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Discussing Adolescent Sexual Health in African American Churches

Terrinieka T. Williams, PhD[1], **Darcy Dodd, BA**[2], **Bettina Campbell, MSW**[3], **Latrice C. Pichon, PhD, MPH**[4], and **Derek M. Griffith, PhD**[2]

[1] Johns Hopkins University, Bloomberg School of Public Health, Department of Population, Family, & Reproductive Health, Baltimore, MD

[2] University of Michigan, School of Public Health, Department of Health Behavior & Health Education, Ann Arbor, MI

[3] YOUR Center, Flint, MI

[4] University of Memphis, School of Public Health, Division of Social and Behavioral Sciences, Memphis, TN

Abstract

This study describes the ways in which two African American churches discuss adolescent sexual health topics. Six focus groups were conducted in two churches in Flint, Michigan that reported no formal sexual health programming for their congregants. Three themes emerged to highlight the different perspectives about the role of churches in adolescent sexual decision-making and sexual health education 1) churches as sources of sexual information; 2) churches as complex communities; and 3) recommendations for sexual education in churches. Participant responses suggest that churches can and should serve a resource for sexual health information. Implications for practice and research are discussed.

Keywords

faith-based; adolescent sexual health; African American; qualitative

INTRODUCTION

Churches have been and continue to be important in African American communities (Lincoln et al., 2001). Churches have the ability to mobilize masses and disseminate appropriate and accurate information on sexual health. Further, faith-based organizations (FBO) and their leaders are highly respected, valued, and influential in many communities of color and are viewed as credible sources of information and guidance (Eke et al. 2010; Wimberly, 2001). Because so many people turn to FBOs for guidance and spiritual support, they may also serve as a key venue for helping youth with sexual decision-making. However, FBOs seem to be an underutilized setting for sexual health education and programming. In the current study, we describe the ways in which two African American churches discuss adolescent sexual health topics.

Address all correspondence to: Terrinieka T. Williams, Ph.D., Johns Hopkins University, Bloomberg School of Public Health, Department of Population, Family and Reproductive Health, 615 N. Wolfe Street, E4614, Baltimore, MD, 21205; tewillia@jhsph.edu; (410) 955-5817- office, (410) 955-2303- fax..

Sexual Health among African American Adolescents

During adolescence, children develop a new awareness of themselves (Galatzer-Levy & Cohler, 1993). Adolescence has been described as “a time of choice” because youth experience social changes in families, communities and schools. Furthermore, the importance of youth's identity and the ability to make independent decisions increases during this time (Larson et al., 1984). In particular, adolescence is a time of sexual experimentation and risk taking. While some youth explore their sexuality in healthy ways, others participate in sexual behaviors that place them at an increased risk of contracting HIV and other sexually transmitted infections (STIs) (Gunatilake, 1998).

Compared to their peers, African American adolescents tend to become sexually active earlier, engage in sexual activity more frequently, and be less likely to use condoms the first time they have sexual intercourse (Centers for Disease Control and Prevention, CDC, 2008; Madison, et al., 2000). Further, African American high school students are more likely than White and Hispanic students to have had sexual intercourse, have had four or more sexual partners, and currently be sexually active (CDC, 2010). HIV disproportionately affects young African-Americans; in 2009, young Blacks accounted for 65% of diagnoses of HIV infection reported among persons aged 13-24 (CDC, 2010). Although the magnitude of the sexual health risk among African American adolescents is clear, it is not clear what strategies will be most effective in reducing risky sexual behaviors among African American young people.

Influences of Religion on Adolescents’ Sexual Behaviors

According to the National Study of Youth and Religion, 87% of high school students in the U.S. are affiliated with an organized religion (Smith & Faris, 2002). There is considerable evidence that religious affiliation, participation and importance have a positive influence on adolescents. For example, in several studies, religious affiliation has been associated with less cigarette, alcohol and marijuana use, higher self-esteem, and more positive family relations (Vakalahi, 2001; Denton, Pearce, & Smith, 2008; Smith et al., 2002). Further, researchers contend that churches provide youth with role models, moral direction, spiritual experiences, positive social and organizational ties, and community and leadership skills, all of which have been associated with healthy teen development (Regnerus & Elder, 2003; Smith & Kim, 2003).

