Reducing African-American Women's Sexual Risk: Can Churches Play a Role?

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Purpose: This study investigates: 1) perceptions of clergy regarding their current counseling and the need for future programs concerning sexual risk-taking, 2) sexual risk behaviors among a group of African-American women, 3) women's attitudes regarding condom use, and 4) women's receptiveness to church programs regarding sexual risks.

Methods: The clergy of 50 randomly selected predominantly African-American churches in five North Carolina counties were contacted regarding participation. Female parishioners ages 18–30 from participating churches were invited to complete written surveys concerning women's health.

Results: Of 50 clergy repeatedly contacted, 38 declined to participate and eight did not complete the interview. Only four interviews could be completed. Counseling regarding sexual risk was not common among the four clergy. They often advised parishioners to practice abstinence. Survey data was received from 142 respondents at 14 churches. Nearly 84% of the women surveyed had a history of sexually transmitted diseases (STDs). Almost all of the respondents were receptive to a church program regarding sexual risks.

Conclusions: Despite the sexual risks among African-American women, in this study, many clergy were unwilling to address prevention and were uncomfortable discussing issues related to sexual health. However, the few clergy who agreed to participate were very receptive to future programs.

Key words: African Americans ■ women's health ■ sexually transmitted diseases ■ churches ■ prevention

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BACKGROUND

African Americans disproportionately bear the disease burden of sexually transmitted diseases (STDs), including HIV and AIDS. In North Carolina, African Americans, representing 22% of the population, account for 74% of new syphilis, 81% of gonorrhea, 65% of chlamydia, and 66/67% of HIV/AIDS cases reported each year.[1-3] These statistics highlight the disturbing health disparities that exist between whites and African Americans. Over the last decade, these differences have increased for African-American women. In 1990, African-American women were 18.5% of all HIV disease reports. In 2001, that percentage had grown to 24.2%—a 32% increase.[4] The disparity has become even more pronounced for AIDS cases. In 1990, African-American women represented 13.5% of all AIDS cases, but by 2001 they represented 21.4% (a 59% increase in proportion for that group).[4]

The Centers for Disease Control and Prevention surveillance shows that HIV/AIDS is a growing problem in the adolescent and young-adult populations, especially among minority females.[5] The most common route of transmission of STDs/HIV to women is unprotected heterosexual sex.[1,2,5] Lack of protection with a condom is a risk factor for many African Americans.[6,7] A study of African-American and Hispanic youths shows that only 46% of young African-American women stated that they used a condom at last intercourse.[8] When asked specifically about consistent condom use, only 35% of young African-American women reported they always used condoms with a nonsteady partner, and 24% always used condoms with their steady partner.[8] In focus group research among African-American women, participants felt that it was unlikely that their partners were able to maintain a sexually monogamous relationship. They also felt that women were at the highest risk when in a relationship with a man who also had sex with men. Women also described reluctance by men to use condoms and their own inability to negotiate condom use with their partners. Many women had a negative attitude towards condoms, especially the ability of spermicide to cause irritation and the decrease in sexual enjoyment.[9,10]

