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Attitudes and beliefs related to HIV/AIDS in urban religious congregations: Barriers and opportunities for HIV-related interventions

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Abstract

HIV-related stigmas have been seen as a barrier to greater religious congregation involvement in HIV prevention and care in the United States and elsewhere. We explored congregational and community norms and attitudes regarding HIV, sexuality, and drug use through a qualitative case study of 14 diverse religious congregations in Los Angeles County, California between December 2006 and May 2008. Data collected included semi-structured interviews with 57 clergy and lay leaders across the congregations, structured observations of congregational activities, review of archival documents, and a questionnaire on congregational characteristics.

Across and within congregations, we found a wide range of views towards HIV, people with HIV, and populations at risk for HIV, from highly judgmental and exclusionary, to “loving the sinner, not the sin,” to accepting and affirming. Attitudes and norms about HIV, homosexuality, and substance abuse appeared to be related to the type and intensity of congregational HIV-related activities. However, even among the higher activity congregations, we found a range of perceptions, including ones that were stigmatizing.

Results suggest that affirming norms and attitudes are not a prerequisite for a congregation to initiate HIV activities, a finding relevant for HIV service providers and researchers seeking to engage congregations on this issue. HIV stigma-reduction is not a prerequisite for congregational

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HIV involvement: both may occur simultaneously, or one before the other, and they dynamically affect each other. Strategies that are congruent with congregations' current levels of comfort and openness around HIV can themselves facilitate a process of attitudinal and normative change.

Keywords

USA; HIV; religion; stigma; institutional sociology; urban congregations; homosexuality; substance abuse; interventions

INTRODUCTION

Stigma is a social process that devalues individuals or groups possessing some characteristic considered 'undesirable' by society (Goffman, 1963). HIV stigma – prejudice, discrimination, and negative attitudes towards individuals, groups, and communities with or at risk for HIV - has been noted as a challenge to preventing HIV and providing HIV care worldwide (Herek, 2002; Parker & Aggleton, 2003; Reidpath et al., 2005). HIV-related stigma arises from concerns about sexual promiscuity, homosexuality, and drug use as well as historically high mortality rates (Berrenberg et al., 2002; Diaz et al., 2001; Gostin & Webber, 1998; Herek et al., 2003; Lee et al., 2002; Marin, 2003; Mays & Cochran, 1987; Stokes et al., 1996; Valdiserri, 2002).

For churches and other faith-based organizations (FBOs), religious beliefs that condemn homosexuality and substance abuse may contribute to or strengthen these general sources of HIV stigma (Schulden et al., 2008; Smith et al., 2005; Tyrell et al., 2008; Williams et al., 2011). Yet, FBOs have been proposed as institutions that could be critical to the community response to HIV. FBOs have served as venues, participants, and organizers of HIV testing (Whiters et al., 2010), housing for HIV positive individuals (Derosé, Dominguez et al., 2010), prevention education (Agate et al., 2005; Berkley-Patton et al., 2010; Griffith et al., 2010; Lindley et al., 2010), and food, social support, pastoral care, and other services for people living with HIV (Derosé et al., 2011; Bazant & Boulay, 2007; Leong, 2006). And studies of FBO efforts across multiple countries have found that care and support activities are considered traditional strengths of FBOs, even though HIV prevention efforts have been highly contested within religious circles, often disrupting collaborative efforts (Parker & Birdsall, 2005; Tiendrebeogo & Buyx, 2004; Woldehanna et al., 2005).

In the United States, involvement in HIV care and prevention is not common among FBOs, and partnerships between public health entities and FBOs to address HIV are rare (Agate et al., 2005). In one national study, only 10% of religious congregations offered some sort of health services (Trinitapoli et al., 2009); in a survey of congregations in Philadelphia, only 11% reported an AIDS ministry (Cnaan & Boddie, 2001). Although stigma is often cited as a barrier to faith-based involvement in HIV, less is known about the *range* of norms and attitudes toward HIV that exist in, among, and around congregations, and how these norms and attitudes are related to congregational involvement in HIV-related activities.

