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Factors Contributing to the Development of an HIV Ministry within an African American Church

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Abstract

Having an HIV ministry within a church depends on the religious culture of that church. However, little is known about how a church's religious culture influences an HIV ministry. This study's purpose was to examine how an African American church's religious culture supported the development, implementation, and maintenance of an HIV ministry within the church. An ethnographic case study research design was used. Data were collected through interviews, non-participant and participant observations, review of pertinent documents, and survey of congregants. Results revealed the following as important for an HIV ministry: (a) a belief in helping others and treating everyone with respect and dignity, (b) feelings of compassion toward individuals infected with HIV, and (c) HIV education. This information can assist in developing interventions to enhance the African American church movement toward HIV ministries.

Keywords

African American; faith; HIV; HIV Ministry; religious culture

While HIV has touched many lives throughout the nation, it has impacted minorities at much higher rates than other ethnic groups. Although African Americans comprise about 12% of the total U.S. population, they represent 46% of all HIV cases in the United States (Centers for Disease Control and Prevention [CDC], 2010). The state of Illinois ranked sixth in highest prevalence of newly diagnosed cases of HIV, and the rate of infection for Chicago was 26.9 per 100,000, double the rate for the overall state of Illinois (13.5 per 100,000; Illinois Department of Public Health, 2008). Over the past 20 years, while rates of HIV infection have decreased for Caucasian adults and remained relatively stable for other ethnic groups, rates have continued to increase for African Americans (CDC, 2010).

African American churches can serve as an effective and much needed force in the battle against HIV (Baker, 1999; Jarama, Belgrave, Bradford, Young, & Honnold, 2007; Newman,

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Williams, Massaquoi, Brown, & Logie, 2008). However, only a few African American churches have become more open to addressing the needs of HIV infected congregants, which has spurred the development of HIV ministries (Harris, 2010).

Twelve published research studies exist on African American churches with HIV ministries. These studies can be categorized into two groups: descriptions of HIV ministries designed for African American churches and descriptions of the potential roles, barriers, or supports for African American church involvement in HIV ministry.

Four studies described the development and implementation of HIV ministries (Berkley-Patton et al., 2010; Hicks, Allen, & Wright, 2005; Koch & Beckley, 2006; Leong, 2006). These studies included a total of 21 Baptist, Methodist, and non-denominational churches with HIV ministries where congregation size ranged from 150 to 3,000. They examined the factors that shaped the development and implementation of HIV ministries. Three of the studies used a qualitative approach (Hicks et al., 2005; Koch & Beckley, 2006; Leong, 2006) that included interviews of 3–36 clergy and church members. Leong (2006) and Hicks and colleagues (2005), also used observations and document reviews. One study used a community based participatory method (Berkley-Patton et al., 2010) that involved researchers, clergy and lay leaders in the development and implementation of an HIV ministry.

Eight descriptive studies (Brown & Williams, 2005; Coyne-Beasley & Schoenbach, 2000; Harris, 2010; Khosrovani, Poudeh, & Parks-Yancy, 2008; McKoy & Petersen, 2006; McNeal & Perkins, 2007; Smith, Simmons, & Mayer, 2005; Tesoriero et al., 2000) explored the potential roles, barriers, or supports for the African American church's involvement in the dissemination of HIV education and services. The studies had sample sizes ranging from 18 to 331 and all studies used a combination of questionnaires and open-ended interviews. Samples were recruited from Baptist, Methodist, and Pentecostal churches. These studies focused on the perceptions of the clergy (Brown & Williams, 2005; Coyne-Beasley & Schoenbach, 2000; Khosrovani et al., 2008; McKoy & Petersen, 2006; McNeal & Perkins, 2007; Smith et al., 2005), as well as the perceptions of the congregants (Harris, 2010; McNeal & Perkins, 2007; Tesoriero et al., 2000) about the roles the church was willing to play and potential barriers to HIV programming.

