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Strategies to Promote African American Church Leadership Engagement in HIV Testing and Linkage to Care

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Abstract

A vital piece in implementing and sustaining HIV testing and linkage-to-care within Black churches is the support of the pastors and church leadership. In order to promote church-based HIV testing and linkage-to-care, we explored pastor and church leaders' (1) HIV-related knowledge, (2) their perception of congregant and community engagement in HIV-related risks, and (3) the potential role of the church in HIV testing and linkage-to-care. We conducted focus groups with 57 church leaders and 8 interviews with pastors across 6 churches in Baltimore, MD, USA. Conventional content analysis was used to analyze the qualitative data. The leadership demonstrated different levels of knowledge of the need for confidentiality and the HIV testing process and reported that low levels of HIV knowledge among their congregants was related to low perceived risk of contracting HIV. Pastors and church leaders indicated that community members engaged in sexual risk and drug use but denied that any of their congregants engaged in such behaviors. Finally, pastors and church leaders as stated that churches were best suited as HIV service centers. These findings can be used to develop culturally appropriate interventions for pastors and church leaders to be better equipped and willing to incorporate HIV testing and linkage-to-care in their churches.

Keywords

HIV testing; church; linkage to care; church leadership

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Introduction

Despite increasing governmental effort, HIV and AIDS rates among Black Americans remain unacceptably elevated. The Center for Disease Control and Prevention (CDC) estimated that Black Americans accounted for 45% of new HIV diagnoses in 2015 and 13% of Blacks living with HIV did not know their HIV status [1]. Moreover, 53% of total deaths among people living with HIV or AIDS (PLWHA) were comprised of Black Americans in 2014 although they represent only 12% of the U.S. population [1]. *The National HIV/AIDS Strategy (NHAS)* aims to ensure that 80% of PLWHA have an undetectable viral load, 85% be linked to HIV care less than 1 month from first diagnosis. and 90% be retained in medical care by 2020 [2]. According to *the National HIV Surveillance System* data, however, 65.3% of PLWHA were Black Americans, and of those, 53.5% were retained in care, and only 48.5% had an undetectable viral load at their most recent test [3]. The promotion of HIV testing and linkage to care are essential to halting transmission, improving PLWHA's general health, and early initiation and adherence to antiretroviral therapy in the Black community.

Increasing the availability of HIV testing within community-based organizations is a viable strategy to promoting HIV testing and linkage to care. The Black Church is one such organization, which continues to play a vital role in the lives of their congregants and surrounding community members [4, 5]. More importantly, Black churches have made increasingly positive strides in the incorporation of HIV testing and prevention interventions, programs, and ministries into their venues [6-9]. Through the co-location of health services, the Black Church could increase access and availability of HIV related services for the Black community [2]. Therefore, it is important to support Black churches in their efforts to expand HIV services to include testing and linkage to care.

The pastors and members of the church leadership (e.g., deacons, trustees, and ministry leaders) represent the administrative and leadership body of the church and determine its vision and direction. Without their support, it is unlikely that HIV testing would be accepted or integrated within the cultural framework of the church [10]. Congregational support has been found to be critical to the health of many Black Americans, including PLWHA in terms of leveraging social support of HIV testing and services [11-14]. Unfortunately, congregations whose leaders fail to discuss sexuality and condemn PLWHA may be more likely than other congregations to breed HIV stigma and shame among their congregants [15-17]. Thus, the importance of intervening with pastors and church leaders cannot be ignored.

Although there are existing faith-based HIV testing interventions [18-20], few if any also incorporate linkage to care. Furthermore, there is a paucity of research focused on Black church leaders' views on the role the church leadership could have in linkage to care. Interventions must be developed and implemented in ways that are culturally appropriate and resonate with the church leader's spiritual beliefs and equip them to take an active stance in promoting HIV testing and linkage to care in Black communities. The purpose of this study is to explore the HIV related knowledge, perceived HIV-related risks, and potential role of the church in HIV testing and linkage to care from the perspective of

pastors and church leaders. We also sought to solicit responses from Black faith leaders about the potential role of that Black churches could play in HIV testing and linkage to care.