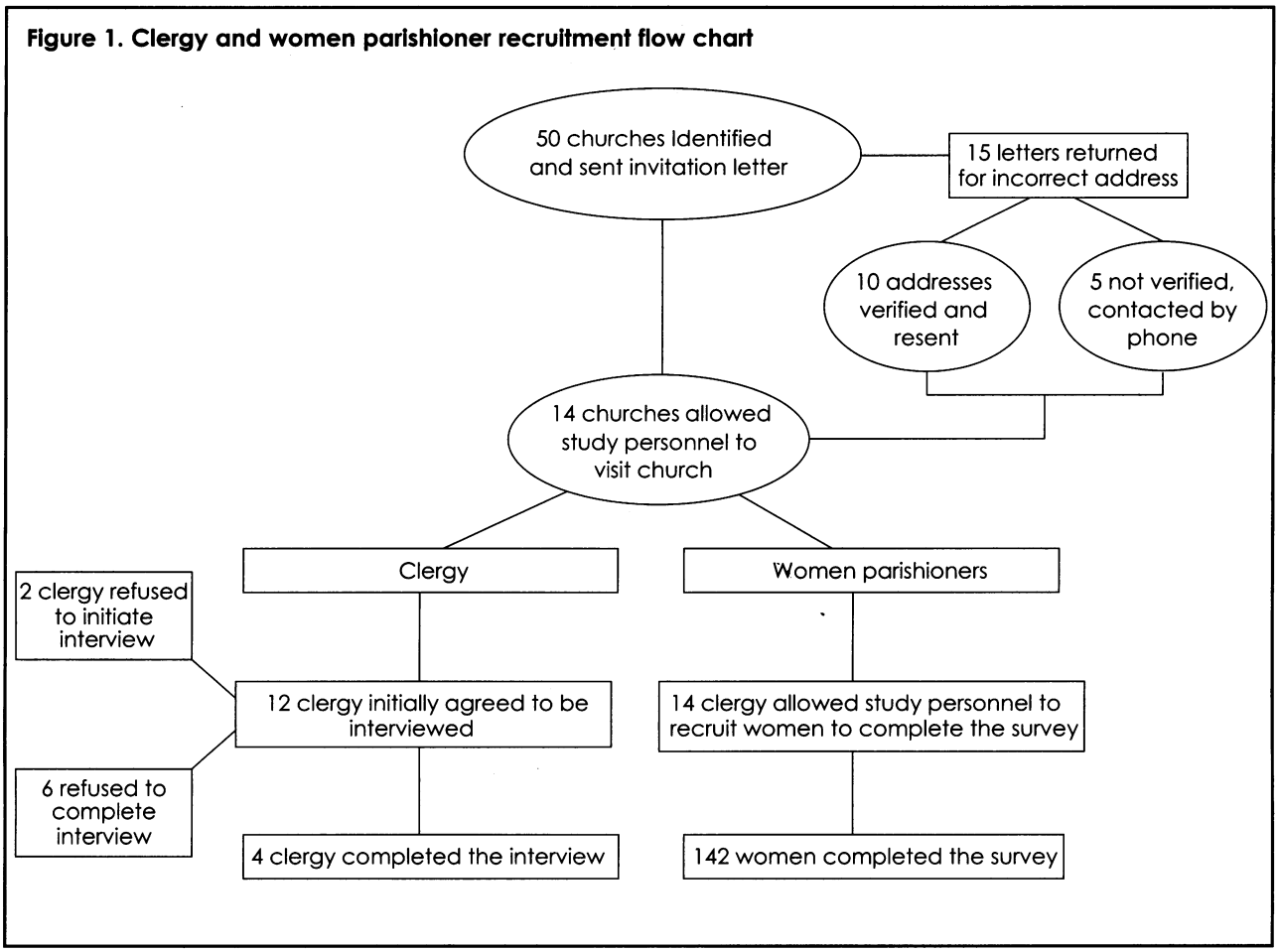
Similarly, in other studies, African-American women who have a perceived risk of HIV (for example, accepting that their partners were not monogamous) do not report using of condoms.[9]

A number of STDs/HIV and unintended pregnancy prevention interventions have been designed to target African-American women; however, little progress has been made in reducing rates.[11] In light of the increasing prevalence of these health issues, it is necessary to broaden prevention strategies. One strategy that has not been fully investigated for STDs/HIV and unintended pregnancy prevention includes partnerships with church and faith-based organizations.[12-15]