The findings revealed that only a small percentage of African American churches were actively involved in HIV programming or in delivering messages about HIV to congregants (Brown & Williams, 2005; Coyne-Beasley & Schoenbach, 2000; Harris, 2010; Khosrovani et al., 2008; McKoy & Petersen, 2006; McNeal & Perkins, 2007; Smith et al., 2005). McKoy and Petersen (2006) found that of the 50 churches contacted for participation on the potential roles of African American churches in HIV, only 4 were willing to participate. Fewer than 11% of churches studied had an HIV ministry in place (McKoy & Petersen, 2006; Smith et al., 2005). Tesoriero and colleagues (2000) found that only 16% of churches in the state of New York had HIV programs or services.

The barriers that prevented African American churches from becoming involved in HIV programming were their unwillingness to discuss topics concerning sexuality, particularly homosexuality and promiscuity (Baker, 1999; Coyne-Beasley & Schoenbach, 2000; McKoy & Petersen, 2006; Smith et al., 2005), the clergy's unwillingness to encourage development of an HIV ministry (Baker, 1999; Berkley-Patton et al., 2010; Hicks et al., 2005; Koch & Beckley, 2006; Leong, 2006; McCoy & Petersen, 2006; McNeal & Perkins, 2007; Merz, 1997; Smith et al., 2005), lack of financial and community resources/support (Baker, 1999; Berkley-Patton et al., 2010; Hicks et al., 2005; Koch & Beckley, 2006; Leong, 2006; McCoy & Petersen, 2006; McNeal & Perkins, 2007; Merz, 1997; Smith et al., 2005), failure to adopt

a theology that affirmed marginalized individuals and recognized members living with HIV (Berkley-Patton et al., 2010; Hicks et al., 2005; Koch & Beckley, 2006; Leong, 2006), and the congregation and community being uninformed and uneducated about HIV (Berkley-Patton et al., 2010; Hicks et al., 2005; Koch & Beckley, 2006; Leong, 2006). Additional barriers included stigma against people living with HIV (PLWH) and the clergy's beliefs that their congregations and communities were not at risk; clergy underestimated the extent to which their congregants engaged in risky behaviors--men having sex with men, IV drug users, and participation in risky sexual behaviors (Baker, 1999; Coyne-Beasley & Schoenbach, 2000; Hicks et al., 2005; McCoy & Petersen, 2006; Smith et al., 2005).

Findings also revealed that the few churches with HIV ministries provided testing services; pastoral care and counseling; and general information/education about HIV, food, housing, support groups, and referral services for individuals infected with or affected by HIV. HIV-related information was provided through sermons and brochures (Berkley-Patton et al., 2010; Hicks et al., 2005; Koch & Beckley, 2006; Leong, 2006). One church's program also provided bleach kits for disinfecting needles as well as facilitated condom distribution (Koch & Beckley, 2006).

The above findings are generally consistent with the views of Baker (1999), Brown and Williams (2005), Hicks and colleagues (2005), McNeal and Perkins (2007), Merz (1997), and Smith and colleagues (2005) who suggested that the African American church's religious culture has slowed the church's response to HIV. The church holds beliefs or opinions that HIV is caused by behaviors deemed to be morally reprehensible, including homosexuality, promiscuity, and drug use. These behaviors are typically considered to be against the church's norms or standards on how to behave and may generate attitudes or feelings about PLWH leading to the marginalization of these individuals.

The Constitutive Ethnographic Theory of Social Organization (Dorr-Bremme, 1985), a model that explains how educational and other programs can be constructed, defines culture as shared beliefs (opinions or convictions), norms (a standard model or pattern), and attitudes (feelings or positions) as well as knowledge (factual information). Therefore, the church's *religious culture* is the shared beliefs, norms, attitudes, and acquired knowledge that church members use to interpret their experiences about HIV and to support their behavior related to HIV ministry program development (the creation of the plan), implementation (the successful execution of the plan), and maintenance (sustaining execution over time; Garfinkel, 1967; Mehan & Wood, 1975; Spradley, 1979).

To ensure the success of an HIV ministry within a church, the religious culture of that church must support it (Baker, 1999; Merz, 1997; Smith et al., 2005; Tesoriero et al., 2000). Very little attention has been paid to exploring how religious culture influences the development, implementation, and maintenance of an HIV ministry within the church. To understand the unique factors that might enhance African American church participation, it is necessary to obtain an in-depth comprehensive and culturally relevant perspective of factors that enable a church to develop and maintain the HIV ministry. This information can lay the foundation for the development of culturally sensitive instruments and interventions for use in African American churches in the support of HIV programming.

