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Bringing Evidence-Based Sexual Health Programs to Adolescents in Black Churches: Applying Knowledge From Systematic Adaptation Frameworks

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Abstract

Previous studies have documented Black churches' receptivity to implementing adolescent sexual health programs within their congregations. Some authors have argued for new sexual health programs to be designed specifically for churches, similar to the development of school- and community-based interventions. However, strategies and curricula used in secular settings may also be effective in influencing sexual behaviors among youth in churches. The current study examined the ways in which the phases of two theorized intervention adaptation frameworks were reflected in the desired key components of a church-based sexual health program. Participants in this community-based participatory research project were youth, parents, and faith leaders from nine Black churches in Baltimore, Maryland. Our findings suggest that the priorities of church stakeholders are consistent, rather than discordant, with the current paradigms of evidence-based sexual health programs and intervention adaptation. Future research and practical implications are discussed.

Keywords

adolescent health; community-based participatory research; faith-based; qualitative

Compared to their White peers, Black 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, 2011). Black churches may be a viable and sustainable location for prevention services, since they are often a central resource in distressed communities (Grayman-Simpson & Mattis, 2013; Lincoln & Mamiya, 1990). Black churches have historically been an important pillar of the African American community, and thus may be uniquely positioned to influence health

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outcomes among adolescents these communities (Billingsley & Caldwell, 1991; Coyne-Beasley & Schoenbach, 2000; Rubin & Billingsley, 1994). For example, Black churches have successfully implemented EBIs for adult congregants related to heart disease, diabetes, obesity, and cancer (Campbell et al., 2007). Thus, their interest in and capacity to address health are evident. Although few church-based health programs have targeted youth, adapting evidence-based interventions (EBIs) for adolescent sexual health may be a cost-efficient approach to disseminating them to community and church settings.

Churches are open to discussing sexual health topics within their communities (Lightfoot et al., 2012; McNeal & Perkins, 2007; Pichon et al., 2012; M. V. Williams, Palar, & Derosé, 2011; T. T. Williams, Dodd, Campbell, Pichon, & Griffith, 2014; Woods-Jaeger et al., 2014), but no study has yet reported sexual health outcomes for a church-based sexual health program for youth. One publication has detailed the adaptation of an evidence-based sexual health curriculum to the church setting for adults (Wingood et al., 2013). Another study adapted several EBIs for adolescents in a church setting but did not report sexual health outcomes (Marcus & Marianne, 2004). Still, these preliminary findings demonstrate the feasibility of promoting sexual health among churchgoing adolescents. These findings beg us to systematically adapt evidence-based sexual health programs to improve adolescent health outcomes through partnerships with churches.

The systematic process of adaptation allows researchers to modify programs and make them more culturally relevant, without significantly reducing the effect of the program (Tabak, Khoong, Chambers, & Brownson, 2012). A number of models exist to assist with the widespread dissemination and implementation of evidence-based health interventions. In particular, two research groups have synthesized the work in this area to develop theory-based frameworks, which provide a guide for program adaptation in communities to reach vulnerable groups. Wingood and DiClemente's (2008) ADAPT-ITT (Assessment-Decision-Administration-Production-Topical experts-Integration-Training-Testing) model consists of eight sequential phases that inform researchers of a prescriptive method for adapting EBIs. Nápoles, Santoyo-Olsson, and Stewart's (2013) approach outlines seven methodological phases for adaptation that focus on the integration of the EBI with community best practices. Table 1 outlines the phases of both frameworks along with key components of sexual health programs desired by participants. The current study examined the ways in which the phases of these two theorized intervention adaptation frameworks were reflected in the desired key components of a church-based sexual health program. In this study, adolescent sexual health programs were defined as activities that were tailored for the developmental needs of adolescents and explicitly discussed sexual and reproductive health topics.

Method

This research project was designed and conducted collaboratively by a university and community organization. We adhered to the principles of community-based participatory research (Israel, Eng, Shulz, Parker, & Satcher, 2012).

Participants

Four groups of participants from nine Black Christian churches were selected to participate: senior pastors, youth ministers, parents of youth aged 13 to 19 years, and young people aged 13 to 19 years. The senior pastor ($n = 9$) and youth minister ($n = 9$) from each congregation participated in an in-depth interview. A total of 45 youth (ages 13–19) and 38 parents participated in 15 focus groups. All participants identified as Black/African American. No identifying information was collected from focus group participants.

