Author Manuscript

Author Manuscript

Author Manuscript

Author Manuscript

HHS Public Access

Author manuscript

J Assoc Nurses AIDS Care. Author manuscript; available in PMC 2018 May 24.

Published in final edited form as:

J Assoc Nurses AIDS Care. 2018 ; 29(3): 406–416. doi:10.1016/j.jana.2017.11.004.

African American Church Engagement in the HIV Care Continuum

Jennifer M. Stewart, PhD, RN,
Assistant Professor, Johns Hopkins University School of Nursing, Baltimore, Maryland, USA

Hyejeong Hong, MSN, FNP, and
PhD Candidate, Johns Hopkins University School of Nursing, Baltimore, Maryland, USA

Terrinieka W. Powell, PhD
Assistant Professor, Johns Hopkins University Bloomberg School of Public Health, Baltimore, Maryland, USA

Abstract

Providing comprehensive services across the HIV care continuum through African American churches may improve HIV treatment outcomes for African Americans. We explored the feasibility of a church-led HIV care program in six churches in Baltimore, Maryland. Church leaders ($n = 57$) participated in focus groups and eight pastors participated in interviews. Data were analyzed by qualitative hybrid thematic analysis. Findings revealed eight themes: four themes were related to linkage to care: being unaware of community resources, concerns about HIV-associated regulations, ongoing personalized contact with HIV-infected persons, and desire for integration of spiritual education; four themes were related to HIV care and support services, including existing church infrastructure, provision of HIV support groups, using the church as an HIV care resource hub, and prevention education for uninfected people. These findings can support initiatives and efforts to promote delivery of HIV services along the HIV care continuum through African American churches.

Keywords

African American church; AIDS; faith; HIV care continuum; HIV testing

African Americans remain the racial/ethnic group most affected by HIV, with a high infection rate approximately eight times that of Whites (Centers for Disease Control and Prevention [CDC], 2016a; Siddiqi, Hu, & Hall, 2015). The disproportionate prevalence of HIV has been magnified in several African American-populated metropolitan areas, such as Baltimore, Maryland. The City of Baltimore has been ranked fifth in highest proportion of an African American population and 10th in highest prevalence of newly diagnosed HIV of any major metropolitan area in the United States (CDC, 2016b). A number of challenges

*Correspondence to: jstewa44@jhu.edu(Jennifer M. Stewart, PhD, RN).

Disclosures

The authors report no real or perceived vested interests that relate to this article that could be construed as a conflict of interest.

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

may contribute to the epidemic among African Americans, including lack of awareness of HIV status, lack of access to HIV care, and poverty (CDC, 2016a). These racial and geographical inequities led to the national priority of increasing access to care and improving health outcomes for people living with HIV (PLWH; White House Office of the Press Secretary, 2013).

The HIV Care Continuum, often referred to as the HIV treatment cascade, outlined sequential steps of HIV health care from initial diagnosis to achieving the goal of viral suppression (White House Office of the Press Secretary, 2013). Despite efforts to intervene to improve the numbers in the HIV care continuum, African American rates of linkage to care (74.9%), treatment (48.0%), and viral suppression (35.2%) remain below the goal (CDC, 2014). Research focused on reaching care continuum goals for African Americans highlights the following as the most common barriers: (a) depression/mental illness, (b) HIV-associated illness, (c) competing life activities, (d) expensive and unreliable transportation, (e) stigma, and (f) insufficient insurance (Yehia et al., 2015). Conversely, the following are considered as common facilitators: (a) social support, (b) patient-friendly clinic services (transportation, co-location of services, scheduling/reminders), and (c) positive relationships with providers and clinic staff (Yehia et al., 2015). Community also influences care engagement at each stage of the continuum by impacting levels of stigma and available social support (Mugavero, Amico, Horn, & Thompson, 2013). Thus, community and social support may be a necessary condition to increase the African American transition through the care continuum.

Among community-based institutions, churches may be uniquely positioned to intervene in the HIV care continuum, especially for African Americans who, as a group, present a stronger religious affiliation than other racial groups (Pew Research Center, 2009; Wingood et al., 2013). African American churches have long provided a wide range of social services for their congregants and neighboring communities, including counseling related to employment, housing, finances, and health care (Barber, 2015). Therefore, encouraging churches to become more involved in HIV prevention, screening, and treatment for African Americans remains an important strategy, particularly in HIV high-prevalence areas (Pingel & Bauermeister, 2017). Thus, offering church-led HIV services from prevention for uninfected people to care for PLWH can be a vital step in community-based approaches.