Therefore, the purpose of this study was to examine how an African American church's religious culture supported the development, implementation, and maintenance of an HIV ministry. For the purpose of this study, an African American church is a religious institution with both an African American pastor and African American associate pastor(s) that has an African American membership of at least 90%. The research questions studied were:

1. What role did the religious culture have in the development of an HIV ministry within the church?
2. What role did the religious culture have in the implementation of an HIV ministry within the church?
3. What role did the religious culture have in the maintenance of an HIV ministry within the church?

Methods

Research Design

An ethnographic case study research design was used to examine how one African American church's religious culture supported the development, implementation, and maintenance of an HIV ministry. This method allowed for an in-depth study of culture with the purpose of better understanding (Creswell, 2003). The primary goal of ethnography is to describe the culture of a social group or system and reveal how that culture influences beliefs and behaviors. Ethnography can be both a research product and a research process (LeCompte & Schensul, 1999). The product is the narrative or story of a group of people that includes some of the history and illuminates daily lives and practices. A case study provides the opportunity to thoroughly analyze a group or organization. The content of an ethnographic case study can address the group's beliefs, norms, and attitudes (LeCompte & Schensul, 1999).

Participants were recruited from March 2010, through June 2010. Data collection occurred during the period from April 2010, through July 2010.

Setting

A church located in a Midwest urban community was selected because it had an HIV ministry that was founded in 1993 and because it would provide rich information about the development, implementation, and maintenance of an HIV ministry in an African American church. It had a total church membership of more than 8,000 congregants and its ministry provided services to its members and the surrounding community.

Sample

The sample consisted of 9 individuals involved in the development, implementation, and maintenance of the HIV ministry: one pastor, one pastor emeritus, one associate pastor, and six church members identified by these pastors as having had a role in the development, implementation, or maintenance of the HIV ministry. An additional 50 members of the general congregation were asked about their awareness of the HIV ministry to gain additional information about their general acquired knowledge of the HIV ministry.

Instruments

Data were collected by multiple qualitative methods and included the following tools: non-participant observation summary, participant observation guide, document review guide, ethnographic interview guide, and HIV ministry awareness questionnaire. A demographic questionnaire was also used. The authors developed all of the aforementioned instruments.

The non-participant observation summary provided a detailed summary of relevant events observed but not participated in by the researcher: the event location, people involved, behaviors, and direct quotes that related to the beliefs, norms, attitudes, and acquired knowledge. The participant observation guide was used when the researcher participated in activities during the HIV ministry and church services. Examples of participant observations

included reading passages from the Bible out loud or participating in prayer, singing, and communion services. Document review was used to review and evaluate documents pertaining to the church's culture and related to the development, implementation, and maintenance of the HIV ministry. These documents included church doctrines and mission statements, HIV ministry planning agendas, HIV ministry program curricula, books, HIV education brochures, and a resource guide. It required documenting information such as the type of document, age of the document, source of the document, and information regarding the church's beliefs, norms, attitudes, or acquired knowledge.

Three individualized, specific ethnographic interviews were used. Each interview guide consisted of open-ended questions that elicited information on the church's beliefs, norms, attitudes, and acquired knowledge. The ethnographic interview Developer Guide was designed to be used with individuals who played a role in the creation of the plan for the HIV ministry. The ethnographic interview Implementer Guide was developed to be used with individuals who played a role in making the plan for the HIV ministry happen. Lastly, the ethnographic interview Maintainer Guide was developed to be used with individuals who played a role in sustaining the HIV ministry over time. The interviews lasted approximately 30 minutes to 2 hours.

The HIV Ministry Awareness Questionnaire included only one question that asked whether or not the congregant had heard of the HIV ministry program in the church. This question was used to gauge the congregants' knowledge of the HIV ministry. The questionnaire took 1–3 minutes to complete.