To explore this issue, we conducted a qualitative case study of 14 urban congregations. In this paper, we examine two primary questions from this study: 1) what are the range and types of norms and attitudes (from stigmatizing to affirming) among congregational leaders towards HIV and related risk behaviors (i.e., sexuality and substance abuse)? 2) How do norms and attitudes relate, if at all, to the congregation's level of involvement in HIV-related activities or services?

Conceptual Framework

Our conceptual framework draws on our past work to conceive of four factors influencing the involvement of religious congregations in HIV-related activities: norms and attitudes, organizational structure and process, resources, and demographics (Mendel et al., 2008, Derose, Mendel et al., 2010). In this conceptualization, the category of “norms and attitudes” is intentionally broad, including individually-held attitudes, beliefs, values, knowledge and cognitions, as well as their manifestations as community or congregational norms.

This paper focuses and expands on the “norms and attitudes” component of the framework by unpacking the notion of stigma towards HIV and its relationship to other norms and attitudes associated with congregational involvement in HIV activities. The analysis further explores how these dimensions at the individual and collective levels interact with one another and with other norms and attitudes—such as perceptions of HIV need in the congregation or community, and competing congregational and community needs—that are described by clergy and lay leaders as influencing involvement in HIV activities. For example, some congregations might have a negative moral appraisal of people with HIV as “sinners,” especially if associated with “undesirable” characteristics and behaviors such as homosexuality or substance abuse, but still maintain an accepting stance towards people with HIV that embodies the belief that all individuals are created in the image of God. Recognizing a continuum from affirming to stigmatizing valences on each dimension also permits understanding stigma not as a dichotomous phenomenon (i.e., someone is either stigmatized or not), but rather as a continuous variable, on which middle positions might include moral appraisals of people with HIV as being not necessarily better or worse than others, or orientations toward people with HIV that are accepting or tolerant as opposed to either welcoming or rejecting.

METHODS

Case Study Methods

During 2006–07, we recruited 14 religious congregations of diverse race/ethnicities, faiths, and sizes in Los Angeles County, California. Through discussions with community experts, our community advisory board (CAB), and other sources (e.g., local faith-based and HIV resource directories), we compiled a list of 80 congregations potentially involved in HIV activities in three areas most impacted by HIV in Los Angeles County. We administered a brief telephone screening survey (with a response rate of 88%) to these congregations. The survey included questions on HIV and other health activities conducted by the congregation and congregation characteristics. With the CAB’s assistance, we selected a purposive sample of 14 congregations from these 80, all of which had some health-related activities, to obtain variation on important issues such HIV/AIDS activity (including those with very low or no discernable activity), race/ethnicity, denomination, religion, and size. Three of the congregations that were initially invited declined to participate and were replaced in the sample by similar congregations. In recognition of the time commitment for participating in the study (congregations did multiple interviews, allowed observation of their activities and services, and were engaged over several months to a year), each congregation received an unrestricted financial contribution to their organization (\$500 USD).

Data Collection—We collected case study data using multiple methods: in-depth, semi-structured *interviews* with clergy and lay leaders; structured *observations* of church services and health activities; review of congregational *documents*, newspaper stories and other secondary sources; and a brief, self-administered *questionnaire* on congregational characteristics. Within each case study congregation, interviewees were selected based on

recommendations from senior clergy, field observations, and lay leaders of health-related activities or ministries. We interviewed 3–6 individuals per congregation who were identified as knowledgeable about congregation health and HIV-related activities by senior clergy and/or lay leaders. Fifty-seven individuals across 14 congregations were interviewed from December 2006 to May 2008.

The interviews typically lasted 1.5 hours (range 1–4 hours) and were conducted in person, in English or Spanish, by two or three members of the project using a semi-structured format. Interviews were also audio-recorded and transcribed verbatim in English or Spanish. Interviewers reviewed draft interview notes and transcripts for completeness and accuracy. We used structured field note templates for the observations of religious services, health and HIV-related activities, and local neighborhood context. Ethical approval for the study was obtained from the Human Subject Protection Committee at the RAND Corporation.

