

Working With Faith-Based Communities to Develop an Education Tool kit on Relationships, Sexuality, and Contraception

Jennifer Torres

University of Texas Health Science Center at Houston, School of Public Health, jennifer.d.torres@uth.tmc.edu

Kimberly Johnson-Baker

University of Texas Health Science Center at Houston, School of Public Health, kimberlyjohnson@uth.tmc.edu

Sheryl B. Bell

University of Texas Health Science Center at Houston, School of Public Health, sheryl.b.bell@uth.tmc.edu

Jamie Freeny

University of Texas Health Science Center at Houston, School of Public Health, jamie.c.freeny@uth.tmc.edu

Sharon Edwards

sedwards@cornerstone.to

See next page for additional authors

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Authors

Jennifer Torres, Kimberly Johnson-Baker, Sheryl B. Bell, Jamie Freeny, Sharon Edwards, Susan R. Tortolero, and Honora I. Swain-Ogbonna

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INTRODUCTION

Although historic gains have been made in teen pregnancy prevention, geographic and racial/ethnic disparities remain a problem.¹ Nationwide, the teen birth rate fell 57% between 1991 and 2013² and decreased another 9% from 2013 to 2014.¹ However, teen birth rates are still consistently higher in the southern and southwestern regions of the United States² than in the rest of the United States, and they are higher among Black teens than among White teens.^{1,2} Texas, in particular, continues to have among the highest teen birth rates in the United States.² In 2015, the Texas rate was 34.6 per 1000, compared with the national rate of 22.3 per 1000, so that Texas, along with New Mexico, had the third highest rate in the United States.³ Furthermore, Black teens in Texas have a higher birth rate than their White peers (34.3 per 1000 compared with 20.9 per 1000).³ Given the broad effect of teen pregnancy on teen parents and their children,⁴ disproportionately affected communities would benefit from innovative approaches to address teen pregnancy. One such approach is to build the capacity of faith-based institutions to address the sexual health needs of their members, especially those that serve high-need communities. According to the Office of Adolescent Health, faith-based communities (FBCs) are critical to the sustainability of teen pregnancy prevention initiatives because they support the role of families in sexual health development, connect young people to caring adults and resources, and offer youth services or refer youth and their families to meet immediate needs.⁵ Given that the primary reason for the recent decline in teen pregnancy is attributed to both an increase in teens' use of contraceptive methods and an increase in their use of highly effective methods,⁶ it is imperative that teen pregnancy prevention efforts within FBCs include accurate information about effective contraceptive methods.

FBCs provide strong social networks and social capital resources, both of which are needed to sustain teen pregnancy prevention initiatives. This is especially true for African-Americans, who attend church more often than any other racial/ethnic group in the US population.⁷ Increasingly, FBCs serving African-Americans seek to provide sexuality education related

primarily to HIV prevention efforts, while balancing their role as purveyors of morality.^{8,9} Moreover, research indicates that faith leaders are receptive to sexual health information that is consistent with the core components of evidence-based sexual health interventions.¹⁰⁻¹² FBCs are well positioned to influence healthy sexual decision making among teens.¹³ When teens were asked in a national survey about factors that influenced their decisions to engage in sex, most reported that morals, values, and/or religious beliefs were the most influential.¹⁴

Accordingly, there is a need for comprehensive, user-friendly resources designed for FBCs that provide critical decision-making information related to pregnancy prevention, including contraception.¹⁵ Moore et al outline strategies for this type of effort, which include equipping church leaders with appropriate materials and activities “packaged in a tool kit to efficiently communicate about sex topics.” However, because of the perceived incongruence of the use of contraception with biblical teachings and the general levels of distrust based on historical complications, it is unclear how churches in the African-American community will receive a tool kit that provides extensive information on sexuality and contraception.^{16,17}

This article provides an overview of the development of a sexuality education tool kit inclusive of contraception for use in a Christian FBC.

METHODS

The sexuality education tool kit was developed as part of a larger, community-wide initiative aimed at increasing community support for greater contraception access for teens and young women residing in an underserved, predominantly African-American community in southeastern Texas.