The demographic questionnaire was used to obtain basic demographics of the church as a whole and, thus, provided information on the church's social context. It included questions to estimate the total number of active members, their socioeconomic status, and percentage of men and women members, age ranges, and ethnicity for the HIV ministry as well as the church. This information was elicited from the pastor as well as the current leaders of the HIV ministry. This demographic questionnaire was self-administered and took approximately 15 minutes to complete.

Procedure

After receiving approval from the University of Illinois at Chicago Institutional Review Board and from the pastor, one author executed the research. This author conducted all interviews, non-participant observations, participant observations, and document reviews, as well as administered questionnaires. After completing the interview with the pastor, the author interviewed the pastor emeritus and the associate pastor, followed by interviews with HIV ministry leaders and others instrumental in the development, implementation, and maintenance of the ministry. The author asked each interviewee for pertinent documents at the conclusion of the interview. All interviews took place at a mutually agreed upon venue. All interviews were audiotape recorded.

While conducting interviews with the HIV ministry leaders, the author conducted four non-participant and three participant observations in the HIV ministry. These observations provided rich information on key events, meetings, presentations, and interventions. They also included verbatim quotes of what people said. Condensed notes, which represented a shorthand account of the observation, were made first. This account was filled in with details immediately following the observation. Additional documents from the HIV ministry were also reviewed at this time. Lastly, the survey of a convenience sample of the general congregation was made to assess their knowledge of the HIV ministry. These individuals were recruited as they were leaving or going to church services or at other church events.

Data Analysis

The data from the demographic questionnaire were analyzed using descriptive statistics, namely median and percentages. The percentage of individuals who were aware of the HIV ministry was determined by the HIV ministry awareness questionnaire. Interview data were transcribed verbatim from the audiotape recordings by the author and checked by the second author. The data from the interviews, the non-participant observation summary and the participant observation guide were analyzed and interpreted throughout the data-gathering period and at the conclusion of data collection. The author coded these data and the second author checked the coding for any discrepancies. These data were analyzed in accordance with Auerbach and Silverstein's (2003) grounded theory coding method. The transcribed interviews, non-participant observation summary and participant observation guide provided *raw text*, which was narrowed down to *relevant text*, or the text related to the specific research concerns. The relevant text was searched for *repeating ideas* or the use of the same or similar words and phrases to express the same ideas. From these groups of repeating ideas, *themes* were gleaned. Themes were groupings of repeating ideas that had something in common. The themes were further grouped into more abstract ideas termed *theoretical constructs*. Lastly, a *theoretical narrative* was constructed that served as the summary of the participants' experiences by weaving together their own words and the researcher's theoretical framework.

Results

The church is in a large metropolitan area with a reported membership of 8,854. Based upon the church's records, the church is located in a predominately African American community that has a median income of \$43,201. The socioeconomic status and educational status of church members were not available in these records. However, according to the church historian, the church was reported to be of mixed income. The records revealed that males made up approximately 28% of the membership and females 72%. Approximately 3% of church members were ages 0–12, 4% were ages 13–18, 5% were ages 19–25, 22% were ages 26–40, 34% were ages 41–55, 22% were ages 56–70, and 10% were older than 70. The church was approximately 97.5% African American, 1.0% Caucasian, 1.0% Latino, 0.03% Asian, and 0.47% other.

Nine interviews were conducted. Of the 9 individuals interviewed, 2 were involved in the development, 3 in the implementation, and 4 in the maintenance of the HIV ministry. Five church members were coordinating the HIV ministry and its activities at the time of the interviews. Approximately 4 of these 5 members were African American and 1 was biracial; 2 were male and 3 female. Three were between the ages of 41 and 55, 1 was between the ages of 56 and 70, and 1 was between the ages of 26 and 40. One person had some college or vocational school experience, 2 had a Bachelor's degree, and 2 had a Master's or professional degree.

Four non-participant observations and three participant observations were conducted. The 4 non-participant observations included 2 HIV ministry meetings, an HIV ministry sponsored event on HIV clinical trials, and an event showcasing resources and prevention and education materials available from the HIV ministry. The non-participant observations took 30 minutes to 2 hours to complete. The three participant observations included three church services. The church services were approximately 2 hours each.