Measures

Semistructured, in-depth interview and focus group protocols were collaboratively developed by university and community partners. The protocols were designed to guide a discussion on the church's potential influence on its youths' sexual and reproductive health. Questions included inquiries about general adolescent characteristics, existing youth programs, and issues faced by teenage congregants.

Procedures

All interviews were conducted by a team member from the university with a team member from the community organization serving as a note taker. Nearly all of the interviews and the focus groups were held at the individual churches. All focus groups were held separately but simultaneously. Each adult participant provided written, informed consent prior to participation. Written parental permission and informed assent were obtained for all participants who were younger than 18 years of age. In-depth interviews ranged from 67 to 145 minutes in duration while focus groups ranged from 46 to 125 minutes in duration. At the conclusion of each interview, pastors and youth ministers were thanked for their participation and given information about the next steps of the broader research project. At the end of each focus group, participants were given \$25 for their time.

Data Analysis

All interviews and focus groups were digitally recorded and transcribed by a professional transcriptionist. Each recording was verified by a study team member, who corrected any discrepancies or omissions. These verified transcripts were then imported into Atlas.ti qualitative data analysis software. Data were analyzed using a content analytic approach (Hsieh & Shannon, 2005). The study team developed a preliminary codebook based on the interview and focus group guides and the specific aims of the study. An iterative process was applied to identify additional codes that emerged from the transcripts. There were 45 codes in the final codebook. After independently coding transcripts, two coders met to review and compare codes. All discrepancies were discussed and resolved by consensus. Once all transcripts were coded, the codes were compared across documents to identify commonalities. Peer debriefings were used to enhance the credibility and trustworthiness of our findings (Creswell, 1998; Miles & Huberman, 1994).

Results

The alignment between the adaptation phases and participants responses are described below. Table 2 includes a list of representative quotes for each theme.

Engaging Stakeholders

Both adaptation frameworks begin with a structured engagement of stakeholders. Wingood and DiClemente (2008) call this first phase “Assessment,” which includes focus groups, interviews, and needs assessments, while Nápoles et al. (2013) break the process into two phases: building partnership infrastructure and gathering information from multiple inputs. Similarly, participants in the current study identified the involvement of stakeholders, especially that of pastors and parents, as crucial to implementation success (Quote 1). Participant comments are also consistent with program effectiveness literature; a review of school-based sexual health interventions found that involvement from family and communities was associated with program effectiveness for adolescents (Busch, Leeuw, Harder, & Schrijvers, 2013). Engaging church stakeholders in the planning process is described as advantageous in two specific ways. First, it allows researchers to elicit buy-in from potential implementers and champions. Second, these early conversations enable partners to collectively identify barriers and develop solutions before implementing a program. Therefore, our findings reflect congregants’ accurate assessment of the important first steps in the implementation adaptation process.

Identifying the Evidence-Based Intervention

The next phase of adaptation as described by Nápoles et al. (2013) and Wingood and DiClemente (2008) is the selection of an appropriate EBI based on the current research and the knowledge gained from community input and needs assessments. There has been substantial investment in developing adolescent-focused sexual health programs in schools, clinics, and community settings. Analyses of these programs have posited the following key features of effective interventions: a theory-driven approach, contraceptive knowledge building, interactive education to support skill building, and a focus on sexual behavior change (Franklin & Corcoran, 2000; Frost & Forrest, 1995; Kirby, 1999, 2002; Nation et al., 2003; Robin et al., 2004). A few studies have shown that certain content of evidence-based sexual health curricula may conflict with church values (Lightfoot et al., 2012; Woods-Jaeger et al., 2014). Nonetheless, evidence from our study suggests that church members and leaders are amenable to implementing evidence-based sexual health programs possessing the following qualities: (1) authenticity of the curriculum, (2) relevance to youth, and (3) prioritization of relationships. Each subtheme is described below.