Religious affiliation and participation also has been shown to reduce African American adolescents’ likelihood of initiating or engaging in sexual behavior and to delay the onset of sexual activity (Francis et al. 2009; Smith et al., 2005). Adolescents who report frequently attending church, actively participating in church, or who rate religion as something that is important in their lives are less likely to be sexually active than their peers who report lower religiosity (Davidson et al., 2008; Nonnemaker et al., 2003; Lefkowitz et al., 2004). Unfortunately, research also suggests that religious adolescents may be less likely to use contraceptives when they become sexually active (Adamczyk & Fellson, 2008; Bruckner & Bearman, 2005). Although it seems that religiosity is a protective factor for encouraging youth to delay sexual debut, religiosity may also be a risk factor for youth who decide to become sexually active. Thus, it is critical for churches to consider ways in which they can both address the benefits of abstinence and the importance of protection.

Current Study

Pargament and Maton (2000) noted that researchers might be more effective in planning and implementing interventions in communities in which religion has a substantial influence if they better understands the role of religious institutions in those communities and collaborate with them accordingly. In the current study, we partnered with two churches to

better understand the ways in which churches might serve as a sexual health resource for African American adolescents. There were two mains goals for this paper. First, we described the salient messages about sex, sexuality and relationships in churches. Second, we documented existing and desired sexual health resources available to adolescents within churches. Thus, we introduced the largely unexplored perspectives of adult and adolescent congregants to the discourse of involving churches in sexual health education.

Methods

Creswell (1998) noted that qualitative methods are often appropriate for in-depth exploration of a topic. In particular, focus groups allow for questions to be asked in an interactive group setting where participants are free to talk with other group members about a certain topic (Krueger & Casey, 2000). Thus, in order to understand how African American churches discuss adolescent sexual health topics, focus groups were conducted with members of two Christian churches in Flint, Michigan.

Context

Genesee County, where Flint is located, ranked seventh in Michigan in 2009 for the total number of people living with HIV/AIDS in the un-incarcerated population; the majority of people living with HIV/AIDS in Flint were African American (Michigan Department of Community Health, 2009). These statistics suggest that African American adolescents in Flint are at high risk of becoming infected with HIV during their lifetime, and prevention interventions are needed to enhance adolescents' ability to make decisions to abstain from sexual intercourse or engage in safer sexual intercourse.

Participants

Thirty adolescents and 19 adults participated in six focus groups. Adolescent focus group participant ages ranged from 12 to 18 (M = 15, SD = 2). Adult participant ages ranged from 31 to 61 (M = 47, SD = 11). Nearly all participants were African American (84%). The majority of participants were also women (67%). All participants reported that they typically attend church with their families at least once a week. Table 1 lists detailed information regarding the age, gender and ethnicity of the participants.

We also asked youth about their sexual experiences. As noted in Table 2, over 40% of adolescents reported having sex at least once in their lifetime. However, it is clear that many of these experiences may not have been recent because few adolescents reported having had vaginal, anal or oral sex in the past 30 days.

Measures

Two semi-structured interview protocols (i.e., one for adults and one for adolescents) were developed. The protocols asked participants about several aspects of their church experiences. The protocols were piloted on a group of adults interested in adolescent and community health. The interview protocols were revised after they were piloted and as data were collected and analyzed (Creswell, 1998). The final interview protocols each consisted of nine major questions. For the purposes of this study, we focused on responses regarding the actual and desired sexual health education resources in churches. Sample items include, "What types of messages do you hear about sex in church?" and "What are some pros and cons to talking about sex in churches?" Demographic information collected included: age, gender, household size, educational level, and church attendance, sexual behavior history (adolescents only) and household income (adults only).

Procedures

For this study, we followed community-based participatory research (CBPR) principles outlined by Israel and colleagues (1998). University and community partners invited two churches in Flint, Michigan, to participate in the current project. Using recruitment materials designed by the university and community partners, a member from each church recruited youth and adults to participate in focus groups. To capitalize on the advantages of conducting focus groups with faith communities, all focus groups were held in the churches on days and times that were convenient for participants. Focus group participants were categorized by age; there were two adult-only focus groups and four adolescent-only focus groups. In order to participate, adult participants were required to sign a consent form. Adolescent participants were required to submit a signed assent form and parental consent form. Prior to the start of the focus group, all participants also completed a brief demographic questionnaire. No identifying information was collected.

All respondents agreed to be audiotaped. Participants were only allowed to participate in one focus group. Upon completion of the demographic survey and focus group, participants were each compensated with a $20 Visa gift card for their participation. All data was collected between November 2010 and February 2011. The duration of the focus groups ranged from 50 minutes to 115 minutes.

