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"Living the life God sees for women": an exploration of religion, gender-based power dynamics, and sexual decision making within African American faith-based communities

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"Living the life God sees for women": an exploration of religion, gender-based power dynamics, and sexual decision making within African American faith-based communities

By

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2015

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An abstract of
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Abstract

"Living the life God sees for women": an exploration of religion, gender-based power dynamics, and sexual decision making within African American faith-based communities

By Kaitlin Piper

Introduction: Despite advancements in prevention strategies, HIV/AIDS continues to be a prominent health and social justice issue, especially for African American communities in the South. The African American church has a unique opportunity to reach their congregation and community for sexual health education efforts. However, traditionally male dominated leadership and patriarchal gender norms within the church pose challenges to empowering women to make safer sexual health decisions.

Methods: To explore perceptions of gender roles and women's empowerment, 42 semi-structured interviews were gathered from female members of 16 predominantly African American churches in Atlanta, GA participating in a larger faith-based HIV prevention program. Grounded theory guided data analysis and a diverse team coded interviews using NVivo.

Results: Findings suggest that vulnerability to negative sexual health outcomes may partly be attributable to a lack of women's empowerment and prevention education within the church. Furthermore, traditional religious practices placing men in positions of authority limit women's control over decision-making within their church, family, and relationships. Due to these gender-related power imbalances, many respondents recalled instances where they engaged in risky and unwanted sexual behavior because they lacked authority over their partner's actions. Moving forward, respondents want churches to provide young women with the knowledge and skills necessary to negotiate sexual decisions with their partners.

Conclusions: Not only should church programming promote partner equality, but it should also instill confidence and autonomy in all facets of women's lives; therefore, enabling women to be key advocates for their own well-being and the health of the community.

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Introduction

HIV Infections in the United States

Human Immunodeficiency Virus (HIV), the virus that causes AIDS, is considered one of the world's most serious public health challenges (Kaiser Family Foundation, 2018). Since the beginning the epidemic in the 1980s, tens of millions of people have died of AIDS-related causes, and globally, there are 36 million people currently living with HIV (Kaiser Family Foundation, 2018). Although the number of new HIV diagnoses declined 20% from 2008-2016 in the U.S., it continues to be a prominent health issue. Currently, 1.1 million individuals are living with HIV in the U.S. and approximately 40,000 individuals are newly diagnosed each year (Centers for Disease Control and Prevention, 2016a).

The South is considered the epicenter of the HIV epidemic, as seven of the ten states with the highest rates of HIV infection are located in this region. Although Southern states comprise 38% of the total population, they account for over half of new HIV diagnoses and AIDS-related deaths. Additionally, individuals living with HIV in the South are less likely to know their status, less likely to be linked to care within one month of diagnosis, and are three times more likely to die of HIV/AIDS compared to other regions of the U.S. (Centers for Disease Control and Prevention, 2016a).

HIV Infections among African American Women

In addition to regional inequalities, disparities in HIV infections exist among racial and ethnic groups. According to the CDC, African Americans, more than any other racial/ethnic group, bear the greatest burden of HIV in the U.S., with the South having the largest proportion

of African Americans living with HIV (Centers for Disease Control and Prevention, 2016a). Although African Americans only comprise about 14% of the population, they account for 55% of new HIV diagnoses in the South (Centers for Disease Control and Prevention, 2016a).

Specifically, HIV/AIDS is one of the top ten leading causes of death for African American women ages 20-54 (Centers for Disease Control and Prevention, 2014). African American women are among the fastest growing groups with HIV infection, with rates of new HIV infections 16 times higher among African American women compared to white women (Centers for Disease Control and Prevention, 2015). Therefore, 1 in 48 African American women will be diagnosed with HIV in her lifetime compared to 1 in 880 white women (Centers for Disease Control and Prevention, 2016b). The vast majority (87%) of HIV infections among African American women are attributed to heterosexual sex (Centers for Disease Control and Prevention, 2012).

Gender-Related Power Dynamics among Heterosexual Couples

African American women's ability to practice safer sex behaviors- including consistent condom use- is a vital component of HIV prevention strategies. However, the ability to practice these behaviors is complicated within intimate relationships, where sexual decisions must be negotiated between partners. In many relationships, sexual decision making is not shared equally, with one partner having greater ability to control sexual activity and engage in behavior against their partner's wishes (Amaro & Raj, 2000; Blanc, 2001). These power imbalances within relationships are typically gender-related, with women having less sexual freedom and control over their partner's actions (Pulerwitz, Gortmaker, & DeJong, 2000; Wingood & DiClemente,

1998). Power imbalances in relationships make it difficult for women to negotiate safer sex behaviors or advocate for their sexual interests (Amaro & Raj, 2000), feeling a need to accommodate the desires of their males counterparts (R. W. Connell, 2014). Ultimately, this can lead to sexual risk taking and the transmission of HIV (Shearer, Hosterman, Gillen, & Lefkowitz, 2005; Soler et al., 2000; Wingood & DiClemente, 2000).

Gender Norms in Society and Religious Institutions

Although interpersonal-level factors are important determinants of sexual decision making and individual risk, structural-level norms dictate what behaviors, characteristics, and roles are appropriate for males and females (R. Connell, 1987). Gender-related power imbalances in relationships arise due to norms set within society (Blanc, 2001). One powerful norm setting agent is religion, which serves as the foundation for community values. Through both cultural practices and scripture, religious institutions model gender expectations for men and women within the church, family, and relationships (R. Connell, 1987; Riggs, 2008). For instance, the hierarchical structure of most churches places men in positions of leadership and power. Also, Biblical teachings typically depict males in positions of authority and place women in more subordinate roles (Casselberry, 2017). Similarly, religious families have a strong influence on gender role development among children, where Biblical teachings about male supremacy in the household are traditionally modeled within these family contexts (Cunningham, 2001; Fuegen, Biernat, Haines, & Deaux, 2004; Witt, 1997). The expectations that are taught and exhibited within the church and religious families may reinforce societal norms

surrounding gender and potentially illustrate appropriate behavior for males and females in intimate relationships.

Understanding how the intersection of religion and gender norms operate in sexual decision making is an especially important consideration for African American women, as they are considered one of the most religious subpopulations. Based on a national survey, 74% of African American women consider religion a very important component of their lives. Similarly, 87% of African American women turn to religion during times of difficulty, compared to only 60% of the general population (Washington Post-Kaiser Family Foundation, 2012). Furthermore, African American women are typically affiliated with historically Black Protestant Churches, which are more likely to be located in the South, the epicenter of the HIV epidemic (Pew Forum on Religion & Public Life, 2008).

Study Purpose and Research Questions

The pathways through which religion, gender norms, and sexual decision making are related are generally unknown. Also, studies that explore decision making within interpersonal relationships rarely consider how institutional and family-level norms contribute to these partner dynamics. Given the theoretical relationship between religion, gender norms, and sexual decision-making, this study will address three primary research questions:

1) How are gender norms and gender-based power dynamics modeled within predominantly African American churches in the South?
2) How are gender norms and gender-based power dynamics modeled within African American religious families?

3) How do gender norms modeled within churches and religious families contribute to sexual decision making among African American women in the South?

Theoretical Framework: Theory of Gender and Power

Based on the research questions, the purpose of this study is to explore how gender norms modeled by churches and religious families in the South influence relationship power dynamics and sexual decision making among African American women. Several constructs from the theory of gender and power make it a useful framework for addressing the relationships between religion, gender norms, and sexual decision making. This social structural theory explores the mechanisms that characterize gender relations between men and women (R. Connell, 1987). The fundamental structures of labor, power, and cathexis operate to consistently segregate power and designate gender norms for men and women. These structures are rooted within society and are reinforced within institutions (such as churches) and families, leading to gender-based expectations of women's role in society and in relationships. These expectations can also generate the risks that adversely affect women's health, such as the inability to advocate for oneself in a relationship and practice safer sex behaviors (Wingood & DiClemente, 2000).

The theory of gender and power utilizes three interrelated structures: the *sexual division of labor*, *sexual division of power*, and *structure of cathexis* (Figure 1). These structures examine how hierarchical relationships between men and women arise due to disparities in economic potential, control of resources, and gender norms. The first structure, the *sexual division of labor*, refers to the designation of men and women to different occupations,

confining women's career paths and limiting their economic potential. The *sexual division of power* examines the abuse of power and control, where men have a greater ability to influence the actions of others. Lastly, the *structure of cathexis* refers to social norms, which define expectations for men and women's role in society and relationships. Operating at the societal, institutional, familial, and interpersonal levels, these structures produce unequal relationships between men and women. All three of these structures are interrelated and reinforce each other to increase women's vulnerability to diseases, such as HIV (Wingood & DiClemente, 2000). This study considers how all three of these structures influence sexual decision making among church-affiliated African American women in the South.

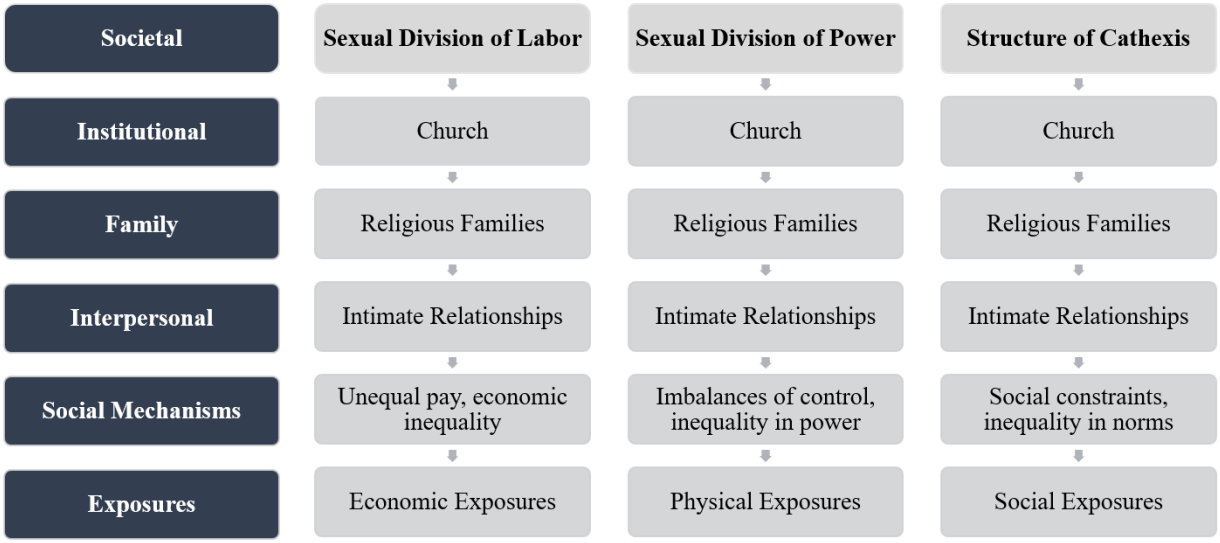

Figure 1. Overview of the theory of gender and power

LITERATURE REVIEW

Gender and Power in Sexual Relationships

Gender-based power arises due to the expectations and norms shared by society about appropriate behaviors and roles for males and females. Hierarchical power relationships between men and women form within society, institutions, families, and relationships (Koester, 2015). Unequal control over economic resources, unequal gender roles, and limited control over sexual decisions (such as when and how to have sex) can place women at risk for worse sexual and reproductive health outcomes (Wingood & DiClemente, 2000). In many cases, sexual relationships are unbalanced so that men have more power than women, giving men greater sexual freedom and rights over sexual decision making. These power differentials make it difficult for women to gain autonomy over their sexual decisions, submitting to the wishes of their male partners. For the purposes of this study, we consider traditional gender roles, where males perform a more agentic role, the prominent norms that define dynamics between males and females in sexual relationships (Sanchez, Fetterolf, & Rudman, 2012).