Methods

This study was conducted in Baltimore, Maryland in partnership with 6 Black Christian churches. All research protocols were approved by the Johns Hopkins School of Nursing's Institutional Review Board prior to study initiation. For the purposes of this study, church leadership was defined as any congregant identified by the pastor as a ministry leader, deacon or trustee within the church that would also have input on the implementation of programs within the church.

Recruitment and Participants

We used a purposive sampling technique and employed several strategies to recruit participating churches. We first ensured the support of the pastor followed by the support of the church leaders for participation. Recruitment strategies included handing out postcards, reaching out personally to Black church leaders and congregants, attending several events designed for faith leaders, and going door-to-door to churches in the target areas to identify the potential churches for participation.

Inclusion criteria for each church included that the church must have a Black American population of greater than or equal to 60%, the church must reside in the Baltimore metropolitan area, and must have a pastor willing and able to provide support for collecting data within the church. Inclusion criteria for the pastor was that he or she must be over the age of 18, be the self-reported pastor or minister of the church and be willing and able to provide written consent for participation. Church leaders were identified by the pastor and then screened by the research team. They also had to be over the age of 18, self-report as a leader within the church (which was confirmed by the pastor) and willing and able to provide written consent.

Procedures

Data were collected from February 2015 through September 2015. All the interviews and focus groups were conducted within the participating churches. Interviews and focus groups were scheduled at a convenient date and time based on participant availability. We obtained the informed consent of all participants. Each participant completed a demographic survey prior to their interview or focus group (see details in Table 1). Given our previous work with churches we understood that there is often a power differential between pastors and church leaders within churches. Thus, we elected to perform interviews with pastors, and focus groups with church leaders so both parties would be comfortable and candid in their responses. Focus group members were given a pseudonym during the group to protect their identity. Recordings were professionally transcribed and all identifying information was removed from transcripts and demographic surveys.

Both focus groups and interviews were facilitated and co-facilitated by a trained member of the research team. Focus groups ranged in size from 8 to 10 and included both men and women. Focus groups and interviews lasted approximately 1 to 2 hours. We then checked

the transcripts against the recordings for accuracy and removed any remaining identifiers. Both interview and focus group participants were compensated $50 for their time.

Measures

Pastors and church leaders completed a demographic survey, which assessed their gender, age, position in the church, marital status, education and income. Following completion of the demographic survey, participants took part in an interview or focus group.

Semi-structured interview and focus group guides were developed to allow for flexibility in our line of questioning while maintaining the in-depth nature of qualitative inquiry. The interview and focus group guides were developed by the investigators via a comprehensive review of literature and extensive previous work with churches. Example questions included: (1) What do you currently know about (a) HIV/AIDS, (b) HIV testing and (c) linkage to care?; (2) What behaviors are people in the church doing that may put them at risk for HIV?; (3) What behaviors are people in the community doing that may put them at risk for HIV?; and (4) What role should the church have in HIV testing and linkage to care?

Data Analysis

Conventional content analysis was used to deductively analyze the qualitative data [22], meaning that codes were initially determined a priori. Content analysis focuses on the contextual meaning of the text and is designed to provide a subjective interpretation of the content of data through the systematic classification process of coding and identifying themes or patterns. Our approach was particularly useful as it allowed us to draw upon the participants' words and ideas, yielding a greater understanding of their needs in designing the intervention and increasing the relevance of the findings.

All data were digitally recorded, and then professionally transcribed. After a research team member verified the accuracy of each transcript, they were hand coded by two members of the study team. The two analysts who coded the transcripts reviewed, reconciled, and revised any coding discrepancies. The coding manual was further refined within group discussions with all members of the research team. Themes were first developed based on patterns and topics that persisted throughout both the interviews and focus groups. Then additional themes were developed through comparison and contrast of the interviews and focus groups. To enhance credibility of the results we used three techniques: member checking, investigative team journaling, and peer debriefing immediately following focus groups and interviews [add citation]. The goal of this process was to ensure that the interpretations of the researcher reflected the perspectives of participants.