Data Analysis

Each focus group was labeled alphabetically based on the order in which they were conducted. All focus groups were audiotaped and transcribed verbatim for analysis. A university research assistant verified all transcripts against the original audiotapes to ensure that the transcripts were accurate. After each transcript was verified, it was imported into a qualitative software program, NVIVO (QSR International Pty Ltd, Version 8.0, 2010), to assist in data analysis. Transcripts were analyzed inductively using a qualitative content analytic approach (Hsieh & Shannon, 2005). With this approach, we created a coding manual by comparing each focus group to others and then categorizing answers to common questions as well as analyzing different perspectives on central issues. Specifically, the following five steps were employed during the coding process: 1) organizing the responses in the discussion group notes into a series of restatements (data chunks), 2) double checking the restatements, 3) coding the restatements into categories, 4) combining coded restatements across discussion groups and participants to form one consolidated document per case study, and 5) reviewing the consolidated document to identify themes to be included in written discussion group results. As such, data were coded and classified in order to identify themes or patterns that addressed our research questions. The final coding manual contained 37 codes. Ultimately, themes were developed based on patterns and topics that persisted throughout the focus groups.

Three techniques were employed to augment the credibility of findings: prolonged engagement, journaling and peer debriefing (Creswell, 1998; Miles & Huberman, 1994). The goal of this process is to ensure that the interpretations of the researcher reflect the perspectives of participants (Denzin & Lincoln, 1994; Toma, 2006). Furthermore, a second coder was utilized to check the consistency of coding. The joint coding was geared toward listening to the words of the respondents together and arriving at a consensus of understanding the ideas presented. When the coders disagreed about the codes for a section of data, they resolved the disagreements by discussing the disputed text until consensus was reached.

Results

While each group highlighted different perspectives about the role of churches in adolescent sexual decision-making and sexual health education, several issues appeared to be consistent across all groups. The following three themes emerged from the focus groups: 1) churches as sources of sexual information; 2) churches as complex communities; and 3) recommendations for sexual education in churches.

Churches as sources of sexual health information: “Wait until you're married”

Participants cited pastors’ sermons as the main source of sex, sexuality, and relationship information in their congregations. Adults remarked that their pastors discussed a wide range of sexual health topics from a biblical perspective, including abstaining from premarital sex, pregnancy outside of marriage, homosexuality, the difference between love and sex, as well as marriage.

> By coming to church, pastor preaches on just about every issue related to family life. – Adult in Group C

Although pastors’ sermons were the principal mode of sexual health education in the churches, they were not the only form. Youth in one church mentioned the opportunity to discuss sexual health concerns with their Sunday school teachers. Whereas some youth thought these ongoing conversations were beneficial, others did not view them as an important resource. In another church, youth recalled an isolated sexual health presentation in their church in which they viewed pictures depicting sexually transmitted infections (STIs). However, adolescent participants expressed disappointment with this sexual health presentation from their church as it used scare tactics rather than facilitate discussions around sexual health.

Youth felt that the most salient messages about sex, sexuality and relationships from the pulpit were about premarital sex and homosexuality. Unanimously, adult and youth participants noted that their pastors believed God reserved sexual relations exclusively for married couples. Pastors presented sex as a “sacred” act to be shared between a man and a woman who are united in the bond of marriage.

> You know, sexuality is for married couples. It's not for individuals, regardless of what society says is correct. From the church's point and the biblical aspects of it is for married couples. – Adult in Group A

> The Church is right, gets its messages from God, so I believe that you should abstain until marriage. – Adolescent in Group F

Adolescent participants also explained that their churches’ messages about sex frequently implied that any sexual acts before marriage were sinful and carried serious negative consequences, namely unintended pregnancy, STIs or eternity in hell. Consistently, adult participants noted that the church neglected to portray sex as a natural and beautiful act, and instead focused heavily on the physical risk factors and sinful nature of pre-marital sex. When asked about the messages they hear about sex in church, offered the following messages:

> Wait until you're married because if you do it [have sex] before, then you're a sinner, and you're gonna go to hell. – Adolescent in Group D

> And I don't think the sex talk ever stays to just sex, „cause they always want to bring it into, “Oh, but then you're going to get pregnant. Like, if you have sex, you're getting pregnant, you're getting STDs” and all this stuff. – Adolescent in Group D

Furthermore, when asked about the biblical reasons for abstaining until marriage, youth struggled to provide explanations. Some youth reasoned that in order to adequately safeguard against outcomes such as STIs and teen pregnancy, churches should offer information about "protection". Youth participants disagreed with adults' concern that providing information about sex encourages sex; youth adamantly maintained that seeking knowledge about sex does not indicate or lead to a desire to have sex. Adolescents described the social and emotional contexts in which teenage sex often takes place, repeatedly referring to "the heat of the moment", in addition to pressures from peers and partners. They explained that messages about abstinence are not applicable in the heat of the moment, and that it is important for youth to be prepared and responsible in the case that they end up having sex.