In general, women are less likely to exhibit characteristics associated with masculinity, such as dominance and assertiveness. Studies have shown that women are more likely to perceive themselves in passive roles in their workplace, families, and relationships (Kiefer & Sanchez, 2007; Sanchez, Phelan, Moss-Racusin, & Good, 2012). These differentiated gender characteristics are perpetuated because society is more accepting of individuals who follow their defined gender roles. For instance, both men and women alike find it more attractive for a woman to possess more passive traits that are associated with femininity (Moss-Racusin &

Rudman, 2010). When men and women deviate from these desired behaviors, they often face disapproval. This disapproval leads them to conform to their assigned gender roles in the future, fearing deviance will lead to punishment. This cycle, where individuals are punished for nonconformity, reinforces gender stereotypes (Rudman, Moss-Racusin, Phelan, & Nauts, 2012).

Numerous studies have shown that adherence to traditional gender norms dictate how men and women approach and enact sex (McCabe, Tanner, & Heiman, 2010; Meston & Buss, 2007). Reasons for engaging in sexual activity differ between men and women, where males are more likely to be motivated by status enhancement, while women are more likely to engage in sex for emotional reasons such as love (Meston & Buss, 2007). Additionally, according to gender norms, men are assumed to initiate and direct sexual activities, while women are intended to play the complementary submissive role and conform to their partner's desires (Lawrance, Taylor, & Byers, 1996). Because of these differing expectations, girls typically describe first-time sexual encounters as something that just "happened to them". Contrarily, boys described themselves as proactive agents in their sexual encounters and discussed the strategies used to obtain sex (Martin, 1998). Although relationships are becoming more egalitarian, women continue to report difficulty with self-promotion (Kiefer & Sanchez, 2007; Sanchez, Phelan, et al., 2012) and perceive themselves as conforming to traditional gender roles (McCabe et al., 2010).

Studies have shown that conformity to gender roles is associated with harmful sexual behaviors, such as sexual coercion and intimate partner violence. Because men are socialized to pursue and initiate sex, they are more likely use either psychological or physical force to coerce

women into unwanted sexual activities (Katz, Tirone, & Schukrafft, 2012). Furthermore, greater endorsement of masculine gender roles is associated with a stronger support of male-initiated verbal coercion (Eaton & Matamala, 2014), violence, such as a man slapping his wife, (Vandello, Bosson, Cohen, Burnaford, & Weaver, 2008) and intimate partner perpetration behaviors among males (Santana, Raj, Decker, La Marche, & Silverman, 2006). Because of these gendered beliefs, women experience higher rates of unwanted sexual behavior, and one nationally representative study found that 24% of females and 4% of males reported forced or coerced sexual experiences (Haydon, McRee, & Tucker Halpern, 2011; Katz et al., 2012). These unwanted, coercive, or violent behaviors limit women's ability to advocate for their sexual interests and practice safer sex behaviors, which ultimately increases their risk for HIV and other negative sexual health outcomes. (Dunkle et al., 2004; Jewkes, Dunkle, Nduna, & Shai, 2010; Li et al., 2014; Raiford, Seth, & DiClemente, 2013).

When one partner has more control over the relationship, it makes negotiations of safer sex behaviors- like use of condoms- challenging. In one study, nearly 20% of young women reported that they never had the right to make decisions about their contraception (Rickert, Sanghvi, & Wiemann, 2002). Studies have found that individuals that endorse gendered beliefs are significantly less likely to use condoms or contraceptives compared to those who believe in more equitable relationships between men and women (Impett, Schooler, & Tolman, 2006; Karim, Magnani, Morgan, & Bond, 2003; Pleck, Sonenstein, & Ku, 1993; Santana et al., 2006; Tang, Wong, & Lee, 2001; Zambrana, Cornelius, Boykin, & Lopez, 2004). One study found that women with high levels of sexual relationship power were five times more likely to use

condoms consistently compared to women with low levels of power (Pulerwitz, Amaro, Jong, Gortmaker, & Rudd, 2002). Furthermore, 52% of inconsistent condom use among women can be attributed to low relationship control (Pulerwitz et al., 2002). The benefits of equitable decision making is also known, as shared decision making is significantly associated higher rates of consistent condom use (Harvey, Bird, Galavotti, Duncan, & Greenberg, 2002).

Although many relationships follow these traditional dynamics, there is some evidence that suggests heterosexual relationships have become more egalitarian overtime. Recent studies indicate that women are more sexually dominant and initiate sex more frequently than in the past (Dworkin, Beckford, & Ehrhardt, 2007). In some cases, men and women reverse gender roles, where women pressure their partners into sex, and studies indicate that males report high levels of unwanted sexual behavior (Vannier & O'Sullivan, 2010). These role reversals and more egalitarian behaviors are most likely to occur in long-term romantic relationships, where men and women are more likely to be sexually compliant for purposes of relationship maintenance (Vannier & O'Sullivan, 2010). Despite these movements towards more egalitarian relationships, heterosexual relationships continue to rely on traditional gender norms to define partner dynamics (Seal & Ehrhardt, 2003; Vannier & O'Sullivan, 2011; Wiederman, 2005).

Gender and Power in Faith-Based Communities

Gender-related power dynamics arise due to socially constructed meanings associated with each sex. The way gender is interpreted within society reflects and perpetuates hierarchical power relations between men and women, where women are perceived as inferior.

Recently, institutions have received attention for the role they play in defining these gender expectations. One example of an institution that acts as a powerful norm-setting agent are churches, which can define community values and reinforce societal expectations for men and women (Riggs, 2008).

Because religion and its associated practices are typically considered the ultimate answer to questions about life, it can define one's worldview. To faithful believers, religion can be the answer to the unknown, which provides a sense of comfort and purpose. However, religion is something that must be practiced and followed in a specific way for a person to be in good health spiritually, emotionally, and physically. Organizing their life around this worldview, believers follow both a moral code sanctioned by the divine and a set of cultural practices established by the religious institution (Dillon, 2009).

Male power in the church is formed based on the interrelated structures of power and cathexis, where men are designated to leadership positions and Biblical scriptures depict appropriate roles and behaviors for men and women (Casselberry, 2017). Because dominant groups are more likely to capture power in institutions, patriarchal norms can inform practices within churches. Typically, churches assign the sexes to distinct roles in the church, with males being more likely to be placed in decision-making roles; whereas, women are more likely to be placed in nurturing or caretaking positions (Riggs, 2008). The majority of leadership roles- including ministers, elders, and pastors- are held by males, and in some denominations, women are banned from these positions. The ordination of women, into ministerial or pastoral positions, has been a controversial topic in some religions, since these positions have been

traditionally reserved for men (Jones, Thorpe, & Wootton, 2008). Churches' restrictions on the ordination of women varies based on the branch of Christianity. For example, the Greek Orthodox religion has established the position of deaconess recently, but the Catholic church remains committed against female deacons and priests. Although ordination is becoming more common among women in certain denominations, it remains less socially acceptable for women to hold leadership positions, such a bishop or pope, as these roles are traditionally restricted to men due to theological and cultural beliefs (Jones et al., 2008). Arguably, the preferential placement of males into church leadership positions is a form a discrimination that disadvantages women from achieving equality in their church, community, and relationships (Women for Women International, 2003).

Furthermore, religious teachings and Biblical passages depict women in subordinate positions (Riggs, 2008). For instance, the Bible describes men as being created in the image of God (Genesis 5:1, New American Standard Bible); whereas, women came from the rib of man, serving as his companion and helper (Genesis 2:22). Religious teachings typically endorse male supremacy in the household and ascribe to "natural" gender roles, where men are breadwinners and women are homemakers. There are also assumed power differentials for men and women in families where men are the head of the household and women are expected to obey the wishes of her husband (Ephesians 5:23). Furthermore, in terms of sexual behavior, Christian religions typically have stricter expectations for women to maintain chaste, where virginity at marriage is of high social value (Riggs, 2008). The church has also been known to speak against use of contraception and abortions, preventing women from having the ability

to choose when and if to have children. In general, the church has been traditionally constrictive of women's ability to make autonomous decisions and attain equitable roles in society (Women for Women International, 2003). This is especially true for churches in the South, which are more likely to ascribe to these traditional religious views (Pew Forum on Religion & Public Life, 2008).

As more women are taking leadership positions in the church, traditional gender norms have become more egalitarian overtime. However, religious individuals are still more likely to have traditional views about men and women's role in society and relationships. For instance, individuals who participate in religion are more likely to hold gender inequitable attitudes such as women need children to be fulfilled, women who work are not adequate mothers, men deserve jobs more than women, men make better political leaders, and a university education is more important for boys than girls (Seguino & Lovinsky, 2009). Religion helps to sustain gender inequality, and religious institutions provide a culture and framework for how men and women should interact in society. Therefore, individuals who attend church frequently are regularly socialized within this gender normative culture and possess more gender inequitable beliefs compared to those who attend church less frequently (Antje Röder, 2011).

In this paper, we focus on the distribution of power between men and women at the institutional, familial, and interpersonal levels. Specifically, we consider how the distribution of power within religious institutions, religious families, and intimate relationships influences sexual decision making and individual-level sexual health outcomes for religious African American women in the South. Because little is known about how gender norms produced

within religious contexts influence sexual-decision making in faith-based communities, semi-structured qualitative interviews were conducted with 42 women from 16 predominately African American churches in Atlanta, Georgia.

METHODS

Sample Selection

The sample for the current study was taken from a larger HIV prevention randomized control trial (RCT). This RCT- Training and Empowering African American Churches on HIV/AIDS (TEACH)- assessed the feasibility of disseminating P_4 for Women, a comprehensive HIV prevention program, within 20 predominantly African American churches in Atlanta, Georgia between May 2013 and August 2016 (Wingood, Simpson-Robinson, Braxton, & Raiford, 2011). Central constructs from the theory of gender and power guided intervention development and dissemination. Inclusion criteria for church participation in the larger study included: (1) located in the five metro Atlanta counties with the highest prevalence of HIV, (2) provide written pastoral consent, (3) have a predominantly African American congregation, and (4) agree to the one-year participation period. Churches who met these criteria, were required to select at least one church leader, such as executive staff or ministry directors, who could oversee dissemination of P_4 for Women within their church. They were also asked to select at least two female program facilitators, who would teach the HIV prevention sessions. Overall, 130 leaders and facilitators from 20 churches were enrolled in the program, with an average of six participants per church.

For the current study, all program leaders and facilitators were invited to participate in semi-structured qualitative interviews to gather in-depth information on their beliefs about sexual health and HIV. Pre-interviews were conducted before dissemination of P_4 for Women program materials, and post-interviews were conducted after the churches had sufficient time (6+ months) to implement the HIV prevention sessions at their church. Interviews were voluntary, and no compensation was provided. For the current study, female respondents who completed both the pre- and post- interview were included in the analysis (n=42).

Data Collection

Private, one-on-one semi-structured interviews were utilized to gather personal opinions, beliefs, and experiences. Respondents were given the opportunity to select a location for the interview. In general, the interviews were conducted in quiet locations in the community, at participating churches, or at Emory University offices. Interviewers were a diverse group of trained graduate research assistants and study staff, with ages ranging from 22-55 years. Interviews were audio recorded and lasted 60 minutes on average. Audio files and transcripts were stored on a secured server. Written consent was obtained prior to each interview.

