Teen Pregnancy Prevention and African American Faith-Based Organizations: Lessons Learned from the Southern Nevada Teen Pregnancy Prevention Project

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Abstract
African American faith-based organizations have long been recognized as vital resources in the African American community. Within the Social Determinants of Health Framework, various barriers and facilitators to implementing HIV and STI prevention activities within these faith-based organizations have been identified. The Southern Nevada Teen Pregnancy Prevention project implemented an evidence-based teen pregnancy prevention intervention targeting African American youth ages 14-19 years in African American faith-based organizations in Clark County, NV. This manuscript presents the lessons learned from this project. In addition to confirming some of the barriers and facilitators previously identified in the literature, this manuscript also identifies additional barriers and facilitators based on the experiences of this project, which can further enhance future work with these organizations.

Introduction
African American faith-based organizations (FBOs) are cornerstones of and respected institutions within the community in which they are located. Often, these FBOs are not only a place of worship, but serve as a collective voice for change, advocate for social justice and human rights, serve as a meeting place for social action organizations, and provide education and information, including health education to its members [1-3]. As such, these FBOs represent a potentially underutilized partner for public health programming, addressing health disparities, and providing a targeted audience with education and/or HIV prevention services are:

- The doctrine of the FBOs may vary across denomination, such that certain denominations may be more accepting of issues related to sexuality and religion than others [5,3].
- Addressing reproductive health issues can conflict with the religious doctrine [4,3,7].
- Evidence-based strategies and interventions are not congruent with the beliefs and culture of the FBO [2].
- Unwillingness of or lack of interested by FBO leadership to provide comprehensive sexuality education and/or HIV prevention services [1,6].
- Promoting condoms can be viewed as condoning sex [2].
- FBOs face financial and resource constraints that inhibit ability to provide comprehensive sexuality education and/or HIV prevention services [7,8].
- Stigma and homophobia may exist among FBO leadership and/or congregation [7,3].
- FBOs may want to emphasize abstinence instead of comprehensive sexuality education [1].
- Congregation and/or leadership may not think that the youth affiliated with their FBO are at risk for HIV/AIDS, STIs, and/or teen pregnancy [1].
- Lack of knowledge by FBO leadership about the severity of the local issues related to HIV/AIDS, STIs, and/or teen pregnancy [7].
- Discussing human sexuality in faith settings is considered to be inappropriate [7].
- Age, lack of experience, and experience of pastor may make an FBO less likely to participate [7].

In spite of the barriers that may prevent the participation of FBOs in comprehensive sexuality education and/or HIV prevention services,
The Center for Health Disparities Research (CHDR) at the University of Nevada Las Vegas (UNLV) along with its partners received funding for the Southern Nevada Teen Pregnancy Prevention Project (SN-TPPP) from the Office of Adolescent Health (OAH) at the US Department of Health and Human Services to implement an evidence-based teen pregnancy prevention intervention. The purpose of SN-TPPP was to implement the evidence-based teen pregnancy prevention intervention, Becoming a Responsible Teen (BART), with African American youth between the ages of 14 and 19 years in African American FBOs in Clark County, Nevada. In order to participate in the project and receive the intervention, parents/legal guardians completed a registration packet that included an informed consent form.

BART was developed for use with African American youth, optimized contact time into 8 intervention sessions, and was designed to be implemented in community settings [14]. BART has been shown to be effective in HIV prevention intervention, as well as reducing rates of and behaviors associated with teen pregnancy, as well [14]. Table 1 outlines the BART curriculum.

<table>
<thead>
<tr>
<th>Session Title</th>
<th>Session Focus</th>
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</thead>
<tbody>
<tr>
<td>Session 2: Making Sexual Decisions and Understanding Your Values</td>
<td>Focuses on HIV/AIDS related stereotypes and associates HIV with drug use</td>
</tr>
<tr>
<td>Session 3: Developing and Using Condom Skills</td>
<td>Focuses on discussing proper condom use in preventing HIV/AIDS</td>
</tr>
<tr>
<td>Session 4: Learning Assertive Communication Skills</td>
<td>Focuses on strengthening problem solving and communication skills with potential partners</td>
</tr>
<tr>
<td>Session 5: Practicing Assertive Communication Skills</td>
<td>This session enhances Session 4 by incorporating participants to practice utilizing their assertive communication skills by roleplaying in cumbersome situations</td>
</tr>
<tr>
<td>Session 6: Personalizing the Risks</td>
<td>Focuses on group discussions to probe feelings about peers and others living with HIV/AIDS</td>
</tr>
<tr>
<td>Session 7: Spreading the Word</td>
<td>Focuses on reviewing the previous six sessions that prepare the participants to disseminate the learned information to their family and friends about HIV/AIDS</td>
</tr>
<tr>
<td>Session 8: Taking BART with you</td>
<td>Participants communicate how the program has affected their lives</td>
</tr>
</tbody>
</table>