Participants received messages that deemed homosexuality and same-sex relationships as examples of sexual immorality. However, many youth believed that the delivery of messages regarding homosexuality was often offensive and insensitive. They asserted that the pastor should be more considerate of the feelings of homosexual youth in the congregation and refrain from condemning them. Some youth did not agree with anti-homosexuality messages, while others agreed with the messages but felt they were communicated in an unnecessarily severe way.

> And he also said that homosexuality was wrong, according to biblical principles, and that God made Adam and Eve, not Adam and Steve. – Adult in Group A

> I don't think he should project them in, like, such a harsh manner because regardless what we believe, there's still gonna be people out there who are homosexual... Like, the way he says it, sometimes it can be very rude and come off very bad to the homosexuals. – Adolescent in Group B

> OK, we supposed to not be doing homosexuality and stuff like that. But I feel the pastors, sometimes they have to be very, very careful of how they say it, because they was some homosexuals, you know, in the church that day. And some of them got, like, very offended. Yeah, very offended. – Adolescent in Group B

Churches as complex communities: The "church family"

While youth and adults both described the church as a tight-knit community, they expressed differing views on how this affects the church's capacity to offer sexual health programming. Youth frequently voiced anxiety about church members' tendencies to judge others and gossip. They also worried that adults would assume any youth asking about sex was sexually active. Youth found this unsettling, as they valued maintaining an image of innocence among adults in their church. In particular, they feared that their parents may find out what they are discussing or receive inaccurate accounts of their sexual activity. In addition, some youth hypothesized that talking about sex with adults in the church would be awkward and embarrassing. Several youth explained that, due to such concerns, they would not feel comfortable talking to adults in their church about sex.

> Sometimes when you go and talk to some adult [in church], they might automatically think, like, "Oh, you're having sex or you're about to have sex." When not necessarily, you're not going to. You're just asking for advice about it. – Adolescent in Group B

> Maybe it is people like that [with whom you have an open relationship] in the church, but some people, some adults, you can't tell your business to because, you know, they might go back and tell. – Adolescent in Group D

> Everyone in the Church is really close. My Sunday school teacher is like my aunt. If I talked to her about sex, I'd be scared of my family finding out. – Adolescent in Group F

Both youth and adults criticized members of their church family for being hypocrites. Participants gave a number of examples of adults whose behaviors at church were inconsistent with their behaviors outside of church. Interestingly, adolescents considered the contradictory behavior of adults as a sign of congregants being “fake”, but adults viewed these behaviors signifying that people are “human”. Still, both youth and adults agreed that adults who send conflicting messages about their value systems ultimately have a negative impact on youth who observe them. By modeling behaviors not supported by the teachings of the church, adults discourage youth from living up to the standards set by God.

> And I don't like to say that we fall into this stereotype, but most church people tend to be hypocrites, and so, they want to call somebody else out on their sin when it's known, but yet, they got skeletons in they own closet, and they trying to keep them hidden. – Adolescent in Group B

> Some things that I know that I have been guilty of and I see also, we, as adults, are hypocrites in a sense because we come to church. We preach this and that, and we say we live Christ like, but then you go to work, and you're talking about your co-worker, and you can't stand this person... It's an eye opener for our kids. – Adult in Group C

> Some people in Church act good and are praising, then out of Church they have bad habits and don't use what they learn in Church. – Adolescent in Group F

Despite these sentiments, several adults asserted that people in church do not gossip and can be trusted to talk to teens about sex in confidence. Although there are exceptions, they explained that most people in their congregations are accepting and embracing of people who have sinned. They offered the example of the church showing support for mothers raising children out of wedlock.

