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Religious Congregations' Involvement in HIV: A Case Study Approach

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Abstract

Comparative case studies were used to explore religious congregations' HIV involvement, including types and extent of activities, interaction with external organizations or individuals, and how activities were initiated and have changed over time. The cases included 14 congregations in Los Angeles County representing diverse faith traditions and races-ethnicities. Activities fell into three broad categories: (1) prevention and education; (2) care and support; and (3) awareness and advocacy. Congregations that engaged early in the epidemic focused on care and support while those that became involved later focused on prevention and education. Most congregations interacted with external organizations or individuals to conduct their HIV activities, but promoting abstinence and teaching about condoms were conducted without external involvement.

Opportunities exist for congregations to help address a variety of HIV-related needs. However, activities that are mission-congruent, such as providing pastoral care for people with HIV, raising HIV awareness, and promoting HIV testing, appear easier for congregations to undertake than activities aimed at harm reduction.

Keywords

HIV; Religious congregations; Community-based responses

Introduction

There are an estimated 300,000 religious congregations in the U.S. [1] and national surveys have found that half of all adults attend religious services at least monthly [2]. The potential role of congregations in promoting health and reducing health disparities has been of persistent interest to public health professionals and policymakers over the last three decades [3–6]. Congregations are often the last institutions to leave distressed neighborhoods, thereby shouldering much of the burden of caring for community needs [7]. The 2006–2007 National Congregations Study found that 82% of congregations provided social services either formally or informally [8].

Because of congregations' extensive roles in addressing social needs, it has been proposed that congregations could play an important role in the response to HIV [9], particularly among racial and ethnic minorities who bear a disproportionate burden of HIV infection. For example, in 2006, 46.1% of those estimated to be living with HIV in the U.S. were black and 17.5% were Latino [10], whereas only 12% of the population was black and only 15% was Latino [11]. However, there have been few systematic attempts to assess the extent of congregational involvement in HIV prevention and support services [12]. Further, researchers have noted that religious messages about AIDS that connected the disease with sin [13,14] and religiously-based stigma towards homosexuality have created an obstacle to AIDS action by the faith community [15]. But it is not clear to what extent these conservative views have persisted over time and across various faith groups.

Descriptive studies of congregation-based HIV prevention efforts in the U.S. have largely focused on the African American community and/or have resulted from partnerships between public health entities and individual congregations [9,16–20], and an increasing number are emphasizing the importance of community-based participatory research approaches [21–23]. Few studies have examined HIV prevention efforts that are largely initiated and run by congregations themselves [24–26]. Even fewer studies have focused on congregations' pastoral care and social support of people with HIV [27,28]. Studies of faith-based organizations' (FBOs) HIV efforts outside the U.S. have generally concluded that care and support activities for people with HIV are considered "traditional strengths" of FBOs, while HIV prevention efforts have been highly contested within religious circles, often disrupting collaborative efforts [29–31]. These challenges to collaboration have most often resulted from differing views on appropriate prevention messages, e.g., some FBOs' reluctance to promote condoms and some health providers' insistence that promotion of condoms should be the primary prevention strategy. Although little is known empirically about U.S.-based congregational involvement in care and support activities, the challenges of doing comprehensive HIV prevention activities in congregational settings are well known [24,32,33]. For example, researchers have noted that some religious leaders are unwilling to discuss sensitive topics, are only willing to emphasize abstinence and "be faithful" strategies, do not believe that their members are at risk, or are simply not interested in the topic [32].

This paper reports findings from a study of urban congregations' involvement in HIV, including prevention, care and support and other activities, conducted in Los Angeles County, the second largest AIDS epicenter in the United States. Since the actual or potential mechanisms by which religious congregations may become involved in HIV activities are poorly understood, we framed our study drawing on the diffusion of innovations literature [34] and the branch of institutional theory that addresses the diffusion of new organizational forms and practices [35–39]. Institutional theory is well-suited to taking into account the cultural and constitutive aspects of religious organizations (e.g., mission, identity, purpose) that may differentiate congregations from commercial or even other types of nonprofit organizations [40]. Our resulting framework identifies four sets of factors—norms and attitudes, organizational structure and process, resources, and demographics—that influence congregations' willingness and capacity to adopt, implement, and maintain HIV-related activities [41]. This paper examines in detail the latter portion of this framework—the types of HIV-related activities that congregations engage in over time—with a focus on three research questions:

1. What is the range of HIV activities that congregations engage in, and who do these activities serve?
2. To what extent do these activities involve interaction with external entities, especially health and public health organizations?
3. How are such activities initiated within congregations, and how do they change over time?