The Social Determinants of Health Framework as related to teen pregnancy prevention were also a key consideration when implementing and program. Clark County, Nevada is an optimal area to address a teen pregnancy [15]. Implementing BART with African American teens serves to increase knowledge, skills and access to health resources in order to further close the gap and support health equity by reducing teen pregnancy.

To implement BART, project staff recruited African American FBOs to participate in the project. FBOs served as the host site for the implementation of the project and recruited youth to participate. Project staff worked with the FBOs to schedule the onsite sessions. FBOs were asked to provide a liaison to the project. This person was responsible for reminding youth to attend the sessions and communicating information between FBO leadership and project staff. The project provided the intervention materials, a substantial snack for session participants, trained facilitators as well as monitored the implementation. FBOs that participated were compensated $500 by the project to offset expenses that may have occurred as a result of their participation.
Results

Over a 5 year period, the SN-TPPP implemented the BART intervention in 35 unduplicated African American FBOs in Clark County, NV. Five hundred (500) African American teens between the ages of 14 and 19 completed 75% or more of the intervention sessions. Over 70 persons from the community were trained as facilitators to implement the evidence-based intervention with fidelity. The results presented below reflect the experience and lessons learned from the implementation of project activities.

Lessons Learned

Numerous lessons were learned from this project. The lessons were identified as either barriers or facilitators to the implementation of the project. The facilitators are presented first followed by the barriers.

Facilitators

The following are lessons that were learned by the project, which resulted in the successful implementation of the project and intervention.

Invested FBO Leadership: Pastors embraced the need for teen pregnancy prevention as well as HIV/STI prevention for youth. Regardless of participation in the project, pastors generally felt that that education focused on teen pregnancy prevention was needed in the community. Among those pastors whose FBOs participated in the project, those pastors reported knowing someone who was infected with HIV, having been a teen parent, teen pregnancy occurring within their FBOs, and/or recognizing that teens that attended their FBO were at high risk for HIV, STIs, and/or teen pregnancy. In some cases, pastors reported that even though they felt that a potential conflict between the project and church doctrine may exist, they felt that the need to educate their youth in a modern world, which meant that they had to confront issues associated with risky sex behavior(s).

Present the Abstinence Message: A method for addressing the potential conflict with religious doctrine was the development and implementation of a session on abstinence that was added to the beginning of the intervention as the first session. The session focused on abstinence based on information from existing sexual education resources was developed by SN-TPPP staff specifically for this project. This session received the approval of the Office of Adolescent Health to ensure that this adaptation did not compromise the original intent of the intervention. Pastors appreciated the recognition that their beliefs reflect abstinence and that the abstinence message was carried throughout the intervention as the only 100% method for remaining HIV-free and not pregnant.

Use Ready-Made Groups: The project had its most success when implementing the intervention with FBOs that had youth groups that met on a consistent basis. When the project was able to implement intervention sessions on the same night and at the same time that the youth group at the FBO usually met, then youth were more likely to attend the sessions. Asking youth to come on a night when they normally do not attend activities at the FBO created transportation issues for the youth. In addition, sessions followed the schedule that these groups generally had, so intervention sessions were postponed a week if the FBO had an event that conflicted with an intervention session. The school calendar was also taken into consideration. The project staff learned that if youth were not in school on a particular day, then they were generally less likely to come to intervention sessions at the FBO.

Make Participation for Youth Easy: FBOs were asked to identify a liaison from within who knew the youth, could help recruit participants, and work with project staff. The liaison was also responsible for sending out reminders about the intervention session schedule. This person could follow up with youth who did not attend a session(s) to work with them and their families to promote attendance.

Since intervention sessions lasted 1.5 to 2 hours and were held on weekdays, providing participants with a substantial snack allowed for sessions to infringe upon the evening meal time. Initially, FBOs that participated early on in the project were compensated more money to provide this snack. Over time, due to the limited space and resources that some FBOs had, the project assumed the role of providing the snack from local restaurants. The financial compensation that was then provided to the FBOs was reduced to reflect their reduced responsibility.