Several studies have found barriers to and facilitators of implementing church-based HIV programs in racial/ethnic minority communities; however, the research questions for these studies were derived from congregant perspectives on HIV-related stigma, HIV prevention, or HIV screening promotion interventions (Berkley-Patton, Moore, et al., 2013; Berkley-Patton, Thompson, et al., 2013; Pichon & Powell, 2015; Pichon, Powell, Ogg, Williams, & Becton-Odum, 2016; Pryor, Gaddist, & Johnson-Arnold, 2015; Williams et al., 2016). These studies left many unanswered questions about church leader perspectives on the feasibility of a focus on HIV care in African American churches. Therefore, two objectives were set for our study: (a) to explore views on African American church involvement in the entire HIV Care Continuum, and (b) to understand the factors that influence successful church-based HIV care interventions, as perceived by pastors and church leaders in Baltimore. The objectives resulted in two main research questions: (a) In what ways are church-based

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

linkage to care and support for remaining in HIV care impeded or facilitated within Christian African American churches in Baltimore? and (b) What resources in church communities can be used for such services? To answer these questions, the perspectives of pastors and church leaders were studied. Church leaders were included because their support is often critical to the success of HIV programs and interventions.

Methods

Design and Sample

We used an exploratory-descriptive approach for this qualitative study, which allowed for an in-depth study of the feasibility of integrating services along the HIV care continuum in African American churches. We collected qualitative data from eight interviews with pastors and six focus groups with church leaders ($n = 57$) across six churches in Baltimore. Of the participating churches, four were Baptist, one was Episcopal, and one was nondenominational. For purposes of our study, church leaders were defined as those identified by the pastor as having a leadership role that could impact implementation of HIV testing and care interventions in the church.

We used a convenience sampling strategy (Jupp, 2006) by handing out postcards, reaching out to African American church leaders and congregants, attending several events designed for faith leaders, and going door-to-door to churches in the targeted areas to identify potential churches for participation. Inclusion criteria for the churches from which participants were recruited were that the church had to (a) have an African American population of greater than or equal to 60%, (b) be in the Baltimore metropolitan area, and (c) have a pastor willing and able to provide support for collecting data within the church. Inclusion criteria for the pastor were that s/he had to be (a) at least 18 years of age, (b) the self-reported pastor of the church, and (c) willing and able to provide written consent for participation. Church leaders had to be (a) identified as leaders within the church as confirmed by the pastor, (b) at least 18 years of age, and (c) willing and able to provide written consent.

Procedures

Our study was approved by the Johns Hopkins University Institutional Review Board prior to the beginning of the study. Data were collected from February through September 2015. We conducted interviews with pastors and focus groups with church leaders because we expected that, due to the power differential between pastors and leaders within churches, church leaders might not be comfortable being candid with their responses if their pastors were present. All interviews and focus groups were conducted at the church in which the participant was a member and were scheduled at convenient dates and times for participants. We obtained informed consent from all participants prior to collecting data. Focus group participants were given a pseudonym during the session to protect their identities; pseudonyms are used in the quotes below. All identifying information was removed from transcripts and surveys.

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

Focus groups and interviews were co-facilitated by a trained member of the research team. Focus groups ranged in size from 8 to 10 participants and included both men and women. All participants were compensated $50 for their time. Focus groups and interviews lasted approximately 2 hours, and were digitally recorded and professionally transcribed. We then checked transcripts against the recordings for accuracy and removed any remaining identifiers.

Measures

Semi-structured interviews, focus group guides, and surveys were developed by the investigative team after a comprehensive review of the literature and extensive previous work with church-based populations. The semi-structured format allowed for flexibility in our line of questioning while maintaining the in-depth nature of qualitative inquiry. Surveys were administered prior to participation in focus groups or interviews and included questions about demographics, religiosity, comfort discussing HIV, HIV-testing behaviors, HIV-related beliefs, perceived HIV risk, and church norms. Participants were given a brief description about each stage of the HIV care continuum before questions were asked. Interview and focus group guides included six broad questions; for example: *Tell me about some of the barriers and facilitators to HIV testing in your church; Tell me about some of the barriers and facilitators to linkage to care in your church; Tell me about some of the barriers and facilitators to providing support services and treatment to PLWH in your church*; and *What resources do you have in place that could support HIV testing, linkage to care, and treatment?*

Analysis Strategy

We used a qualitative hybrid thematic analysis approach to analyze the data, which incorporated both a data-driven inductive approach (Boyatzis, 1998) and a deductive a priori template of codes approach (Crabtree & Miller, 1999). This approach complemented the research questions by allowing themes to emerge directly from the data using inductive coding. We determined a priori that we would solicit information from six churches, interview individuals with the title of pastor, and conduct focus groups with all identified and available church leaders. This resulted in a sample of 57 church leaders and eight pastors.

