A Multi-Level Approach for Promoting HIV Testing Within African American Church Settings

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Abstract

The African American church is a community-based organization that is integral to the lives, beliefs, and behaviors of the African American community. Engaging this vital institution as a primary setting for HIV testing and referral would significantly impact the epidemic. The disproportionately high HIV incidence rate among African Americans dictates the national priority for promotion of early and routine HIV testing, and suggests engaging community-based organizations in this endeavor. However, few multilevel HIV testing frameworks have been developed, tested, and evaluated within the African American church. This article proposes one such framework for promoting HIV testing and referral within African American churches. A qualitative study was employed to examine the perceptions, beliefs, knowledge, and behaviors related to understanding involvement in church-based HIV testing. A total of four focus groups with church leaders and four in-depth interviews with pastors, were conducted between November 2012 and June 2013 to identify the constructs most important to supporting Philadelphia churches' involvement in HIV testing, referral, and linkage to care. The data generated from this study were analyzed using a grounded theory approach and used to develop and refine a multilevel framework for identifying factors impacting church-based HIV testing and referral and to ultimately support capacity building among African American churches to promote HIV testing and linkage to care.

Introduction

AN ESTIMATED 1 IN 32 AFRICAN AMERICAN women and 1 in 16 African American men will acquire HIV in their lifetimes.¹ Approximately 25–38% of this population are living with HIV and are unaware of their status.² Individuals who are unaware of their status transmit nearly 70% of new cases of HIV to others.^{2,3} In addition to promoting transmission of the disease, the avoidance of HIV testing also leads to many African Americans being diagnosed too late to receive the full benefit from life prolonging treatment.⁴ Furthermore, HIV testing and linkage to care is not only a high priority of the National HIV/AIDS Strategy (NHAS) for the United States but also complements the NIH's strategic plans for promotion of HIV testing and eradicating the HIV epidemic among African Americans.^{5,6} Therefore, early and routine HIV testing is an imperative first step toward addressing the disparate HIV incidence and prevalence rates among the African American population.

For this population, the African American church offers a potentially valuable inroad to improving HIV testing rates.

African Americans are markedly more religious than any other racial or ethnic group. With approximately 87% of African Americans reporting a religious affiliation and 79% reporting formal attendance,⁷ the African American church also routinely has access to a significant number of African Americans. The church has served as a venue for several effective health-related behavior change interventions.^{8,9} Although the church has been shown to have an active presence in the implementation of interventions to reduce obesity, screen for cancer, reduce diabetes incidence, and promote nutritional health,^{10–12} integration of interventions for HIV and AIDS in churches has been challenging.

Historically, the African American church embraced a conservative role and framed HIV infection as a moral rather than a health issue.¹³ This has contributed to the slow response to integrating HIV risk reduction interventions. Despite this history, the church has recently begun to take a more active stance in the area of HIV interventions by integrating HIV ministries and programs focused on HIV prevention, care, and support of people living with HIV and AIDS.^{14,15} A church-based approach is also in alignment

with the NHAS goal to involve the faith community in HIV risk reduction and promote non-traditional venues for HIV testing that have the potential to improve access and combat medical mistrust.⁵ Thus, the timing is ideal to begin the process of developing and implementing HIV testing and referral related interventions within African American church settings.

Factors impacting HIV testing

The most commonly cited barriers for HIV testing among African Americans includes: low perceived risk, mistrust of the medical system, and HIV stigma.^{16–20} Despite engaging in high-risk HIV related behaviors including substance use, concurrency, improper or non-condom usage, many individuals have perceived their risk for contracting HIV as low. This low perceived risk has been associated with African Americans not seeking HIV testing despite their actual risk profile.¹⁶

Mistrust has led to apprehension among African Americans about engaging the medical system.²¹ There is a lack of culturally responsive testing strategies that are effective in reaching and educating African Americans about HIV. Strategically combating the barrier of mistrust of the medical system can result in a sustainable increase in numbers of African Americans getting tested for HIV within environments that are comfortable for them. HIV-related stigma also has been shown to have an impact on HIV prevention, testing, disclosure, care, and treatment decisions.¹⁹ The effects of stigma can be compounded by perceptions of discrimination associated with race and/or social status, which in turn contributes to the cumulative effects of HIV related stigma on African American populations.

Factors impacting HIV testing in African American churches

Increasing numbers of studies have focused on HIV prevention efforts in African American churches. A framework with which to understand the process of integrating HIV prevention efforts into churches has been previously presented.²² However, the focus of this research is on HIV testing, rather than prevention, as very few studies have examined the factors that contribute to HIV testing in African American churches. Of those published, it was found that two things promoted HIV testing in church affiliated populations: their level of concern about their personal HIV risk, and their level of HIV knowledge.¹⁵

Perception of risk is vital in both church populations as well as in the African American community as a whole. And although basic knowledge of HIV alone does not often change behaviors, HIV knowledge may have a role in supporting HIV testing. There is an urgent need to develop a responsive framework and related strategies that have the potential to address the unique factors associated with promotion of HIV testing and linkage to care among the African American population with the African American church at the forefront of this effort.

Based on the literature, a guiding framework was developed. The framework focused broadly on the factors that were found to impact decisions to get tested for HIV. This framework guided the collection of the formative data and allowed us to explore the roles of several factors in making decisions about HIV testing in church settings. We explored the

following factors: low perceived risk, mistrust of the medical system, HIV stigma, and church-specific concepts of HIV knowledge and perception of risk for HIV. The framework was then further refined through focus groups and interviews.