Condom Demonstrations Can Be Done in FBOs: The condom demonstration session was treated like any other session as a part of the BART intervention. Project staff and intervention facilitators did not call attention to this session of the intervention either during discussion with FBO leadership about participation and in explaining the intervention to participants. To respect the FBO and its members, wrappers, condoms, and other trash used in the demonstration were gathered and disposed of by project staff and intervention facilitators outside of the FBO. Condoms were not readily made available for teens through the project, but were provided to those who specifically asked for them. Project staff and intervention facilitators also provided participants with referrals to local resources, including condom distribution sites and sexual health clinics, upon request.

Use Community Persons to Implement the Intervention: For this project, the intervention facilitators were community persons who were trained by the project to implement the intervention. Each facilitator completed 20 hours of training, which included 16 hours of intervention training plus an additional 4 hours of training on the project and mandatory reporting. During the training, participants were observed by project staff to determine which persons were most ready to be facilitators and which persons needed some additional support from the project before being assigned an FBO site. As new facilitators were trained over the course of the project, they were paired with facilitators who had experience with implementation of the intervention so that the newer facilitator could have additional hands on training. Additionally, to facilitate a safe and confidential environment for participants, facilitators that had any type of relationship with a specific FBO were not allowed to implement the intervention at that FBO.

In accordance with funding requirements, intervention facilitators were formally observed by project staff. This observation was guided by a checklist, based on the intervention. Where appropriate, feedback for improvement was provided. Facilitators also documented fidelity in the implementation of the intervention after each session.

Availability of Project Staff: In addition to the FBO providing a liaison, a project staff member was also onsite during the implementation of the intervention session. The role of this person was to serve as a liaison between the project, intervention facilitators, and FBO; troubleshoot problems that may arise onsite; answer questions that parents and others may have about the project; ensure that project-related materials and supplies were available; receive the delivery of the substantial snack; and ensure that intervention sessions were implemented as planned. In order to maintain the safe and confidential environment for participants, the onsite staff person did not teach intervention sessions, except in emergency situations when a facilitator was not able to attend the session.

Barriers

The following identified barriers challenged the successful implementation of the project and intervention. Where appropriate, strategies for addressing the barrier that arose are provided below. In some cases, strategies to address the barriers could not be identified and implemented; so consequently, are not presented here.

Conflict with Religious Doctrine: Project staff made sure to not discuss religious doctrine with pastors and FBO leadership, in part because project staff is not as familiar with the doctrine. Due to federal funding, project staff had to adhere to a policy in which federal funds could not be used to support religious doctrine. As such, project
staff had to ensure that activities, such as having prayer at the beginning
or end of a session, were done separate from the project-related
activities. Pastors were encouraged to have an additional session
with the participants after the project completed its implementation
to discuss with the teens how what they learned through the project
fit within the FBO’s doctrine.

This policy of not using federal funds to support religious doctrine
also impacted those FBOs who were opposed to having the condom
demonstration session taking place in their facility. Per discussions
with OAH staff, project staff had to present the option of moving all of
the intervention sessions out of their facility in order to not highlight
the condom demonstration session. If moving all of the sessions from
the facility was not feasible, then often it was determined that the
FBO could not participate in the project.

Decision Making Varies by FBO: The decision to participate in the
project were, in general, made by the pastor of the FBO. In some
cases, decisions were made at different levels within an FBO. The
level at which the decision to participate in the project was made was
unique to the FBO and not consistent within or across denominations.
Persons who attended the FBO and wanted their teens to participate
in the intervention did not automatically translate to the leadership
of the FBO agreeing to participate in the project.

FBO Having Limited Resources: FBO resources varied significantly.
Some FBOs had multiple rooms available in their facility; whereas, others had just their sanctuary for meeting space.
Project staff had to be creative in adapting to the available space
in order to meet the requirements of the intervention. Not all FBOs
have full-time office staff that could assist the project with copying
project-related materials and securing of resources to provide needed
supplies. Consequently, the project provided all of the materials and
supplies needed for implementation of the intervention sessions.

Federal Funding Guidance: Funding for this project was provided
by the OAH in the Office of the Assistant Secretary at the US
Department of Health and Human Services, as discussed earlier, based
on guidance provided by the Office of Adolescent Health, the project
had to ensure that federal funds were not used to support religious
document. For example, intervention sessions were not allowed to be
implemented at the same time that FBO religious services were being
conducted. Intervention sessions had to be distinct from religious
services. In addition, the condom demonstration session that was part
of the intervention had to be conducted in the same manner as the
other sessions. FBOs that made requests that conflicted with policy
and/or guidance from the OAH were not able to participate in the
project.