Methods

Case Study Design and Data Collection

Religious congregations vary substantially in their organizational structure, membership, culture and guiding philosophies, and often operate as highly dynamic communities [1]. We chose a comparative case study design that allows in-depth exploration of congregational dynamics, incorporation of multiple sources of data and perspectives within congregations, and comparison of HIV activities across types of congregations [42,43]. Such an approach provided the time needed to develop rapport critical to eliciting information on a sensitive topic within close-knit communities [44]. We employed several community-based participatory research methods, including on-going involvement of a community advisory board (CAB), formative interviews with community faith-based and public health experts, and, as described below, reciprocal interaction and feedback with our congregational research participants [41]. CAB members included religious and public health leaders identified through the research teams' community contacts and other key informants. CAB members were involved throughout the course of study, including proposal development, study design and implementation, and interpretation and dissemination of results. CAB members played strong roles in helping to identify and recruit congregations, design the research protocol and materials, and develop ways to disseminate the results to non-research audiences.

Congregational Sampling and Case Selection—Our study focused on the three geographic areas within Los Angeles County that are most highly affected by HIV, according to county health department surveillance data. We compiled a list of 80 congregations that were identified by our community experts and other local sources as having been involved in HIV activities in the three study areas and administered a brief telephone screening questionnaire (with a response rate of 88%). The questionnaire included questions about current and past HIV and other health activities conducted by the congregation, the number of regular participants of the congregation, and the racial-ethnic

breakdown of regular participants. Using the screening data in consultation with our CAB, we identified a purposive sample of 14 congregations to obtain variation on our principal outcome of interest (level and type of HIV activities) as well as factors that are known to influence the implementation of HIV and other types of health programs in congregations, such as racial and ethnic profile of the congregation, religious denomination or faith tradition, and congregational size and resources [12,45]. To be considered as a case, congregations had to have conducted some kind of health activity (HIV or any other health issue); 4 congregations screened did not meet this criterion. Of those congregations initially invited to participate, three declined—one because of “competing congregational activities,” a second because the congregation was between pastors, and the third did not give a reason—and were replaced in the sample by similar congregations. Each congregation received an unrestricted financial contribution of \$500 for participation in the study.

Data Collection—We collected data during multiple visits over roughly a 6–9 month period for each case congregation between December 2006 and May 2008. Our methods included:

- *qualitative, in-depth interviews* with clergy and lay leaders, covering leaders’ background and experience, congregational involvement in health and HIV activities, denominational and congregational policies (regarding HIV, homosexuality, and drug and alcohol use), leader and congregation attitudes, and community characteristics and collaborations
- *a congregational information form* (most often completed by the senior clergy) with basic information about congregational membership, resources, and programs or ministries
- *observations* of religious services, health and/or HIV-related activities, and the facility and neighborhood context
- review of *archival information* about the congregation and its health and HIV activities

A total of 57 persons were interviewed across the 14 congregations (3–6 per congregation), including at least one clergy and one lay leader at each. In-person interviews using a semi-structured protocol and typically lasting 1.5 h (range 1–4 h) were recorded digitally and detailed interview notes were taken. Audio-recordings were transcribed verbatim and Spanish transcripts were translated to English. The research team was diverse racially and ethnically, and the primary researchers involved with the Spanish-speaking congregations were bilingual (all study materials were translated into Spanish and validated prior to use). We used structured field note templates for the observations of religious services, health and HIV activities, and neighborhood context. The religious service observation guide included observational data about the service (number and demographics of attendees, duration, language, clergy and lay leader roles) as well as a narrative section to describe more in depth the observations made before the service, overall impressions of worship style, and the sermon or religious teaching provided. The health activity observation guide focused on similar observational data about the health activity, and the facility and neighborhood guide focused on providing a spatial map (physical structures, aesthetics, and physical orientation towards the community), a social/activity map (observed social interactions), and neighborhood context (types of surrounding streets, buildings, landmarks; ethnic/cultural makeup of the area, condition of surrounding area). All this information contributed to providing a comprehensive description of the congregation and its context.