We employed a three-phase data analysis process. First, two coders from the research team independently pulled data from structural (by question) and content (by topic) codes for thematic analysis. Codes were developed a priori as well as inductively. Both coders scrutinized the data line by line to systematically generate initial codes related to our research interest across the data for pastors and church leaders as well as within individual data. Second, the coders collated the codes into potential themes, gathering all data relevant to each potential theme. Initially the coders analyzed across the interviews and focus groups separately, followed by an analysis of the interview and focus group transcripts together. When it was found that the pastors and church leaders gave similar answers regarding feasibility, we analyzed the interviews and focus groups together. Finally, the coders and all research team members involved in qualitative data collection engaged in ongoing

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

discussions throughout the analysis to refine the specifics of each code, generating clear definitions and appropriate names for each theme.

Inter-coder reliability was assessed throughout the coding process by comparison of codes independently generated by each coder, identifying discrepancies, and coming to consensus via research team discussions (Burla et al., 2008). Themes were developed based on patterns and topics that persisted throughout the interviews and focus groups. Finally, the two coders extracted quotes that related to and illuminated the research questions. Saturation was established in keeping with the principles of saturation; when no new themes emerged, collection was closed (Fusch & Ness, 2015).

Several steps were also taken to ensure trustworthiness of the qualitative data. Credibility was ensured by making several visits to each church, and attending church services to develop a familiarity and understanding of the culture of each church. Thick detailed descriptions of the phenomena under study in the words of the participants were used. Upon completion of interviews and focus groups, member checks were done via provision of a summary of what was discussed during the session and asking whether it accurately reflected what was said. Last, during debriefings, the principal investigator and research staff discussed beliefs, assumptions, and biases and how those might affect data analysis, as results were iteratively and collectively found and confirmed as a group (Krefting, 1991).

Results

Participants were predominately female (60%), older than age 56 years (44.6%), and married (64.6%). Most participants had some college education (36.9%), lived in an urban setting (58.5%), and had a household income of $50,000 or greater (55.9%; Table 1). All churches had between 100 and 250 members. Pastors and church leaders were all recruited from the six participating churches. Eight key themes emerged as care feasibility was analyzed in terms of the domains of linkage to care, as well as treatment and support services. Within each domain, we then categorized barriers and facilitators to care feasibility (Table 2).

Linkage to Care and Follow-ups

Overall, four themes emerged regarding linkage to care feasibility. Two of the themes were classified as barriers and two as facilitators to linkage to care feasibility. The themes identified included: (a) unaware of available community-based linkage-to-care resources, (b) concerns regarding regulations related to linkage to care, (c) strategies to maintain personal contact with PLWH, and (d) the benefit of incorporating spiritual education into health care.

Unaware of available community-based linkage-to-care resources—At the linkage-to-care point in the cascade, approximately 52 participants indicated or agreed that support from outside resources would be necessary. Although they hypothesized that there were likely a wealth of resources to tap for PLWH, they had limited knowledge of how and where to get access to these resources. For example, one pastor stated:

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

> I think that [there] might possibly be a wealth of resources for linkage to care. The problem is, I don't know if our community knows—especially an African American community—knows how to tap into that linkage for care. So, I think there is a lack of communication as to how those individuals tap into those resources. (Pastor, church 4)

This pastor alluded to the fact that knowledge of resources was especially low for those in the African American community. Although church leaders were willing to serve as liaisons to linkage to care, they stated they would need additional support to know how the linkage-to-care process worked and how to initiate it.

Concerns regarding regulations related to linkage to care—Six of the eight pastors and four of the church leader focus groups agreed that they were very concerned about how to navigate whatever regulations might impact the ability to link individuals to care. They were also unclear about maintaining confidentiality and which guidelines to follow if a PLWH needed to be linked to care. One church leader stated,

> I am not sure exactly what the rules would be, but I do understand that when we start to get into HIPAA [Health Insurance Portability and Accountability Act] and people's medical results that we can only do so much … there's a lot of stuff we can't do with whatever rules there might be. (Faith, church leader, church 1)

Because of the unknown guidelines and regulations for church-based HIV testing results, concerns regarding how to best link PLWH to care was a significant barrier to address.

