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Pastor and Lay Leader Perceptions of Barriers and Supports to HIV Ministry Maintenance in an African American Church

Jennifer M. Stewart

University of Pennsylvania, School of Nursing, Philadelphia, PA, USA stewj@nursing.upenn.edu

Abstract

Abstract Clergy and lay leaders have a pivotal role in the development and maintenance of HIV Ministries within the African American church. However, little is known about the actual roles these men and women have, the barriers they face and the supports they have found in the development and maintenance of an HIV Ministry. The purpose of this study is to examine the role, barriers and supports clergy and lay leaders experienced in the development of a long-standing HIV ministry in an African American church. These data were gathered from a larger ethnographic study, which examined the role of religious culture in the development, implementation and maintenance of an HIV ministry. Data for this study were collected through in-depth semi-structured interviews. Results revealed that the primary role of clergy and lay leaders involved dispelling myths surrounding HIV and ensuring congregational support. The primary barrier to the development and maintenance was views regarding sexuality. The primary support was their relationships with congregants that lived with HIV and AIDS. This information can assist in developing interventions to enhance the African American church movement toward HIV ministries.

Keywords

African American; Faith; Clergy; Lay leaders; HIV; HIV ministry

Introduction

HIV infection continues to negatively impact the African American community. In 2009, African Americans were 9 times more likely to be diagnosed with HIV infection, as compared to the White population (Office of Minority Health 2006). Although African Americans comprise only 14 % of the total US population, they represent a staggering 44 % of all human immunodeficiency virus (HIV) cases in the United States [Centers for Disease Control and Prevention (CDC), 2008]. Given this major health disparity, innovative approaches are needed to reduce HIV risk and to support and care for individuals infected with HIV and AIDS in the African American community.

Historically, the African American church has had a vital role in the lives of many African Americans and their communities (Pew Forum on Religion and Public Life 2008). It has been instrumental as a conduit for health promotion programs focusing on conditions such as heart disease (Sutherland et al. 1995), diabetes (McNabb et al. 1997) and cancer (Campbell et al. 2007). The African American church could also serve as an effective and much-needed force in the battle against HIV (Jarama et al. 2007; Baker 1999). Given that 85

% of African Americans report a religious affiliation and 79 % of African Americans report formal attendance at a Christian church (Pew Forum on Religion and Public Life 2008), the potential impact of HIV risk reduction, care and support messages delivered by the church has substantial implications.

Clergy and lay leadership play a significant role in governing whether HIV risk reduction, care or support may be delivered in their congregations. Decisions about health promotion interventions and ministries are primarily regulated by the clergy and lay leaders. It is not surprising then that the decision to develop a HIV Ministry often has much to do with the clergy and lay leaders beliefs and perceptions regarding involvement in HIV education and risk reduction.

Nine articles have examined the perceptions of clergy and lay leaders on the church's involvement in HIV education and risk reduction (Brown and Williams 2005; Coyne-Beasley and Schoenbach 2000; Cunningham et al. 2011; Harris 2010; Khosrovani et al. 2008; Koch and Beckley 2006; McKoy and Petersen 2006; McNeal and Perkins 2007; Smith S et al. 2005). Overall, it was found that clergy and lay leaders both recognized the need for HIV education and risk reduction and were open to the prospect of such programs (Coyne-Beasley and Schoenbach 2000; Cunningham et al. 2011, Harris 2010; Khosrovani et al. 2008; McNeal and Perkins 2007; Smith et al. 2005). However, very few were actively engaged in HIV education or risk reduction activities. In fact, only between 11 and 39 % of African American churches were actively engaged in HIV education and risk reduction activities (Brown and Williams 2005; McNeal and Perkins 2007; McKoy and Petersen 2006; Smith et al. 2005; Tesoriero et al. 2000).

The primary barrier to involvement in HIV programming was the church's view of sexuality and homosexuality. The majority of clergy were only comfortable teaching abstinence exclusively (Coyne-Beasley and Schoenbach 2000; McKoy and Petersen 2006; McNeal and Perkins 2007). In some cases, clergy stated that topics such as anal sex, homosexuality and condom usage were taboo (Coyne-Beasley and Schoenbach 2000; McKoy and Petersen 2006; McNeal and Perkins 2007). Additional reported barriers included clergy and lay leader's: concern regarding lack of financial and community resources/support (Berkley-Patton et al. 2010; Koch and Beckley 2006; Leong 2006; Smith et al. 2005), a failure to adopt a theology that affirmed marginalized individuals and recognize congregants living with HIV and AIDS (Berkley-Patton et al. 2010; Koch and Beckley 2006), and the congregation and community being uninformed and uneducated about HIV (Berkley-Patton et al. 2010; Koch and Beckley 2006).