Within-case Analysis

We created single case summaries that incorporated data from the various sources (interviews, observations, congregation information form, archival information) to develop an overall picture of each congregation and its involvement in health and/or HIV, including the types of activities, how and when they started and ended, and what factors have facilitated them or posed challenges to implementation. We validated each case summary by presenting it to congregational leaders in a congregational feedback session, providing an opportunity for study participants and others to reflect as a group on their congregation's history and future plans for health and/or HIV activities, and to fact-check and offer additional information.

Cross-case Analysis

Qualitative Coding—We performed extensive coding of interview transcripts to identify prominent themes across the congregation cases. We used content coding procedures to mark quotations related to the major variables in our conceptual framework [46–48]; and we used an inductive approach to identify new themes and sub-themes [49,50]. These themes and sub-themes were related to: the types of HIV and other health activities conducted by congregations, how they are organized and implemented, and facilitators and barriers to implementing and/or sustaining them; congregational policies and congregational and community attitudes regarding HIV, homosexuality, drug use, sexual behavior, and health issues in general; and congregational background and dynamics more generally (e.g., mission, priorities, polity). In this paper, we examine themes related to HIV activities, including types of activities, how they began and changed over time, and whether and how they involved interaction with external entities. Interaction with external entities was defined broadly and ranged from attending events hosted by outside groups (or having outside groups or individuals attend congregation events) to actively organizing projects together with external groups or individuals. Research team members worked in pairs using qualitative text management software [51] to test-code, then fully code, the interview transcripts, periodically double-coding transcripts at prescribed intervals to maintain inter-rater reliability, resolve discrepancies, and con-firm emergent themes by consensus.

Comparative Analysis—Interview transcript data were summarized and arrayed into a data display matrix [52,53] showing each major theme and sub-theme related to HIV activities by congregation. These data were supplemented by information from the congregation feedback presentations and discussion notes of the feedback sessions, as well as by data from the congregational information and observational forms (religious service, health activity, and neighborhood context). These data allowed us to categorize congregations on selected dimensions such as membership size, racial/ethnic composition, religious denomination, and level of HIV activity. For the last, we used a categorization of: (1) low activity (activities are infrequent or not targeted specifically to HIV); (2) medium activity (activities are more frequent than once a year and may target HIV, but are an extension of what congregations already do, such as providing pastoral care or health fairs); and (3) high activity (activities are frequent, target HIV, include multiple types of activities above and beyond what congregations traditionally do). Use of tabular displays facilitated systematic identification of themes across congregational cases and helped to triangulate findings from various data sources [43,54].

Cluster Analysis—We performed a cluster analysis to examine the extent to which the congregations implemented particular sets or groupings of HIV activities. We identified clusters of HIV activities that tended to co-occur within congregations using a *k-means* optimization algorithm that seeks to minimize within-cluster variance and maximize variability between clusters. This produces clusters in which group members are similar to

one another and groups are as different as they can be. To prepare the data for the cluster analysis, we generated an activity-by-activity matrix that contained a *positive match* score for each pair of activities indicating the number of times that both activities co-occurred in a congregation as a percentage of the total number of occurrences [55]. With the *k-means* procedure, the analyst specifies the number of clusters desired, and the algorithm determines the members of each cluster using the optimization approach described above. The analyst chooses the number of clusters (and their components) that best fit the data by comparing the relative change in optimization functions when moving between solutions with different numbers of clusters [56]. The cluster analysis was performed in a general computing and simulation software package [57] using a specialized cluster analysis toolbox [56]. We visually display the clusters by mapping the *positive match* ties between the HIV activities using network analytic software [58], with the layout based on a “spring embedding” algorithm that places activities with the highest match scores to one another closest in the graph [55].

Results

Congregational and Interview Participant Characteristics

Table 1 describes key characteristics of the congregations ($n = 14$) and interview participants ($n = 57$). Six of the congregations were predominantly African American, 4 were Latino (3 primarily Spanish-speaking and 1 English-speaking), 2 were white, and 2 were of mixed composition (i.e., no racial-ethnic group $\geq 70\%$). The congregations exhibited a range of denominations (Jewish Reform and various Christian, including Catholic, Mainline Protestant and Evangelical/Pentecostal) and membership sizes (from less than 150 members to several thousand). Slightly more men (30) than women (27) were interviewed, and more lay leaders (35) than clergy (22).