Strategies to maintain personal contact with PLWH—All pastors and about 80% of the church leaders were enthusiastic about potential involvement in linkage to care. Their desire was to maintain close and personal contact with a newly diagnosed PLWH. One participant indicated this desire, saying, "So the church, we would work to get the person back in, so that we can have a face-to-face follow-up. So, then we can deliver them the personal information that we need them to have—both religious and medical" (Lucy, church leader, church 1).

Participants believed that this was one way to provide compassionate care to individuals who might still be dealing with the initial shock of an HIV diagnosis. One church leader said,

> You get a positive result and you're probably not even thinking about it right. You're just dealing with the shock experience and all. So, to get someone linked to care takes sitting with them one-on-one and supporting them through what's next. (Rebecca, church leader, church 2)

The church may provide an opportunity to give more personalized and compassionate care at the linkage point in the cascade. This could facilitate the process of linkage to care overall by spending an ample amount of time to build a supportive relationship to ensure accountability in beginning treatment.

Follow-up was a critical component and entry point for providing care and support for PLWH and prevention education for uninfected individuals. Participants provided details regarding envisioned components of the follow-up process. One of the six pastors who spoke

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

of a formalized follow-up process indicated the most detailed follow-up process. It entailed a three-step process of follow-up for PLWH that would include calls, personal visits, and support groups that would be implemented by church leaders. Church leaders further elaborated on the process: “We can call them” (Ben, church leader, church 5). “If they have a phone number that we can call,” (Gwen, church leader, church 5). “And we just, you know, maybe see what community they live in, come out to visit personally and just help them tap into the community resources” (Anita, church leader, church 5). “And just still kind of offer —offer some mental and emotional support” (Gwen, church leader, church 5).

Pastors and church leaders provided common suggestions that church-based linkage to care would be initiated with a follow-up call and/or home visits. Once the initial shock of the diagnosis was addressed, the person could transition into a church support group and be linked to pertinent community resources. This process could provide continuous support throughout the various phases of HIV care and maintenance. It was suggested as the best way in which churches could play an active role.

Benefit of incorporating spiritual education with health care—All focus groups with church leadership indicated that church-based HIV care was an opportunity to incorporate medical care with spiritual principles. Seven of the eight pastors also indicated that they felt this would enhance coping and disease management for PLWH. One pastor stated, “For the treatment piece, we could especially support the spiritual aspects of dealing with the HIV or AIDS and the medical condition. That’s for those who test positive” (Pastor, church 4). Along this line, a church leader stated:

> Whoever would come to a church for treatment would not only receive a personal relationship, but will have the opportunity to receive a relationship with the Lord, and would get the medical piece that we would offer through whatever course of study we will put together in the form of HIV/AIDS treatment. (Arthur, church leader, church 1)

The entire church leadership saw the integration of spiritual aspects of treatment and care as including a reaffirming of the relationship with God and people in the congregation. They felt this was the best strategy to deliver and reinforce health care and treatment. Another church leader elaborated on the importance of churches providing additional spiritual support, saying:

> I think if we are going to like care for someone with HIV, care is just not a one-time thing, you got be able to support their doctor treatment. And I think us being a faith-based organization and business, we have to provide that support. If we are Christians, we’re supposed to love each other. Love says, “I’m going to be with you.” We have to be active in supporting them. (Curtis, church leader, church 3)

The support the church leadership was willing to provide often stemmed from Christian principles of love and belief in caring for others.

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

HIV Care and Support Services

Four themes were identified as offering treatment and support services. All themes indicated that support services were the most viable route for church involvement. Themes included: (a) ability to build on existing church infrastructure, (b) viability of provision of support groups, (c) opportunity to provide prevention education, and (d) using the church as an HIV care resource hub.

Ability to build on existing church infrastructure

Five of the six churches that participated in our study had existing health ministries or programs in place at the time of the study. These ministries were thought to be an ideal forum for integrating HIV treatment and support services. One church leader stated, “So we have a structure. We can just bring in the HIV experts” (Darlene, church leader, church 4). Another church leader also reemphasized,

> We have a health and wellness meeting day. We have nurses, volunteers. So, we have this group that could talk about HIV treatments … we’re trying to educate our congregation in different diseases and treatment so they can help themselves. (Patrice, church leader, church 1)

By using the existing infrastructure, churches could more easily transition into HIV testing, linkage to care, and treatment by normalizing these activities and including them as a part of overall health and wellness. Transportation, information, resources for social services, and resources regarding financial support for medications were also discussed as ways to enhance existing ministries to support PLWH.