Qualitative Data Analysis

Qualitative interviews were analyzed using content coding procedures to identify themes related to the major topics in our conceptual framework and interview protocol (Weber, 1990) as well as an inductive approach to identify new themes that were then added to the codebook (Strauss & Corbin, 1990; Weber, 1990). Themes were hierarchically structured, with sub-themes created as appropriate. Higher level themes included types of HIV and other health activities conducted by congregations, and the ways in which the activities were organized and implemented; congregational and community norms and attitudes regarding HIV, homosexuality, drug use, sexual behavior, and health issues in general; and congregational background and dynamics more generally (e.g., mission, polity, membership composition). Sub-themes were created as appropriate and drew out specificity within these broader themes. For example, under “Types of HIV activities”, sub-themes included “Prevention and Education”, “Care and Support”, and “Awareness and Advocacy”

Research team members worked in pairs using qualitative text management software (Muhr, 2006) to test-code, then fully code, the interview transcripts, periodically double-coding transcripts at prescribed intervals to maintain inter-rater reliability, resolve discrepancies, and confirm emergent themes by consensus. Field observations and archival documents were used to provide context to the cases and help inform analysis of the interview data.

Thematic analysis—All quotations and notes related to the main codes of interest for this paper (attitudes towards HIV, homosexuality, drug use, and sexual behavior) were reviewed by 3 of the co-authors (RNB, KP, KPD). We examined how attitudes related to HIV disease, sexual behaviors, and substance use varied among the congregations. Here our interest was to determine variations in salience and range of attitudes towards sub-groups, particularly gays and lesbians, sexually active unmarried people and substance abusers.

In addition, we categorized the level of congregational HIV activity as determined by our previous analysis (Derose et al., 2011) in terms of: 1) low HIV activity—congregational activities are infrequent or not targeted specifically to HIV (e.g., a yearly AIDS mass); 2) medium HIV activity—activities occur more than once a year and may target HIV, but are an extension of what congregations traditionally do, such as providing pastoral care to people with HIV; and 3) high HIV activity—activities are frequent, target HIV, and include multiple types of activities above and beyond what congregations traditionally do.

RESULTS

Congregational and Interview Participant Characteristics

Table 1 describes key characteristics of the congregations ($n=14$) and interview participants ($n=57$). Selected congregations were racially and ethnically varied and included 3 primarily Spanish-speaking congregations and 2 mixed-race congregations. They also varied by size, denomination, and religion. All congregations had at least some HIV activity: 6 were categorized as high HIV activity, 4 as medium HIV activity, and 4 as low HIV activity. We interviewed more men than women and more lay leaders than clergy. We did not collect information on respondent age, but the majority appeared to be over thirty.

Congregational Norms and Attitudes towards HIV

Respondents expressed a wide range of norms and attitudes about HIV, from profound stigma to full acceptance of people living with HIV and those most at risk for it. However, most congregational participants – clergy and lay leader – expressed orientations that fell in the midrange of this continuum.

At the stigmatizing end of the continuum, participants tended to link HIV to sin and condemned people with HIV for having engaged in risk behaviors that are contrary to scripture or doctrine. For example, a pastor from a Pentecostal (Latino immigrant) congregation described HIV as a judgment from God:

Regarding the ones that are not affected, many believe that AIDS is a judgment from God, and in fact we believe so because I have studied some about its origin and everything. So it's God's judgment for all the lasciviousness and everything else that exists in the world.

However, few participants expressed solely judgmental attitudes towards people with HIV; instead, many invoked a call to compassion for the person with HIV, often tied to a belief that one should “love the sinner, not the sin.” For example, a pastor at a Mainline Protestant (African American) congregation expressed disapproval of homosexuality together with a feeling of love for all humanity, including people with HIV, based on the idea that God is the ultimate authority:

See, I do embrace the homosexual. But, like I said, the lifestyle, and the morality of it, I don't embrace, because of what scripture says....But what I teach the people, then God is the judge. He'll do the judging. We are to love people. You can love people [into] the kingdom of God, but you can't hate people into the kingdom....Because a person has AIDS does not give you the right to hate that person....