Congregational HIV Activities

Table 2 provides an overview of the different types of HIV activities of our case study congregations, the populations served, and the extent of external interaction to conduct these activities. As noted earlier, most U.S.-based literature on congregations' involvement in HIV has focused exclusively on prevention activities [12,32], though a handful of studies have also identified activities related to caring for and supporting people with HIV [27,28]. Based on these distinctions, we initially coded HIV activities of our case study congregations into subcategories of “prevention & education” and “care & support” activities. However, our qualitative coding identified other activities that did not fit in these groups and were related to more general awareness-raising (i.e., not prevention-specific) and advocating for individuals affected by HIV. Thus, we added a third “awareness & advocacy” grouping to our final categorization of HIV activities.

Prevention & Education—The most common congregational prevention and education activities (in which more than half the congregations were involved) included conducting workshops on HIV or incorporating HIV education into a workshop on a related topic, distributing HIV education materials, and promoting abstinence for HIV prevention. Most of these activities focused on congregational members, especially youth, and about half involved interaction with external organizations or individuals. The one exception to this latter trend was promoting abstinence, which was done by congregational leaders alone. For example, a Latino evangelical/non-denominational pastor, when asked about HIV-related activities, described their efforts to teach youth to abstain from sex:

But we try to work with [the youth], and we teach them not to get involved in any sexual activities.... Some of these youth, we don't know what they're doing behind

closed doors and all that. And so we try to teach them and we have Bible studies for them and we have group sessions for them and they talk about...there's a thing they call *Passion for Purity*, and it talks about all that.

Other HIV prevention activities that were somewhat common (i.e., in which a third to a half of the congregations were involved) included health fairs (in which HIV was addressed), on-site HIV testing, discussing condoms as a way to prevent HIV, incorporating HIV prevention messages into counseling and educational programs related to drug and alcohol use/abuse, and participating in externally sponsored HIV workshops. These activities tended to focus both on the congregation and community (e.g., the neighborhood surrounding the congregation for health fairs, specific sub-groups like addicts for prevention education), and there was a broad range in the extent of external interaction. Some activities, such as HIV testing and health fairs, were always done with the involvement of external entities, whereas talking about condoms was done by congregational leaders. Further, most of these congregational efforts that involved talking about condoms also emphasized abstinence. For example, one African American Mainline Protestant pastor commented:

We have a ceremony around a marriage band for our young people. We try to teach abstinence. We know it doesn't always work. And of course, kids come up pregnant and things like that. But the official policy and what we really try to stress is abstinence; and if abstinence is not working, then protection.

Finally, the least common activity (i.e., involving at least one, but less than a third of congregations) within the prevention and education category was supporting external organizations focusing on HIV prevention. None of the case study congregations reported distributing condoms or using other harm reduction strategies such as needle exchange (where injection drug users can obtain clean hypodermic needles at little or no cost).

Care & Support—The most common care and support activities included pastoral care of people with HIV and their families (e.g., spiritual support, prayer, and counseling) and support of local AIDS service organizations (ASOs) (e.g., financial donations, volunteering, and in-kind donations). Most of the pastoral care activities focused on congregation members and involved little interaction with external organizations or individuals; support of local ASOs focused on the broader community and generally involved a good deal of interaction with external organizations.

Care and support activities that were somewhat common included providing direct support to people with HIV, either in the congregation or in the community, such as meals, assistance with daily activities, and referrals to medical care or social services. These activities tended to involve a high degree of external interaction, since congregations often needed to work through local HIV clinics, support organizations, or rehabilitation centers to reach people with HIV, or to refer to these places for resources the congregations did not possess themselves.

Less common activities included sponsoring support groups for people with HIV, support of international ASOs, and spiritual retreats for people with HIV, which served a mixture of congregation and community and frequently involved interaction with external organizations. None of the congregations reported having been involved directly in providing hospice care or medical care for people with HIV (even though two congregations had parish nurse or other programs that provided primary medical care and support for other chronic health conditions on-site).