Viability of provision of support groups—All six of the church leader focus groups recommended that support groups be organized and offered within the church for those infected with HIV. This would be a continuation of the individualized support that was initially provided in the linkage-to-care phase. The need for support was thought to be a need for those who tested positive for HIV. One church leader explained, “Yeah, I think that’s an important component. The support group. That’s where you feel stronger. You need someone who’s living with HIV to be an integral part of that” (Fran, church leader, church 4).

The focus was to provide support groups to help PLWH cope emotionally. It was also thought of as an opportunity to provide support to family members of PLWH. As a pastor stated:

> An entire family support group with counseling for the infected person and the affected persons. I could think of that [taking place] here. Family support, counseling, medication information—would probably be sort of like a holistic program for HIV if that makes sense. (Pastor, church 3)

Churches have the unique opportunity of having members across the lifespan and many families. Providing support services to both the PLWH and his/her extended support network is a natural avenue to pursue. Participants agreed that support groups could be led by the

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

pastor, assistant pastor, or a group of volunteers. It was suggested that support groups meet weekly or monthly based on need.

Opportunity to provide prevention education—Five pastors and about 60% of church leaders also addressed the fact that many would test negative for HIV, but still need HIV prevention education to remain negative. One church leader said,

> Once they receive their results that's when your intervention should take place with them … you sit down with them and let them know, okay this is what education is available to you since you're negative … to keep yourself from getting the disease or passing it on." (Felicia, church leader, church 6)

Participants thought HIV-prevention messages during follow-up with uninfected individuals should include information on how to prevent HIV acquisition. In this way, the idea of linking people to care was not limited to PLWH. Instead, participants also expressed the importance of linking HIV-uninfected individuals to valuable resources to reduce the risk of contracting HIV.

Using the church as an HIV care resource hub—Church leaders envisioned that they would (a) provide spiritually based support for HIV care maintenance and (b) serve as liaisons between PLWH and their respective places of health care. The first step included making PLWH aware of community-based resources that would further help manage their care and diagnosis. As church leaders said, "And just, you know, maybe just help them tap into the medical resources" (Tammy, church leader, 5). "We would–we will do it. Just to be that resource for them" (Craig, church leader, 5).

In addition to being a resource hub to help PLWH access health care resources and information, church leaders elaborated on their potential roles as navigators to ensure that people were attending their medical visits, taking their medications, and tapping into resources to keep them healthy. In the words of one church leader, "And we would make sure they made it to their appointments. Call them up and take them over if need be." (Toya, church leader, church 3)

Discussion

Involving African American churches in supporting care and services at each stage of the HIV care continuum could bolster national efforts to address HIV treatment gaps for African Americans. Studies have noted that many faith-based efforts related to HIV infection have focused on prevention (Pichon & Powell, 2015). Our findings extend previous work in church-based HIV testing to the exploration of linkage to care and follow-up. Specifically, promoting church participation in linkage to care and follow-up will require training to maintain confidentiality and to develop awareness of partnerships with community-based linkage-to-care resources. Although not fully aware of the steps involved in linkage to care, participants in our study had knowledge of the importance of their roles in the care continuum and speculated that personalized contact with PLWH could bolster linkage-to-care efforts. The opportunity to provide comprehensive education and prevention messages

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

for both PLWH and uninfected individuals is an important approach for churches to consider.

Participants reported more barriers to involvement in linkage to care, suggesting that this element of support may be more difficult for churches. Reinforcing treatment, on the other hand, was reported to be more feasible. Several ways in which church-based support services could enhance adherence to treatment were suggested: providing support groups for those infected with or affected by HIV, spiritually centered care and support, and HIV treatment information. It has been found that social support is a critical piece of maintaining a long and healthy life for PLWH (Chouinard & Robichaud-Ekstrand, 2003; Reblin & Uchino, 2008). Including churches in this element of care would be a complement to providing spiritual needs. Given churches' longstanding roles in social service provision, they could also consider providing tangible support services such as housing, transportation, and food security, which often impact an individual's ability to maintain a treatment regimen.