We describe the development of the sexuality education tool kit in five phases: (1) building relationships with faith leaders; (2) piloting educational sessions within churches; (3) gaining insight from participating faith leaders; (4) creating the tool kit; and (5) collecting feedback from facilitator training and tool kit implementation for future evaluation.

Phases 1 through 3 were conducted according to common principles of community engagement and participatory action research¹⁸ to understand the current concerns related to teen pregnancy prevention and to ensure

mutuality for moving forward in the design of the sexuality education tool kit.

For phases 4 and 5, we used a theory- and practice-based approach to develop and implement the sexuality education tool kit. The Social Cognitive Theory¹⁹ and social influence models²⁰ guided content and structure, which were designed to encourage communication between parents and youth, healthy relationships, and sexual risk reduction with an emphasis on contraception. The Social Cognitive Theory posits that knowledge, self-efficacy, and outcome expectations play an important role in behavior and acknowledges the significance of role models in the environment. Social influence interventions emphasize the context of social interactions and social norms. Social influence models also informed facilitator training and implementation of the tool kit. We identified and used key community members in the community who were capable of influencing others.

The tool kit is also informed by previous practice-based research that underscores key elements in working with FBCs on sexual health, including involving FBCs in program development, partnering with a community liaison, incorporating spirituality and culturally appropriate messaging, and building the capacity to create a sense of ownership.²¹

Below we describe the five phases of development of the sexuality education tool kit.

Phase 1: Building Relationships With Faith Leaders

The first phase of program development – building relationships with faith leaders – was the most important and the most challenging. Historical and current-day racism has had a negative effect on the sexual and reproductive health of African-American women,²² so that a sensitive approach is required during education around these topics. African-Americans have a history of distrust of medical research, especially in regard to contraception. Conspiracy beliefs about fertility regulation and perceived discrimination are common and play a role in contraception use among African-American women.¹⁷ These factors cannot be ignored in teen pregnancy prevention efforts and require respectful and honest dialogue with community leaders. Based on community engagement and participatory action research,¹⁸ we enlisted the help of key members of the FBC to understand concerns related to teen pregnancy prevention and to

ensure that educational activities and materials were acceptable, respectful, appropriate, and medically accurate. We also sought the assistance of a community liaison familiar with church culture to reach out to local faith leaders who would participate in the piloting of educational activities. The community liaison connected with faith leaders in the area and approached the sensitive topic of sexual health education in the church. During initial meetings, faith leaders reviewed all educational content, which included topics on healthy relationships; sexual health (puberty, anatomy, consequences of sex); and contraception. All faith leaders were receptive to providing the educational content, including the information on contraception; however, they wanted to ensure that the greatest emphasis be placed on healthy relationships because they felt this was a neglected topic in adolescent sexual health development.

Phase 2: Piloting Educational Sessions Within Churches

During phase 2, nine churches agreed to pilot educational sessions for both parents and youth within their congregations. Experienced educators from our staff led the sessions. Graduate students were present during sessions to help take observational notes regarding activity implementation, participant reaction, and group dynamics. Youth and parents/adults participated in separate, simultaneous educational sessions. Each group participated in at least two sessions (in two cases, the youth requested an additional session). Health educators used a variety of educational methods during each session, including group discussion, video/song clips, interactive activities, role plays, and fact sheets with resources to take home for further discussion. Churches that participated received a financial incentive.

The parent/adult sessions focused on the importance of age-appropriate sexuality education inclusive of healthy relationships, puberty, reproduction, birth control, and strategies for starting and maintaining a dialogue about healthy sexuality. Although the sessions were parent-focused, it was important to include other adult influencers, especially grandparents. Grandparents often have a prominent role in the lives of their grandchildren and can be willing to have conversations about sexual risk reduction.²³ Including other adult influencers allowed more youth support and increased awareness among the community as a whole.