Authenticity of the Curriculum—Adult participants identified abstinence until marriage as preferable but also acknowledged that youth do not always choose abstinence. Therefore, comprehensive sexual education within their congregations was unanimously deemed to be the best option (Quote 2). Specifically, participants supported the delivery of comprehensive, accurate and candid information about sexual health including sexually transmitted diseases and contraception. Youth participants were especially vocal about the straight-forward delivery of sexual health information (Quote 3). This finding is encouraging because many EBIs for adolescents include a discussion of both abstinence and contraception, as well as the risks of unprotected sex and methods to avoid these risks (Franklin & Corcoran, 2000; Frost & Forrest, 1995; Kirby, 1999, 2002; Nation et al., 2003). Thus, the format of many existing EBIs likely meets the expectations set by churchgoing youth, parents, and faith leaders.

Relevance to Youth—Effective sexual health programs should deliver developmentally and socioculturally content that is relevant to participants (Franklin & Corcoran, 2000; Nation et al., 2003). Consistently, participants expressed the need for educational activities that were both relevant to their social contexts and applicable to their daily lives (Quote 4). Rather than resisting such activities, church leaders welcomed all strategies to engage youth and reduce youth sexual risk taking. Many sexual health EBIs for adolescents already include activities that address social pressures and allow participants to personalize information received (Kirby, 1999). Our findings offer additional support for tailoring programs to the adolescents' lived experiences, rather than diluting information because the program delivery site is a church.

Prioritization of Relationships—Participants were also concerned with providing youth the skills to build relationships and establish healthy boundaries. Youth participants expressed an especially strong interest in learning more about these topics; many had witnessed the negative impact of teen dating violence within their friendship networks (Quote 5). Teaching communication and negotiation skills within a relationship are essential components of evidence-based sexual health programs (Franklin & Corcoran, 2000; Frost & Forrest, 1995; Kirby, 1999; Robin et al., 2004). Therefore, evidence-based sexual health interventions for adolescents are already designed to address one of the key concerns of the faith leaders as well as African American churchgoing youth and their families.

Adaptation

After an EBI is selected for implementation, the next step is to adapt and integrate the content for the community (Nápoles et al., 2013; Wingood & DiClemente, 2008). The discussion of sexual health topics may evoke silence and discomfort in some churches. Therefore, framing adolescent sexual health in a way that is respectful and shame-free is essential. Participants believed that religious principles such as the imperfection of human beings and forgiveness would allow churches to discuss sexual health without condoning continued sexual interactions outside of marriage. A variety of stakeholders also proposed the use of scripture to introduce a range of relevant topics such as sex, sexual expectations, and relationships (Quote 6). Furthermore, adolescents themselves were enthusiastic about drawing parallels between scripture and sexual health. Such adjustments to an evidence-based sexual health program align with adaptations for culturally diverse groups. The existing adaptation frameworks include processes for integrating culturally relevant information and EBIs. Thus, incorporating religious values and scriptural texts into an existing EBI could be one example of a church-based iteration of the EBI.

Final Steps

The final steps of adaptation include equipping and training community members in the intervention, implementing the program, and conducting a rigorous evaluation of the adapted program (Nápoles et al., 2013; Wingood & DiClemente, 2008). Evaluation of adolescent health programs in churches has not been the norm (Campbell et al., 2007). Nonetheless, evaluation is essential to the development of effective programming based in evidence. Strong evaluations of church-based sexual health programs will facilitate the acceptability

and uptake across congregations and increase their reach and impact on the most vulnerable youth.

Discussion

Previous researchers have provided methods to facilitate the systematic integration of evidence-based programming into new settings. Findings from the current study suggest that existing adaptation frameworks can be applied to deliver evidence-based sexual health programs to adolescents in church settings. Formative research has shown that implementing sexual health programs in churches is desired and feasible (Marcus & Marianne, 2004; McNeal & Perkins, 2007; M. V. Williams et al., 2011; T. T. Williams et al., 2014). Our findings suggest that the priorities of church stakeholders are consistent, rather than discordant, with the current paradigms of evidence-based sexual health programs and intervention adaptation.

Despite our findings, several challenges have been noted regarding church-based adolescent sexual health programs. There continues to be considerable stigma around sexual orientation (Cunningham, Kerrigan, McNeely, & Ellen, 2011; Lease & Shulman, 2003). In addition, many faith leaders lack the skills and knowledge to effectively address these issues in their congregations (Kruger, Lewis, & Schlemmer, 2010; Lightfoot et al., 2012; Pichon et al., 2012). Funding and coordinating change among multiple constituencies also limit the ability of some churches to implement evidence-based sexual health programs (Stewart, 2014; M. V. Williams et al., 2011). Furthermore, parents and adolescents often have discordant views about the key components of sexual health discussions. Assessing and building capacity within the churches and families are implicit in the first steps of both adaptation frameworks. Engaging key stakeholders in developing effective, tailored solutions to these challenges will likely facilitate successful uptake and implementation of such programs among churches.