> As a church family, I'm so glad to be at [name of church] because you can bring your child, even if you're not married, and you're still gonna be embraced. You aren't gonna be looked down upon. – Adult in Group C

Adult participants also frequently referred to the capacity of the church family to guide youth in sexual decision-making. They explained that as part of a church family, adult congregants care about youth and their well-being and would accordingly lead them in the right direction. In addition, by providing encouragement and affection, congregants can make youth feel loved and improve their self-esteem, which can lead to sound sexual decision-making. Adult participants also maintained that adults in the church can serve as alternative resources for youth who cannot or do not wish to discuss sex with their parents.

> But I still say that church will influence them more so not to [have sex] because they're, you know, you're around people, like I said, that really care for you and care about what you're doing. – Adult in Group A

> So, by being in a church family, there are some people around you that you may develop attachments with, relationships with, that you can throw some questions to them, that you're ashamed to ask your parents. – Adult in Group C

Recommendations for sexual education in churches: “This would work best for me”

Youth and adult participants widely expressed the need for young congregants to receive more guidance and information around issues of sex. Many felt that the church should play a more active role in providing these resources. In addition to a deficit in preventative

knowledge, adult participants expressed concern that youth in the church lack information on how to cope with STIs and pregnancy. Participants made various recommendations for how the church could increase their involvement in sexual decision-making among youth, such as making sexual health brochures available, which could be picked up anonymously, posting information about local sexual health resources on the church's website, addressing the emotional aspects of sex, and having a question box where youth could anonymously ask questions related to sex, sexuality and relationships. Yet, participants predominately proposed that the church offer young congregants the opportunity to discuss sex, either in support groups or one on one with an adult. Participants explained,

> I think, like, you know, sitting around in a group, talking about things like this, it would be best for me. I mean, I get that some people wouldn't want to talk about it, but just like, you know, we were all timid when we first came in here, but you got us out of our little shells. And now, you can't get us to shut up. So, I mean, I just feel like we should just have some kind of support group for the youth in our church. – Adolescent in Group B

> So, on top of giving them the information, and teaching them biblical [information], we have to talk to them about the emotional factors because some of them get messed up and turn to get even more sexually active. – Adult in Group A

Both youth and adult participants emphasized the importance of youth feeling comfortable raising questions and talking freely about concerns related to sex in the church. However, youth and adults often diverged on their priorities for who should lead open conversations with young congregants about sex. Youth highlighted important characteristics of the individual. For example, many youth noted that both youth and adults could be effective messengers of sexual health information in their congregations. In particular, youth participants tended to envision a support group in which teens could freely discuss issues around sex with one another and with a non-judgmental person who would keep their sensitive conversations private. In addition to being non-judgmental and respectful of confidentiality, other ideal traits included being professional, “real”, youthful, and funny.

> We had this one lady come in, and she was talking about how she used to be a prostitute and everything. And at the end, I think, like, she, actually, she was probably one of the realest people that I could honestly say that spoke that day. Because she admitted that she knows it was a sin and we're gonna do, you know, whatever happens, happens. – Adolescent in Group D

Unlike the youth focus on characteristics of the discussion leader, adults highlighted the importance of the messenger's affiliation with their church. Adults largely conveyed preference for congregants leading programming around sex rather than outsiders. Overall, adults wanted teens to feel they can turn to a trustworthy adult congregant to guide them in accordance with church teachings or point them to other resources for sexual health information. They reasoned that members of the church are best equipped to provide youth with valuable messages about sex, informed by church teachings. They contrasted these messages with those disseminated by media, schools, peers, and people “on the street”.

While youth had reservations, they did not rule out the possibility of effective sexual education programming led by adults in their church. In fact, they frequently described adults as having learned from mistakes related to sex and, as a result, having valuable advice to offer youth. Some even expressed appreciation for a mother who organizes get-togethers at her home for youth to discuss issues of their choice, including sex. Adults concurred that it is important for adult congregants to share their past experiences with sex through testimonials. Moreover, adult and youth participants reasoned that because their pastors

reformed their lives, they are uniquely qualified to serve as reliable sources of advice regarding sex.

> The pastors in our Church have reformed their lives, used to be having sex and drinking all the time, had guns. Now they can give advice, and you listen. People around are going through or have been through things, and you might have no idea. These people can help you. - Adolescent in Group F

> I'm like, “If you don't talk to me about it [sex], then how am I supposed to know? How am I supposed to learn from your mistakes?” And that's what they [my parents] always tell me, “I want you to learn from my mistakes. I want you to be better.” If you don't tell me about it, how am I supposed to know to learn from it? – Adolescent in Group B

Discussion

Without relevant sexual health information, adolescents who are sexually active face significant risks that are not addressed by teachings on abstinence until marriage. Youth who are currently abstaining will likely one day have sex, either within or outside of marriage, and will need comprehensive knowledge about sexual health before their first sexual encounter. To this end, the current study sought to better understand the ways in which two African American churches discuss adolescent sexual health topics.