The semi-structured pre- and post-interview guides, consisting of a predefined set of topics and questions, were used to direct the interviews. However, interviewers were given flexibility to ask additional questions when necessary. The pre-interview guide covered the following topics: initial attitudes towards the TEACH program, existing health education offerings within the church, opinions about sexual and reproductive health education in

churches, and religious upbringing. The post-interview guide included the following topics: experiences with the TEACH program, perceptions of HIV in the community, and the role of social context and relationships in sexual health. A survey was used to collect demographic information during enrollment into the TEACH program. Emory University's Institutional Review Board approved all study procedures prior to data collection.

Data Analysis

All interviews were transcribed verbatim by trained study staff, and a secondary transcription was conducted to ensure accuracy of the initial transcripts. A grounded theory-driven approach guided coding and analysis, allowing for themes to emerge from the data (Charmaz, 2002). Using 20% of the interviews from both the pre- and post-interviews, a codebook, with codes specific to gender and power, was developed by a diverse coding team of three graduate research assistants. Open coding of the first five interviews was conducted by each team member. The team then met to discuss identified codes. Open coding continued for the 20% sample of interviews, and the coding team met regularly to discuss and reach agreement on new codes. This process continued until saturation of codes (when no team member identified new codes related to gender and power) was reached.

Once the codebook was developed, the same team of three graduate research assistants coded all pre- and post-interviews. The team met weekly to discuss their analysis and code until 100% agreement was reached. Interview transcripts were coded using QSR NVivo 11 software (QSR International Pty Ltd, 2015). For this study, relevant codes included: "gender related differences in relationships", "gender differences in the family", "gender differences in sexual

health education", "gender-related consequences of sex", "gender standards in the church", and "gender specific differences in church positions" (Appendix 1). The codes were then arranged into larger themes, and the three constructs from the theory of gender and power were used to organize the analysis.

RESULTS

Respondent Characteristics

The sample included 42 women from 16 different churches in Atlanta, GA (Table 1). The mean age of the respondents was 47.6 (*SD* =14.0) years. Most respondents either started or completed a masters or doctorate level degree (47.6%). Regarding marital status, 31.0% were single, 31.0% were married, 28.6% were divorced, and 9.5% were widowed. Approximately half of the respondents had a church position title: two respondents were pastors, two were ministers, two were reverends, four were church administrators, nine were ministry or organization leaders, and one was a First Lady (the Pastor's wife). The remaining respondents (52.4%) were church members and congregants, who did not have a leadership title. Most respondents were affiliated with a Baptist church (40.5%), while the remaining respondents were affiliated with non-denominational (33.3%) and African Methodist Episcopal (AME) (26.2%) churches. Additionally, most respondents were affiliated with a large church (42.9%) or mega church (50.0%).

Table 1. Respondent characteristics, *n*=42

	***n* (%)**
Age, mean (*SD*)	47.6 (14.0)
Education	
High School Graduate/GED	3 (7.1)
Associates Degree	5 (11.9)
Some College	7 (16.7)
College Graduate	7 (16.7)
Started/Completed Graduate School	20 (47.6)
Marital Status	
Single/ Never Married	13 (31.0)
Married	13 (31.0)
Divorced	12 (28.6)
Widowed	4 (9.5)
Church Position Title	
Pastor	2 (4.8)
Minister	2 (4.8)
Reverend	2 (4.8)
First Lady	1 (2.4)
Administrator	4 (9.5)
Ministry/Organization Leader	9 (21.4)
No Title	22 (52.4)
Church Denomination	
Baptist	17 (40.5)
Non-Denominational	14 (33.3)
African Methodist Episcopal	11 (26.2)
Church Size [a]	
Small	0 (0.0)
Medium	3 (7.1)
Large	18 (42.9)
Mega-Church	21 (50.0)

[a] Churches with an average weekend attendance <50, between 51 and 300, between 301 and 2,000, and >2,000 were defined as small, medium, large, and mega churches, respectively (USAChurches.org).

Overview of Results

The respondents discussed three major themes related to gender and power: (1) gender dynamics in the church, (2) gender dynamics in the family, and (3) gender dynamics in intimate partner relationships (Figure 2). At the institutional level, the *sexual division of power* and the *structure of cathexis* operated within churches to segregate power and define expectations for men and women. At the family level, the *structure of cathexis*, also functioned within families to define expectations for sons and daughters as well as mothers and fathers. Similarly, at the interpersonal level, the *structure of cathexis* and *sexual division of power* formed the framework for how men and women interacted within intimate partner relationships. The last construct from the theory of gender and power, the *sexual division of labor*, was not discussed by the respondents. The emergent themes and associated constructs are described below and also summarized in table 2.

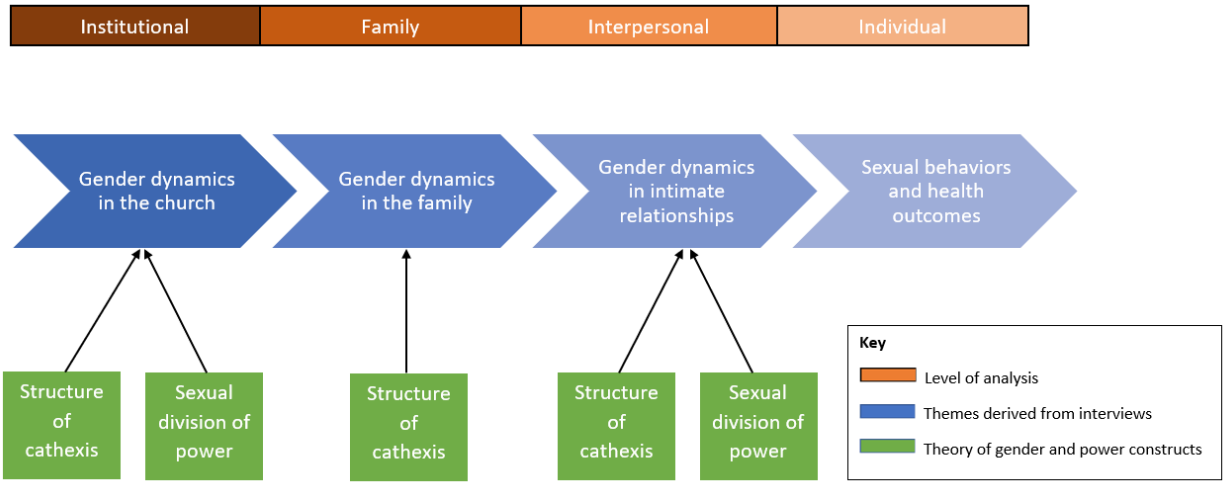

Figure 2: Application of theory of gender and power to sexual decision making among religious African American women

Table 2. Emergent themes and related quotes

Gender Dynamics in the Church
Sexual Division of Power
"Even though I was the locomotive, everything that we did was approved by Pastor, he knew exactly what we were doing all along when we first connected with the [sexual health program]. I got his approval-permission so he was very much aware of everything" (First Lady, age 55, large Baptist church)
"So I would always have to say it starts with the pastor, okay. It starts with the head because wherever the head goes, the body follows…. if the pastor is pushing [sexual health education] and then the pastor aligns the right people underneath him that have that same passion for the very thing he's pushing, then it has a chance." (Church member, age 51, Baptist mega-church)
"Women lead. Women have the power. So if we start with the women and the elders, I think it would get them to talk about sex." (Church member, age 51, Baptist mega-church)
"[The First Lady's] really involved in some of the women's groups and especially the young adults, so if she, you know, says or talks about certain things, then they definitely will listen to her because she has a stronger impact." (Church member, age 34, non-denominational mega-church)
Structure of Cathexis
"Even growing up when someone became pregnant they would have them come before the church conference and they would have to sit there and be embarrassed. They would be asked not to come back to church until after they had the baby and then they would have to come before the church conference and sort of be welcomed back in after they say 'I'm sorry and won't do it again.' But I've never saw them do this with the male. I've only seen them do this with the women, and I never appreciated that. We don't do that anymore thank goodness in the church, but this was sort of engrained in me from early on, that you don't do this." (Assistant Pastor, age 60, large AME church)
"One of my girlfriends, she stopped going to church altogether, because this is when she was young, one of her friends got pregnant, and they were all going to church…So the girl gets ostracized by the adults because she's pregnant, and nothing happens to the boy, so my friend just said, 'I'm not going back to church anymore because that wasn't right.'" (Church Secretary, age 63, large AME church)
"Especially if she's a young adult- if it's a young person and they become pregnant, the parents of the children that was once hanging around them, that one girl, they move her. They make their kids leave her alone. So she becomes isolated by herself… I've seen that actually happen. So like it's something contagious and she touch them they're now gunna become pregnant." (Church member, age 51, Baptist mega-church)
"Like for me I was one that got pregnant out of wedlock and being a leader of the church. And so that was something they HAD to deal with because I'm in the public eye and so, you know of course there were some that wanted to pitchfork me and crucify me. But there were more members who were comforting to me and was very supportive." (Pastor of Outreach and Education, age 35, Baptist mega-church)
Gender Dynamics in the Family
Structure of Cathexis

"My mother's sexual education was 'You're a girl, and you can get pregnant.' And she was OBSESSED with her boys not stopping their education to have to take care a baby. And my kind sweet mother was saying to women 'You better keep your girls in because my boys are out.' And it was almost like because I was a girl, it was almost like a two-prong thing. The girl was responsible, not the boy." (Church member, age 72, AME mega-church)
"*So fathers aren't gonna talk about it with daughters. They don't talk about it with sons. Mothers usually have to be the one that have to be informed because she's gonna talk to both daughters and sons."* (Minister, age 54, large non-denominational church)
"I try to say to my son too, I'm like, 'you must know that whatever happens to her is going to happen to you. So, if she gets pregnant and has to go work at Walmart as a greeter, you gonna be right on the other side of the door with her at Walmart as a greeter. Because her life is not going to be the only life that stops'. I keep reminding him of that aspect of it. Because normally the boy goes on about their life and it's the girl that's sad, and I'm like, 'You're going to be sad right along with her, okay?'" (Church member, age 56, AME mega-church)
Gender Dynamics in Intimate Partner Relationships
Structure of Cathexis
"I think people who have sorta reckless sexual behaviors…I wanna say mostly women because we tend to not try to protect ourselves. We always rely on the males to protect ourselves, to protect themselves against it, but then when they don't, it's like we feel as if we have no other option. But in actuality we do. There's female contraceptives as well. So I think mostly women, they put themselves at risk." (Church member, ae 28, large non-denominational church)
"And with the gender, I think there's a lot of work that needs to be done with females because see- and particularly African American females- because traditionally they don't want to ask the guy to use a condom. They just have not been properly informed and educated." (Head of the Women's Ministry, age 68, Baptist mega-church)
Sexual Division of Power
"Look at the cases for a young teenage girl and boys, there may be boys who are more powerful, and the girls see that as 'I don't have a choice' so they give in to someone." (First Lady, age 55, large Baptist church)
"They don't want to lose that person and they aren't really empowered with themselves and know like, 'Oh, it's okay for me to do this and say this if I don't want to.'" (Church member, age 20, non-denominational mega-church)
"And your self-esteem, if you're kinda just getting around to where you're getting your first little piece of attention, you're vulnerable, you're weak and if you haven't had conversations about what to do and what not to do, he's gonna lead you to do whatever." (Church Administrator, age 32, large Baptist church)
"So many times it's like be sure the man has the condom on it. You be in charge of your body- for African Americans like okay sister girl, you in charge, you know you can't just depend on him-maybe it's an old condom, or maybe he doesn't have a condom at all so you go prepared. You don't have to depend on anybody else, you have the power." (Church member, age 32, AME mega-church)

Gender Dynamics in the Church

Sexual Division of Power: What power do men and women hold within the church? Who controls the sexual health narratives within the church?