The youth sessions focused on characteristics of healthy relationships, puberty, anatomy and reproduction, and birth control, including

abstinence. The sessions also included an anonymous question-and-answer portion open to any topic related to sexual health. Participants were given a message about the importance of seeking information from a credible and trusted source, preferably a caring adult with whom they could have conversations related to sexual health.

Phase 3: Gaining Insight From Faith Leaders

For phase 3, faith leaders were invited to participate in a semi-structured, one-on-one interview to discuss their motivations for participating, congregant feedback, and their opinions regarding the role of the church in teen pregnancy prevention.

We conducted interviews with five faith leaders from participating churches. Interviews were conducted by the community liaison, and notes were taken by a member of our research team. Major insights emerged in the following three domains: (1) motivating factors, (2) working through barriers, and (3) feasibility and sustainability (**Table 1**). Insights gained from these interviews were used to inform the development of training activities, finalize tool kit materials, and plan for future evaluation.

All faith leaders felt that the primary motivating factor for their interest and participation was to provide education and meet the needs of their congregants. Many felt that the church has a major role in providing fact-based education, specifically for parents, so that they in turn can provide their youth with credible information. Although no one cited money as the primary motivator for participating, two faith leaders said that the financial incentive they received for participating was helpful, as they often face financial barriers that prevent them from providing additional educational programming to their congregants.

All faith leaders were comfortable with the topics covered during the educational sessions. One faith leader stated that some congregants were initially concerned that discussing contraception would “invite” youth to have sex; however, after the first session, they understood the benefit of youth understanding all the facts related to reproductive health. Faith leaders reported that the feedback from attendees in phase 2 was overwhelmingly positive. Adult congregants stressed that the sessions were much needed, and that if they had received the same information when they were young, they might have made more informed choices. When asked about comfort with the inclusion of contraception, church

leaders ultimately deferred to their responsibility to provide current, fact-based information to their congregation. One faith leader stated that even though discussing prevention methods like condoms and contraception conflicted with church teachings, he felt that parents had every right to do so. He even mentioned that as a father, his message would be different from his message as a faith leader.

All faith leaders agreed that training their congregants is key to ensuring that they continue to implement activities. Some also felt that having an outside agency provide the information ensured credibility and accuracy.

Table 1. Faith Leader Insights

Domain	Major Insights	Quotes
<p><i>Motivating Factors</i></p>	<p>A. The role of the church is to educate everyone, including pastors, youth ministers, parents, and youth by providing fact-based information.</p>	<p><i>I am not an expert on sexuality, I try to be an expert in the preaching of God's word, if we don't talk to young people about these topics, statistics will continue to increase, we have to educate.</i></p> <p><i>I believe what the Bible says as far as edifying, giving hope, sharing knowledge; what motivated me was the knowledge piece, I believed parents would gain from having this information.</i></p> <p><i>Youth ministers and workers need to be educated in order to provide factual information and guidance to youth in the church.</i></p>
	<p>B. It is critical to meet the various needs of those they serve.</p>	<p><i>Everything starts in church. Church is to be the foundation, pastors back in the day talked about everything, whatever people needed. Any topic you talk about, BC, sex awareness, etc is appropriate.</i></p> <p><i>The church is a spiritual place but obviously we have to be able to understand that Christ addressed all the needs of people.</i></p>

	<p><i>The need is the motivation, and the [offer of] finances made it clear.</i></p>	
<p><i>Working Through Barriers</i></p>	<p>Comfortable with topics, but concerned about initial parent reaction and message delivery (having leaders participate in training would alleviate this concern).</p>	<p><i>I feel that healthy relationships, healthy communication, puberty, and anatomy are most important; however, I don't think any of it makes me uncomfortable, not even contraceptives ... we have parents who may rebel, but if you talk to me I will intervene to make it happen.</i></p> <p><i>We got all positive comments after they participated in the sessions, some were reluctant and did not feel the topics were appropriate but after they heard about what was said they felt better.</i></p> <p><i>Sometimes we need to take people out of their comfort zone. If we can keep giving knowledge to the generation under us they can carry it on.</i></p>
<p><i>Feasibility and Sustainability</i></p>	<p>Training in-house membership is critical to ensure credibility and continuation.</p>	<p><i>I would be comfortable having some of my people trained, getting educated and gaining knowledge on the topic; they would be able to help the congregation and others they come across in the wider community. I don't think there is anything that would prevent me from offering this sort of session.</i></p> <p><i>I think it would be good to train someone internally, I would be comfortable having teen leaders learning so they can deliver the message and training ... I would not do it because I cannot do everything and pastors already have a lot of responsibilities.</i></p>

