leaders were defined as senior pastors and youth ministers.

Congregation recruitment

Nine churches (eight Baptist and one African Methodist Episcopal) located in Baltimore communities with high teen birth and sexually transmitted infection rates participated in the FAITH project. Each congregation received a $1,000 stipend. Faith leaders were not individually compensated for study involvement. Faith leaders were responsible for selecting dates for the focus groups to be held and recruiting focus group participants. They announced the project at Sunday morning worship services and within ministry meetings. Research team members also created fliers to distribute and post in the congregations.

Participants

Four groups of participants were included in the study: senior pastors, youth ministers, parents of youth aged 13–19 years, and adolescents aged 13–19 years. Two faith leaders from each congregation ($n = 18$) participated in an in-depth interview. Forty-five adolescents participated in seven focus groups. Thirty-eight parents participated in eight focus groups. All participants identified as black/African-American. No identifying information was collected from focus group participants.

Interview and focus group guides

Semistructured, in-depth interview and focus group guides were collaboratively developed by university and community partners. The guides were designed to facilitate a discussion on the church's potential influence on its youths' sexual and reproductive health. All participants were asked similar questions to ensure comparability across participant type. However, follow-up probes were used to allow for completeness of participant responses. Table 1 lists the contents of the interview and focus group guides and sample codes from each section.

Procedures

In-depth interviews were scheduled at a time, date, and location convenient for faith leaders. Focus groups were held at the individual churches on different days determined by the senior pastor. Repeated scheduling conflicts prevented one church from hosting parent and adolescent focus groups. Equipment failure prevented the recording of an adolescent focus group at another church. Parent and adolescent focus groups were held at the same time, but in separate rooms at each church. The focus groups ranged from 3 to 11 participants in size and included both male and female participants. Each adult participant was provided written, informed consent before participation. In addition to obtaining parental permission for participants who were under 18 years of age, a written informed assent was obtained from all youth participants. Participants were assigned a unique study identification number to protect their privacy.

All data were collected by five members of the research team (three university partners and two community partners). Table 2 provides demographics and roles of each data collector. All interviews and focus groups were digitally recorded. In-depth interviews ranged from 67 to 145 minutes in duration; focus groups ranged from 46 to 125 minutes in duration. At the conclusion of each interview, pastors and youth ministers were thanked for their participation and given information about the next steps of the broader research project. At the end of each focus group, parents and youth participants were given $25 for their time. All research protocols were approved by the university's institutional review board.