Based on the respondents' descriptions of their church communities, power differentials between men and women can impact how churches approach sexual health education. Although power has become more evenly distributed among men and women in the church, senior pastors, who are the primary decision-making agents for the church, are predominantly men. Because senior pastors carry the most authority, they can control the sexual health content taught in the church and the availability of women's health programming. The First Lady of a large Baptist church, age 55, described how she had to obtain permission from her husband (the senior pastor) to proceed with implementing a women's sexual health education program in her church. She explains:

> *Even though I was the locomotive, everything that we did was approved by Pastor, he knew exactly what we were doing all along when we first connected with the [sexual health program]. I got his approval-permission so he was very much aware of everything.*

Despite the First Lady's influence and leadership over the women's ministries, the senior pastor makes the final decisions about women health programming. Not only does the pastor control the programs available in the church, he also has the power to shape how the congregation will respond to the program's content. One member of a Baptist mega-church, age 51, indicated that it is vital for the senior pastor to be fully committed to promoting women's sexual health.

If the pastor is supportive of the movement, then the congregation will follow his lead. She stated:

> *So I would always have to say it starts with the pastor, okay. It starts with the head because wherever the head goes, the body follows…. if the pastor is pushing [sexual health education] and then the pastor aligns the right people underneath him that have that same passion for the very thing he's pushing, then it has a chance.*

A Pastor of Outreach and Community Development at a Baptist mega-church, age 35, further described this sentiment: *"If [the senior Pastors] say the sky is yellow, the sky is yellow, so they are the person that has the biggest influence within the church because they're the person that ministry kind of revolves around, the senior leader."* Because of the senior pastor's authority, the congregation's beliefs about women's sexual health and available programs are largely dependent upon his teachings.

The women also described how the hierarchical power structure in the church can sometimes place limitations on women's health and limit the sexual health content that is taught to the congregation. One respondent, who was the Leader of the Health Ministry at a medium-sized AME church, age 69, was trying to educate her congregation on safer sex practices but faced pushback from her Pastor: *"[The Pastor] said…'Condoms are for married people'. I wanted to hit him. Just wanted to hit him!"* She had another negative experience when she was trying to convince her Pastor to take a stand against sexual harassment in the church:

> *I think sometimes ministers, the male ones, get kind of… queasy, you know, about talking about things. I have said to my pastor because I KNOW that there are some men in this church that speaks out of line to women and about certain things. And so, I told him when he was assigning our programs, I said, 'Now Pastor, I would like for YOU to be over the men's ministry so that YOU can talk to them about what not to say, you know, to women or about women, you know.'…So he told me, 'Oh, I'll do that.' And then when he made the appointments, he made himself over the marriage ministry and then gave another minister to be over the men's ministry.*

The respondents discussed how male Pastors sometimes felt 'queasy' or uncomfortable confronting women's health issues. Respondents believed that women were more effective in leading sex education efforts and promoting contraceptive usage amongst congregates. The Pastor of Outreach and Community Development at a Baptist mega-church, age 35, explained that without the involvement of women in church leadership positions, it is unlikely the church will support contraceptive usage:

> *I think that they're getting to the point of listening-I think because they still have a problem with women in ministry you know, and that's dumb so you know-I'm hoping that before we are dead and gone that they'll get more to [contraceptives] but I don't really see it mainstream.*

While some respondents described situations where male Pastors did not accept their ideas or promote women's sexual health in the church, other respondents described their Pastors as "open minded" and willing to candidly talk about sex in the church. One church

member from a Baptist mega-church, age 38, described her Pastor as "… *a very open person, and he wants to save people's lives. So, I guess if – I guess he felt that by educating people on HIV, that would help save [lives]."* She goes on to explain that her Pastor has personal experience with HIV, which encouraged him to be more involved in prevention efforts: *"I know he always speaks every year at HIV day. But he gets up in front of the whole church during service and tells his story. And it sticks to my mind because his story is very interesting to me."* Male pastors with a personal connection to sexual health education were more willing to use their position of power to promote women's health and contraceptive usage within the church.

Although the male senior pastor is typically the decision-making agent within the church, most of the education and outreach activities are led and initiated by women. It was evident from the interviews that women collectively held a lot of power within their church communities and were capable of introducing positive change. One member of a Baptist mega-church, age 51, expressed this idea saying, *"Women lead. Women have the power. So if we start with the women and the elders, I think it would get them to talk about sex."* Additionally, when trying to introduce women's health issues within the church, it is important to involve powerful female leaders, especially the First Lady. One member of a non-denominational mega-church, age 34, explained, *"[The First Lady's] really involved in some of the women's groups and especially the young adults, so if she, you know, says or talks about certain things, then they definitely will listen to her because she has a stronger impact."* As another example of the significance of female leadership, one Health Ministry Leader of a medium-sized AME church, age 69, was excited that her church is appointing a female Bishop for the first time. She is

hopeful that this Bishop will help lead women's health efforts within her church, and she explained, *"We're gonna get a new bishop for this area….And it's a woman. It's our first woman bishop…And so, I know I can talk to her, and I know she would be, you know, very happy for [women's sexual health education]."* Although senior pastors make the final decisions, respondents believed that women can collectively sway the opinions of congregates and leadership. Involving female leadership, such as First Ladies, can also be powerful in implementing women's health programming.

Structure of Cathexis: What expectations does the church have for men and women's sexual activity?

The church is a powerful institution in the community that defines norms and expectations for men and women in the congregation. Traditionally, the church placed a higher social value on women's virginity at marriage and punished women that deviated from this expectation. The Assistant Pastor of a large AME church, age 60, recalled how the church punished women for pregnancy outside of marriage:

> *Even growing up when someone became pregnant they would have them come before the church conference and they would have to sit there and be embarrassed. They would be asked not to come back to church until after they had the baby and then they would have to come before the church conference and sort of be welcomed back in after they say 'I'm sorry and won't do it again.' But I've never saw them do this with the male. I've only seen them do this with the women, and I never appreciated that. We don't do that anymore thank goodness in the church, but this was sort of engrained in me from early on, that you don't do this.*

A Church Secretary at a large AME church, age 63, emphasized how these punishments were unequitable because the man did not receive the same rejection and shame from the church, and she said:

> *One of my girlfriends, she stopped going to church altogether, because this is when she was young, one of her friends got pregnant, and they were all going to church…So the girl gets ostracized by the adults because she's pregnant, and nothing happens to the boy, so my friend just said, 'I'm not going back to church anymore because that wasn't right.'*

Many of the respondents were raised in church environments that shamed women for pre-marital sex or pregnancy by shunning them from the community. However, men were exempt from these consequences. The expectation that women remain chaste is an ideal that remained with the respondents over their lifetime.

The way the church handles pre-marital sex and pregnancy outside of marriage has changed overtime. Today, the consequences for pre-marital sex and pregnancy are more lenient, but the respondents mentioned that there are still ramifications for these actions. For instance, congregates may be more likely to judge women rather than men for pregnancies outside of marriage because the woman's sin is 'visible'. A Church Administrative Assistant at a large non-denominational church, age 48 explained:

> *So I would say it's definitely looked at negatively when you see a single person pregnant, they kind of give the side eye, you know, and that's just human nature. Because we, that's a more, I think a more visible sin is especially when you get pregnant.*

Not only will they face shame from the congregation, but pregnant women may also be shunned by their social group at church, and a member of a Baptist mega-church, age 51, explained:

> *Especially if she's a young adult- if it's a young person and they become pregnant, the parents of the children that was once hanging around them, that one girl, they move her. They make their kids leave her alone. So she becomes isolated by herself… I've seen that actually happen. So like it's something contagious and she touch them they're now gunna become pregnant.*

Although women today are not ostracized from their church, they still face shame, judgement, and embarrassment. Compared to men, women are more likely to face judgement from other congregants because pregnancy makes their sin 'visible'.

These consequences can be worse for women who are in church ministries or leadership positions. A Reverend and Director of Christian Education at an AME mega-church, age 46, described how pregnant leaders are viewed by the church:

> *Oh, you still have that large group of people who are horrified by this person. That 'Oh, my gosh, they're pregnant?!' And, you know, if they're singing in the choir or serving in ministry, 'They should sit down until after the baby is born.' It really divides the church because you have a group that feels that they should be able to continue in those ministries, but you have a very large group of them who feels they shouldn't.*

The Pastor of Outreach and Education at a Baptist mega-church, age 35, was pregnant before marriage, and described how some church members wanted to 'crucify her', and she said:

> *Like for me I was one that got pregnant out of wedlock and being a leader of the church. And so that was something they HAD to deal with because I'm in the public eye and so, you know of course there were some that wanted to pitchfork me and crucify me. But there were more members who were comforting to me and was very supportive*.

She goes on to explain that church leaders were more critical of her pregnancy because they wanted to protect church appearances: *"I mean they were pretty much in leadership the ones that, you know, were critiquing me. But it was more laypersons who were very supportive."* A member of an AME mega-church, age 72, also discussed how a pregnant Youth Group Leader stepped down from her position at the church:

> *Well with our youth group, our leader was pregnant, and she decided on her own, and she was also a school teacher, she decided on her own that she didn't want to get in her advanced stages of pregnancy and be before the youth group. And I remember nobody pressured her… but she decided to step down.*

Today, women face consequences from the church when they have pre-marital sex. These consequences can be worse for women in leadership positions because the church wants to uphold the expectation that women should remain abstinent until marriage.

Gender Dynamics in the Family

Structure of Cathexis: What expectations do religious families have for son's and daughter's sexual activity? Who is expected to teach children about sexual health within families?

Similar to churches, the *structure of cathexis* operated within family contexts to define how children were educated about sexual health. When the respondents were growing up, if they received any information on sexual health from their parents, their mother was the parent

who delivered the education. Fathers played a very limited role in their children's education. A member of a non-denominational mega-church, age 20, said:

> *My dad didn't talk to me about it at all. But um my mom she just she just basically told me like things are out there, and I shouldn't be having sex... But it wasn't like a in depth conversation like how I wish it would have been now looking back on it.*

Even though mothers were responsible for delivering sexual health information to their children, the education was limited and rarely included any information on contraceptive usage. Comparable to gender expectations in churches, the respondents' mothers had different expectations for their sons and daughters, and typically placed more responsibility on girls to make appropriate choices. Describing her mother's expectations, a member of an AME mega-church, age 72, explained:

> *My mother's sexual education was 'You're a girl, and you can get pregnant.' And she was OBSESSED with her boys not stopping their education to have to take care a baby. And my kind sweet mother was saying to women 'You better keep your girls in because my boys are out.' And it was almost like because I was a girl, it was almost like a two-prong thing. The girl was responsible, not the boy.*

Placing blame on their daughters, mothers also told them: *"You could get raped like that! You shouldn't be hanging out with that kid!"* (Church member, age 43) and "*Be aware of how men look at you. Be aware of how you dress, how you smile."* (Church administrator, age 44). Daughters had to be mindful of how they dressed and acted, so they wouldn't acquire unwanted attention from men. However, sons were not expected to behave similarly.