Research has focused primarily on barriers impeding the development of HIV ministries in the African American church, which included a variety of religious cultural beliefs and norms. Little attention has been paid to factors that support clergy and lay leaders in the development of HIV ministries, and virtually no study has examined the factors that have supported the maintenance of such ministries over time. This information can be instrumental in encouraging the development of effective faith-based HIV interventions that can also be sustained over the long term and are in keeping with the religious culture of the church.

The purpose of this study was to examine the role, barriers and supports clergy and lay leaders experienced in the development of a long-standing HIV ministry in an African American church. These data were gathered from a larger ethnographic study which examined the role of religious culture in the development, implementation and maintenance of an HIV ministry. The research questions studied in this paper are the following:

- What role did the clergy and lay leaders have in the development and maintenance of the HIV Ministry?
- What barriers did the clergy and lay leaders experience in the development and maintenance of the HIV Ministry?
- What supports did the clergy and lay leaders experience in the development and maintenance of the HIV Ministry?

Methods

Research Design

These data were gathered from a larger ethnographic case study which examined the role of religious culture in the development, implementation and maintenance of an HIV Ministry in an African American church. In addition to participant and nonparticipant observations as well as significant document review, several in-depth interviews were conducted with key clergy and congregants who had primary roles in the development, implementation and maintenance of the ministry. This work analyzes the data collected from the in-depth interviews with the clergy and lay leaders involved in the development and maintenance of the HIV Ministry in this church only. Participants were recruited from March 2010 through June 2010. Data collection occurred during the period from April 2010 through July 2010.

Setting

Participants were clergy and lay leaders from a church located in a Midwest urban community. This particular church was selected because it had a HIV ministry that had been in existence for nearly 20 years. It had a total church membership of more than 8,000 congregants. As a large church, the pastoral staff included a pastor, a pastor emeritus and eight assistant pastors. Additionally, formal lay leaders exist for each of the church's ministries including the HIV Ministry.

Sample

The sample consisted of 5 clergy and lay leaders of the HIV Ministry. Specifically, it consisted of the pastor of the church, the pastor emeritus, one assistant pastor who preceded over the HIV Ministry and two formal co-leaders of the ministry.

Instruments

Data were collected via a semi-structured interview guide developed by the author. The interview guide consisted of open-ended questions that elicited information regarding the role of the participant in the HIV Ministry, supports and barriers to the development and maintenance of the HIV Ministry. The interviews lasted approximately 30 min to 2 h.

Procedure

After receiving approval from the University of Illinois at Chicago Institutional Review Board and from the pastor, the author executed the research beginning with conducting all interviews. After completing the interview with the pastor, the author interviewed the pastor emeritus and the associate pastor, followed by interviews with HIV ministry lay leaders. All interviews were audiotape recorded and transcribed and then checked for accuracy.

Data Analysis

Interview data were transcribed verbatim from the audiotape recordings. The author coded the data that were checked for discrepancies. The data were analyzed in accordance with Auerbach and Silverstein's (2003) grounded theory coding method. This method involved 5

primary steps: (1) transcribing and analyzing the interview or the *raw text*, (2) narrowing the raw text down to relevant text or the text related to the specific research concerns, (3) searching relevant text for *repeating ideas* or the use of the same or similar words and phrases to express the same ideas, (4) gleaning *themes* or groupings of repeating ideas that had commonalities from these groups of repeating ideas and (5) grouping themes into more abstract ideas termed *theoretical constructs*.

Results

The church is in a large metropolitan area with a reported membership of 8,854. On the basis of the church's records, the church is located in a predominately African American community that has a median income of \$43,201. Records also revealed that males made up approximately 28 % of the membership and females 72 %. Approximately 3 % of church members were 0–12, 4 % were 13–18, 5 % were 19–25, 22 % were 26–40, 34 % were 41–55, 22 % were 56–70 and 10 % were older than 70 years of age. The church was approximately 97.5 % African American, 1.0 % Caucasian, 1.0 % Latino, 0.03 % Asian and 0.47 % other. Five interviews were analyzed. Of the 5 African American clergy and lay leaders, 2 were female and all were between the age of 35 and 70 at the time of interview.

Roles

There were three major themes in the clergy and lay leaders' perception of their roles in the development and maintenance of the HIV Ministry. They included: (1) to dispel myths regarding HIV, (2) to reinforce support for the HIV Ministry within the church and (3) to make sure that the ministry was in alignment with the church's vision.