The church has historically played a major role in African-American culture. It often serves as both a social and spiritual outlet for church members and continues to be at the center of major movements in African-American culture.[16,17] Given the importance of the church and the burden that STDs/HIV and unintended pregnancy have on African Americans, inclusion of the church in efforts to reduce these rates would seem appropriate. Creating partnerships with faith-based organizations has improved participation and intervention outcomes in projects regarding diabetes awareness, physical activity and cancer prevention.[18-22] The previous success of these church interventions provides a potential model and opportunity to create a new intervention for STDs/HIV and unintended pregnancy prevention in the African-American population that can be implemented in many settings, community or church-based. There has been little research on the role of the church in combating the AIDS epidemic in African Americans. Recent research into HIV/AIDS prevention programs in the church setting brings to light some barriers such as financial issues and lack of resources that clergy experience to providing such programs.[23]

However, these sexual topics are more sensitive than topics previously considered. Given their sensitive nature, it is worth first exploring the need for sexual risk reduction programs among African-American women who attend church, the current messages that clergy provide to African-American women regarding sexual risks, and the feasibility of using churches in broadening prevention messages. This research, therefore, sought to determine: 1) perceptions of clergy regarding their current counseling and the need for future programs, 2) sexual risk behaviors among a group of African-American women attending churches, 3) women's attitudes regarding condom use, and 4) women's receptiveness to church programs regarding STDs/HIV and unintended pregnancy.

Figure 1. Clergy and women parishioner recruitment flow chart



METHODS

A list of >200 predominantly African-American churches in the Triangle area of North Carolina (defined as Wake, Orange, Durham, Chatham, Lee, Johnston, Franklin, Vance and Harnett counties) was compiled using the telephone directory searching for traditionally African-American denominations and the principal investigator (PI)'s (McKoy) personal knowledge of local churches. These counties, located in central North Carolina, are both rural (Chatham, Franklin, Johnston, Harnett and Vance) and urban (Wake, Durham, Orange and Lee).[24] Combined data from these counties show that African Americans represent approximately 23.6% of the population.[25]

Fifty church names were randomly selected for study inclusion. The leading clergy of selected churches were mailed a letter of introduction describing the project as an investigation into "the utility of a faith-based intervention to reduce the number of African-American women who contract HIV and other sexually transmitted infections (STIs)." This contact letter, mailed in June 2003, requested that clergy personnel either call the study personnel or return the enclosed appointment form with the most convenient time to call or visit the church. The letter explained that the intention of the scheduled visit was to interview clergy and/or survey female parishioners between the ages of 18–30. Approximately 15 letters were returned because of mailing

Table 1. Clergy interview questions

1. Do you see the effects of the sexual risk taking behaviors in your church and community? If so, how so and how often?
2. Do you have a program in your church or is there one in your community that counsels women on STDs/HIV? If so, do you participate or refer people?
3. What is your personal view on increasing (and barriers to) condom use among African-American women?
4. Do you feel qualified to counsel women on medical and social issues concerning STDs/HIV? If so, what do you think qualifies you? If not, would you be willing to be trained by a health educator or healthcare professional so that you would be qualified?
5. Do you feel your congregation would participate in a program that would include education concerning condoms, STDs and HIV?

Table 2. General characteristics of African-American women from churches in the Triangle counties of North Carolina completing the survey

	Mean	Range
Age	24.5	(18–30)
Number of Children	1.1	(0-5)
	n	**%**
Marital Status		
Married	39	28
Separated/divorced	4	2
Single	98	69
Widowed	1	1
Sexual Relationship		
Yes	131	92
No	11	8
Level of Education		
College degree	19	13
Graduate/professional degree	2	1
High school/GED	93	66
Tech or vocational school	22	16
Some high school	6	4
Household Income		
$10,000–$20,000	18	13
$20,000–$30,000	50	35
$30,000–$40,000	46	32
$40,000–$50,000	15	11
>$50,000	13	9