The findings from the current study were consistent with previous research noting that faith leaders do indeed discuss sex and sexual health topics in their congregations (McNeal & Perkins, 2007; Valentine, 2008). Unfortunately, the messages mentioned by participants tended to highlight the immorality of certain decisions rather than address the health concerns around sexual behaviors. One explanation for this is the lack of sexual health training provided to pastors. Pichon and colleagues (in press) noted that pastors who received training increased their comfort in discussing key sexual health topics (e.g., oral sex, vaginal sex, masturbation and condom negotiation). Perhaps an important next step for researchers interested in involving churches in sexual health promotion is to better understand the ways in which seminary and divinity schools prepare pastors to discuss sex.

Findings from participants illuminate the multiple perspectives on the ways in which a tightly coiled social network might influence sexual health decisions. Although Israel (1982) noted the importance of the intensity and density of social networks, this seems to be less true for youth who are seeking sexual health guidance from fellow church-goers. Both adults and youth acknowledged the benefits, but youth also discussed the disadvantages of such highly complex networks. In particular, the presence of gossip and hypocritical activities among adults often discouraged youth from fully disclosing sexual health information to faith leaders. Creating an open space for candid dialogues has the potential to strengthen trusting relationships with congregants and faith leaders.

While churches often use messaging and programming around sex to *regulate* young congregants’ sexual behavior, youth participants largely desired that the church take further measures to *inform* them about sex. The youth in the focus groups demonstrated skepticism about messages they receive from adults, leading them to appreciate adults who can be “real” when offering perspectives on sex. Still, participants offered a number of recommendations for congregants to serve as sexual health resources for youth. For example, by facilitating workshops or discussion groups and creating non-judgmental spaces for youth to discuss relevant subject matter, churches can more effectively engage youth and generate guidelines which youth can apply in their daily lives. Crawford and colleagues (1992) found that although few pastors provided sexual health prevention and intervention

services, most (80%) were willing to consider outreach and social service programming to be provided throughout their churches. The findings from this study offer a first provide concrete areas for pastors to consider as they create and expand their sexual health promotion efforts. Faith leaders who speak more openly about previous lifestyles and current struggles might be able to facilitate discussions around sex and sexuality as well as provide concrete examples of forgiveness and compassion.

Strengths and Limitations

This study is not without limitations. First, the study's findings are based on data gathered from a small, non-representative sample of African American adolescent and adult congregants. Second, the study relies on self-reported data and focuses on constructs that are likely to evoke socially desirable responses. Third, the sample did not include pastors or other faith leaders. Taken together, these limitations suggest the need for interpretive caution. Additional research involving larger, representative samples of African American congregants will be crucial to fully understanding the ways in which churches across geographical regions and denominations might serve as sexual health resources for African American adolescents.

Despite these limitations, this study makes several important contributions to the literature. First, study findings speak to the often assumed, but rarely empirically studied, disconnect between sexual health messages from faith leaders and the daily experiences of youth.Therefore, partnerships that involve youth, faith leaders, and researchers might be best positioned to inform faith-based prevention efforts designed to address adolescent sexual health. Second, the findings highlight the ways in which tightly coiled social networks can influence sexual health discussions. Future studies might consider further exploring how to maximize the benefits of strong church networks in order to better address the sexual health needs of adolescent congregants. Finally, this is one of few studies that reports adults and adolescents agreeing that churches' could become a more comprehensive sexual health resource. Thus, the findings underscore the importance of examining churches as potential venues for sexual health education for African American adolescents.

Conclusion

There is much for researchers to learn about the role of religious settings in the lives of individuals and communities (Brodsky, 2000). Findings from this project will enable researchers and church leaders to better address issues of sexual health with African American adolescents in their churches. In particular, the findings may be used to inform future faith-based sexual health prevention skill-building interventions. For instance, faith leaders could receive additional training during seminary education on effective strategies for disseminating health information to youth (Sexuality Information and Education Council of the United States, 2004). Congregations could provide additional resources for ministries and/or support groups for families to strengthen communication, and sexual health communication. This would provide the necessary support for both youth and adults to receive more guidance and learn new skills on how to communicate with one another about sexual health topics.