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 [21]. Themes were developed based on patterns and topics that persisted throughout the interviews and focus groups. Lastly, the two coders extracted quotes that related to and illuminated the research question. Saturation was established in keeping with the principles of saturation in that no new themes emerged the close of data analysis [22].

Results

The sample was predominately female (60%), over the age of 56 (44.6%) and married (64.6%). Table 1 lists detailed demographic information about the sample. Qualitative findings highlighted ways to encourage leaders in supporting and accepting the integration of HIV testing and linkage to care within Black churches (see Table 2).

HIV Related Knowledge

In the area of HIV Related Knowledge, two themes emerged: (1) knowledge of the importance of confidentiality and privacy in HIV testing and (2) knowledge of the steps in the linkage to care process. In comparing pastoral interviews and church leadership focus groups, an additional theme was salient among pastors that was not discussed among church leaders: (1) lack of knowledge regarding the HIV testing process.

HIV Knowledge Overall Theme 1: Importance of confidentiality and privacy in HIV testing.—Pastors and church leaders were aware of the confidential nature of HIV testing. The pastor from church 1 stated, “I know it’s confidential. Held confidential or it’s kept confidential I should say.” A church leader reaffirmed this knowledge in a slightly different way saying, “It’s private as far as individual information is being retained with only to themselves, whoever they give consent to, and the doctors or establishment.” (M.M., church leader, church 3).

Pastors and church leaders knew that HIV testing results needed to be confidential as well as private and personal. As a result, church leaders began to discuss how to ensure that both confidentiality and privacy could be maintained within their own church-based HIV testing efforts. Some possibilities included engaging people from outside of the church to perform testing and setting up private spaces within the church building for testing.

Knowledge Overall Theme 2: Steps in the linkage to care process.—Pastors and church leaders reported accurate on were able to articulate the steps in the linkage to care process. One church leader stated, “there are agencies that you can link up to and get confirmation tested, medications, counseling et cetera…most health facilities could also manage your care including your primary physician. (I.B., church leader, church 3)

Like this church leader, others were aware of these steps and specific facilities and mechanisms to ensure proper treatment and care. A pastor stated, “The doctor would get back with you and confirm and go over the results with you. And from that point forward the doctor will give you instruction on getting your treatment, perhaps provide a case worker and other needed resources” (P.F., church 5). Pastors and church leaders indicated that linking people to care involved and linkage to other HIV services and resources. In additional leaders noted that how to confirm a positive result, provision of information on potential antiretroviral treatment regimens and overall health and nutrition needs, and psychosocial support services to treatment were all a part of the linkage to care process.

Pastor Specific Theme: Low level of self-reported HIV testing knowledge—There were noted differences in reported levels of knowledge regarding HIV testing between

the pastors and church leaders. This difference focused on the initial HIV testing procedure. Pastors admitting having lower levels of knowledge or no knowledge at all of HIV testing. For example, when asked what he knew about HIV testing, one pastor responded, “Nothing. Absolutely nothing about the testing.” (P.H., church 4). Interestingly, this sentiment was echoed across all pastor interviews. In contrast, church leaders had more knowledge about HIV testing. One church leader stated,

> You can get tested through rapid testing which is an oral swab. You can [also] get tested through your blood. So normally what happens is that they’ll take a swab first, if it comes back positive, then they normally take you for blood work to get a confirmation. (G.C., church leader, church 6)

Despite the fact that pastors knew little about HIV testing it did not G.C. reported difference affects their willingness to implement HIV testing in their congregations or learn more about the process.

Perception of HIV risk

Two themes emerged in this domain: (1) low perceived risk for HIV was due to low HIV knowledge, and (2) sexual risk, homosexuality and drug activity as primarily community risk factors. However, pastors and church leaders differed in their thoughts on drivers of HIV. In addition, pastors also noted the presence of HIV risk among congregants, while church leaders perceived youth and the community to solely be at risk.