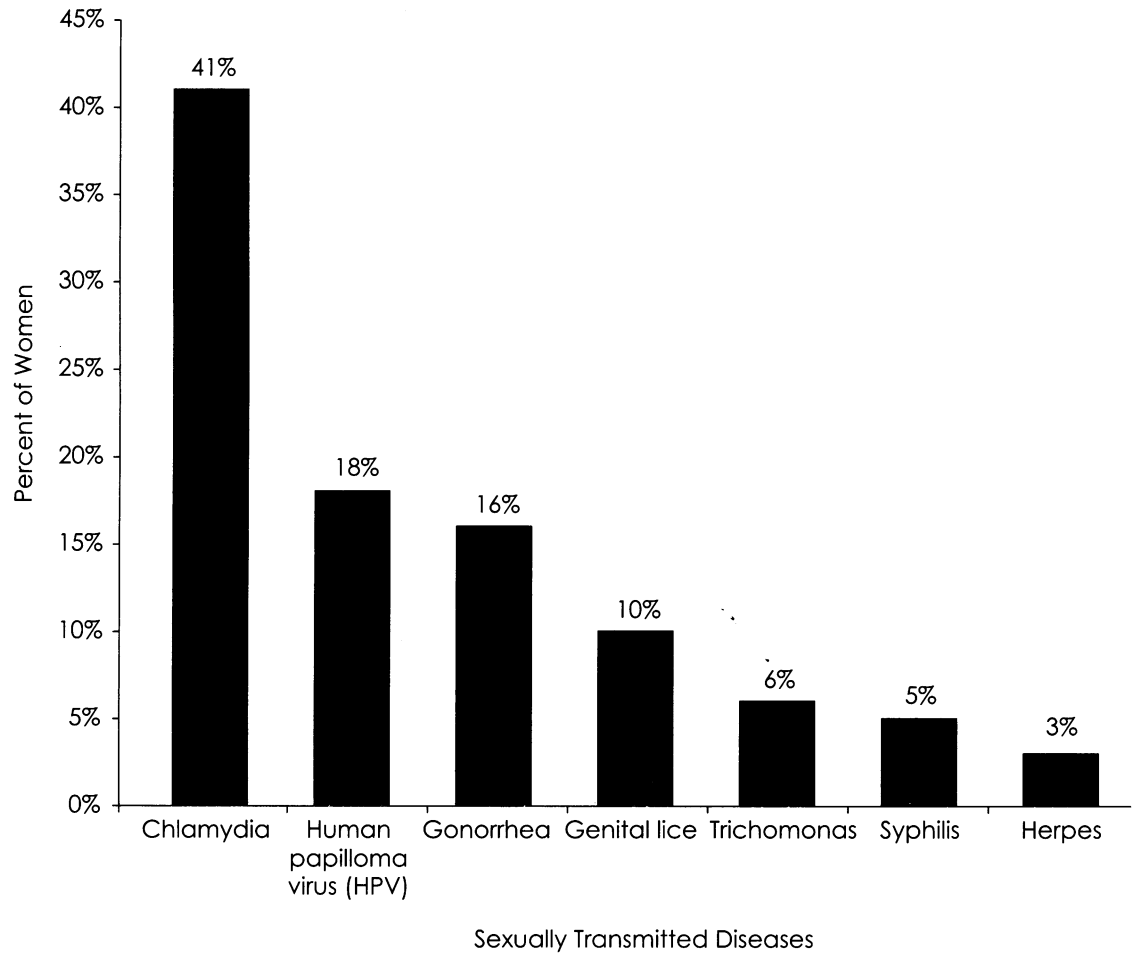
address discrepancies. Study personnel called each of these churches in an attempt to either verify mailing address or possibly speak to available clergy. Ten church addresses were updated, and the letters were mailed a second time. For churches whose addresses could not be verified by phone, study personnel called up to three times. Among the remaining 35 mailings, each church that did not respond within 10 days was also called three times in order to speak to available clergy.

Between July and October 2003, the PI visited the churches that agreed to participate during a major service, most often Sunday morning worship. Some clergy did not consent to be interviewed but did agree to allow study personnel to survey their female parishioners. Clergy personnel were interviewed privately in offices in the churches before Sunday morning worship. A semistructured interview guide was used for the clergy interviews (Table 1). The interviewer took notes during each interview and noted the sex and approximate age range of each clergy interviewed.