Development of the HIV Ministry

The HIV ministry was developed in 1993 and the estimated length of this stage was 7 years. Its mission statement was to "comfort through support, education, and training for

individuals, families, and friends affected by HIV disease”. The majority of the developmental efforts were spent in the development of programs to comfort and support PLWH with a small risk reduction component emerging later in the process. The inception of the ministry was greatly influenced by the pastor emeritus’ personal encounter with a parishioner dying from AIDS. The parishioner’s wife and children had abandoned him upon discovering his diagnosis. The pastor emeritus reported that the dying parishioner convinced him that the church should be involved in caring for individuals dying of AIDS. The pastor emeritus stated,

He [the parishioner] said, “Nobody should have to die like this,” and he was right; and his sister and I and a few people in the choir gathered around him and made sure his death was as peaceful as it could be. But then we decided that no, this can’t happen, this is not how a church is supposed to function. And that was really the germination of the AIDS ministry, how it started.

The developers had two major beliefs that supported the development of the HIV ministry: the beliefs that pastoral leadership and support were pivotal in the development of an HIV Ministry and the belief in the acceptance of all individuals regardless of sexual orientation. One interviewee said, “I would say that’s very important, pastoral leadership... If the pastoral leadership of the church is not supportive it ain’t going to happen because people will follow his lead.” Observation of materials generated by the HIV ministry at its inception, including displays presented at the HIV ministry’s resource booth and in the church’s main lobby, credited pastoral leadership as the “visionaries” for the HIV ministry.

In regard to acceptance of all individuals regardless of sexual orientation, a review of the denomination’s doctrine stated that the church was “liberal and supporting of homosexuality and does not require acceptance of any particular view or rigid doctrine but instead it is in support of mutual understanding, and love which must run through everything.” The church’s history also stated that all God’s children were loved by God and accepted by God.

During the development phase of the HIV ministry, the general norm was that the church’s role was to provide for the needs of its congregants whatever they were. A review of the history of the church showed a longstanding practice of the church providing for the needs of the community and the congregants. Overall, the church embraced the community and its congregants.

As the HIV ministry was developed, the general attitude of the congregation was said to be positive. The developers in particular felt compassion toward PLWH. For example, one interviewee said,

Having a human face on both the virus and on full-blown people helps people relate to it and respond to it in a very different way, and most of which I can say are not as judgmental and are understanding and compassionate... We had compassion, not stigma.

In the development of the HIV ministry, acquiring knowledge was paramount for ministry members and congregants. The major theme was the promotion of knowledge for members and congregants. The members and pastor created informational sessions for the congregants and mandatory trainings for HIV ministry volunteers to reduce the stigma and ignorance surrounding HIV. Training sessions covered basic knowledge of HIV (pathophysiology, transmission, terminology, resources, prevention, etc.). The HIV ministry training manual gave information on the history of HIV, HIV terminology, and pathophysiology of HIV, as well as HIV prevention and resources. Specifically, the manual provided information on when the HIV virus was recognized, what a retrovirus was, how the HIV virus attached to CD4+ T cells, the HIV replication process, the effects of HIV on the

immune system, modes of transmission through bodily fluids, signs and symptoms of infection, how HIV could be diagnosed, common treatments (antiretroviral drugs), prevention of infection through safe sex practices (including reduction of partners, condom use, and abstinence), as well as numbers for hotlines, case management resources, clinics' support groups, and substance abuse services.

Information about HIV was also provided to the congregation via newsletters, information in church bulletins, resource tables, posters, and forums. One interviewee said,

The AIDS ministry would have forums at least once a year, Sunday afternoon where you have somebody from CDC, somebody from the Board of Health on the panel, somebody from...an epidemiologist from the medical profession, somebody who is HIV positive, somebody with full-blown AIDS and a family member, and they would all present 5 to 10 minutes, on that hour panel, and then you can have all the questions and answers you wanted.

Implementation of the HIV Ministry

As the implementation of the HIV ministry began to take place, members expressed a belief that they had been called to fight against the stigma of HIV and to help those who were infected with or could be affected by HIV. For example, one interviewee stated,

I believe what is right is the fight against the stigma, to uplift those who are wounded not only by their illness, but by the secrets and lies that they have to live with....we wanted to be conscious of our role and our purpose of either hurting or healing our community as it relates to HIV.