Towards the more accepting end of the continuum, people who either had been personally affected by HIV or recognized that their congregation or community had been affected tended to discuss HIV in this way even while recognizing that HIV remains an uncomfortable topic. A lay leader from a Catholic (African American) congregation noted that HIV has had a very personal impact on the church community and emphasized that it is a health and not a moral issue:

I think that within the church community...that somewhere along the way someone has been touched by [HIV]. By that, I mean it may be your brother, it may be your cousin, and we have had some parishioners who themselves have passed away.it's not moral because for me from day one it's been a health issue.

A Rabbi from a Jewish (White) congregation also discussed HIV as a public health issue, tying his congregation's concern to being located in a community that is highly affected by HIV:

Well, [HIV is] an issue in terms of prevention and we're concerned about it with our kids, with our high school kids moving forward that they know how to protect themselves, that they know what safe sex is and stuff....but I don't know of anybody here who is HIV positive...as far as I know, it's not a big issue internally. It's an issue for us because we're part of a community where it's a big issue.

Finally, at the accepting end of the continuum, a few respondents expressed attitudes of solidarity and affirmation for people with HIV. At a Mainline Protestant (mixed race) congregation, a pastor talked about how taking a strong and public stance in support of people with HIV was an important signal that these people were welcomed at the church:

And so we knew if we [displayed this AIDS symbol publicly]....that it was a way of saying to the community, "You're loved.".... "We're open, and we love everyone. And you will always be able to walk in these doors." And that's big. It was, I think, of a huge and symbolic importance to the gay community and to the church community. It was such a witness to say... because there are a lot of churches who would turn people away.

Relationships between Attitudes towards HIV and those towards Sexuality and Substance Abuse

HIV-related attitudes were closely tied to sexual behavior, particularly among respondents with mostly negative attitudes towards HIV. Respondents who condemned HIV as a consequence of sin often linked this attitude to judgments about homosexuality, having multiple sexual partners, and sex outside of marriage, all of which they considered contrary to scripture or religious doctrine.

Congregational leaders who had negative attitudes towards HIV were likely to condemn homosexuality. The pastor of a Pentecostal (Latino immigrant) congregation suggested that doctrine prohibiting sex outside of marriage and homosexuality protected congregants (and other believers) against HIV:

I think the church has been an important element within society because it has prevented a lot of people from becoming infected, due to us not believing in promiscuity, because we're teaching our youth the importance of being consecrated in that area, sexually, for God. Also because we don't have gay communities. So that has kept us away from HIV.

Some respondents did not condemn heterosexual extra-marital sex as strongly as they did homosexuality. While sex outside of marriage and/or non-monogamy were often considered wrong, they were also recognized as problems of natural human temptation, and therefore forgivable.

On the other hand, those respondents who expressed solidarity with people with HIV and who talked about HIV-positive individuals in an affirming way tended to view homosexuality as part of human diversity. One Catholic priest in a predominantly Latino congregation expressed the belief that people do not choose to be gay, but that it's part of "God's design":

Yeah, well, you've got this thing where people say, "Well, somebody chooses to be gay." Nobody chooses to be gay, that's insane. That's just absolutely implausible. You are gay, whether genetically or something else... That's God's design for you, nothing wrong with that. That's God's Will.

A pastor at a Mainline Protestant (mixed race) congregation went further to state that the church welcomes all people regardless of sexual orientation, and seeks to counteract the negative experiences that gay and lesbian congregants experienced in previous religious settings:

Too many gay and lesbian persons feel rejection from the church, especially churches they've grown up in, from family. And we want to create a place where they are welcomed as a child of God.....We have a lot of recovering Southern Baptists here....and folks who have been disenfranchised, either by their families or their church, or told that they can't come to church anymore, because they're not worthy-because they're gay or lesbian.