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Autobiographical Paragraph

Terrinieka T. Williams, PhD, completed her doctoral degree in Community Psychology from DePaul University. She is currently an Assistant Professor at Johns Hopkins Bloomberg School of Public Health in the Department of Population, Family and Reproductive Health and is a core faculty member in the Johns Hopkins Center for Adolescent Health. Dr. Williams' conducts research that has theoretical, practical, and policy implications in three complementary areas: (1) African American adolescent well-being, (2) educational and health disparities, and (3) community-engaged research using a variety of approaches and methodologies.

References

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

Brodsky AE. The role of religion in the lives of resilient, urban African American, single mothers. Journal of Community Psychology. 2000; 28:199–219.

Bruckner H, Bearman PS. After the promise: The STD consequences of adolescent virginity pledges. Journal of Adolescent Health. 2005; 36:271–278. [PubMed: 15780782]

Centers for Disease Control and Prevention. Youth Risk Behavior Surveillance: United States, 2007. Morbidity & Mortality Weekly Report. 2008; 57(SS4):1–131. [PubMed: 18185492]

Centers for Disease Control and Prevention. [December 9, 2011] HIV among Youth. 2010. from http://www.cdc.gov/hiv/youth/pdf/youth.pdf

Crawford I, Allison KW, Robinson WL, Hughes D, Samaryk M. Attitudes of African-American Baptist ministers toward AIDS. Journal of Community Psychology. 1992; 20:304–308.

Creswell, JW. Qualitative inquiry and research design: Choosing among five traditions. Sage; Thousand Oaks, CA: 1998.

Crowe J. Community attachment and satisfaction: The role of a community's social network structure. Journal of Community Psychology. 2010; 38:622–644.

Davidson JK, Moore NB, Earler JR, Davis R. Sexual attitudes and behavior at four universities: Do region, race, and/or religion matter? Adolescence. 2008; 43:189–220. [PubMed: 18689097]

Denton, ML.; Pearce, LD.; Smith, C. Research Report number 8. National Study of Youth and Religion, University of North Carolina at Chapel Hill; 2008. Religion and spirituality on the path through adolescence..

Denzin, NK.; Lincoln, YS. Introduction: Entering the field of qualitative research.. In: Denzin, NK.; Lincoln, YS., editors. Handbook of qualitative research. Sage; Thousand Oaks, CA: 1994. p. 209-219.

Eke, AN.; Wilkes, AL.; Gaiter, J. Organized religion and the fight against HIV/AIDS in the black community: The role of the Black Church.. In: McCree, et al., editors. African Americans and HIV/AIDS: Understanding the Epidemic. Springer; New York, NY: 2010.

Francis SA, Liverpool J. A review of faith-based HIV prevention programs. Journal of Religion & Health. 2009; 48:6–15. [PubMed: 19229620]

Galatzer-Levy, RM.; Cohler, BJ. The essential other: A developmental psychology of the self. Basic Books; Boston: 1993.

Gunatilake, S. Recognizing and preventing sexually transmitted diseases among adolescents.. In: Henderson, A.; Champlin, S., editors. Promoting teen health: Linking schools, health organizations, and communities. Sage Publications; Thousand Oaks, CA: 1998. p. 100-116.

Hsieh H, Shannon SE. Three Approaches to qualitative content analysis. Qualitative Health Reports. 2005; 15:1277–1288.

Israel BA. Social networks and health status: linking theory, research and practice. Patient Counseling and Health Education. 1982; 4:65–79.

Israel BA, Schulz AJ, Parker EA, Becker AB. Review of community-based research: Assessing partnership approaches to improve public health. Annual Review Public Health. 1998; 19:173–202.

Kruger, RA.; Casey, MA. Focus groups: A practical guide for applied research. Sage; Thousand Oaks, CA: 2000.

Larson R, Csikszentmihalyi M, Freeman M. Alcohol and marijuana use in adolescents' daily lives: A random sample of experiences. International Journal of addictions. 1984; 19:367–381.

Lefkowitz ES, Gillen MM, Shearer CL. Religiosity, sexual behaviors and sexual attitudes during emerging adulthood. Journal of Sex Research. 2004; 41:150–159. [PubMed: 15326540]

Lincoln, CE.; Mamiya, LH. The black church in the African American experience. Duke University Press; Durham, NC: 2001.