Implementers of the HIV ministry felt that Christians should help others and treat them with respect and dignity in all circumstances. This exemplified the primary norm in the church during the implementation phase. For example, one interviewee stated, "If we profess to be Christian or spiritual or religious or whatever one may claim to be that we are to love our neighbor as we love ourselves."

HIV ministry implementers were characterized by an attitude or feeling of excitement and passion about their involvement in the HIV ministry. One interviewee stated, "We were excited about being compassionate and passionate about meeting the needs of our community; a great sense of purpose."

During the implementation phase, the theme that emerged regarding acquired knowledge was that HIV education had to be provided for members and congregants. One interviewee said, "I can't emphasize enough the need for comprehensive training, mandatory training for anybody that wants to be in this ministry." Training was developed and implemented by the HIV ministry and continued to the time of this research. It consisted of five sessions. Each session was 4 hours in length and was conducted on Saturdays. Attendance at all sessions was mandatory for church members who volunteered in the HIV ministry. The first session covered the definition, history, and virology of HIV; immunology; and components of the immune system. The second session covered HIV testing (ELISA and Western Blot), stages of HIV infection, current drugs, and treatment. The third session covered transmission, infectious process and chain of infection, HIV prevention, and its effects on women and children. The fourth session covered social and psychological aspects of HIV. The fifth and last session included pastoral and spiritual care of individuals living with HIV. Individuals who facilitated the sessions included physicians, chairpersons of the departments of medicine at local hospitals, county clinical specialists, professors, social workers, and ministers. One interviewee stated,

They didn't know much, that's exactly why the pastor thought that it was important that we get out there and do some training for the various ministries. We thought that that was one way to educate people. There was often information in the bulletin, statistics about how it impacted people, and about how you can get it or how you can't get it.

The estimated length of this stage was 1–2 years.

Maintenance of the HIV Ministry

The church and HIV ministry members believed that Jesus calls all Christians to love others, particularly those who are generally neglected, ignored, and discriminated against. This was one of the foundational beliefs of the HIV ministry. One interviewee said, "I believe that Jesus calls us to engage those that have been marginalized in society. Jesus was calling the disciples to engage, to heal, to love, to liberate those with leprosy". Another interviewee stated,

God has called us to the task of caring for those who are sick among us, who are on beds of infliction, who are in need with HIV, AIDS, and education, health care, all of it...God created us all. We all have equal footing at the cross.

The church's doctrine called congregants to support the oppressed and strive for social justice and liberation for all, just as Jesus did.

The second belief was that service in this ministry was about human beings who deserved to be cared for and loved. One interviewee said, "It's an issue very much one of humanity, very much a love ethic. It's about basic humanity." The denomination's doctrine stated, "Love must run through everything." These beliefs were consistent with the mission to support, educate, and train individuals, families, and friends affected by HIV disease.

By the time of our research, the HIV ministry and its presence in the church had become the norm. It was an integral and important component of the church. As one interviewee stated,

The HIV ministry has been a continual tradition at the church. It has been a model program. It is in line with the teaching of the church over the years. The core values were already set in place before I got here. The hardcore work had already been done. So it's a part of the culture now. It's expected.

Observations of sermons delivered during weekly worship services showed that the HIV ministry had become a part of the culture as it was mentioned during sermons and announcements without reactions of resistance or shock being noted in the congregation.

The general attitude of the congregation was positive toward the HIV ministry. For example one interviewee said, "...for the most part I would say people are supportive and they really like having the HIV and AIDS Ministry. In terms of the church we've been welcomed and encouraged." Observations of the attitudes of the congregants toward the information booth that provided information resources about the prevention of HIV, condoms, and other materials, showed that people felt positive and engaged, asked questions about HIV, and took the materials available.

The members of the HIV ministry had acquired a great deal of knowledge about HIV and knew that rates were on the rise in the African American community, particularly in certain age groups. One interviewee stated,

I know we have a large percentage of our community here at the church that have been infected or affected by AIDS. We know the fastest growing population is 55 and above and the infection rate among those who are between 16 and 26.