Our findings also revealed critical components and barriers to consider in designing interventions for churches wishing to be more involved in HIV testing, linkage to care, and engagement in care. To overcome these barriers, church leaders and pastors must have information that is tailored to their unique needs, roles, and responsibilities within the church. For example, encouraging church leaders who are involved in health and wellness ministries to receive additional training in HIV would facilitate greater involvement within the context of church roles and responsibilities. Because churches are not often equipped to provide medication for treatment, the preferred role, based on our findings, would be in the support of treatment rather than the management of medication regimens.

As other investigators have indicated, partnerships with other community-based organizations would be needed to meet the goal of church-based HIV linkage to care and treatment (Stewart, 2015). Other investigators have indicated the need to promote compassion and reduce HIV stigma in training church leadership (Galvan, Davis, Banks, & Bing, 2008). Our findings, however, did not indicate that HIV stigma was a critical barrier to HIV linkage to care and treatment services. Given the historically conservative stance of African American churches on sexuality (Ward, 2005), it is likely that stigma related to homosexuality is a more important area to address in future research and in training church leaders to address HIV within the context of Christian compassion and nonjudgment. By leveraging the willingness, compassion, and potential health care expertise of congregants, the existing infrastructure could be enhanced to include HIV linkage to care/follow-up and medication adherence as critical pieces of healthy living.

Our study was not without limitations. The sample was limited to six African American Christian churches in Baltimore and was specific to those churches; our qualitative research method provides findings that are not generalizable to other church populations (Cleary, Horsfall, & Hayter, 2014). In addition, participant willingness to participate may have contributed to respondent bias. However, we feel that the small sample size and participant characteristics still provided in-depth information and built a foundation for further study.

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

Our study contributes to the literature on faith-based HIV care involvement in several ways. First, it is one of the first studies to consider how African American churches may assist HIV efforts beyond prevention, education, and testing. Second, it reinforces previous findings that some African American churches are eager to support HIV care (Stewart, 2015) and offers strategies to promote their involvement. Third, our study can serve as a foundation on which future researchers and practitioners can build as they partner with churches, local AIDS service organizations, and individual patients to improve the health and well-being of those infected with and affected by HIV. Study findings can be used to develop strategies to promote church involvement to increase care and services at each stage of the HIV Care Continuum. Strategies could include partnering with local AIDS service organizations to promote linkage to care and treatment, engaging church leaders and members who are in health professions to lead linkage to care and treatment through existing ministries, encouraging churches to hold support groups for PLWH, and providing technical assistance for issues of confidentiality and counseling of PLWH and uninfected individuals living with high risks.

Our findings have implications for research, including using the information presented here to develop faith-based HIV linkage to care and treatment interventions and to further pastor and church leader education and training to better understand HIV care and to deliver messages to the congregation and surrounding community. Nursing implications include the fact that linkage to care is a natural fit for nurses and health care professionals who are church congregants. Nurses can provide HIV information and relay knowledge, in addition to the necessary skill sets to manage linkage to care and holistic services for PLWH. Church-based HIV ministries often incorporate church health professionals as leaders or liaisons (Berkley-Patton, Thompson et al., 2013).

Conclusion

Due to continued disparities in HIV prevention and treatment outcomes for African Americans, it is imperative to take a multifaceted approach by engaging individuals, communities, and organizations integral to the daily lives and traditions of African Americans. Working with African American churches to provide HIV prevention, testing, linkage to care, follow-up, and support services to PLWH is an important strategy. We offer a vital first step in understanding the feasibility of comprehensive interventions across the HIV care continuum in African American churches.

Acknowledgments

This study was supported by the National Institute of Mental Health (K23MH106378, Principal Investigator [PI]: Jennifer M. Stewart); and Johns Hopkins Center for AIDS Research (1P30AI094189; PI: Richard Chaisson); National Institute of Nursing Research (F31NR016910-01A1; PI: Hyejeong Hong), National Institute of Drug Abuse (1K01DA042134-01A1, PI: Terrinieka W. Powell); and the Centers for Disease Control and Prevention (1U48DP000040, PI: Freya Sonenstein).

References

Barber KH. Whither shall we go? The past and present of Black churches and the public sphere. Religions. 2015; 6(1):245–265. https://doi.org/10.3390/rel6010245.