Madison SM, McKay MM, Paikoff R, Bell CC. Basic research and community collaboration: Necessary ingredients for the development of a family-based HIV prevention program. AIDS Education and Prevention. 2000; 12:281–298. [PubMed: 10982119]

McNeal C, Perkins I. Potential roles of Black churches in HIV/AIDS prevention. Journal of Human Behavior in the Social Environment. 2007; 15(2):219–232.

Michigan Department of Community Health. [April 12, 2011] HIV/AIDS rates by race/ethnicity in 25 highest HIV prevalence counties in Michigan: Focus on Hispanics. 2009. from http://www.michigan.gov/documents/mdch/07_01_2009_HIVAIDS_Rates_by_Race_ethn_Counties_07.2009_286633_7.pdf

Miles, RP.; Huberman, A. Qualitative data analysis: An expanded sourcebook. 2nd ed.. Sage; Beverly Hills, CA: 1994.

Nonnemaker JM, McNeely CA, Blum RW. Public and private domains of religiosity and adolescent health risk behaviors: Evidence from the National Longitudinal Study of Adolescent Health. Social Science & Medicine. 2003; 57:2049–2054. [PubMed: 14512236]

Pargament, KI.; Maton, KI. Religion in American life: A community psychology perspective.. In: Rappaport, J.; Seidman, E., editors. Handbook of community psychology. Kluwer Academic/Plenum Publishers; New York: 2000.

Pichon LC, Griffith DM, Williams TT, Allen JO, Addo A. Faith leaders' comfort level implementing an HIV prevention curriculum in a faith setting. Journal of Health Care for the Poor and Underserved. in press.

Regnerus MD, Elder GH Jr. Staying on track in school: religious influences in high- and low- risk settings. Journal for the Scientific Study of Religion. 2003; 42:633–649.

Sexuality Information and Education Council of the United States. [December 9, 2011] On the Right Track. 2004. from http://www.siecus.org/_data/global/images/OnTheRightTrack.pdf

Smith, CM.; Denton, ML. Soul searching: The religious and spiritual lives of American teenagers. Oxford University Press; Oxford: 2005.

Smith CM, Denton ML, Faris R, Regnerus MD. Mapping American adolescent religious participation. Journal for the Scientific Study of Religion. 2002; 41:597–612.

Smith, C.; Faris, R. Religion and the American adolescent delinquency, risk behaviors, and constructive social activities. National Study of Youth and Religion; Chapel Hill, NC: 2002.

Smith, C.; Kim, P. Research Report number 5. National Study of Youth and Religion, University of North Carolina at Chapel Hill; 2003. Family religious involvement and the quality of parental relationships for families with early adolescents..

Toma, JD. Approaching rigor in applied qualitative research.. In: Conrad, CF.; Serlin, RC., editors. The Sage handbook for research in education: Engaging ideas and enriching inquiry. Sage; Thousand Oaks, CA: 2006. p. 405-424.

Vakalahi HF. Adolescent substance use and family-based risk and protective factors: A literature review. Journal of Drug Education. 2001; 31:29–46. [PubMed: 11338964]

Valentine JA. Impact of attitudes and beliefs regarding African American sexual behavior on STD Prevention and control in African American communities: Unintended consequences. Sexually Transmitted Diseases. 2008; 35:S23–S29. [PubMed: 18923333]

Wimberly, AES. Braithwaite; Taylor, editors. The role of black faith communities in fostering health.; Health Issues in the Black Community. 2nd Ed2001. p. 129-150.

Table 1

Participant Demographics (N = 49)

Demographic Characteristic	Adult (n = 19)	Adolescents (n = 30)
Age		
• Range	31-61 years	12-18 years
• Mean	47 years	15 years
Gender		
• Male	5 (26%)	11 (30%)
• Female	14 (74%)	19 (70%)
Ethnicity		
• African American	18 (95%)	23 (77%)
• European American	0	1 (3%)
• Multiracial	1 (5%)	6 (20%)

Table 2

Adolescents' Reports on Sexual Behaviors (n=30)

With how many people have you had...	0	1-2	3-4	5 or more
Vaginal/anal sex with over your lifetime	17 (57%)	9 (30%)	3 (10%)	1 (3%)
Oral sex in the past 30 days	25 (83%)	4 (13%)	1 (3%)	---
Vaginal/anal sex in the past 30 days	22 (73%)	6 (20%)	1 (3%)	1 (3%)