Newsletters placed in the bulletin gave statistics about HIV infection. For example, per an HIV ministry newsletter, “African Americans represent 12% of [the] population but the majority of HIV cases.” The HIV ministry also distributed statistical information at their information booth. This information included the prevalence and rates of infection in the United States and in the African American community, as well as among homosexual men, women, adolescents, children, and the elderly. The HIV ministry also widely distributed information through the use of pamphlets and posters on substance abuse resources and on HIV transmission, treatment, testing sites, and prevention strategies, including condoms, abstinence, and reduction of partners. Given the HIV ministry’s wide distribution of HIV materials, it is not surprising that 94% of the 50 congregations who answered the HIV ministry awareness questionnaire were aware of the HIV ministry. Observations of meetings demonstrated that the ministry tried to be well informed on statistical information concerning HIV in the community and the state at large by bringing in guest speakers to inform participants about the rates of HIV in the surrounding African American community.

During the HIV ministry’s forums information was also presented with a focus on the adolescent population of the church. The HIV ministry occasionally partnered with the substance abuse ministry during these forums and covered topics such as substance abuse, peer pressure, and pregnancy in a manner that was better suited for adolescents and their particular concerns. Although the adolescent forum and other forums sponsored by the HIV ministry did not keep records of the total number of individuals attending their forums, it was estimated that between 70 and 150 congregants attended each forum. The estimated length of this stage is 17 years and ongoing.

Discussion

This study explored the role of religious culture on the development, implementation, and maintenance of an HIV ministry within one African American church. This is the first study to examine supports for an HIV ministry in an African American church from the HIV ministry’s inception to its maintenance. The concept of religious culture (beliefs, norms, attitudes, and acquired knowledge) and its role on the development, implementation, and maintenance of an HIV ministry have not been explored prior to this study. Previous research has focused primarily on barriers and not supports, especially supports within the context of the religious culture. The results revealed that the primary common themes among the development, implementation, and maintenance phases of the HIV ministry were (a) a belief in helping others and treating them with respect and dignity, (b) feelings of compassion toward individuals infected with HIV, and (c) an emphasis on the importance of HIV education for ministry members as well as for the general congregation. In addition to the aforementioned themes, pastoral leadership and support and acceptance of all individuals regardless of sexual orientation were prominent themes in the development phase. Additional themes for the implementation phase were a belief that members of the ministry were called to fight against the stigma of HIV and a feeling of excitement and passion about personal involvement in the ministry. Lastly, in the maintenance phase the importance of integrating the HIV ministry into the culture of the church emerged as a theme.

Factors identified previously that support HIV programs or ministries include: HIV programs or ministries that were supported by an awareness and acceptance of PLWH, knowledge about the prevalence of HIV in the surrounding community, and a theology that was open to addressing sensitive issues (Brown and Williams, 2005; Coyne-Beasley and Schoenbach, 2000; McKoy and Petersen, 2006; McNeal and Perkins, 2007; Smith et al., 2005). These findings were consistent with our results. Other findings consistent with our results included the necessity of incorporating input from health professionals, having liaisons between local health departments, and church leadership (Agate et al., 2005; Baker,

1999; Jacknik, Isberner, Gumerman, Hayworth, & Braunling-McMorrow, 1984), pastors and their congregations having a strong commitment to the fight against HIV, and being willing to take ownership of the project (Agate et al., 2005). Ongoing HIV education for the members and congregants was paramount in this study and was consistent with other research findings (Agate et al., 2005; Baker, 1999; Jacknik et al., 1984).

Six HIV programs have been reported in the literature (Agate et al., 2005; Baker, 1999; Jacknik et al., 1984; MacMaster et al., 2007; 2004; Merz, 1997). All focused exclusively on the HIV risk reduction component. Only one was maintained over time (Agate et al., 2005). In our study the HIV ministry focused primarily on caring for and comforting individuals infected with HIV and their families. Its HIV risk reduction component constituted a small portion of the ministry. It appeared that programs that focused exclusively on HIV risk reduction were less likely to be maintained over time, which may have been due to the singular focus on the risk reduction aspect.