Risk Perception Overall Theme 1: Low perceived risk due to low HIV knowledge—Both pastors and church leaders believed that lack of knowledge of HIV contributed to low perceived risk. One church leader stated, “It’s the lack of knowledge. All I'm saying is they don’t even think about the fact that they may acquire HIV” (J.B., church leader, church 4). A pastor echoed this sentiment saying, “it’s the educational part of it, what is HIV, how do you get it…Not knowing that puts them at risk. So, it’s the educational piece there” (P.W., church 1).

Both pastors and church leaders said that lack of knowledge and subsequent low perceived risk put African Americans at greater risk for contracting HIV. They went on to hypothesize that if churches provided additional education about HIV, AIDS, and risk profiles, people would be more likely to get tested for HIV and reduce their risk behaviors.

Risk Perception Overall Theme 2: Sexual risk/homosexuality and drug activity in community—Pastors and church leaders stated that the risky sexual behaviors, particularly unprotected sex, put individuals in the community at. In a dialogue between church leaders about what puts someone in the community at risk for HIV it was said,

> “Not using protection” (K.H.). “Yeah unprotected sex and people not telling their status” (P.D.). “Guys and girls, they’re being as you say down-low” (R.S.).
>
> “Men getting a lot of guys on a down-low and not telling you. Then they come back to relationships with you, yeah” (S.B.). (Church leaders, church 5)

As noted above, church leaders alluded to unprotected sexual activity sexual concurrency as risky behavior and men having sex with both men and women. In addition, lack of condom use or discussions on sexual activity outside of the main relationship was said to be a risk factor for contracting HIV within community members. It was very clear from these statements that sexuality was an important driver of rates of HIV.

Drug activity in the community was also a part of the pastors and church leaders' conceptualizations of HIV associated risk. The pastor of church 5 said, "the drug activity is very high. Heroin, cocaine, lacing of drugs, I mean you can just name it, it's there all of it is prevalent. I can see it being very prevalent and very high in our zip code." (P.F., church 5). The leadership reported seeing individuals in the community surrounding the church that they thought were using drugs on a frequent enough basis to report it as a risk factor aside from sexual activity.

Pastor and Church Leader Differences: drivers of HIV—In contrast to pastors, who focused on individual level drivers such as unprotected sex and homosexuality, many church leaders highlighted several social and interpersonal factors that contributed to risk. Within one group for example, when asked about what contributes to HIV related risk in the community the dialogue was,

> "Unemployment and poverty" (C.Y.) … "And then it's you know, it's the community violence. (F.D.) Yeah, and domestic violence. And relationship communication, you know what I mean? Probably mental illness too." (C.Y.). "Yeah, well, in our community, you've got prostitution and the sex trafficking, you got all kinds of that too. That's related to the money and resources issues" (B.D.) (Church leaders, church 6).

Poverty as well as lack of health care access were also frequently mentioned. In addition, there were links expressed between community violence and associated trauma with HIV. Thus, while church leaders focused on the community as a high-risk population, they were quick to note that factors that put communities at risk for HIV were broad and multifaceted. Lastly, HIV testing should target youth first.

Pastor Specific Risk Perception Theme: HIV-related risk behaviors among congregants—Pastors were certain that HIV associated risk behaviors happened within the congregation as well as the community. Church leaders, on the other hand, denied this to be true. When asked about the risk behaviors that may be present in the church, the pastor of one church stated,

> Well, this is the church—a lot of promiscuity takes place. Unprotected sex, maybe multiple partners… a lot of young men are coming out of the closet…its [these] individuals that build the congregation and [they] no longer see that particular lifestyle as a taboo. (P.J., church 6)

Although pastors were aware of the risk behaviors their congregations were involved in they also stated that they had little influence over private matters. One pastor said, "When I look at my church, the type of behaviors that are present I can't stop…So, it's only so much that I can do except to teach… because you don't know who has HIV. (P.T., church 3). Despite the

prominent and influential role many pastors have in their churches, it seems that they also felt powerless to impact the HIV risk behaviors they knew their congregation was engaging in.