Interestingly, attitudes toward condom use as an HIV prevention strategy seemed less charged than attitudes towards homosexuality. A minority of respondents (who were all Catholic) noted official denominational policies against condom use, but even among these respondents there was a general consensus that teaching people about condoms is important for HIV prevention. One Catholic lay leader at an African American congregation expressed this attitude:

Condom use is the big one for the Catholic Church. And to be honest with you, I don't know when they're going to turn things around....I have said the very first thing I talk about is abstinence, because really, that's the only 100 percent...And secondly, monogamy. But you've got to go... a step further by speaking of condoms, because they're not going to be abstinent...they're not going to be.

There were also some respondents who focused on "helping people make good and healthy choices" concerning sexual behavior, rather than only seeing sex as permissible in marriage. Such attitudes were apparent even in congregations in which there was a theological preference for abstinence outside of marriage. A pastor from a Mainline Protestant (African American) congregation described this "dual belief" in both abstinence and harm reduction strategies when describing the counseling provided to a male congregant who may have had sexual contact with other men in prison:

Now the best practice is abstinence, because you know the Bible says to abstain [from] fornication....But I'm just very open with him, and he talked to me, he said, "No, Reverend [name omitted]," he says, "I haven't had sex with any guys in prison." And I said, "Well, I'm not going to ask you what you did. I'm taking you at your word, but I'm telling you, if you have had sex with any guys in prison, here's what you do...you go, you get tested," I said, "and you use condoms, at least for a year."

Attitudes towards substance and alcohol use and abuse were less judgmental and more varied than those concerning HIV and sexual activity outside marriage. For example, one pastor at an evangelical (Latino) congregation linked HIV and homosexuality to sin, but when it came to alcohol, he said "I can't show anybody in the Bible where it says, 'Drinking alcohol is a sin,' you see." A pastor at a Mainline Protestant (African American) congregation talked about the high salience of substance abuse issues for the congregation because of congregants' own addiction problems or those of friends and family:

Some [participants in the substance abuse ministry] come in just to sit in because they've got a family member that's on drugs and they've been an enabler to help them stay on drugs....a lot of them do come just for that because rarely will you find anybody in this country today...that don't know somebody that's been touched by drugs and alcohol.

HIV Attitudes by HIV Activity Level

We found that norms and attitudes varied by HIV activity level. The most common activities in the low activity congregations were HIV education within more general health-related workshops, clergy or lay leader participation in externally sponsored HIV/AIDS trainings or workshops, and occasional pastoral care for people with HIV. Among low-activity congregations, two main themes were dominant: stigma and low priority. Regarding stigma, as one pastor from an evangelical (Latino) congregation described congregants' attitudes as, "It's more like, 'Oh man, you have AIDS,' like cooties. 'You have cooties, oh, get away, we don't want to get it.' I think that's where it's from." Participants in the low-activity congregations also were more likely to view homosexuality as a sin and to make strong statements in favor of sexual abstinence until marriage. HIV was also regarded as a low priority in these congregations. For example, a priest from a Catholic (Latino) congregation commented: "I would say [HIV is] far down on the pecking order. Now whether it should be is, of course, another question." A lay leader from a Pentecostal (Latino) congregation stated, "Well to be honest, I haven't even taken it into account, I haven't even considered it." A pastor from the same congregation offered more context for this sentiment when he said, "I think it's more of a priority for us to have a shelter for say, the unemployed, of which there are many."

For medium activity congregations the most common HIV activities were HIV education via workshops or printed materials, health fairs that include HIV issues, talking to congregants about HIV prevention (i.e. condoms, abstinence), and support of AIDS service organizations. A common theme for these congregations was transformation from a position of fear about HIV to understanding and acceptance. This was best illustrated by a pastor from a mainline Protestant (African American) congregation when he described how education around HIV positively changed congregational and denominational attitudes:

I mean, the taboos that we were dealing with along that line, and that's what I liken AIDS to just for my own point of reference, how afraid we were to even voice that that was what was going on because we had bought into the theology of the religious right and the conservatives, and the evangelicals whose theological posture was such that it was God's condemnation upon the sin of homosexuality, and then education helped us understand. The statistics helped us understand that, you know, that it wasn't the case...