Participant recruitment was facilitated through clergy in two ways; either clergy introduced the project and study personnel to the congregation and encouraged women to take part, or clergy introduced study personnel to the congregation and allowed them time during the service to briefly explain the project. The target audience was female parishioners aged 18–30, based on the increased risk of STDs and unintended pregnancy for this age group.[5,26] Surveys and envelopes, to ensure privacy, were distributed to women at the conclusion of the religious services either in the church fellowship hall or in the sanctuary. Women were asked to complete the survey, place it in the envelope and return it to study personnel. Study personnel were available to read questions or explain any unfamiliar words, such as the names of STDs. However, no study personnel were approached with questions.

The survey questions addressed general demographic information such as age, marital status, education level and annual income. The survey also assessed past medical and sexual history, including condom use/nonuse and history of STDs. Consistent condom use was defined as an answer

Figure 2. Percentage of women reporting a history of an STD (n=142)



of "every time" when asked how often they used condoms during intercourse in the past 12 months. Inconsistent condom use was defined as any response where condoms were used less than "every time." Consistent condom nonuse was defined as an answer of "never" when asked how often condoms were used in the past 12 months.

Women were queried about their willingness to participate in a church intervention that would discuss women's health, including STDs/HIV and unintended pregnancy prevention. This section also included a Likert scale from 1–6, which sought to ascertain women's general confidence in condoms and their own sexual health, with a series of statements concerning condoms with which the women could agree or disagree (such as "I am more likely to use condoms when having sex with a new partner"). Choosing 1 on the Likert scale meant that women strongly agreed with the statement, and 6 meant they strongly disagreed.

No incentives were given for participation in the study. The institutional review board of the University of North Carolina approved the project.

RESULTS

Five (10%) churches responded—two by mail and three by phone—to the initial letters to 50 churches. Nine (18%) additional churches agreed, after speaking to the PI by phone, to have study personnel visit their churches either to interview clergy, survey women or both. Twelve clergy initially agreed to be interviewed by study personnel; however, only four completed the interview (Figure 1). Two clergy refused to initiate the interview after learning more about the topic, and six who began the interview refused to complete it because they did not feel the topic was appropriate to discuss in church. Of the clergy who completed the interviews, all were African-American, three out of four were female, and their approximate age range noted by the interviewer was 30–35 years old. Of the eight clergy who did not complete the interviews, all were African-American males, all approximately aged ≥45 years.

Perceptions of Clergy Regarding Current Counseling and Need for Future Programs

The four clergy who completed the interviews reported that their parishioners did not confide in them about STDs and that there were no programs currently in place to address them. Three of the four clergy personnel did not regularly counsel on STDs/HIV; when they did, it was based on either an abstinence-only policy with some biblical references (Romans 6:23, Exodus 20:14) or advising the parishioner to speak with a doctor. The four clergy expressed an interest in learning more and stated that they would readily accept the assis-

Table 3. Percent of women who "strongly agree," "agree" or "agree a little" with statements concerning condoms (n=142)

	Percent
Condoms work to prevent disease and pregnancy	83
I am not in danger of getting an STI or HIV/AIDS	85
I worry about getting pregnant when I have sex without a condom	11
Condoms make sex less enjoyable for me	73
Condoms make sex less enjoyable for my partner	77
I can relax and enjoy myself when I use condoms during sex	77
I have a latex allergy that makes me unable to use condoms	7
It is difficult to talk with my partner about using condoms	30
Using condoms means I don't trust my partner	78
If I ask my partner to use a condom he will believe I don't trust him	63
I am more likely to use condoms when having sex with a new partner	65
If I ask my partner to use a condom he will believe I'm having sex with other people	61
It is difficult to get condoms in preparation for sex	56
Condoms are hard to use in the heat of the moment	54
A condom can be used more than one time	46
Condoms can be stored in my wallet or glove compartment of my car	61
I have read the directions on how to properly put on a condom	49
I can tell by looking at someone if they have an STI or HIV/AIDS	35
The price of condoms prevents me from using them	56
I don't worry about getting an STI when I have sex without a condom	75

tance of a health educator to discuss sexual risks.