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

Berkley-Patton J, Moore E, Berman M, Simon SD, Thompson CB, Schleicher T, Hawes SM. Assessment of HIV-related stigma in a US faith-based HIV education and testing intervention. Journal of the International AIDS Society. 2013; 16(3 Suppl 2):18644. https://doi.org/10.7448/ias.16.3.18644. [PubMed: 24242259]

Berkley-Patton J, Thompson CB, Martinez DA, Hawes SM, Moore E, Williams E, Wainright C. Examining church capacity to develop and disseminate a religiously appropriate HIV tool kit with African American churches. Journal of Urban Health. 2013; 90(3):482–499. https://doi.org/10.1007/s11524-012-9740-4. [PubMed: 22815053]

Boyatzis, RE. Transforming qualitative information: Thematic analysis and code development. Thousand Oaks, CA: Sage; 1998.

Burla L, Knierim B, Barth J, Liewald K, Duetz M, Abel T. From text to codings: Intercoder reliability assessment in qualitative content analysis. Nursing Research. 2008; 57(2):113–117. [PubMed: 18347483]

Centers for Disease Contol and Prevention. Progress along the continuum of HIV care among Blacks with diagnosed HIV – United States, 2010. Morbidity and Mortality Weekly Report. 2014; 63(05): 85–89. [PubMed: 24500286]

Centers for Disease Contol and Prevention. HIV among African Americans. 2016a. Retrieved from https://www.cdc.gov/hiv/group/racialethnic/africanamericans/

Centers for Disease Contol and Prevention. HIV surveillance report, 2015. 2016b. Retrieved from http://www.cdc.gov/hiv/library/reports/hiv-surveillance.html

Chouinard M, Robichaud-Ekstrand S. Social support contribution to health and to the adoption and maintenance of health behaviours [in French]. Recherche en Soins Infirmiers. 2003; (75):21–37. [PubMed: 14725168]

Cleary M, Horsfall J, Hayter M. Data collection and sampling in qualitative research: Does size matter? Journal of Advanced Nursing. 2014; 70(3):473–475. https://doi.org/10.1111/jan.12163. [PubMed: 24450874]

Crabtree, BF., Miller, WL. Doing qualitative research. Thousand Oaks, CA: Sage; 1999.

Fusch PI, Ness L. Are we there yet? Data saturation in qualitative research. Qualitative Report. 2015; 20(9):1408–1416.

Galvan FH, Davis EM, Banks D, Bing EG. HIV stigma and social support among African Americans. AIDS Patient Care & STDs. 2008; 22(5):423–436. [PubMed: 18373417]

Jupp, V. The SAGE dictionary of social research methods. Thousand Oaks, CA: Sage; 2006. https://doi.org/10.4135/9780857020116

Krefting L. Rigor in qualitative research: The assessment of trustworthiness. American Journal of Occupational Therapy. 1991; 45(3):214–222. [PubMed: 2031523]

Mugavero MJ, Amico KR, Horn T, Thompson MA. The state of engagement in HIV care in the United States: From cascade to continuum to control. Clinical Infectious Disease. 2013; 57(8):1164–1171. https://doi.org/10.1093/cid/cit420.

Pew Research Center. A religious portrait of African-Americans. 2009. Retrieved from http://www.pewforum.org/2009/01/30/a-religious-portrait-of-african-americans/

Pichon L, Powell T. Review of HIV Testing efforts in historically Black churches. International Journal of Environmental Research and Public Health. 2015; 12(6):6016–6026. https://doi.org/10.3390/ijerph120606016. [PubMed: 26030470]

Pichon L, Powell T, Ogg S, Williams A, Becton-Odum N. Factors influencing Black churches' readiness to address HIV. Journal of Religion & Health. 2016; 55(3):918–927. https://doi.org/10.1007/s10943-015-0117-3. [PubMed: 26345680]

Pingel, ES., Bauermeister, JA. 'Church hurt can be the worst hurt': Community stakeholder perceptions of the role of Black churches in HIV prevention among young Black gay and bisexual men; Culture, Health & Sexuality. 2017. p. 1-14.https://doi.org/10.1080/13691058.2017.1338756

Pryor JB, Gaddist B, Johnson-Arnold L. Stigma as a barrier to HIV-related activities among African-American churches in South Carolina. Journal of Prevention & Intervention in the Community. 2015; 43(3):223–234. https://doi.org/10.1080/10852352.2014.973279. [PubMed: 26151171]

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

Reblin M, Uchino BN. Social and emotional support and its implication for health. Curr Opin Psychiatry. 2008; 21(2):201–205. https://doi.org/10.1097/YCO.0b013e3282f3ad89. [PubMed: 18332671]

Siddiqi, AE., Hu, X., Hall, HI. Mortality among Blacks or African Americans with HIV infection – United States, 2008–2012. 2015. Retrieved from https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6404a2.htm

Stewart JM. A multi-level approach for promoting HIV testing within African American church settings. AIDS Patient Care & STDs. 2015; 29(2):69–76. https://doi.org/10.1089/apc.2014.0160. [PubMed: 25682887]

Ward EG. Homophobia, hypermasculinity and the US Black church. Culture, Health & Sexuality. 2005; 7(5):493–504.