Phase 4: Finalizing the Tool Kit

In phase 4, the sexuality education tool kit is informed by evidence, theory-based strategies, and feedback from phases 1, 2, and 3. It comprises seven 1-hour sessions for youth and nine 1-hour sessions for parents/adults.

The youth sessions (**Table 2**) are designed to increase knowledge of the characteristics of healthy relationships, puberty, anatomy and reproduction, and effective methods for reducing sexually transmitted infections and unplanned pregnancy. They are also designed to address attitudes toward healthy decision making related to sexual behavior, encourage critical thinking, and offer local resources (ie, clinical services).

Table 2. Youth Session Topics

Session 1. Healthy relationships: What is healthy?
Session 2. Healthy relationships: Consent
Session 3. Know your body: Puberty
Session 4. Know your body: Anatomy and reproduction
Session 5. Making responsible decisions: Abstinence
Session 6. Making responsible decisions: Preventing HIV/sexually transmitted infections (STIs)
Session 7. Making responsible decisions: Birth control

The parent/adult sessions (**Table 3**) are designed to build comfort and confidence when they provide youth with age-appropriate, medically accurate information related to sexual health. Recurring messages throughout all sessions prompt adults to give open and honest responses to youth questions, avoid judgment and shaming, and stay engaged in the lives of their youth. The tool kit also includes an optional session on faith and adolescent sexuality; this includes a study guide containing Bible verses and discussion questions that support adolescent sexual health education.

Table 3. Parent/Adult Session Topics

Session 1. Healthy relationships: What is healthy?
Session 2. Healthy relationships: Setting personal boundaries
Session 3. Healthy relationships: Consent
Session 4. Healthy relationships: Abstinence and the consequences of sex
Session 5. Healthy relationships: Birth control
Session 6. Knowing how the body works: Anatomy
Session 7. Knowing how the body works—Puberty, menstruation, and reproduction
Session 8. Having the conversation, Part I: What to say
Session 9. Having the conversation, Part II: How to say it
Optional: Faith and adolescent sexuality study guide

Phase 5: Tool Kit Training and Implementation

During phase 5, we trained selected members of the church to facilitate use of the sexuality education tool kit, monitored implementation, and collected feedback to inform future evaluation. The selection of facilitators was determined by guidance from the pastor on the basis of their role in the church as respected, influential members in the community. A 1-day session was held with facilitators to train them on the contents of the tool kit and share lessons learned from phase 2. We trained 14 facilitators, who represented six churches, to implement the tool kit during the summer of 2016. A total of four churches implemented the tool kit. Two churches did not implement (in one case because of facilitator health issues; the other did not provide a reason).

RESULTS

Congregation Feedback

After the tool kit implementation, we collected 11 reaction surveys from participating youth (82% female) and 23 parents/adults (78% female). All participants were African-American. After attending the tool kit sessions, all adult participants reported that they felt more comfortable talking about healthy relationships, consent, puberty, reproduction, sexually transmitted infection (STI) transmission and prevention, and birth control. Among youth, 72% reported that they were more knowledgeable about healthy relationships, consent, reproduction, and STDs. In addition, we received promising feedback about intended condom use (82%), clinic use (64%), and birth control use (91%) if youth chose to have sex. This feedback warrants a full-scale evaluation of the sexuality education tool kit for FBCs.

Facilitator Feedback

Facilitators participated in a post-implementation focus group and provided the research team with feedback on successes, challenges, and suggestions for improvement (**Table 4**).