This study is not without limitation. There was an overwhelmingly positive response to providing adolescent sexual health programs in churches among our participants. It is possible that this positive response was due to selection bias. The small sample size also limits the generalizability of the study to other communities. Faith leaders and religious families in this study may be more open to adolescent sexual health programs than elsewhere because of the high rates of HIV infection and early pregnancy in Baltimore, Maryland. We did not collect demographic data on participants. Therefore our ability to contextualize the responses was also limited.

Despite these limitations, this study makes several important contributions to the literature. This is the first study to use qualitative data to support the theorized methodological phases of adaptation. Our findings provide a road map for future researchers to successfully adapt adolescent sexual health programming into church settings. This study also incorporated input from a variety of stakeholders, including youth, parents, senior pastors, and youth ministers. This diversity of views presented a representative understanding of the degree to which participants endorsed church-based adolescent sexual health programs.

The higher risks of disease and unwanted pregnancy that Black youth experience are real and urgent. The field is now well positioned to adapt evidence-based sexual health programming to church settings in order to reach Black adolescents. We have the tools to foster better health outcomes; it is incumbent on us to use them as we seek to improve the well-being of our nation's young people.

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Table 1.**Outline of Two Adaptation Frameworks and Participant Desires.**

Theme	Adaptation Framework 1: Wingood and DiClemente (2008)	Adaptation Framework 2: Nápoles, Santoyo-Olsson, and Stewart (2013)	Participants' desired key components
Theme 1: Engaging Stakeholders	1. Assessment of community needs by engaging with population and key stakeholders	1. Establish infrastructure for translation partnership	1. Engage with church members and leaders
Theme 2: Identify Evidence-Based Intervention	2. Decision: selection of an evidence-based intervention to be adopted or adapted	2. Identify multiple inputs—information gathering	2. Identify evidence-based intervention consistent with needs of youth in churches
Theme 3: Adapt	3. Administration of theater tests to evaluate reception	3. Review and distill information—synthesis	3. Incorporate scripture and religious values consistent with sex education
Theme 4: Final Steps	4. Production of adaptation 5. Engagement of topical experts to provide feedback 6. Integration of expert advice to adaptation 7. Training of staff to implement program 8. Testing of pilot program	4. Adapt and integrate program components—translation 5. Build general and specific capacity—support system 6. Implement intervention—delivery system 7. Develop appropriate design and measures—evaluation	4. Implement and evaluate

Table 2.

Representative Quotes From Study Participants.

Quote number	Theme	Participant	Quote
Quote 1	Engaging stakeholders	Youth minister	There will probably be some things that we need to go through with the parents first to let them know what the curriculum looks like. And maybe even getting input from them about what information they think the children need to have and how they see that ... Some parents are very comfortable in being very honest in giving their children information. Some still are not.
Quote 2	Authenticity of Curriculum	Parent	Because realistically we know that some young people are going to get sexually involved so they should know what choices are available to them and how to protect themselves.
Quote 3	Authenticity of Curriculum	Youth	I feel as though they should keep it real, like don't tell me about the birds and the bees, don't tell me that at all, just tell me the real deal, I'm 17.
Quote 4	Relevance to Youth	Youth minister	We need to focus on the things that they idolize. We need to focus on the rap artists, the R & B artists. We need to focus on the type of clothes. We need to focus on the social ills that are going on. Because a lot of times, the social ills are what's pushing them into those different areas, because they're being glorified in certain ways.
Quote 5	Relationships	Parent	I don't feel that relationships are discussed enough. I feel that they are given plenty of information on the sexuality part, but I don't think that how to have a relationship, how to approach a relationship, why should you have a relationship, any of the guidelines for being in a relationship, I don't think that is discussed often enough. And love doesn't always mean sex, you know.
Quote 6	Adaptation	Youth	I mean like I said they talk about sex in the Bible so they can kind of relate it like, I don't know, like bring it together, like talk about how sex is ... in the Bible and religion and how it is in real life.