The HIV ministry in our study had been maintained for nearly 20 years. Long-term maintenance may have been due to the church's culture that supported the ministry's mission. In addition, the program was systematically incorporated into the culture of the church, further solidifying its maintenance over time

Limitations

One possible limitation to this study was that it took place within a church belonging to a denomination that was open and affirming to homosexuality. African American churches with a doctrine that supports homosexuality tend to be more willing to discuss topics concerning sexuality, particularly homosexuality and promiscuity (Baker, 1999; Coyne-Beasley & Schoenbach, 2000; McKoy & Petersen, 2006; Smith et al., 2005), and as such may be more willing to develop, implement, and maintain a HIV ministry than African American churches that are unwilling to have these discussions. The results from this study may not be generalizable to those churches.

Steps were taken to maintain scientific rigor and minimize the effect of the study's limitations. The technique used for establishing credibility in this study was prolonged engagement. Prolonged engagement, or spending time to learn the culture and gain trust, was established by spending 4 months in the church to build relationships and learn more about the church culture. Attending church services, meetings, and programs, and having discussions with key informants and congregants helped to achieve this. Second, transferability was established by using detailed descriptions (Patton, 2002) taken directly from observations and interviews. Lastly, the researcher kept a journal, recording personal reactions throughout the study.

Practice Implications

Health professionals can use a religious culture framework to understand a given church culture, which can prove to be invaluable in developing an HIV ministry that can be maintained over time. Health professionals, including nurses, can help churches gain understandings about their cultures, specifically the beliefs, norms, attitudes, and acquired knowledge related to HIV. Health professionals can work with the church to create a culture that encourages a theology that is open to addressing the sensitive issues of sexuality and HIV through dialogue. During these dialogues, the health professional can assist the church to explore the beliefs, norms, attitudes, and acquired knowledge that may play a key role in inhibiting the development and maintenance of an HIV ministry. Health professionals can then provide assistance to churches to help change these inhibiting beliefs, norms, and attitudes, as well as provide church members with comprehensive and correct knowledge

about HIV. The health professional would be working with the church to create a culture that would promote the development, implementation, and maintenance of an HIV ministry. In essence, they could help to develop a culture that encourages a theology open to addressing sensitive issues of sexuality and HIV through dialogue.

Research Implications

More research is needed to explore the role of religious culture on the development, implementation, and maintenance of HIV ministry programs on a larger scale, including multiple denominations in both rural and urban settings across all socioeconomic levels. Models specifying a church's shared beliefs, norms, attitudes, and knowledge that promote the development, implementation, and maintenance of an HIV ministry program are needed to generate strategies to move churches forward in the fight against HIV. These models and strategies need to be systematically tested to determine efficacy in promoting the development, implementation, and maintenance of an HIV ministry in African American churches. Using community-based participatory research methods would endorse the involvement of pastors, lay leaders, and congregants in creating models and strategies to focus on promoting a religious culture conducive to the development, implementation, and maintenance of an HIV ministry program.

Conclusion

The findings from our study add to the research regarding the role of the African American church in HIV ministry. The data show that the beliefs, norms, attitudes, and acquired knowledge of a given church can be instrumental in providing a framework for understanding and supporting the church's role in an HIV ministry. In general, these findings can be used to illuminate the importance of religious culture in understanding the role of African American churches in HIV ministry. Each of the components of religious culture (beliefs, norms, attitudes, and acquired knowledge) play an important role in the development, implementation, and maintenance of an HIV ministry.

Clinical Considerations

- Health professionals can use a religious culture framework to understand a given church culture, which can prove to be invaluable in developing an HIV ministry that can be maintained over time.
- Health professionals, including nurses, can help a church gain an understanding of its culture, specifically its beliefs, norms, attitudes, and acquired knowledge related to HIV.
- Health professionals can work with the church to create a culture that encourages a theology that is open to addressing the sensitive issues of sexuality and HIV through dialogue. During these dialogues, the health professional can assist the church to explore the beliefs, norms, attitudes, and acquired knowledge that may play a key role in inhibiting the development and maintenance of an HIV ministry. Health professionals can then provide assistance to help the church change these inhibiting factors.

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