Among the 14 churches where women were surveyed, church populations varied from small congregations of approximately 20–25 up to >200 parishioners at each service. The 142 women who completed the survey were of varying socioeconomic and educational levels (Table 2). The women's ages were between 18–30 years old, with the average age at 25. Most women had ≥1 child (66%) and were currently in a sexual relationship (92%).

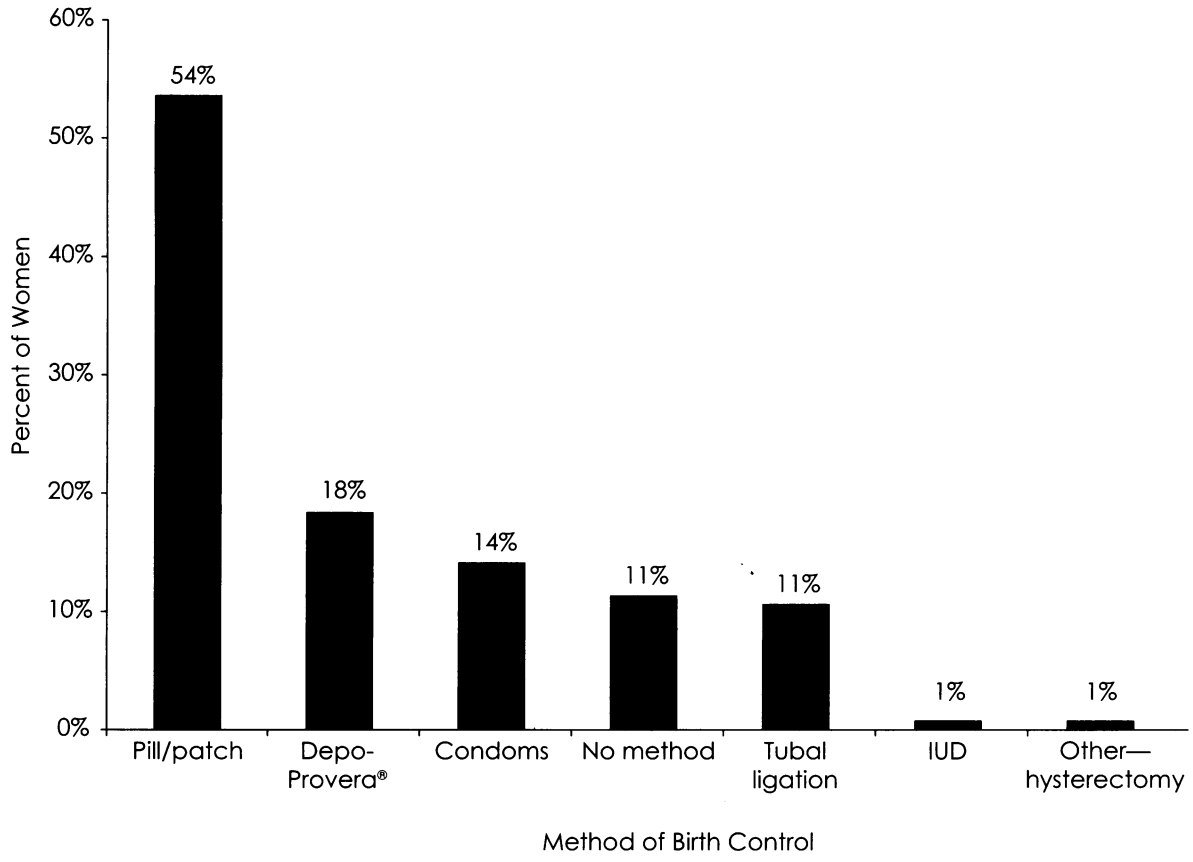
Sexual Risk Behaviors among a Group of African-American Women Attending Church