In addition to placing more responsibility on their daughters, mothers from religious families had stricter expectations for their daughters to remain abstinent until marriage. They told their daughters: *"If you have sex you're going to hell."* (Bible School Facilitator, age 31), "*Stay away from boys you could get pregnant*." (Church member, age 34), and "*keep your dress down and your panties up"* (Church Secretary, age 63). Although the respondents received limited information on how to protect themselves during sex, their mothers' biggest concern was that they would become pregnant before marriage, and a Church Administrator from a large Baptist church, age 32, explained, *"My mom was more concerned about a baby and so no one really discussed with me about the other things in the middle with condoms and STDs and the bacteria."* If the girls became pregnant, they would embarrass their religious families, and many respondents recalled their mothers saying, "*If you get pregnant, you're gonna have to leave here.*"(Assistant Pastor, age 60). When they were growing up, the respondents encountered a sexual double standard that placed more responsibility on girls to remain abstinent and prevent unwanted pregnancy. If an unwanted pregnancy or sexual encounter did occur, girls were more likely to be condemned for their behavior.

Although parents have more equitable expectations for their sons and daughters today, mothers remain the primary sexual health educators. A Minister from a large non-denominational church, age 54, discussed the limited role of fathers in sexual health education today: "*So fathers aren't gonna talk about it with daughters. They don't talk about it with sons. Mothers usually have to be the one that have to be informed because she's gonna talk to both daughters and sons."* Similarly, a Health Resource Ministry Representative from a Baptist mega-

church, age 63, discussed how she took the initiative to teach her children about sexual health because her husband was uncomfortable:

> *And I had to make a conscientious decision that I wanted to be their first point of contact. And even though I wasn't comfortable, I found that my husband wasn't comfortable, so I had to get comfortable real quick. You know because they were growing up. And I knew one of us had to do that otherwise we were gonna place them at risk of being exposed and not having the educational tools that they needed to make good decisions.*

With or without fathers' involvement, the respondents were committed to teaching their children about sexual health and empowering them with information to make healthy choices. A member of a non-denominational mega-church, age 46, described how she tried to be a better educator than her mother:

> *As I got older, [my mother] was kinda like, 'Don't bring kids in. Don't have sex'…but she wasn't as open as I am. And her behavior about sex health is the reason why I don't address sex the same way with my daughter. It's not that my mother was horrible. That was the best that she could do.*

Unlike their experience growing up, the respondents wanted to ensure that their daughters were prepared to have sex, and a member of a Baptist mega-church, age 51, described how she educated her daughter:

> *I did it so different with my daughter. She is so informed. The idea was to wait, that was the ideal- She was all for it, but she went away to college and life happens and she met the guy- but I always taught her I said 'your first time shouldn't be something that you hide.' That should be a wonderful moment because you don't get your first time back again…So I taught her, I said 'use a condom.' I said 'check the expiration date.'*

The education that the respondents provided their daughters was not blaming or shameful. They empowered their daughters with the education and skills necessary to make healthy sexual decisions. They also taught their daughters to be assertive in their relationships and not submit to their partner's wishes, and a Director of Education from a Baptist mega-church, age 60, described how she empowered her daughters:

> *I mean condom use 100% all the time. You can't use it one time and then don't use it the next time. You have to use it 100 PERCENT of the time… and tell the man NO! If he can't consent to using a condom then NO! That's what I tell my kids… NO!*

Not only are the respondents talking with their daughters, but they are also educating their sons. A member of an AME mega-church, age 56, wanted her son to understand that he is equally responsible in sexual relationships, and she discussed:

> *I try to say to my son too, I'm like, 'you must know that whatever happens to her is going to happen to you. So, if she gets pregnant and has to go work at Walmart as a greeter, you gonna be right on the other side of the door with her at Walmart as a greeter. Because her life is not going to be the only life that stops'. I keep reminding him of that*

aspect of it. Because normally the boy goes on about their life and it's the girl that's sad, and I'm like, 'You're going to be sad right along with her, okay?'

Today, mothers have similar expectations for their sons and daughters. The respondents held both their sons and daughters responsible for preventing HIV and unwanted pregnancies. To avoid repeating the past, the respondents educated their children on methods to protect themselves and their partners in sexual relationships.

Gender Dynamics in Intimate Partner Relationships

Structure of Cathexis: Who is expected to make sexual decisions within relationships?

The *structure of cathexis* operated within intimate partner relationships to define gender roles for men and women. The respondents believed that sexual decisions ideally should be shared equally between men and women in intimate relationships. A Health Ministry Representative from a non-denominational mega-church, age 23, described this concept, explaining, *"I feel like [your partner] should play a pretty serious role-if you guys are being intimate then both of you should have a say so in how you want to go about that sexual intimacy."* A member of a large Baptist church, age 54, believed that shared decision making is the key to safe and healthy sexual behavior: *"I think if he loves or she loves you, then he or she should want you guys to have safe, healthy sex. So I think collectively, that should be the both of you guys' decision."*

Although equitable decision making is desired, institutional norms expect women to assume subordinate or submissive roles that limit their autonomy. First, the respondents discussed that 'in today's society' women are expected to engage in sex, so they may feel

pressured to consent to unwanted sexual activity. A member of a large non-denominational church, age 60, explained this concept, saying:

> *To truly value a woman as opposed to just someone-because nowadays it's like that's expected when you're in a relationship to give yourself up. And then you look at it as being weird if you don't. Or you're a lesbian or something's wrong with you if you can't have sex before marriage.*

The respondents also discussed that women are disadvantaged in safer sex negotiations because men are traditionally responsible for using protection. A member of a large non-denominational church, age 28, explained how women rely on men to protect them:

> *I think people who have sorta reckless sexual behaviors…I wanna say mostly women because we tend to not try to protect ourselves. We always rely on the males to protect ourselves, to protect themselves against it, but then when they don't, it's like we feel as if we have no other option. But in actuality we do. There's female contraceptives as well. So I think mostly women, they put themselves at risk.*

The respondents believed that, traditionally, women aren't supposed to ask a man to use protection. Further explaining this concept, the Head of the Women's Ministry at a Baptist mega-church, age 68, discussed:

> *And with the gender, I think there's a lot of work that needs to be done with females because see- and particularly African American females- because traditionally they don't want to ask the guy to use a condom. They just have not been properly informed and educated.*

Although the respondents want men and women to have equitable responsibility in relationships, traditional gender roles place women at a disadvantage. Because men are expected to be responsible for using condoms, women feel uncomfortable or unable to negotiate use of protection.

Sexual Division of Power: Who has more control over sexual decision making within intimate relationships?

In addition to these gender roles and expectations that exist within intimate relationships, the respondents discussed how power dynamics (related to the *sexual division of power*) also disadvantaged women. Because men are afforded more power in relationships, some women felt unable to advocate for their own interests, and a First Lady of a large Baptist church, age 55, explained, *"Look at the cases for a young teenage girl and boys, there may be boys who are more powerful, and the girls see that as "I don't have a choice" so they give in to someone."* Similarly, a member of a non-denominational mega-church, age 20, discussed how lack of empowerment can place women at risk: *"They don't want to lose that person and they aren't really empowered with themselves and know like, 'Oh, it's okay for me to do this and say this if I don't want to'"*. Because power is not equally shared between men and women, women may feel compelled to consent to unwanted sexual activity.

Women may also feel unable to voice their interests in sexual relationships because of low self-esteem. A Church Administrator at a large Baptist church, age 32, discussed how men can take advantage of this low-self-esteem and vulnerability:

> *And your self-esteem, if you're kinda just getting around to where you're getting your first little piece of a attention, you're vulnerable, you're weak and if you haven't had conversations about what to do and what not to do, he's gonna lead you to do whatever.*

As referenced in the previous quote from the Church Administrator, low self-esteem and lack of relationship control are closely linked. Because many young women experience feelings of low self-worth, intimate relationships are mechanisms that help them feel loved, desired, and 'worthy'. Because women value the love and affection they receive from a committed partner, women may consent to the subordinate role in their relationship for purposes of relationship maintenance. A Church Administrator from a large Baptist church, age 32, recalled an experience where she consented to unprotected sex because she felt 'weak': *"I mean every time we got together, he was able to influence me to.. 'No, we don't need to [use protection]'…somebody that I LOVE, you know…I would be weak."* Furthermore, having a committed partner can make women feel safe, which diminishes her perceived need for protection. A Bible School Facilitator from a medium-sized non-denominational church, age 31, explains this concept: *"It depends on how you feel about the person because a person that really got all your emotions can really influence you the wrong way….and you can easily feel 'Oh no, I'm safe. He love me.' And that might not even be the case."* Similarly, a Reverend of Christian Education from a large AME church, age 67, said:

I guess I would say once you get into a relationship and you feel like you quote, 'in love' and then you may be more influenced to let go, I don't want to say inhibitions, but some of your ways of thinking, you might go, 'well I'm in love, and I'll do this and this and so.'

Additionally, the respondents discussed how women want to please their partners, and a Church Administrator from a large Baptist church, age 32, explained, *"Especially as a woman, you know, you, you want to please him, you want him to like you, um, so I think that has a BIG role."* To maintain their relationships and continue to feel loved, women sometimes consented to unwanted sexual activity. A lack of empowerment hindered their ability to voice their concerns and negotiate sexual decisions with their partners.

Because gender expectations and power-dynamics within intimate relationships place women in vulnerable positions, the respondents emphasized the need for women to take responsibility for their own sexual decisions and advocate for their interests in relationships. Although decisions should be shared equally, the respondents described many instances of male-dominated relationship control. Because of their negative experiences with intimate relationships, respondents believed women need to be empowered to make responsible decisions. A member of a large Baptist church, age 54, said, *"You just have to be strong, and you know what, you have to know that it's your responsibility to protect yourself and not your partner's responsibility, that's your responsibility."* Similarly, a representative of the Health Resource Ministry from a Baptist mega-church, age 68, emphasized the importance of autonomous sexual decisions: *"I think everyone is responsible for their own sexual health. I don't think you need to be reliant on anybody else to have that kind of power over you…but*

especially if you're a woman really." Although there are cultural expectations that give men more control over condom usage, the respondents want women to eliminate these expectations because they cannot depend on their partner to make healthy choices. A member of an AME mega-church age 32, explained:

> *So many times it's like be sure the man has the condom on it. You be in charge of your body-for African Americans like okay sister girl, you in charge, you know you can't just depend on him---maybe it's an old condom, or maybe he doesn't have a condom at all so you go prepared. You don't have to depend on anybody else, you have the power.*

The respondents were adamant about empowering women to take control of their relationships and discuss sexual decisions with their partners. Because the respondents felt that women should not depend on men, women should have their own forms of protection available and be prepared to initiate conversations with their partners.

The respondents also recalled many experiences where they demonstrated control in their intimate relationships. A member of a large Baptist church, age 54, described how she would not consent to any sexual activity until her partner took an HIV test:

> *I've only dealt with one male, and plus I made him wear a condom. But then after he and I broke up, I met another guy-- we were going to become involved, and I made him take a HIV test, I mean RIGHT THERE…I went and bought the kit, and I made him take the test.*

Also, an Administrative Assistant from a large non-denominational church, age 43, was confident in her decision to remain abstinent until marriage and established that expectation with her husband early in their relationship:

> *Well I guess that my husband, we, we established up front, before we started dating, that I was not going to have sex. He respected that…I think it's about being confident in who you are, not being willing to settle for something that goes against what you believe.*

Although women sometimes face difficulties with asserting their sexual interests, the respondents are working to overcome these traditional dynamics, and they described numerous instances where they initiated conversations about safer sex in their relationships.