Church Leader Specific Risk Perception Theme: Community youth at highest risk—In contrast to pastors, church leaders unanimously denied that the congregation was engaging in HIV associated risk behaviors in any way. When asked about the risk behaviors among congregants, church leaders provided consistently similar responses,

"I would say none (D.O.), "Oh none yeah (F.B.), "Yeah none" (E.T.) (church leaders, church 4). When probed further, they continued to deny the congregations engagement in risky sex, drug use or any other related risks. Instead, church leaders endorsed the idea that community members outside of the church were engaging in the high risk behaviors—especially youth. For example, several church leaders noted:

> "Once again, youth thinking they invincible" (F.G.), "Right, right. Nothing is going to happen to them" (S.T.) "Then when they see so much sex on the internet and everything else, they just think hey, that's fun, let's go ahead and do it. They put themselves at risk that way" (F.G.) (Church leaders, church 3).

Media images and peer influence were often reported as precipitating high-risk behaviors among youth in the surrounding community, but once again not within the youth in the church.

Role of the Church in HIV Testing and Linkage to Care

The sole theme in this area was the desire to also combine education and prevention messages with HIV testing. One pastor said,

> I think that there should be at least classes and seminars held within the Black church with a well-planned curriculum that helps to educate people concerning their disease. And it should include the prevention along with the HIV testing… HIV testing and awareness, education, and being compassionate to folks with HIV being led by the African American religious community. (P.B, church 2)

As described above church leaders, all but one focus group felt that a comprehensive approach should be taken with HIV testing by placing it alongside of prevention interventions, awareness activities and support and care of people living with HIV and AIDS.

Pastors also specifically mentioned delivering information through sermons and speaking events within the context of church services saying for example, "as pastor I would take the role on of preaching and teaching about HIV in the center as well as the church" (P. W., church 1). As a religious institution, the church is uniquely positioned to integrate physical, spiritual, and mental health within their programming and messages to the congregation and community. Many pastors and church leaders could leverage that role to destigmatize, educate and provide HIV services through faith-based HIV centers in the community.

Pastors become less involved in community health and well-being issues. Pastors and church leaders suggested that outreach and evangelism driven approaches could be a natural mechanism for the church to engage the community in HIV testing. In contrast to pastors, church leaders emphasized the importance of ensuring that the church had practical training to promote HIV testing in a way that dispelled myths, was compassionate, non-judgmental and confidential. Although enthusiastic about the role they could play in HIV testing and following care, all focus groups with church leaders expressed the need for training to be qualified to test others for HIV, provide counselling, resources, and care. One of the church leaders said, “Well, I think we can provide the testing and that care but I think you have to have training – So I don’t know if – I think first we need to have training for us to be the testers and counselors. (D.B, church leader, church 4). In addition, church leaders also indicated that it might be necessary to provide training in providing affirming care to those of differing sexual orientation. In summary, church leaders stated that the church should be active in HIV testing and linkage to care but needed training to do so.

Discussion

Garnering the support of church leadership is an essential first step to for the implementation of church-based HIV testing. Our findings support other research in that education and training are necessary undertakings in promoting faith-based HIV testing and linkage to care [14, 23]. The development of sermons, integration of HIV prevention and testing, as well as establishing linkages between churches and other community-based AIDS service organizations could be valuable next steps in this field.

A particularly noteworthy finding is the disconnection between pastors’ and church leaders’ views of HIV associated risk. Previous literature has indicated that most pastors perceive their congregations as being at lower or no risk for HIV [23-25]. In contrast, the pastors in this sample reported that there was a high likelihood that members of their congregation, particularly young boys and men, were engaging in risk behaviors that may put them at risk for HIV. Their issue was not with recognizing the risk but with feeling powerless to impact it. For church leaders, on the other hand, it was easier to recognize the risk behaviors that were going on in the community and among youth rather than the church. These findings have implications for interventions that take into account church structure, hierarchy and the flow of information regarding HIV risk. Two strategies should be employed. First work is needed to bring congruence in the perspectives of pastors and church leaders regarding risk. Second both pastors and church leaders need to know more about the actual landscape of HIV risk among African Americans in their community.