Awareness & Advocacy—The most common awareness and advocacy activity among congregations was preaching about HIV, which focused on congregants and did not involve

external interaction. For example, one Catholic lay leader described how a priest talked about HIV to his congregation:

Normally, he'll talk about how it's affecting the community. He will talk about statistics. He will talk about his experiences in dealing with HIV, those who have been affected. And then he will talk about spiritually how it relates as far as loving one another, respecting one another, things like that.

Somewhat common awareness and advocacy activities included participating in and contributing to AIDS Walk events, special worship services on World AIDS Day, education activities to reduce HIV stigma, and public advocacy for people with HIV. These activities focused on the congregation and community and, except for the AIDS worship services, frequently included interaction with external organizations or individuals. The least common activity was displaying memorials for congregants who have died of AIDS.

Interactions with External Entities

As shown in Table 2, on average (across congregations and types of HIV activities), 62% of congregations interacted with external organizations or individuals to conduct their various HIV activities, with 72% of congregations doing so for care and support activities, 62% for prevention and education activities, and 49% of congregations for awareness and advocacy activities. Table 3 identifies the types of external entities across the various types of HIV activities. Of 92 external entities that the 14 congregations reported interacting with to conduct their HIV activities, the most common type of external entity that these involved (36% of external entities) was non-governmental organizations that focus on prevention services (prevention education, testing) and supportive services like hospice care and substance abuse treatment; the second most common was other faith-based organizations (29%), including denominational entities, other congregations, other faith leaders and coalitions, and a religious seminary; and the third most common was health care providers and foundations (20%). Public health and other government agencies comprised only 4% of the external organizations.

Clustering of HIV Activities

Figure 1 graphically maps the connections among the congregational HIV activities based on their degree of co-occurrence within congregations. The clustering pattern with the most concise fit according to the *k-means* analysis yielded a solution with three main groupings (encircled by lines in the figure), plus isolates for the activities that none of the congregations reported doing (condom distribution, needle exchange, HIV hospice/shelter, HIV medical care).

Each main cluster includes a mix of prevention and education, care and support, and advocacy and awareness activities. Based on a general understanding of the nature of the different activities, it appears that the first main cluster in the upper left portion of the graph consists of more general health activities into which HIV issues have been incorporated, such as pastoral care for people affected by HIV, referrals to other community services for people affected by HIV, and HIV education through health fairs. The second main cluster (lower middle of the graph) entails HIV-specific activities that require a higher degree of commitment both symbolically (as in providing "moral support") and resource-wise (involving HIV-related expertise or efforts separate from other congregational activities), such as direct support for people with HIV, holding workshops and programs specifically on HIV and stigma awareness, and participating in local AIDS Walk events. Interestingly, sermons on HIV tend to cluster with this second grouping, suggesting that for clergy to speak to their congregation about HIV reflects a relatively strong commitment to addressing the epidemic. The third main cluster (right-hand side of the graph) contains a variety of HIV

activities that tend to be less common but may require the most commitment, ranging from activities that congregations described undertaking earlier in the epidemic (e.g., HIV support groups, memorials) to those that reflect more recent trends (e.g., support of international HIV activities).

Initiation and Changes over Time in Congregational HIV Activities

A common theme in how HIV activities were started and sustained was that a congregation had a clergy leader who was passionate about the issue and who saw specific ways that the congregation could respond, such as pastoral care, providing food and other tangible support, conducting prevention education with high risk groups such as substance abusers, and advocacy. This passion was often driven by a sense of injustice regarding how people with HIV are stigmatized, particularly by the religious community (e.g., congregations that refused early in the epidemic to perform funerals for people who had died of AIDS), and by having witnessed first-hand the pain, suffering, and death of many who contracted and succumbed to the disease. As one Rabbi explained:

And frankly, I'm the driving force... you asked about programs, how they get decided, I make time... because I buried all [those] men [who died of AIDS] in the late 80's and the early 90's, I remember all their names and their family stories... I don't want anybody to forget...

Clergy leadership notwithstanding, in some cases congregational efforts were initiated by lay members; more importantly, having lay "champions" and a core group of volunteers was commonly mentioned as essential to sustain efforts over time. These lay leaders were often motivated by a personal connection to HIV, e.g., personal experience providing support to a friend or family member with HIV and seeing how this disease affected their loved ones motivated them to act. For example, a Catholic lay leader who had watched her son become very ill with AIDS described this experience:

As [my son] got sicker, and he did get very sick, I would take him to all of his appointments. And he was hospitalized a couple of times. ... And he was having trouble walking. And I was the one caring for him. And it was just hard. It was terribly hard. ... My reason for starting this, for getting heavily involved in this [AIDS] ministry, is that I don't want a mother going through this. If I can do anything to help anybody from seeing their loved ones in that condition and going through that, I will. That's why I really feel strongly about the awareness, the education, the prevention.