Women's Empowerment within the Church: Recommendations from Respondents

The respondents believed that empowering women is necessary to establish equitable relationships between men and women and improve sexual decision making. Because the church is an influential pillar in the community, the respondents wanted the church to be at the forefront of these empowerment efforts. Traditionally, the church placed strict requirements on women to remain abstinent and shamed women who deviated from these expectations. Therefore, the first step towards empowering women is removing the shame and stigma surrounding sex, and a member of a Baptist mega-church, age 51, explained:

> *I think that the church needs to help with removing the negative perspective that surrounds sex- the burden that surrounds sex- the perception that if you discuss sex, you're promoting sex, which I find to be untrue because as stated before, curiosity led*

> *more to my sexual experience whereas now with my daughter, her sexual experiences took place in a very latter part of her life because she was more informed and more knowledgeable. So therefore she made an informed decision, opposed to an emotional decision because she was educated.*

By removing the stigma that surrounds pre-marital sex, churches can begin having open conversations with the congregation and educate women on how to make healthy, autonomous sexual decisions. Respondents also discussed how 'knowledge is power', and a member of a Baptist mega-church, age 43, explained why information is crucial for women's sexual health:

> *Knowledge is power. And we say, 'Don't, don't, don't,' but you're not telling them why you're saying don't. You're just saying don't. Or you're not giving us the tools on how to stay whole or, as we say, a kept woman, how to be that person. Besides scripture. When you're in real life, you're like, 'Um, I'm not whipping out a scripture in the heat of the moment.' I'm not whipping out a scripture, so how do I deal with these- these emotions? How do I deal? Like, it's not just sexual health. It's like mental, emotional, physical abuse that take place as well, so you have to know what a person is dealing with and why they're falling into these traps of unhealthy relationships. So we need to start speaking about what the real problem is.*

Although churches and scripture instruct young women remain 'kept', they do not equip women with the practical skills to remain abstinent. Churches should address this educational gap and openly discuss how to develop healthy sexual relationships.

Some church members discussed what actions their churches are currently taking to empower women. A member of an AME mega-church, age 72, described how her church empowered women to take control of their bodies and health:

> *So we called it empowering young women. You don't have to depend on anybody else, you have the power. To not let this invade your body, this is your body. And then in a Christian way, your body is your temple. We were not advocating abstention, we were just trying to get to all the areas of why you can empower yourself and why [HIV] is rapidly going through our community.*

Encouraging women to love and respect themselves is one method churches are empowering women. Churches can also empower women through building their self-esteem. The Director of Education at a Baptist mega-church, age 60, explained how her church approached women's empowerment:

> *Topics that were easy for us to talk about was trying to tell the ladies you know that you are worthy—that God, God created you and you are beautiful and you know, trying to get them not to ever look down on themselves and this man is not good for you. There's other fish in the sea and you don't have to feel like you are not worthy. You know, that was easier for us to talk about than we knew.*

Women were excited to discuss empowerment and were comfortable having these conversations in the church. Ultimately, empowerment will not only help women establish control in their relationships, but it will also enable them to spread sexual health information to

other community members. A church member from an AME mega-church, age 56 explained this concept:

> *I see it empowering our um young African American women to take control of their body…to give them some more information as to what they can do to protect themselves and therefore learn to teach the same thing to their children, grandchildren, and so on*.

The respondents believed that churches should lead women's empowerment efforts. Empowerment programs in the church should provide education, skills training, and encourage women to take control of their own lives. These programs should instill confidence and autonomy in all facets of women's lives, enabling them to be to be advocates within their churches, families, and communities.

DISCUSSION

Summary of Findings

Research Question #1: How are gender norms and gender-based power dynamics modeled within predominantly African American churches in the South?

Based on the respondents' descriptions of their church communities, the *sexual division of power* and the *structure of cathexis* operated to segregate power and define expectations for men and women in the church. Greater power was afforded to male leadership, especially the senior pastor, who made decisions about the sexual health education available in the church. The pastor also had the power to shape the sexual health beliefs and gender role expectations of the congregation. Ultimately, senior pastors had the power to either promote or inhibit women's sexual health programming in the church, and some women described experiences

where male pastors resisted women's health efforts or were uncomfortable addressing these issues. Many respondents thought having women in senior church leadership positions would help promote women's sexual health, since female leaders are easier to approach about this topic and would be more willing to discuss contraception. However, the lack of women in senior leadership positions is a current barrier to women's sexual health programming in the church.

Although male senior pastors were the primary decision-making agents within the church, most of the educational programming, ministries, and outreach activities were led by women. Many respondents worked closely with their communities to form social ties and deliver resources and education. Because of their community involvement, women can generate collective action and engage the power structures within their churches. Since women are vital components of the African American faith community, they have the ability to improve gender equality, change the beliefs of church congregates and leadership, and transform the way their churches approach women's health. The respondents also believed that engaging female leaders, such as First Ladies, in these change efforts will help facilitate women's health promotion in the church.

In addition to gender-based power differentials, the respondents described how the church community had norms and expectations (*structure of cathexis*) for men and women's sexual activity. These norms traditionally required chastity among women and penalized women for engaging pre-marital sex. Reflecting on their adolescence, the respondents described how pregnant young women were forced to confess their sins and apologize in front

of the church, and sometimes, women had to leave the church for the duration of their pregnancy. When the respondents were growing up, women were held responsible for pregnancies outside of marriage, however, young men were exempted from this shame and punishment.

Although penalties for pre-marital sex are more lenient today, gender norms continue to guide the church's expectations for women's sexual activity. Within present-day churches, women who are pregnant prior to marriage do not have to publicly confess their sins, but they still endure stigma and shame from the congregates. This is especially true for women in church leadership or ministry positions, who are sometimes required to resign their titles to preserve church appearances. If women are not required to resign, they may feel pressured to temporarily remove themselves from church positions to avoid facing judgement from church members. Because pregnancy is what respondents described as a 'visible' sin, men did not face the same consequences.

Research Question #2: How are gender norms and gender-based power dynamics modeled within African American religious families?

The respondents described how the *structure of cathexis* operated within religious families to define expectations for mothers, fathers, sons, and daughters. Based on the respondents' stories, the gender norms exhibited in families mirrored the gender norms in churches. Similar to women's positions within churches, mothers within families were expected to shoulder caretaking and educational roles, which included informing their children about sexual health. Fathers rarely talked with their children about sexual health because they either were not expected to assume this educational role, or they felt uncomfortable speaking about

this this topic. These gender roles persisted overtime, as both the respondents and their mothers were the primary sexual health educators in their families.

Also comparable to church norms, daughters faced stricter expectations to remain abstinent compared to sons. Growing up, the respondents received minimal education from their mothers on sexual health but were expected to remain abstinent. Mothers told the respondents to be aware of how they dressed and acted around men, to stay away from boys, and not to remove their clothes. To avoid bringing shame to their families, mothers also told the respondents they would have to leave the home if they became pregnant before marriage. Mothers were not as concerned with their son's sexual behavior and placed more responsibility on their daughters to prevent pregnancies. Daughters also faced worse consequences for not remaining abstinent and conforming to these gender expectations.

Currently, within their own families, the respondents are utilizing a different approach to sexual health education. Because the education their mothers provided was insufficient and shameful, the respondents chose to better inform and prepare their daughters with strategies to prevent HIV and pregnancy. Not only did they place responsibility on their daughters to make healthy choices, but they educated their sons as well. Respondents believed their parents unfairly excused sons from safer sex responsibility. To overturn these gender double-standards, the respondents ensured that their children were raised in environments that expected sexual responsibility from both men and women.

Research Question #3: How do gender norms modeled within churches and religious families contribute to sexual decision making among African American women in the South?

The respondents grew up in churches and families that modeled gender-specific expectations for men and women. Both their churches and families placed stricter expectations on women to remain abstinent until marriage and punished women for deviating from these norms. Respondents also felt shame and stigma from church members and their families if they had pre-marital sex or did not conform to the gender norms of their religious community. In general, the respondents were raised in environments that disempowered women. They had limited power in the church and rarely held senior leadership positions, which restricted their decision-making authority. They also described experiences where their voices were overshadowed by male leadership, who disregarded women's sexual health programming. Because of the gender norms and power dynamics within these institutional and familial contexts, respondents also struggled to assert their interests in their sexual relationships, since they were not afforded the same power as men.

Within intimate relationships, the *structure of cathexis* and the *sexual division of power* operated to define dynamics between men and women. The respondents discussed how men were traditionally responsible for deciding when and if to use condoms, and because of this expectation, women felt unable to oppose their partners' decisions. This lack of negotiating power leads to risky and unwanted sexual behavior. The respondents also discussed how self-esteem and feelings of attachment were closely linked to power within intimate relationships. Women who had lower self-esteem may be less assertive and be more likely to consent to their partners wishes. Additionally, women who want to maintain their relationships or please their partners are likely to consent to unwanted sexual behavior to avoid creating controversy.

Overtime, the respondents became more aware of norms and power dynamics that existed within relationships, and many respondents are currently taking actions to negate male-dominated sexual decision making. Some respondents described how they initiated conversations and established sexual expectations with their partners, requiring their partners to receive testing or use protection before engaging in sexual activity. Compared to when they were growing up, respondents noted feeling more empowered and assertive in their sexual relationships. This may be due to societal shifts in gender norms, which have become more egalitarian overtime, or it could be a result of women learning from their past experiences. During their lifetime, many respondents experienced unwanted pregnancies, unwanted sexual activity, or HIV, which may have altered their perspectives on sexual health and prompted them to make healthier, more autonomous sexual decisions within their intimate relationships.

Implications for Interventions

Historically Black churches are amongst the most respected institutions in African American communities. Not only are these institutions trusted and valued sources of information, but they are also responsible for developing strong community relationships and supportive social networks (Le, Holt, Hosack, Huang, & Clark, 2016). Black congregations have a substantial history of providing social support and resources, including health referrals, education, and job services, within their congregations and communities (Bopp & Fallon, 2011; Le et al., 2016; Pew Forum on Religion & Public Life, 2008). Recently, churches have been recognized as effective venues for health interventions, since they offer physical space for health programming, a history of community outreach and engagement, and established

relationships with local community organizations (Bopp & Fallon, 2011). In general, faith-based health promotion efforts have been effective in reducing health disparities and addressing health issues within vulnerable populations (Collie-Akers, Schultz, Carson, Fawcett, & Ronan, 2009; Kaplan, Calman, Golub, Ruddock, & Billings, 2006; Kegler, Hall, & Kiser, 2010).

Sexual health promotion and HIV prevention is one area where churches can focus their health education efforts. Utilizing its resources, social capital, and community influence, churches have the capacity to become key advocates for women's sexual health. Recently, Black churches have recognized HIV as a social justice issue and become more involved in HIV awareness (NAACP, 2013). Although a crucial step for the Black church, these faith-based HIV awareness programs rarely address how gender norms and gender-based power dynamics contribute to health outcomes, such as HIV.

According to the respondents, church-based programs should utilize a holistic, multi-faceted approach to sexual health education. Not only should these programs raise awareness of HIV, but they should also discuss gender norms, relationship power dynamics, and empowerment; while providing both men and women with practical skills on how to approach safer sex negotiations, obtain consent, and have healthy, equitable relationships. Although not the focus of this particular study, many respondents also experienced intimate partner violence (IPV) or sexual violence during their lifetime, and they desired churches to incorporate discussions of IPV into these programs as well. Furthermore, the respondents discussed how adolescent girls are more likely to conform to submissive gender roles, making them particularly vulnerable to risky sexual behavior. Therefore, church-based sexual health

education should target teens and young adults, addressing these concepts while they are beginning to navigate their first intimate relationships.