Overall, the facilitators had a positive experience with implementation and felt that the training was beneficial for building confidence and learning from others. They said the sessions were informational and well received by attendees. Facilitators were encouraged by the eagerness of youth to share information with peers. One youth used Snapchat to share part of the session with her friends, while another called her partner on the phone during the discussion about consent so he could listen in real time. It was reported that adults also appreciated the tool kit sessions, especially those on healthy relationships, acknowledging that the sessions helped them evaluate their own adult relationships.

A few challenges were noted. Facilitators reported that both adults and youth had difficulty with the concept of active consent in sexual situations and felt that one session did not allow enough time to address the topic thoroughly. The topic of anatomy and reproduction was also challenging for some facilitators because it was difficult to manage youth of varying ages and levels of maturity. Also, a few males (both adult and youth) did not want to learn about male body parts with the illustrated graphics. Another challenge for facilitators was attaining parental permission. This was because parents are often not present or involved in youth-centered, after-school, and summer activities.

Despite the challenges, most of the facilitators were not deterred from continuing to use the tool kit and offered suggestions to consider for future facilitators and future iterations of the tool kit. All facilitators felt it was important to inform parents adequately and acquire written permission for youth participation. They also felt it was important to “make it fun” for the youth by including music and snacks, and to incorporate technology into the educational sessions.

Table 4. Facilitator Feedback

Successes
<ul style="list-style-type: none">• Training was a good opportunity to learn from other facilitators.• Very informational; participants enjoyed it and thought more people need to hear it.• Some adults realized that their own relationship was not healthy.• Youth saw it as an opportunity to share information with friends.

Challenges

- Consent – participants (both parents/adults and youth) were reluctant to accept that “no response” means “no.”
- Parent permission was difficult to get because parents are not always involved in church.
- When it came to anatomy, some male adults didn’t want to know about male body parts.

Suggestions

- Be prepared for parents to think you’re teaching kids how to have sex.
- Get written parent permission.
- Make it fun – have snacks and music, and include technology.

DISCUSSION

We have described a theory- and practice-based approach to develop and implement a sexual education tool kit with an FBC in an underserved, predominantly African-American community in southeastern Texas. The approach of addressing sexual health in FBCs has substantial support,^{5,7-15,21} and this process confirmed its feasibility and acceptability.

Our formative work could be useful for health professionals using this strategy. The following are lessons learned for health professionals planning to work in FBCs:

- Find an appropriate community liaison. Our work would not have been possible without a community liaison who was familiar with church culture and who had a prominent and respected role in the community. The liaison enlisted the involvement of faith leaders who otherwise might not have been receptive to allowing our staff to work with their congregants.
- Work alongside the FBC from beginning to end to ensure that the intervention is culturally appropriate. For example, the initial goal of the tool kit was to focus mainly on contraception; however, after initial feedback and collaboration with faith leaders, more emphasis was placed on healthy relationships and consent, as these topics are often neglected but necessary to frame adolescent sexual health decision making. Within this framework, it was acceptable to educate about contraception.
- Clearly define the target population. It is not uncommon for families to travel to another community to attend church; therefore, working with a particular FBC does not guarantee that the surrounding

community is exclusively being served by that FBC. Additionally, youth involvement in an FBC does not guarantee parent involvement.

- Choose health professionals/educators who are comfortable and willing to participate in church activities. Our research staff was often included in group prayers and church services, and they had to be comfortable addressing questions about faith and sexuality. Thus, health professionals/educators must have a genuine respect for religious values to partner with FBCs effectively.

The unique social engagement and support network that exist in FBCs create an ideal environment for health promotion. Future steps for the research team will include an evaluation of the sexuality education tool kit with FBCs and the implications for dissemination if it is found to be effective.

CONCLUSION

In this project, we affirmed the willingness of FBCs to meet the sexual health needs of youth and their families. Faith leaders faced barriers similar to those reported in previous studies, including initial discomfort regarding sexual health topics and perceived opposition from the community.¹¹ However, faith leaders remained motivated to overcome barriers by their mission to serve their communities. A sexuality education tool kit that is respectful and guided by the input of an FBC can be a viable and innovative approach to address teen pregnancy.

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