Congregational leaders' descriptions about their congregations' histories of HIV involvement revealed that they became involved at different moments during the 25 year epidemic, and the timing of their initial involvement appeared to be related to the types of HIV activities they undertook. Two of our four most active congregations (in terms of the number and types of different activities they described or were observed undertaking) had been involved in HIV since the 1980s. The four most active congregations were also the four in which openly gay members formed an important part of the clergy and/or lay leadership, despite the fact that two of the congregations belonged to denominations that restricted non-celibate gays' leadership roles. In these early years of the epidemic, the high morbidity presented urgent, daily needs that propelled the congregation to respond in concrete ways ("doing the neighborly thing"), by providing pastoral care, memorial and other commemorative services, and/or helping to meet basic needs. The other two congregations most actively engaged in HIV efforts actually did not exist in the 1980s, though their clergy had been active in HIV issues elsewhere since early in the epidemic. Several other case study congregations became involved in the mid to late 1990s, when activities started to shift away from intensive social support of people with HIV and towards

prevention. Yet another group of congregations became involved in the 2000s and focused on youth or substance abusers for their HIV prevention messages. During the 2000s, activity waned for some of the early adopter congregations, as the changes brought by more effective treatments reduced the sense of urgency and the level of perceived needs. As one Catholic priest expressed:

I have to say that in recent years, as distinct from the '90s, [HIV] has not been on the radar screen as much...Everybody was much more aware [before] because it was in the news more. Then I think we were sadly facing...funerals and hospital visitations all the time.... So, you know, it was just simply on the doorstep a lot more, both locally and, you know, in the public arena.

Discussion

Although the potential role of religious congregations in addressing HIV has been frequently noted, there is little published on the range of congregational activities. Our study, which focused on a broader range of racial-ethnic groups and faith traditions than previous studies [28,59], found that congregations have conducted a wide array of HIV-related programs and services, spanning a variety of prevention and education, care and support, and awareness and advocacy activities. These activities served both congregants and segments of their respective communities. However, our case study congregations did not engage in several activities that address other needs for HIV-related prevention or care, such as condom distribution, needle exchange, HIV medical care, hospice or shelter care, and housing. As noted earlier, prevention activities (particularly harm- or risk-reduction) remain contested within many religious circles, since they often contradict traditional religious doctrine regarding sexual practices and drug use. However, like other studies, we found that congregational leaders varied in the strictness of their adherence to traditional religious teachings and policies regarding condom use and homosexuality [28,60]. Further, several of the activities not done by congregations—particularly those that focused on providing services to people with HIV such as HIV medical care, hospice, shelter care, or housing—were not necessarily contested in congregations, but were merely not done.

The clustering analysis suggests that certain groupings of HIV activities, such as pastoral care for people with HIV or providing HIV education and testing through health fairs, may be relatively easy for congregations to undertake, as they may be able to more easily incorporate them into their existing portfolios of activities. Further, such activities are not in conflict with the overall mission and policies of many congregations. Other activities that group together appear to require a specific focus and devotion of resources toward HIV (including sermons on the topic) or a particularly strong commitment to addressing the epidemic (such as HIV support groups or public advocacy).

Clergy and lay leaders were important to initiating and sustaining congregational responses to HIV. Many of the leaders were motivated by personal experience with the issue (congregants and family members affected by HIV) and were able to influence others in the congregation to join in their efforts. In fact, some described the stigmatization of people with HIV, particularly within the faith community, as a prime motivator for providing congregation-based services. These findings suggest that promising avenues for engaging congregations in the response to HIV are through their leaders, especially by increasing personal contact between congregational leaders and people with HIV. Research in Ghana found that hearing a leader speak about HIV had a substantial effect on congregants' provision of support to people with HIV [61]. Studies elsewhere (e.g., Jamaica, Trinidad, Tanzania, Uganda) have found that faith-based organizations can move from fostering to dissuading stigma through trainings that increase knowledge and understanding of HIV

among clergy and congregation members and increase personal contact between congregational leaders and people with HIV [62–65].