However, for this programming to be effective, churches must transform the gendered scripts and sexual health narratives within their religious communities. First, churches should provide more opportunities for women within senior leadership positions. Allowing women to assume powerful, decision-making positions will remodel the expectations for women's roles within families and intimate relationships. According to the respondents, discussions about sexual health are more likely to be initiated and supported by female church leaders, so this is a critical first-step to sexual health education and empowerment programming within the church. To generate support for female leadership and gender equality, gender training programs can help churches recognize where gender disparities exist within their communities and assist them with developing strategies to empower women.

In addition to promoting women within leadership positions, the church can also help reduce the stigma associated with sex. Although churches no longer publicly shame women for pre-marital sex, unmarried pregnant women still encounter stigma within the church. Fearing judgement from the congregation and leadership, women who are pregnant before marriage feel pressured to resign from their church positions. Removing women from decision-making positions reinforces patriarchal power structures. Additionally, this judgement poses barriers to conversations about sexual health, since women may fear backlash for discussing stigmatized topics within their communities. To help churches address this issue, stigma reduction

interventions can generate awareness about the stigma associated with sex and provide faith communities with spaces for self-reflection and change.

In addition to sexual health education and women's empowerment programs, the church has the ability to engage parents in sexual health education efforts as well. The respondents discussed how the onus of sexual health education is currently placed on mothers. This is consistent with other studies that estimate 77% of mothers and 37% of fathers talk with their children about sexual health (Angera, Brookins-Fisher, & Inungu, 2008). Although supportive father-child relationships are associated with safer sex behaviors among adolescents, many fathers are not discussing sexual health with their children (Regnerus & Luchies, 2006). Programs that train parents on how to discuss sexual health with their children have generally been effective in improving youth outcomes (Santa Maria, Markham, Bluethmann, & Mullen, 2015). However, these programs are primarily targeted towards mothers (Santa Maria et al., 2015), since cultural expectations assume female parents are responsible for educational and caretaking roles. Engaging both mothers and fathers in sexual health education efforts is another area of sexual health education that can be initiated by churches.

Although the programs described above are necessary to promote sexual health and gender equality, there are known barriers to implementation. First, because Biblical teachings promote abstinence and there is stigma associated with pre-marital sex (especially among women), there may be pushback against comprehensive sexual health programming, especially if senior leadership endorses abstinence-only approaches. Also, empowerment and gender

training programming oppose traditional gender roles that are still desired by some members of the church community. Furthermore, the respondents believed that some male leaders were uncomfortable with discussing women's health and sex education in the church. Because all church programming must be approved by these leaders, implementing programs that oppose traditional teachings may not be endorsed by senior pastors.

To overcome these barriers, the respondents proposed utilizing collective action to build churches' capacity for norm change. To accomplish this, church communities should create spaces where women in the church can convene, share information collectively, and organize in ways for strategic engagement with power structures in the church. The respondents believed that if women took collective action and presented their ideas to senior leadership, leaders would be willing to have open discussions. Because women are critical components of the church community and comprise over 60% of the congregation (Pew Forum on Religion & Public Life, 2008), they hold the majority voice in the church and the ability to collectively influence traditional gender expectations. Also, engaging influential women in the church, such as First Ladies, will give strength to social movements and facilitate engagement with senior leadership. Once they convince the senior pastor to implement and endorse sexual health empowerment programming, the congregation will follow his lead.

Limitations and Future Directions

Although this study presents an in-depth exploration of gender norms in African American religious communities and implications for sexual decision making, it does have several limitations. Because all respondents were female, this study does not consider the male

perspective. Before addressing the current power structures within churches, it is necessary to understand how men perceive gender norms as well. It is especially important to understand how male leaders in the church use their influence and power to shape gender norms in religious communities. Interventions and gender trainings used to establish more egalitarian structures in the church must target the current beliefs of both men and women. Also, when considering sexual decision making, both men and women require knowledge and skills on how to negotiate sexual decisions with their partners.

Furthermore, although generalizability is not the objective of grounded theory-driven qualitative analysis, the respondents do not represent the opinions and beliefs of all religious African American women. Because the respondents were involved in a sexual health intervention, they may be more attuned to issues related to gender and power. Furthermore, most respondents were members of metropolitan mega-churches. These churches typically possess more progressive sexual health beliefs and are known for their innovation, resources, and community programs (Tucker-Worgs, 2011). Small or rural churches may have different beliefs and norms, but they are not represented in this study. Future research should examine the differences in gender norms at churches of varied sizes and geographic locations.

Additionally, many respondents reflected on the gender inequities that occurred during their childhood. Because the average respondent age was 47.6 years, some of their stories may not be relevant to adolescents today, since gender norms in churches and religious families have changed considerably overtime. Future studies should consider focusing on gender inequities and sexual decision making among teens. However, the older adult age group that

was captured in this study is an important population, since they are now mothers and the primary sexual health educators within their families. The older women noted changing their educational practices from those they experienced in their childhood homes, as they had more open conversations with their sons and daughters about sexual health. Future research should focus on these intergenerational shifts in practices to better understand how norms are "inherited" by families.

Although not a limitation related to study methodology, the last construct from the theory of gender and power, the *sexual division of labor*, was not discussed by respondents. This construct refers to the designation of men and women to different occupations, which confines women's career paths and limits their economic potential. No respondent discussed how economic differences between men and women impact sexual decision making. It is possible that the *sexual division of labor* has minimal influence on partner dynamics in this population. However, prior research suggests male-female wage gaps afford men more relationship control and authority over sexual decisions within households (Aizer, 2010). Future qualitative research should consider how this construct operates at institutional, familial, and interpersonal levels to define dynamics between men and women.

Conclusions

The African American church has a unique opportunity to reach their congregation and community for sexual health education efforts. However, traditionally male dominated leadership and patriarchal gender norms within the church pose challenges to empowering women to make safer sexual health decisions. Traditional religious practices placing men in

positions of authority limit women's control over decision-making within their church, family, and relationships. Due to these gender-related power imbalances, many respondents recalled instances where they engaged in risky and unwanted sexual behavior because they lacked authority over their partner's actions. Moving forward, respondents want churches to provide young women with the knowledge and skills necessary to negotiate sexual decisions with their partners. Not only should church programming promote partner equality, but they should also instill confidence and autonomy in all facets of women's lives.

REFERENCES

Aizer, A. (2010). The gender wage gap and domestic violence. *American Economic Review, 100*(4), 1847-1859.

Amaro, H., & Raj, A. (2000). On the margin: Power and women's HIV risk reduction strategies. *Sex roles, 42*(7-8), 723-749.

Angera, J. J., Brookins-Fisher, J., & Inungu, J. N. (2008). An investigation of parent/child communication about sexuality. *American Journal of Sexuality Education, 3*(2), 165-181.

Antje Röder. (2011). Gender role attitudes of migrants – The impact of religion and origin country context *Trinity College Dublin*.

Blanc, A. K. (2001). The effect of power in sexual relationships on sexual and reproductive health: an examination of the evidence. *Studies in family planning, 32*(3), 189-213.

Bopp, M., & Fallon, E. A. (2011). Individual and institutional influences on faith-based health and wellness programming. *Health Education Research, 26*(6), 1107-1119.

Casselberry, J. (2017). *The Labor of Faith: Gender and Power in Black Apostolic Pentecostalism*: Duke University Press.

Centers for Disease Control and Prevention. (2012). CDC Fact Sheet: New HIV Infections in the United States. Retrieved from https://www.cdc.gov/nchhstp/newsroom/docs/2012/HIV-Infections-2007-2010.pdf

Centers for Disease Control and Prevention. (2014). Leading Causes of Death in Females. Retrieved from https://www.cdc.gov/women/lcod/index.htm

Centers for Disease Control and Prevention. (2015). CDC Fact Sheet: HIV among African Americans

Centers for Disease Control and Prevention. (2016a). *HIV Surveillance Report: Diagnoses of HIV Infection in the United States and Dependent Areas, 2015*. Retrieved from http://www.cdc.gov/hiv/library/reports/hiv-surveillance.html

Centers for Disease Control and Prevention. (2016b). Lifetime Risk of HIV Diagnosis. Retrieved from https://www.cdc.gov/nchhstp/newsroom/2016/croi-press-release-risk.html

Charmaz, K. (2002). Grounded theory analysis In Holstein (Ed.), *Handbook of interview research* (pp. 675-694). Thousand Oaks, CA: Sage.

Collie-Akers, V., Schultz, J. A., Carson, V., Fawcett, S. B., & Ronan, M. (2009). REACH 2010: Kansas City, Missouri. *Health Promotion Practice, 10*(2_suppl), 118S-127S. doi:10.1177/1524839908331271

Connell, R. (1987). Gender and power Stanford University Press: Stanford.

Connell, R. W. (2014). *Gender and power: Society, the person and sexual politics*: John Wiley & Sons.

Cunningham, M. (2001). The influence of parental attitudes and behaviors on children's attitudes toward gender and household labor in early adulthood. *Journal of Marriage and family, 63*(1), 111-122.

Dillon, M. (2009). *The sociology of religion*: Wiley Online Library.

Dunkle, K. L., Jewkes, R. K., Brown, H. C., Gray, G. E., McIntryre, J. A., & Harlow, S. D. (2004). Gender-based violence, relationship power, and risk of HIV infection in women attending antenatal clinics in South Africa. *The lancet, 363*(9419), 1415-1421.

Dworkin, S., Beckford, S., & Ehrhardt, A. (2007). A longitudinal analysis of sexual scripts for women who participated in a gender-specific HIV/STD prevention intervention. *Archives of sexual behavior, 36*, 269-279.

Eaton, A. A., & Matamala, A. (2014). The relationship between heteronormative beliefs and verbal sexual coercion in college students. *Archives of sexual behavior, 43*(7), 1443-1457.

Fuegen, K., Biernat, M., Haines, E., & Deaux, K. (2004). Mothers and fathers in the workplace: how gender and parental status influence judgments of job-related competence. *Journal of Social issues, 60*(4), 737-754.

Harvey, S. M., Bird, S. T., Galavotti, C., Duncan, E. A., & Greenberg, D. (2002). Relationship power, sexual decision making and condom use among women at risk for HIV/STDs. *Women & health, 36*(4), 69-84.

Haydon, A. A., McRee, A.-L., & Tucker Halpern, C. (2011). Unwanted sex among young adults in the United States: The role of physical disability and cognitive performance. *Journal of interpersonal violence, 26*(17), 3476-3493.

Impett, E. A., Schooler, D., & Tolman, D. L. (2006). To be seen and not heard: Femininity ideology and adolescent girls' sexual health. *Archives of sexual behavior, 35*(2), 129-142.

Jewkes, R. K., Dunkle, K., Nduna, M., & Shai, N. (2010). Intimate partner violence, relationship power inequity, and incidence of HIV infection in young women in South Africa: a cohort study. *The lancet, 376*(9734), 41-48.

Jones, I., Thorpe, K., & Wootton, J. (2008). *Women and ordination in the Christian churches: International perspectives*: Bloomsbury Publishing.