White House Office of the Press Secretary. Accelerating improvements in HIV prevention and care in the United States through the HIV Care Continuum Initiative. 2013. Retrieved from http://www.whitehouse.gov/the-press-office/2013/07/15/fact-sheet-accelerating-improvements-hiv-prevention-and-care-united-stat

Williams MV, Derose KP, Aunon F, Kanouse DE, Bogart LM, Griffin BA, Collins DO. Church-based HIV screening in racial/ethnic minority communities of California, 2011-2012. Public Health Report. 2016; 131(5):676–684. https://doi.org/10.1177/0033354916662641.

Wingood GM, Robinson LR, Braxton ND, Er DL, Conner AC, Renfro TL, Diclemente RJ. Comparative effectiveness of a faith-based HIV intervention for African American women: Importance of enhancing religious social capital. American Journal of Public Health. 2013; 103(12):2226–2233. https://doi.org/10.2105/ajph.2013.301386. [PubMed: 24134367]

Yehia BR, Stewart L, Momplaisir F, Mody A, Holtzman CW, Jacobs LM, Shea JA. Barriers and facilitators to patient retention in HIV care. BMC Infectious Diseases. 2015; 15(1):1–10. https://doi.org/10.1186/s12879-015-0990-0. [PubMed: 25567701]

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

Key Considerations

- For successful faith-based HIV care support along the care continuum in African American churches, church leaders and pastors must have information that is tailored to their unique needs, roles, and responsibilities within the church.
- Church leader training in maintaining confidentiality and awareness of partnerships with community-based linkage-to-care resources is essential to promote church participation in HIV linkage to care and follow-up.
- There is a need to encourage pastors and church leaders to incorporate spiritual education with HIV health care in the context of church roles and responsibilities, including Christian principles of love and belief in caring for others.

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

Table 1

Demographic Characteristics

Characteristics	Pastors *n* (%)	Church Leaders *n* (%)	*p*-Value	*n*
Age, years				
18-35	0 (0)	3 (5.3)	.603	65
36-55	4 (50)	23 (40.3)		
56+	4 (50)	31 (54.4)		
Gender				
Male	5 (100)	17 (30.4)	.002	61
Female	0 (0)	39 (69.6)		
Marital status				
Single	0 (0)	10 (17.5)	.082	65
Married/committed	8 (100)	34 (59.6)		
Other[a]	0 (0)	13 (55.8)		
Education				
High school or equivalent	0 (0)	8 (14.0)	.001	65
Some college	0 (0)	24 (42.1)		
College degree	1 (12.5)	13 (22.8)		
Advance degree[b]	7 (87.5)	12 (21.1)		
Residence				
Urban (City)	2 (25)	36 (64.3)	.052	64
Suburban (Outside the city)	5 (62.5)	19 (33.9)		
Rural (Country)	1 (12.5)	1 (1.8)		
Household size				
1-2	3 (37.5)	31 (54.4)	.518	65
3-4	4 (50)	17 (29.8)		
5 or more	1 (12.5)	9 (15.8)		
Household income				
Less than USD $50,000	0 (0)	27 (48.2)	.010	64
More than USD $50,000	8 (100)	29 (51.8)		

Note. USD = U.S. dollars.

[a]Other includes living with partner, divorced, widowed, and separated.

[b]Masters and/or doctorate degree.

Author Manuscript

Author Manuscript

Author Manuscript

Author Manuscript

Table 2

Emerged Themes of Church-Based HIV Care Continuum Service Feasibility

Barriers	Facilitators
Linkage to care and follow-up	
Unawareness of available community-based linkage-to-care resources	Strategies to maintain personal contact with people living with HIV infection
Concerns regarding regulations related to linkage to care	Benefit of incorporating spiritual education with health care
HIV care and support services	
	Ability to build on existing church infrastructure Viability of provision of support groups Opportunity to provide prevention and education for HIV-uninfected persons Using the church as an HIV care resource hub