Many respondents had a medical and sexual history that put them at risk for contracting STDs, including HIV. As noted above, most women were currently in a sexual relationship (Table 2). Additionally, 82% of women had a history of an STD—most commonly, chlamydia (41%), human papilloma virus (18%) or gonorrhea (16%) (Figure 2). When asked about the number of sexual partners, 51% of women reported having 1–3 in their lifetime, while 98% of women reported 1–3 sexual partners in the past twelve months. Over one-third of women had more than 4–10 lifetime sexual partners and another 15% had ≥10.

The most popular form of birth control among the women surveyed was a hormonal method, including oral contraceptives or the patch (54%) (Figure 3). Other methods included the injectable Depo-Provera® (18%), tubal ligation (11%), condoms (14%), hysterectomy (<1%) or intrauterine device (<1%). The remaining 11% of women surveyed were not using any form of birth control.

In a separate query, women were asked about consistent condom use. Five percent of women had used condoms every time they had sex in the previous 12 months before the survey. Eighty-one percent of women did not use condoms consistently, stating that they used condoms "more than half of the time," "half of the time," "less than half of the time" or "almost never." The 13% of women who responded that they "never" used condoms in the last 12 months were considered consistent condom nonusers. Two women (1%) stated that this

Figure 3. Birth control methods among women completing survey (n=142)*



* Among those using condoms, 13 women also used another method of birth control

question was not applicable to them.

Among the 39 married women who completed the survey, two (5%) reported condoms as their method of birth control and six were using no method at all. Condom use was more common in single women; nearly 20% of single women reported using condoms. Rates of condom use during the last sexual encounter were not closely related to the number of lifetime sexual partners. Among women with 1–3 lifetime sexual partners, nearly 40% used condoms during their last sexual encounter, while 10% of women with >10 lifetime sexual partners used condoms when they last had sex.

Women's Attitudes toward Condom Use

Although a significant proportion of women had a history of STDs (84%), 85% did not believe they were at risk of STDs or HIV (Table 3). Most women (83%) had confidence in the ability of condoms to prevent disease and pregnancy; however, discussing condoms with their partners was difficult for almost one-third (30%) of women. Eleven percent of women worried about getting pregnant when they had sex without a condom, but contracting a sexually transmitted infection was not a worry to most women (75%) when they had sex under the same conditions.

Many women felt that the condoms introduced a level of mistrust in their relationships. Over three-fourths (78%) of the women surveyed felt that asking their partners to use condoms meant they do not trust them, and most (63%) believed their partners would assume they do not trust them if they asked him to use a condom. More than 60% of women felt that asking their partners to use a condom implied that they, the women, were having sex with other people. Additionally, when condoms were used, they felt that the sexual enjoyment was lessened. However, although many women felt that discussing condoms damaged relationships, nearly two-thirds (65%) of women were more likely to use condoms with a new partner.

Women's Receptiveness to Church Intervention Programs

Nearly all the women supported both community and church-based programs that focused on STDs/HIV and unintended pregnancy, including information on condom use and women's health, for teens and adults. Although women were willing to discuss STDs/HIV and unintended pregnancy prevention in church, they often felt clergy personnel were not available to talk about these issues. More than 85% of women had not spoken to someone in their church about STDs/HIV or unintended pregnancy. Of those who had spoken to someone in their church concerning these issues, they reported never speaking with clergy but most often to a friend (67%) or a family member (33%). None of the 14 churches surveyed had a program where issues concerning STD/HIV prevention could be discussed.