In the medium-activity congregations, we found attitudes towards homosexuality to be more varied and nuanced. While some respondents within medium-activity congregations reported discomfort with homosexuality, the attitudes of other congregants and clergy in such congregations could be best characterized as accepting. For instance, one lay leader from a Jewish (White) congregation observed that "Most of the congregation is fine with [homosexuality] – understands that the current scientific thinking about how being gay is not a choice, but something that you're born with."

In some medium-activity congregations, clergy and lay leaders encouraged abstinence, but felt that people should protect themselves from pregnancy and sexually transmitted infections if they could not sustain abstinence. A pastor from a Mainline Protestant (African American) congregation expressed a typical sentiment:

Well, you know, the preference for me in terms of as I teach and deal with kids is abstinence. But the reality is that they're going to be dealing with their libidos and so you have to deal with safe sex, the precautionary and preventive actions that they can take.

Among high activity congregations the most common activities were HIV education via workshops or printed materials, material or spiritual support for people with HIV, support to

AIDS service organizations, sermons or worship services dedicated to AIDS, participating in walks and marches for AIDS, and engaging in public advocacy and stigma reduction on behalf of people with HIV. High-activity congregations were characterized by substantial acceptance and support of people living with HIV and/or recognition of HIV as an important issue. These congregations tended to have longer histories of working on the issue and more visible groups of gay and lesbian congregants than did the low- and medium-activity congregations. In many of these high-activity congregations, HIV-positive individuals could be open about their HIV status. A rabbi of a Jewish (predominantly White) congregation noted that the support that the congregation showed for people with HIV meant that people with HIV were comfortable being open about their status:

In every single newsletter, we have a big ad that promotes the next dates for our HIV support group. You know, and we're really open about it. And I talk about it. And we have people who are the visible face... they're open about their status.

However, in some of the high-activity congregations, HIV stigma was still an issue. For instance, one lay leader at a Catholic (African American) congregation stated that congregants sometimes believed that getting involved with HIV activities meant that others would think they have HIV:

That's one of the problems is recruiting members, getting people to become members of the AIDS ministry. They're either afraid that people are going to think they have it. I guess that's what it is.

In some high-activity congregations, religious beliefs condemning homosexuality and/or homosexual behavior still dominated the social norms. Some of the high-activity congregations also emphasized abstinence from heterosexual sex outside marriage and drug use. Regardless of these views, however, there were numerous statements in favor of condom use to prevent HIV. For instance, one lay leader from a Catholic (African American) congregation remarked that in discussing the need for condoms to prevent HIV, she tells clergy, "I am not talking about prevention of life. I'm talking about prevention of death." In another high-activity congregation with a strong emphasis on sexual abstinence before marriage, a pastor was explicit in his conversations with youth about the need to use condoms to prevent pregnancy and HIV if they are not going to be abstinent.

In summary, low-activity congregations appeared consistently to consider HIV to be a stigmatizing disease and a low priority. For congregations at the medium HIV activity level, discomfort with HIV and associated behaviors coexisted with beliefs about the importance of addressing HIV, which sometimes resulted from experience with congregation-based HIV activities and/or people with HIV, and sometimes seemed to be the impetus for starting activities. The congregations with higher levels of activity tended more frequently to express attitudes on the affirming (less stigmatizing) end of the HIV attitude continuum, but also showed more diversity by displaying attitudes across the continuum, including ones that were stigmatizing. This group of congregations (of higher levels of HIV activity) was also the most diverse in terms of predominant race/ethnicity and denomination.