Patterns in how HIV activities changed over time within our sample of congregations demonstrate the utility of the notion of organizational imprinting (that is, when organizations or programs retain practices and forms that were prevalent during their founding or initiation) [66,67] and lifecycle approaches (i.e., viewing organizations as social organisms that proceed from founding through various stages of maturity) [68] for understanding congregational involvement in health promotion activities. For example, congregations that responded early in the epidemic tended to focus initially on care and support for people facing what was at that time a devastatingly isolating and terminal illness. Those that sustained their involvement often retained a focus on these initial activities, while also accruing a variety of programs and services. Some reported experiencing a fragmentation and/or waning of activities (particularly in the 2000s in comparison to the late 1980s and early-mid 1990s) with subsequent periods of reassessment, re-grouping, and renewal of the congregation's HIV agenda. Congregations that became involved later in the epidemic, especially after the introduction of antiretroviral therapies and the transformation of HIV into a chronic disease, have tended to focus on prevention and education activities.

Perhaps of most interest to the public health community is that, on average, over 60% of congregations conducted their various HIV activities with at least some degree of involvement with external entities, most frequently community-based organizations focusing on prevention and supportive services. A little over a quarter of the external entities were other faith-based organizations, including denominations and local faith coalitions, which may provide additional avenues of engaging congregations in HIV efforts. Interaction with external organizations or individuals may be one way to engage congregations in HIV-related activities, particularly in the areas of testing and prevention education, since many congregations will not have the capacity to engage in such activities on their own. External entities can provide access to resources (e.g., rapid testing) and expertise (e.g., speakers, health educators), while congregations can provide access to underserved populations, volunteers, and opinion leaders important to carrying out successful testing and prevention efforts.

The study, by nature of its qualitative design, provides rich data and specific examples pertaining to the issues we were exploring, but was not intended to yield a statistically representative sample of the population of all urban congregations. Instead, we used purposive sampling, selecting congregations that varied on a number of dimensions (faith tradition, size, race-ethnicity, and level of HIV activity—with all selected having had at least some type of involvement in HIV issues, even if minimal or having ceased). This method does not allow for a generalizable and quantifiable description of how frequently congregations engage in particular HIV activities or why other congregations do not become involved at all. However, the inclusion of congregations with at least minimal involvement in HIV issues increased our ability to explore a wider breadth of congregational HIV activities. Moreover, since many of the HIV activities identified within our congregational sample were conducted outside of formal HIV or AIDS programs or ministries, they could easily have been missed with close-ended questionnaires and other highly structured research methods. Collection of data from multiple respondents in each congregation and through multiple methods including interviews, observations, and review of archival information frequently provided more extensive information than we could have obtained from any single respondent or method. Thus, given the relative lack of information about the types of HIV prevention, care and support, and other activities in which congregations are involved, the case study methodology utilized in this study illuminates the range of HIV and

other health promotion activities within religious congregations and can inform studies with more structured data collection methods.

Conclusions

Our findings on the range, composition, and level of interaction with external organizations or individuals in congregational HIV activities suggest that opportunities exist for religious congregations to help fulfill a wide variety of public health needs. This is likely to depend on congregations' goals and capabilities [69,70], including their prior experience with health promotion activities, the priorities of congregational leaders, and religious or doctrinal philosophies. Thus, it is unrealistic to expect that every congregation will be willing and able to deliver public health HIV prevention messages such as promotion of condoms for unmarried, sexually-active adults. The Catholic Church prohibits condom use under any circumstances, whereas many other Christian churches are only comfortable promoting them among serodiscordant, married couples and are not comfortable promoting them among men who have sex with men, commercial sex workers, and other unmarried individuals. However, other topics, such as factual information about transmission and the importance of routine HIV testing can likely be disseminated by many congregations in ways that are fully consistent with public health goals. Further, theologically-based messages designed to increase compassion, support, and advocacy for those affected by HIV and reduce HIV-related stigma are likely areas that congregations can have influence.

More detailed examination is needed of how congregational characteristics influence congregations' willingness and ability to become involved in various types of HIV and other health promotion activities. Studies are also needed to quantify the extent to which HIV activities are conducted more generally and with what outcomes. Such analyses would shed light on ways that the public health community may constructively engage different kinds of religious congregations in addressing the HIV epidemic and other critical public health issues.