DISCUSSION

This is a unique approach to gathering clergy's perspectives at predominantly African-American churches about their method of counseling parishioners about STDs/HIV and unintended pregnancy. The difficulty in recruiting clergy into this study was an unexpected finding. The results of our study are remarkable because of the low response rate (8%) we had regarding our project, even with repeated mailings, phone calls and the PI's familiarity with the churches. It was clear that most clergy were not willing to address issues concerning sexual health. The church leaders' unwillingness to speak of these issues in general suggests that some parishioners may not have health education or support in reducing their sexual risk. The difficulty in recruiting churches into the study suggests barriers to implementing sexual health interventions in churches.

Despite the general lack of acceptance of this project, there was the small group of clergy who were willing to be interviewed and to consider having a women's health educator come to their church to inform women on prevention and safer sex practices. However, these clergy reported feeling tension with discussing STDs/HIV prevention with their church audience, primarily because they feel a responsibility to discourage sex before and outside of marriage. Understanding this, interventions should be designed that target minority church communities yet complement the clergy's message without giving conflicting messages around the issues of safer sex and responsible family planning.

As this and other work support, the African-American church serves as an important source of information, and many African Americans are willing to have more health education and intervention in the church.[18,20] The women surveyed were very open to an intervention to promote STDs/HIV and unintended pregnancy prevention, although many did not acknowledge that these issues were serious problems in their own lives as well as their communities. In the population that we surveyed, the majority of women had a history of a STDs, multiple sexual partners and inconsistent condom use, putting them at risk for future STDs/HIV. Condom use was affected by current marital status and the number of lifetime sexual partners. The finding that women who had more sexual partners were less likely to use condoms could be confounded by the fact that these women were usually older and married. The protective value of marriage and monogamy are still in question among African-American women.[9] Similar to previous research with African-American women, the women surveyed underestimated their personal risk of STDs/HIV.[9] This highlights the incongruent thinking that may lead people to take part in risky

behavior. And like research among young Latina women, these women did not want to "damage" their relationships by discussing condoms.[8] An intervention in these communities would need to describe the risk factors for disease and pregnancy and help women find ways to reduce their risk.

With the willingness of women to participate in educational programs concerning STDs/HIV and unintended pregnancy prevention and the cooperation of some clergy to have women's health educators in their churches, an option may exist to begin discussing taboo topics such as safer sex and STD prevention in select churches. To do this, the intervention should be mindful of the barriers that exist for both involving supportive clergy and assisting women in reducing their risk.

This project, intended only to be a descriptive study, was limited by the convenience sampling and the poor response rate from clergy (8%). Respondent numbers could have been affected by the "gatekeeper" model that sought to utilize the clergy in recruiting women. The study personnel did not recruit women without the permission of clergy; therefore, this may have affected the number of surveys that were completed by female parishioners. The women who participated may differ from women who did not participate simply because they had a church leader who was willing to allow study personnel to implement the survey and, in some cases, to interview clergy. We were unable to draw conclusions about women attending churches that we were unsuccessful in recruiting. The fundamental views of churches may differ vastly among churches who chose to participate and those that did not. Clergy personnel who agreed to take part in the interviews may have also had more knowledge concerning the need for STDs/HIV or unintended pregnancy prevention and therefore were more receptive to speaking about these issues with study personnel.

CONCLUSION

The church has been the leading and guiding force for major change in the African-American community. The epidemic of STDs/HIV and unintended pregnancy that plagues this community must also have input from the African-American church in order to make serious headway on a problem that continues to worsen each year. The burden that disease has on the African-American community, especially in comparison with other groups, highlights the need for new interventions that create partnerships between public health and church organizations to make a significant difference to decrease the rates of STDs/HIV and unintended pregnancy among African-American women. In order to ensure the success of any church-based intervention, clergy personnel must understand the seriousness of the problem and must buy into intervention strategies. Future research interests in this arena would need to consider ways to successfully do this. Education and training into the vastness of the AIDS epidemic in the African-American community and the consequences that follow this disease may be one way to draw attention to the issue and get clergy to see the need for more intervention and increase their own participation in combating this problem.

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