DISCUSSION

Range of HIV attitudes

We found a wide range of norms and attitudes towards HIV, people with HIV, and people at risk for HIV among congregational leaders, from highly stigmatizing to accepting and affirming. Along this attitudinal continuum, our respondents offered theological, cultural, and practical justification for their views. Yet, similar to others (Khosrovani et al., 2008; Lindley et al., 2010), we also found diverse, and often conflicting, views towards people living with HIV (and risk behaviors associated with HIV) within the same congregation. The

attitudinal diversity amongst and within congregations about HIV suggest that a priori judgments about congregational interest in HIV activities based on denomination, theology, and demographics could be too constraining.

We also found that attitudes and norms towards HIV, homosexuality, and substance abuse appeared related to the *type* and *intensity* of congregational HIV activities. While we cannot determine whether attitudes influenced the activities, activities influenced the attitudes, or whether both were influenced by some third variable, such as the presence of openly gay members in the congregation, the histories of congregational involvement provided by our informants suggested a trend of increasing HIV activity as congregational norms and attitudes moved from stigmatizing to affirming. However, the heterogeneity in these orientations among congregations with high activity suggests that norms and attitudes are not the only drivers of activity. Further, there may be a bi-directional relationship—norms and attitudes may affect the level and/or type of HIV activity, while congregational involvement in HIV activity may lead to a shift in congregants' norms and attitudes over time through such processes as social learning (Bandura, 1977) and dissonance reduction (Festinger, 1957).

Engaging congregations in HIV prevention, care, and support

Understanding the range of attitudes and some of their sources can be used to identify appropriate congregational activities, particularly for external entities such as health departments or AIDS service organizations that seek to engage congregations. For example, lack of knowledge about HIV seroprevalence and transmission behaviors is likely to be easier to change than attitudes towards homosexuality, given doctrinal positions on the subject. For greater success in engaging religious congregations, HIV practitioners or researchers could begin with congregations that have some degree of positive attitudinal orientation towards HIV or related behaviors/groups, for example, congregations with openly gay and lesbian members.

Yet, it may not be necessary to wait for “affirming” attitudes to develop independently in congregations prior to attempting to engage them in HIV-related activities. Rather, strategies that are congruent with congregations' current levels of comfort and openness around HIV, such as providing information materials and speakers, can themselves facilitate a process of attitude change. For example, we found that a number of our case study congregations had sponsored HIV testing events (Derosé et al., 2011), often as part of larger health fairs. It is possible that congregations with less affirming attitudes would embrace HIV testing more readily than other prevention strategies (such as condom promotion), which in turn could help “normalize” HIV as a health rather than a moral issue, as others have suggested (Koch & Beckley, 2006; McNeal & Perkins, 2007).

Reducing stigma within religious congregation is important, as stigmatizing HIV, homosexuality, and substance abuse may directly harm at-risk populations (Brown et al., 2003). A recent study suggests that interventions aimed at reducing HIV stigma in congregations may be feasible and acceptable when tailored to the specific religious and cultural context, even in congregations where there is visible HIV stigma present (Lindley et al., 2010). Further, in view of FBOs' moral authority, broad reach, and ability to influence attitudes, stigma reduction is an area in which FBO leaders could have an especially strong impact. Previous literature has revealed that the experiences of clergy or lay leaders with HIV education, knowing someone with HIV, or perceiving it as a problem in the community, are all related to the development of faith-based HIV activities within congregations (Agate et al., 2005; Chin et al., 2005; Hernández et al., 2007). Recent research suggests that even across congregations with similar structural and institutional features, this

individual experience and agency of the clergy may lead to very different responses to HIV (Cunningham et al., 2011).

In addition, it may be possible for some congregations to address stigma directly and influence congregational norms and attitudes. Research in Ghana indicated that hearing a leader speak about HIV/AIDS had a substantial effect on congregants' provision of support to people with HIV (Bazant & Boulay, 2007). Studies elsewhere (e.g., Jamaica, Trinidad, Tanzania, Uganda, Tanzania, Malawi) have found that FBOs can move from fostering to dissuading stigma through trainings that increase knowledge and understanding of HIV among clergy and congregations members, increased personal contact between congregational leaders and people with HIV, creating social spaces that are supportive to people with HIV, and direct involvement of people with HIV in congregational prevention, care and advocacy efforts (Campbell et al., 2010; Genrich & Brathwaite, 2005; Hartwig et al., 2006; Muturi, 2008; Otolok-Tanga et al., 2007; Trinitapoli, 2006).