Kaiser Family Foundation. (2018). The HIV/AIDS Epidemic in the United States. Retrieved from https://www.kff.org/hivaids/fact-sheet/the-hivaids-epidemic-in-the-united-states-the-basics/

Kaplan, S. A., Calman, N. S., Golub, M., Ruddock, C., & Billings, J. (2006). The role of faith-based institutions in addressing health disparities: a case study of an initiative in the southwest Bronx. *Journal of Health Care for the Poor and Underserved, 17*(2), 9-19.

Karim, A. M., Magnani, R. J., Morgan, G. T., & Bond, K. C. (2003). Reproductive health risk and protective factors among unmarried youth in Ghana. *International family planning perspectives*, 14-24.

Katz, J., Tirone, V., & Schukrafft, M. (2012). Verbal sexual coercion in young adult heterosexual dating relationships. *Women and mental disorders*, 53-101.

Kegler, M. C., Hall, S. M., & Kiser, M. (2010). Facilitators, challenges, and collaborative activities in faith and health partnerships to address health disparities. *Health education & behavior, 37*(5), 665-679.

Kiefer, A. K., & Sanchez, D. T. (2007). Men's sex-dominance inhibition: Do men automatically refrain from sexually dominant behavior? *Personality and Social Psychology Bulletin, 33*(12), 1617-1631.

Koester, D. (2015). *Gender and Power: DLP Concept Brief 04*. Retrieved from http://publications.dlprog.org/Gender&Power.pdf

Lawrance, K.-a., Taylor, D., & Byers, E. S. (1996). Differences in men's and women's global, sexual, and ideal-sexual expressiveness and instrumentality. *Sex roles, 34*(5), 337-357.

Le, D., Holt, C. L., Hosack, D. P., Huang, J., & Clark, E. M. (2016). Religious Participation is Associated with Increases in Religious Social Support in a National Longitudinal Study of African Americans. *Journal of Religion and Health, 55*(4), 1449-1460. doi:10.1007/s10943-015-0143-1

Li, Y., Marshall, C. M., Rees, H. C., Nunez, A., Ezeanolue, E. E., & Ehiri, J. E. (2014). Intimate partner violence and HIV infection among women: a systematic review and meta-analysis. *Journal of the international AIDS society, 17*(1).

Martin, K. A. (1998). Puberty, Sexuality, and the Self: Girls and Boys at Adolescence. *ADOLESCENCE, 33*, 717-717.

McCabe, J., Tanner, A. E., & Heiman, J. R. (2010). The impact of gender expectations on meanings of sex and sexuality: Results from a cognitive interview study. *Sex roles, 62*(3-4), 252-263.

Meston, C. M., & Buss, D. M. (2007). Why humans have sex. *Archives of sexual behavior, 36*(4), 477-507.

Moss-Racusin, C. A., & Rudman, L. A. (2010). Disruptions in women's self-promotion: the backlash avoidance model. *Psychology of women quarterly, 34*(2), 186-202.

NAACP. (2013). The Black Church & HIV: The Social Justice Imperative. Retrieved from http://www.theblackchurchandhiv.org/

Pew Forum on Religion & Public Life. (2008). The Pew Report on U.S. Religious Landscape Survey.

Pleck, J. H., Sonenstein, F. L., & Ku, L. C. (1993). Masculinity ideology: Its impact on adolescent males' heterosexual relationships. *Journal of Social issues, 49*(3), 11-29.

Pulerwitz, J., Amaro, H., Jong, W. D., Gortmaker, S. L., & Rudd, R. (2002). Relationship power, condom use and HIV risk among women in the USA. *AIDS care, 14*(6), 789-800.

Pulerwitz, J., Gortmaker, S. L., & DeJong, W. (2000). Measuring sexual relationship power in HIV/STD research. *Sex roles, 42*(7), 637-660.

QSR International Pty Ltd. (2015). NVivo qualitative data analysis Software (Version 11).

Raiford, J. L., Seth, P., & DiClemente, R. J. (2013). What girls won't do for love: human immunodeficiency virus/sexually transmitted infections risk among young African-American women driven by a relationship imperative. *Journal of Adolescent Health, 52*(5), 566-571.

Regnerus, M. D., & Luchies, L. B. (2006). The parent-child relationship and opportunities for adolescents' first sex. *Journal of Family Issues, 27*(2), 159-183.

Rickert, V. I., Sanghvi, R., & Wiemann, C. M. (2002). Is lack of sexual assertiveness among adolescent and young adult women a cause for concern? *Perspectives on sexual and reproductive health*, 178-183.

Riggs, M. Y. (2008). *Plenty good room: Women versus male power in the Black church*: Wipf and Stock Publishers.

Rudman, L. A., Moss-Racusin, C. A., Phelan, J. E., & Nauts, S. (2012). Status incongruity and backlash effects: Defending the gender hierarchy motivates prejudice against female leaders. *Journal of Experimental Social Psychology, 48*(1), 165-179.

Sanchez, D. T., Fetterolf, J. C., & Rudman, L. A. (2012). Eroticizing inequality in the United States: The consequences and determinants of traditional gender role adherence in intimate relationships. *Journal of Sex Research, 49*(2-3), 168-183.

Sanchez, D. T., Phelan, J. E., Moss-Racusin, C. A., & Good, J. J. (2012). The gender role motivation model of women's sexually submissive behavior and satisfaction in heterosexual couples. *Personality and Social Psychology Bulletin, 38*(4), 528-539.

Santa Maria, D., Markham, C., Bluethmann, S., & Mullen, P. D. (2015). Parent-based adolescent sexual health interventions and effect on communication outcomes: a systematic review and meta-analyses. *Perspectives on sexual and reproductive health, 47*(1), 37-50.

Santana, M. C., Raj, A., Decker, M. R., La Marche, A., & Silverman, J. G. (2006). Masculine gender roles associated with increased sexual risk and intimate partner violence perpetration among young adult men. *Journal of urban health, 83*(4), 575-585.

Seal, D. W., & Ehrhardt, A. A. (2003). Masculinity and urban men: Perceived scripts for courtship, romantic, and sexual interactions with women. *Culture, Health & Sexuality, 5*(4), 295-319.

Seguino, S., & Lovinsky, J. (2009). *The Impact of Religiosity on Gender Attitudes and Outcomes*.

Shearer, C. L., Hosterman, S. J., Gillen, M. M., & Lefkowitz, E. S. (2005). Are traditional gender role attitudes associated with risky sexual behavior and condom-related beliefs? *Sex roles, 52*(5), 311-324.

Soler, H., Quadagno, D., Sly, D. F., Riehman, K. S., Eberstein, I. W., & Harrison, D. F. (2000). Relationship dynamics, ethnicity and condom use among low-income women. *Family planning perspectives*, 82-101.

Tang, C. S.-k., Wong, C.-y., & Lee, A. M. (2001). Gender-related psychosocial and cultural factors associated with condom use among Chinese married women. *AIDS Education and Prevention, 13*(4), 329-342.

Tucker-Worgs, T. N. (2011). *The black megachurch: Theology, gender, and the politics of public engagement*: Baylor University Press.

USAChurches.org. Church Sizes Retrieved from http://www.usachurches.org/church-sizes.htm

Vandello, J. A., Bosson, J. K., Cohen, D., Burnaford, R. M., & Weaver, J. R. (2008). Precarious manhood. *Journal of personality and social psychology, 95*(6), 1325.

Vannier, S. A., & O'Sullivan, L. F. (2010). Sex without desire: Characteristics of occasions of sexual compliance in young adults' committed relationships. *Journal of Sex Research, 47*(5), 429-439.

Vannier, S. A., & O'Sullivan, L. F. (2011). Communicating interest in sex: Verbal and nonverbal initiation of sexual activity in young adults' romantic dating relationships. *Archives of sexual behavior, 40*(5), 961-969.

Washington Post-Kaiser Family Foundation. (2012). Poll of Black Women in America. Retrieved from http://www.washingtonpost.com/wp-srv/special/nation/black-women-in-america/

Wiederman, M. W. (2005). The gendered nature of sexual scripts. *The Family Journal, 13*(4), 496-502.

Wingood, G. M., & DiClemente, R. J. (1998). Partner influences and gender-related factors associated with noncondom use among young adult African American women. *American journal of community psychology, 26*(1), 29-51.

Wingood, G. M., & DiClemente, R. J. (2000). Application of the theory of gender and power to examine HIV-related exposures, risk factors, and effective interventions for women. *Health education & behavior, 27*(5), 539-565.

Wingood, G. M., Simpson-Robinson, L., Braxton, N. D., & Raiford, J. L. (2011). Design of a faith-based HIV intervention: successful collaboration between a university and a church. *Health Promotion Practice, 12*(6), 823-831.

Witt, S. D. (1997). Parental influence on children's socialization to gender roles. *ADOLESCENCE, 32*(126), 253.

Women for Women International. (2003). *The Impact of Religion on Women in the Development Process*. Retrieved from http://wfwmarketingimages.womenforwomen.org/news-women-for-women/assets/files/critical-half/CHJournalv1.pdf

Zambrana, R. E., Cornelius, L. J., Boykin, S. S., & Lopez, D. S. (2004). Latinas and HIV/AIDS risk factors: Implications for harm reduction strategies. *American Journal of Public Health, 94*(7), 1152-1158.

APPENDIX

Appendix 1: Qualitative Codebook

Code Name	Definition	Example from Transcripts
Gender related differences in relationships	Any comments related to what roles males and females play in sexual decisions. This can include their responsibility to prevent pregnancy or HIV/STDs. This also includes any comments pertaining to gender related power differences in relationships. This can include the limitations placed on males or females with regard to their capacity to act independently and make their own decisions in sexual relationships.	"I think-I think there needs to be a lesson on what is power. What is positive power and what is negative power and when it's *used*, how it can be used in both ways 'cause again, you may have—look at the cases in for a young teenage girl and boys, there may be boys who are more powerful and the girls see that as "I don't have a choice" so they give in to someone."
Gender differences in the family	Any mention of gender specific roles or responsibilities among the adults/parents or children in a family.	"And parents did not believe in premarital sex and all that stuff. And me being brought up as the only girl, it was hard on me."
Gender differences in sexual health education	Gender differences related to who delivers or who is responsible for educating youth about sexual health. This also includes differences in sexual health education presented to males and females. This can relate to the timing of education, the educational content, or the context of the education.	" Um, so that was my mom's job. Dad stayed away from that. She basically just told us she doesn't, um, promote us doing anything. Um, however, she is aware, that we are young people. So if we choose to do anything make sure that we're protected. Be safe about it, don't be crazy about it. But her preference would be for us to not even to do anything."
Gender-related consequences of sex	Perceived differences in the consequences or outcomes of sex for males and females. This can include socio cultural consequences of sex such as punishments, stigma, or shame.	"The ones I've seen that actually became pregnant while in church, usually the group of people that were around them- especially if she's a young adult- if it's a young person and they become pregnant, the parents of the children that was once hanging around them, that one girl, they move her. They move their- they make their kids leave her alone. So she becomes isolated by herself. So cuz- like it's something contagious and she touch them they're now gunna become pregnant. So she becomes isolated by herself."

Gender standards in the church	Any mention of the differences between what the church or Biblical teachings require for men and women in the church. This can include how church members should look or behave.	"Like, I was taught we don't wear- women not to wear makeup and you always supposed to put on a dress, you're not supposed to put on anything pertaining to a man, such as pants, everything like that."
Gender specific differences in church positions	Any mention of what roles males and females play in the church and what their responsibilities are. This can also include who is responsible for making decisions for the church.	"Here at this church because again even though I was the locomotive, everything that we did was approved by Pastor, he knew exactly what we were doing all along when we first connected with the program I got his approval-permission so he was very much aware of everything."