Myths regarding contraction of HIV and its prevalence in the church's surrounding community were found by participants in this study. One of the major roles clergy and lay leaders performed was the consistent attempt to help dispel myths regarding HIV infection. One interviewee said, "well basically what we have been doing and are still doing is going out into the community to let them know about HIV and AIDS and to let them know about the misconceptions they have about it. Its not just a gay disease because anyone that is sexually active can contract HIV and AIDS."

As stated above, clergy and lay leaders play a significant role in deciding which interventions, programs and ministries will be supported. In this same way, the clergy reinforced a congregational structure that supported the HIV ministry. According to the participants, this support was crucial in the development and maintenance of the HIV Ministry. One interviewee said, "well, I am always ensuring the support of the church and the pastoral staff." Another interviewee said "my primary role is leadership in terms of making sure that the church is not only aware of the program but also it has a focused support in the church as a whole."

Churches each have doctrines that govern conduct. However, interpretation of this doctrine varies from church to church. This interpretation can be understood within the context of the vision of the church. The clergy and lay leaders in this study saw one of their roles as making sure that the HIV Ministry was in alignment with the church's vision, doctrine and culture. For example, in regard to making sure that the ministry was in alignment with the church's vision, one interviewee said, "I am here to make sure that the ministry is going along with the church practices and the policies and doing everything according to the church and according to Christ."

The HIV Ministry itself had a variety of roles and activities within the church and community abroad. The activities included providing testing to congregants and the

community at large, educating and providing information regarding HIV transmission, risk and disease progression, passing out condoms, participating in national HIV- and AIDS-related events, collaborating with community health organizations in HIV- and AIDS-related forums and activities and collaborating with other churches in HIV- and AIDS-related education and start-up. This list of roles and activities the HIV Ministry performed constituted a significant involvement in risk reduction as well as support and care of HIV- and AIDS-infected congregants, their families and their community.

Barriers

As a whole, participants reported they faced very little internal struggle in developing the HIV ministry within the church. They all stated that the congregants were accepting of the leadership's desire to develop and maintain the HIV Ministry. Additionally, every participant stated that the maintenance of the HIV Ministry was virtually effortless as it had been integrated into the framework of the church's culture. Its presence and roles had become a norm in their church. Upon further probing, however, interviewees suggested five primary barriers to developing an HIV Ministry within were all situated not within the context of their individual church but within the context of the larger African American community. These five themes included: (1) silence surrounding issues of sexuality, (2) homophobia, (3) HIV-related stigma, (4) outside church community criticisms and (5) unawareness of the impact of HIV and AIDS infection on the African American community.

A conservative stance in regard to sexuality has historically been embraced by the African American church community (Douglas 2003). The notion of talking about sexual matters in the African American church is often regarded as taboo. This creates a level of silence regarding sexuality in the church. In this study, for example, one interviewee said, "the other piece is the inability to talk about sexual issues within the Black community in general. We can talk about it in hip hop culture, we can talk about it in other venues but we can't talk about it honestly in church."

Homophobia in the African American community also posed a major barrier for clergy and lay leaders in developing a HIV Ministry. One interviewee said, "I really believe that a lot of churches still don't want to deal with it (HIV) because they look at it as a homosexual issue. And you know our community is very split on the homosexual issue because a lot of churches still look at that as a sin." Another interviewee said, "There's a lot of religious violence that comes across the pulpit every Sunday in other churches. And a lot of it in terms of homophobia." Lastly, a third interviewee said, "I think the only barriers would be dealing with those churches and breaking through the homophobia." While reports of homophobia in the greater African American church community as a whole seemed prevalent, none of the participants regarded homophobia to be a salient barrier within their own church.

HIV-related stigma represents a devaluation of individuals infected with HIV. Often HIV-related stigma is deeply ingrained within society and within religious beliefs that equate HIV infection with sin. For the participants in this study, it also represented a significant barrier for the development of an HIV Ministry. For example, one interviewee said, "the fact that they (congregants) are infected, the fact that AIDS is what they've got. They don't want to say it. It's the stigma." Another interviewee said, "it's really hard here in the African American community because we deal with so much stigma and ignorance with people with HIV."

Participants were definitive in the barrier the larger African American church community posed as they began the process of developing the HIV Ministry. As a church with a developing HIV Ministry, their moral stance on issues of homosexuality and promiscuity

was often called into scrutiny. The participants found the opinions of other churches to be a significant barrier in the development of an HIV Ministry. For example, one interviewee said, “it was the resistance that we found in the larger church community. That was the biggest barrier, outside of the church.”