Discussion

The Southern Nevada Teen Pregnancy Prevention Project was able
to implement an evidence-based teen pregnancy prevention project
in African American faith-based organizations in Clark County, NV.
Through the implementation of the project, numerous lessons were
learned that reflect the barriers and facilitators to the implementation
of HIV prevention activities in African American FBOs previously
documented in the literature. For example, as identified in the literature,
having congregational and leadership support for comprehensive
sexuality education and/or HIV prevention activities was a facilitator
in implementing these activities in African American FBOs [10-13,
3]. With this project, having invested FBO leadership was a facilitator
in the implementation of the teen pregnancy prevention intervention.
Often, the invested FBO leadership recognized that teen pregnancy
and HIV were issues in the community as well as knew someone
who had HIV and/or was a teen parent, which were also identified
facilitators in the literature [3].

The project found that having a liaison from the FBO, as stated
in the literature, was a key to implementing the teen pregnancy
prevention intervention [1]. Since SN-TPPP was an outside entity
implementing the intervention at FBOs, having a staff person from
the FBO and the project onsite assisted in troubleshooting problems,
as they arose, allowed for problems to be addressed immediately. The
coordination of the two liaisons allowed for smooth implementation
of the intervention at FBOs.

[10] cited that using existing infrastructure, resources, and
influence of the church and its leadership to be a facilitator in the
implementation of HIV-related activities in African American FBOs.
Specifically, in working with youth and teen pregnancy prevention,
the use of ready-made groups and making participation for youth
ewas facilitators. The project found that trying to bring youth
together who did not have a relationship with the FBO or at times
when the youth normally are not onsite reduced attendance, which
made implementation of the intervention sessions difficult despite
having a liaison from the FBO who recruited and reminded the youth
of the intervention sessions.

The Southern Nevada Teen Pregnancy Prevention Project did
identify additional facilitators not previously identified in the
literature. Condom demonstrations can be done in FBOs is a facilitator
for successfully implementing comprehensive sex education. Using
community persons to implement the intervention sessions was
another identified facilitator in this project. The use of community
persons to implement the intervention created community capacity
and promote project sustainability. Future efforts should replicate
and build on the efforts of this project with these facilitators.

Some of the barriers that are cited in the literature were also found
in this project. Conflict with religious doctrine was found with this
project as well as in the literature [4,7,3]. The addition of a session
focused on abstinence eased some of the conflict experienced with
religious doctrine. Based on the experience of the project, other
strategies to address and/or ease this conflict are elusive and may be
non-existent, particularly when there is limited flexibility in adapting
the intervention to reduce this conflict.

Limited resources remain a barrier as found by both the literature [7,8]
and this project. The literature cited that FBOs may not have resources
for HIV-related activities. This project eliminated that lack of resources
by providing the intervention materials, supplies, and staffing, but
experienced lack of resources at times in terms of space at an FBO.
Creative solutions were found by project staff to address space issues.
However, the use of federal funds to address the lack of resources at
FBOs did create barriers as well. The intervention sessions had to
be implemented in and project had to operate within federal funding
guidance, which at times conflicted with the requests of the FBOs.

A barrier identified in the literature was that FBOs may want to
emphasize abstinence instead of comprehensive sexuality education
[1]. This project promoted abstinence along with comprehensive
sexual education, which was acceptable to those African American
FBOs that participated in the project. Often, leaders of these FBOs
acknowledged an understanding that while abstinence is the only way
to definitively prevent teen pregnancy and HIV transmission, they
also understood that youth in the community and with relationships
with their FBO are also engaging in sexual behaviors.

To counteract lack of knowledge of the extent of the problem of HIV
and teen pregnancy within the community [7], project staff presented
current statistics to FBO leadership as a part of the introduction to
the project. This introduction reduced the impact of this barrier on
this project’s activities. Other barriers identified in the literature,
document varying across denominations [6,3], unwillingness or lack
of support to provide HIV prevention [1,8], stigma and homophobia
[7,3], as well as personal characteristics of the pastor [7], were not
encountered as a part of this project.

Conclusion

The Southern Nevada Teen Pregnancy Prevention Project
implemented an evidence-based teen pregnancy prevention

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intervention, which included condom demonstration, in African American FBOs. In the implementation of the project, many lessons were learned, including that African American FBOs will allow condom demonstrations to be conducted within their facilities. Future work is needed to confirm that the barriers and facilitators identified in this manuscript are not unique to this project. The implementation of the BART intervention proved to be a strong platform to reduce teen pregnancy and help achieve health equity.

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