Church leaders were especially concerned about the sexual risk taking among youth. This perception was consistent with epidemiologic data in the surrounding community suggesting that HIV testing and linkage to care efforts should prioritize youth. For example, the incidence rate of HIV among adolescents between the ages of 13 and 19 in Baltimore City was 31.7 as compared to 15.1 per 100,000 population in suburban regions in Maryland during 2013 [26]. Church based HIV testing and linkage to care efforts could certainly target youth in the church and surrounding community.

Church leaders, but not pastors, acknowledged that social factors that influenced rates of HIV in the Black American community. Interventions which acknowledge the social drivers of HIV in the Black community could support efforts of the church leadership to engage in HIV testing through outreach and evangelism. Such preference is an ideal approach as previous studies' implementation of HIV prevention programs included efforts focused on engaging the surrounding communities on social issues [27, 28]. The leadership expressed that the church could be an information and resource hub providing HIV testing, referrals, HIV classes and seminars, and education. This seems to be a natural step to integrating HIV testing into African American churches.

In summary, findings suggest several strategies to promote African American church leadership engagement in HIV testing and linkage to care. First, promote dialogue between pastors, church leadership and researchers to correctly ascertain congregant and community risk. Second, aim to address HIV prevention, testing and linkage to care across the lifespan. Church leaderships was particularly concerned about youth, but churches typically have members across the lifespan that would benefit from HIV services. Third, develop HIV interventions that take into account social drivers of HIV among Black Americans. Lastly, consider leveraging the prominent role that Black churches have in their communities by strategically employing the church's outreach and evangelism mission to reach difficult to reach, vulnerable populations in the community through education and the provision of HIV services.

This study is limited by its small sample size, which is typical of qualitative research [29]. Because our data was collected exclusively in Baltimore, MD with African American Christian churches, the findings may not be generalizable to rural settings or other faith traditions. However, we feel that the small sample size allowed us to get in depth information and build a foundation for further study. In addition, the fact that the churches from which we garnered information were willing to participate in a study about HIV may indicate their openness and willingness towards HIV testing. This may have biased the results.

Despite these limitations, this study contributes to the literature on faith-based HIV prevention and linkage to care in several ways. First, this study used multi-informant approach by including both pastors and church leaders, which demonstrated the differences in knowledge and perspectives across faith leaders. Second, study findings can be used to develop and pilot test interventions for church leaders to promote their involvement in HIV testing and follow up and develop strategies for the engagement of churches in the HIV care continuum. Third, future researchers and practitioners may also use these findings to partner with seminaries and bible colleges in providing clergy training and education on the importance of addressing HIV and other health issues in the congregation and community. This is an avenue yet to be explored and would ensure that the next generation of clergy are well informed about HIV/AIDS and understand the importance of addressing this health concern framed within a biblical and theological perspective and sermons, faith-based curriculums, strategies and interventions. HIV/AIDS associated services can be led by church leaders to promote an open and compassionate dialogue and interventions about HIV testing in the church and community.

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Table 1.

Demographic Characteristics

Characteristics	Pastors n (%)	Church Leaders n (%)	p-value	N
Age				
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[§]	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[†]	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				
Under $50k	0 (0)	27 (48.2)	.010	64
Over $50K	8 (100)	29 (51.8)		

[§]Other includes divorced, widowed, and separated

[†]Advanced degree includes master's degree and professional degree (e.g., PhD, MD, JD, etc.)

Table 2.

Emerged Themes in Faith-Based HIV testing and Linkage to Care

Themes	HIV Related Knowledge	Perception of HIV Risk		Role of Church in HIV testing and linkage to care
		Church	Community	
Overall Themes	(1) : Importance of confidentiality and privacy in HIV testing (2) Steps in the linkage to care process		(1) Low perceived risk due to low HIV knowledge (2) sexual risk, homosexuality and drug activity as primarily community risk factors	(1) Integration of HIV testing services with HIV prevention (2) Churches as centers for HIV education and services (3) Reinvigorating the church in community based HIV outreach
Pastor Specific Themes	(1) Low level of self-reported HIV testing knowledge	(1) HIV-related risk behaviors among congregants		
Church Leader Specific Themes			(1) Community youth at highest risk	(1) Need for comprehensive leadership training