Nevertheless, our study suggests that HIV involvement is not (and need not be) a linear outcome of HIV stigma-reduction: both may occur simultaneously, or one may occur before the other, dynamically affecting each other. If the goal of initiating congregational HIV activities is to transform how the issue is addressed over time within affected communities, then it is important to identify starting places for a wide variety of congregation settings, especially those that may appear less visibly open to HIV involvement. Indeed, a strengths-oriented service model that focuses on what religious organizations can do with their current resources, versus a model that emphasizes what is missing from congregational efforts, may better empower clergy to confront HIV despite ideological resistance (Ramirez-Johnson et al., 2011).

Attitudinal factors must be taken into account together with contextual and institutional features of congregations to explain how and why they get involved in HIV work. Although this paper did not address contextual and institutional factors directly, international studies have noted how FBOs' involvement in HIV has been helped or hindered by contextual or institutional factors (Garcia & Parker, 2011; Murray et al., 2011). In the United States, recent work across diverse ethnic groups and religious settings suggests that being community-oriented and embracing social engagement may be more important than theological orientation in explaining congregational involvement with HIV (Fulton, 2011), and may be a facilitator to overcoming negative attitudes and norms towards HIV such as fear of infection and concerns about social acceptability (Chin et al., 2011).

Our approach to this topic has a number of limitations. We used purposive sampling, thus our results are not representative of congregations in Los Angeles County or of the faith traditions or denominations of which they are members. Further, our small sample size and qualitative approach do not permit comparisons across faith traditions or denominations. Yet, our sampling approach allowed us to document a wide range of norms and attitudes about HIV, homosexuality, and drug use among congregations and to consider how these attitudes are related to one another, and how they relate to HIV congregational activities. In addition, of necessity, our results depend on self-reports that may be subject to socially desirable responding. However, our comparative case study design incorporating in-depth interviews with multiple clergy and congregants, observations of multiple events and services, and data collection over multiple months for each congregation allowed for developing the rapport necessary for eliciting perspectives on sensitive topics and for triangulating findings on perspectives from a variety of sources.

Findings from this research suggest that congregational HIV activities are possible despite the presence of HIV-related stigma and may in fact contribute to the further reduction of

stigma over time. Attitudes and norms undoubtedly affect FBO willingness to address HIV and, along with institutional and contextual factors, the particular HIV-related activities they undertake. However, trying to assess whether FBOs have the “right” attitude may ultimately be a less useful endeavor than determining the kinds of activities that are suitable entry points for addressing HIV in the context of a particular congregation’s culture, belief system, and resources.

- We observed that positive and negative attitudes about HIV and behavioral risk for HIV range across and within urban religious congregations.
- Congregations with substantial HIV-related stigma can still contribute to HIV prevention and care efforts.
- Engaging congregations in some HIV-related activities may increase affirming attitudes towards people with and at-risk for HIV.
- HIV stigma should be viewed continuously rather than dichotomously.

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Table 1**Congregation and Interview Participant Characteristics**

Congregations (n=14)	Frequency
Predominant race/ethnicity ¹	
African American	6
Latino	4
White	2
Mixed	2
Congregation size ²	
Large (501 members)	6
Medium (151–500 members)	5
Small (150 members)	3
Denomination/Religion	
Catholic	3
Evangelical/Pentecostal/Non-denominational	4
Mainline Protestant	4
Baptist	1
Jewish (Reform)	2
Level of HIV Activity	
High	6
Medium	4
Low	4
Interview Participants (n=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

¹The predominant race/ethnicity comprises 70% of regular participants (except for “mixed”).

²Measured in terms of the number of reported congregational participants that attend services monthly.