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Fig. 1.

Cluster analysis of HIV activities that tend to co-occur within a congregation. *Notes:* (1) The graph maps *positive match* scores between pairs of HIV activities, which indicate the number of times that both activities co-occurred in a congregation as a percentage of the total number of occurrences. The layout of activities is based on a “spring embedding” algorithm that places activities with the highest match scores to one another closest in the graph [55]. (2) The three main clusters of HIV activities that tend to co-occur together were identified using a *k-means* optimization technique applied to the *positive match* scores [56]. We indicate the results of the *k-means* analysis on the graph by encircling the activities that fell within each cluster using overlaid shading

Table 1

Congregation and interview participant characteristics

Congregations (<i>n</i> = 14)	Frequency
Predominant race or ethnicity ^a	
African American	6
Latino	4
White	2
Mixed ^b	2
Congregation size ^c	
Large (≥501 members)	6
Medium (151–500 members)	5
Small (≤150 members)	3
Denomination	
Catholic	3
Evangelical, Pentecostal, or non-denominational	4
Mainline Protestant	4
Baptist	1
Jewish (Reform)	2
Interview participants (<i>n</i> = 57)	Frequency
Race/ethnicity	
African American	22
Latino	15
White	18
Asian	1
Other	1
Gender	
Female	27
Male	30
Role	
Clergy	22
Lay	35

^a The predominant race/ethnicity comprises ≥70% of regular participants (except for “mixed”)

^b No individual race/ethnicity comprises ≥70% of regular participants

^c Measured in terms of the number of reported congregational participants that attend services monthly

Table 2

Congregational HIV activities: types, frequency, populations served and percent involving interaction with external organizations or individuals

Types of activity	No. of congregations conducting these activities (<i>n</i> = 14)	Populations served	Percent involving interaction with external organizations or individuals (%)
<i>Prevention & education</i>			
HIV education as part of other workshop or seminar	11	Congregation, esp. youth	45
HIV workshops and seminars	9	Congregation, esp. youth	56
Distribution of HIV educational materials	9	Congregation and community	56
Talking about abstinence	8	Congregation, esp. youth	0
Health fairs including HIV issues	7	Community	100
HIV testing	7	Congregation and community	100
Talking about condoms	6	Congregation, esp. youth	0
Addiction-related services	6	Congregation and community	67
Leader participating in externally-sponsored HIV trainings	5	Congregation leaders	100
Support of external organizations working in HIV prevention	3	Community	100
Average (P & E):			62
<i>Care & support</i>			
Pastoral care	11	Congregation	18
Support of external organizations serving people with HIV	8	Community	100
Direct support to people with HIV (food, personal items, etc.)	7	Community	86
Referrals to medical and social services	6	Congregation	50
Support groups	4	Congregation, some community	50
Support of international HIV work	4	International community	100
Spiritual retreats for people with HIV	1	Congregation	100
Average (C & S):			72
<i>Awareness & advocacy</i>			
Talking about HIV in sermons	10	Congregation	0
Participation in AIDS Walk	7	Community	100
Education to reduce stigma	6	Congregation and community	50
Worship services on AIDS	6	Congregation	33
Public advocacy	5	Community	60
Displaying memorials or symbols dedicated to people with HIV	4	Congregation	50
Average (A & A):			49
Overall average (all activities):			62

Table 3

Types of external entities by types of HIV activities

Types of external entities ^a	Number (%) of external entities	Types of HIV activities ^b		
		Prevention & education	Care & support	Awareness & advocacy
Health services & foundations	18 (20%)	10	17	1
Prevention & social support services	33 (36%)	18	30	11
Public health & other Government agencies	4 (4%)	4	1	2
Faith-based organizations	27 (29%)	16	14	8
Other (e.g., schools and media)	4 (4%)	0	1	3
Individuals (e.g. volunteer speakers)	6 (7%)	3	1	2
Total	92 (100%)	51	64	27

^aThis table only includes external entities that were separately identified by congregational respondents (i.e., other interactions with unspecified entities may have been mentioned that are not included here)

^bThe categories for types of HIV activities are not mutually exclusive (i.e., a particular health services organization may have interacted with a case congregation for more than one type of HIV activity)