Lastly, the lack of awareness of the impact of HIV and AIDS infection on the African American community served as a barrier. Participants reported that in their interactions with other churches and community members, they found that people generally did not realize the magnitude of the effect of HIV and AIDS on the African American community. One interviewee stated, “we really see that people just don't realize that this disease has gotten worse, especially in the African American community.” Another interviewee said, “as long as it remains their disease then you get that resistance, but you start talking about these are our children, our members that changes the response.”

Supports

Three primary supports were found as common themes among the participants' decision to develop and maintain an HIV Ministry. They were (1) a personal relationship with a congregant living with HIV or AIDS, (2) sensitivity to congregational needs and (3) a liberation theological approach.

Participants all reported a personal relationship with a person living with HIV or AIDS in their interviews. This relationship significantly impacted their desire to develop and maintain the HIV ministry. Participants spent great detail in telling the stories of these individuals. For example, one participant said:

The first person to self identify in the membership of being full blown was Frank. Frank came to me. He said, ‘there's no way of dancing around this, I've got AIDS and she (his wife) couldn't deal with it and she left me’. Within three or four weeks he said something that really convicted me, he said, ‘nobody should have to die like this’. And he was right. We 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.

In the wake of deaths from AIDS-related illnesses in their congregation and in the family and community of congregants, the clergy and lay leaders began to respond to HIV and AIDS differently. The participants reported that the needs of the congregants significantly impacted their decisions to develop and maintain a HIV Ministry. For example, one interviewee said, “we've got that pastoral heart, like we see the need and that's essentially how the ministry is supported. We recognized the need in the congregation, that okay people are being affected, they are being impacted, dying you know, we need some sort of support to address this.”

Lastly, participants also indicated that a liberation-based theology drove their desire to develop a HIV Ministry. One interviewee said, “well theologically we believe that Jesus calls us to engage those that have been marginalized in society. Biblically the idea, the disease of leprosy is actually very similar to the treatment of people who have HIV and AIDS and you can update that to our contemporary context so it's very clear that Jesus was calling to liberate those with leprosy and so its in the same motif that we're called to engage.” Another interviewee said, “We are very conscientious, a social justice focus church. And our foundation has been built upon the liberation concept, that concept of meeting people where they are.”

Discussion

The role of clergy in the development and maintenance of an HIV Ministry is significant in African American churches. In this study this role primarily involved educating the congregation and community on HIV and ensuring that the HIV Ministry was integrated into the congregation's framework for long-term support. In spite of the barriers faced from the larger African American religious community, the clergy's personal relationships with, and sensitivity to, the needs of congregants supported the development and long-term maintenance of an HIV Ministry in this African American church.

Few studies have examined the role of clergy and lay leaders in the development and maintenance of existing HIV Ministries, the barriers they faced or the supports that made the ministry possible. This information could prove to be invaluable in developing a framework with which to better understand this process. This understanding could provide a foundation to mobilize other clergy and lay leaders to become involved in HIV education, support and risk reduction. Because of the African American church's significant role in the African American community, their involvement in HIV is crucial.

This study has several limitations. Because of the small sample size, these findings cannot be generalized to the larger population. Additionally, the church belonged to a denomination that was open and affirming to homosexuality. This stance may have had significant impact in the leadership's ability to develop and maintain an HIV Ministry.

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.

Engaging clergy and lay leaders in dialogue regarding the development of HIV Ministries in a way that addresses their congregants' needs and is in keeping with the religious culture of their individual church. Preparing them for potential barriers and enabling them to recognize inherent strengths in their church and their leadership roles may also have significant impact on their decisions to become involved in HIV education, support and/or risk reduction.

Future studies should look at the role clergy and lay leaders can play in mobilizing other clergy and their churches in developing HIV Ministries in their own churches. Additionally, more research is needed on effective behavioral interventions that may influence clergy and lay leaders' beliefs, norms and attitudes regarding the development of HIV ministries in their churches. Because of the prominent role of recognizing individuals infected with HIV and AIDS, it may also be important to promote HIV testing and followup within the African American church which may further promote sensitivity to HIV-infected congregants and encourage the development and maintenance of an HIV Ministry. The results of this study reinforce the body of literature showing the prominent role of clergy and lay leaders in the development and maintenance of HIV Ministries. The roles clergy and lay leaders play in this process as well as the barriers they face and the supports to their effective involvement are vital to the future use of community organizations in the fight against HIV.

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