Methods

This was a qualitative study, which explored the factors associated with church based HIV testing from the perspectives of pastors and church leaders who represented key stakeholders in program development and intervention implementation in their church. Churches with very different levels of involvement in testing were purposefully sought to better understand what motivates and sustains such efforts, as well as barriers or obstacles to such efforts across a spectrum of involvement.

Inclusion criteria for all four of the churches included: (1) black or African American membership of $\geq 60\%$ as identified by the pastor, (2) located in the city of Philadelphia zip codes with highest prevalence of HIV, and (3) pastor willing and able to provide a letter of support for church participation. We took additional efforts to recruit churches with varying levels of involvement in HIV testing. In addition to the aforementioned inclusion criteria for the four churches, we had additional inclusion criteria for each church.

The inclusion criteria for church 1 was that the church must be: (1) conducting routine HIV testing more than 3 times per year, and (2) HIV testing is conducted by a member or members of the church.

Inclusion criteria for church 2 that conducted HIV testing in partnership with an outside organization included: (1) conducting HIV testing more than once per year in an outside location, and (2) HIV testing is conducted by non-members of the church.

Inclusion criteria for church 3 with no HIV testing included: (1) have not conducted HIV testing within the church at any time during the church's history, and (2) considering integrating HIV testing into their church.

Inclusion criteria for church 4 that was resistant to HIV testing included: (1) have not conducted HIV testing within the church at any time during the church's history, and (2) leadership reports being against integrating HIV testing into their church.

Sample and recruitment

Churches were recruited via fieldwork in the African American church community and via attendance at community events, conferences, and forums. Pastoral and church member referrals were also used to identify potential churches for participation. These churches were then narrowed down to the churches that met the criteria for participation. Human subjects approval was obtained from the University's Institutional Review Board (IRB) prior to collecting data. Data collection occurred from November 2012 through June 2013.

Four interviews with pastors and four focus groups with church leaders were used to refine the impact of the aforementioned factors contributing to HIV testing and to generate a framework. Focus groups with church leaders, ($n=39$) and in-depth, semi-structured interviews with pastors ($n=4$) in four churches with varying levels of involvement in HIV testing were conducted. Interviews lasted approximately 1.5 h, while focus groups lasted approximately 2 h. Participants

were compensated \$40 for their time. Interviews and focus groups were done to get a more in-depth view of the process of integration of HIV testing into African American churches. Specifically, church 1 had “embedded testing,” which means that HIV testing was conducted within the church by leaders and was a part of the church’s overall mission. Church 2 participated in HIV testing in partnership with an outside organization. Church 3 had no testing in place but was supportive and ready to begin to incorporate it into their church. Church 4 also had no testing in place but was unwilling/unsure if HIV testing should be conducted in their setting.

All of these churches were located in Philadelphia, an urban city in Pennsylvania. The investigator constructed in-depth semi-structured interview and focus group guides in alignment with the proposed factors impacting HIV testing in the African American church setting. Open-ended questions pertaining to the barriers and facilitators to church-based HIV testing, and follow-up questions about linkage to care and treatment were also explored. In addition pastors and church leaders were asked to address barriers and facilitators to their readiness to integrate HIV testing and or linkage to care into their church.

Focus group and interview questions included but were not limited to: Describe the things that impact having HIV testing in your church? Tell me about the barriers (things that make it hard) and facilitators (things that make it easy) to have HIV testing in your church. What is the role of African American churches in HIV testing? What things were important to consider in designing a program to promote HIV testing in your church?

Procedure

Pastors were approached for participation. Once the pastor affirmed support of church participation, an interview with the pastor was scheduled. After the interview, the pastor identified church leaders to approach for participation in the focus group and acted as a liaison. Willing church leaders were screened and participated in a focus group. All participants consented to participate in the study. Interviews and focus groups were audio recorded and transcribed.

Data analysis

Data were analyzed using the principles of Auerbach and Silverstein’s grounded theory method.²³ In brief, the steps for this method included gathering the transcribed data that provided the raw text, which was then narrowed down to the text related to the specific social, organizational, and individual level HIV testing factors. We then focused analysis on the text, which addressed our aforementioned factors impacting HIV testing in the church. Groups of repeated ideas and themes stood out from this text. The themes were further grouped into more abstract ideas termed theoretical constructs. Next, the transcripts were analyzed to look at information that was not considered in our initial conceptualization of factors impacting HIV testing. Last, a summary of the relevant constructs was developed based on the themes that emerged relating to the proposed framework.

We took several steps to ensure the consistency of our results, including debriefing with participants to ensure that our findings were consistent with the perspectives of the participants and the use of two independent coders who compared findings and addressed discrepancies to reconcile

findings. We also required the lead investigator and research team to discuss findings collectively as well as individually documented biases that may have effected data analysis through reflexive journaling.

Results

Sample characteristics

Church 1 identified as Baptist, church 2 as non-denominational, church 3 as Pentecostal, and church 4 as Church of God in Christ (COGIC). All participants self-reported as black or African American. Pastors ranged from age 44 to 61 (mean age 48) and were all male. Participants in the focus groups ($n=39$) ranged in age from 19 to 74 (mean age 52) with 63% being female. The church leaders were identified by the pastor as being in leadership positions for health and HIV-related ministries, programming for adults and youth, and/or financial support positions for the church ministries and programs. Churches were similar in membership size with a high of 250 members and a low of 150.

The church-based multi-level HIV testing framework

Based on analysis of the data, a multi-level framework was developed to describe the factors likely to promote or discourage the development of HIV testing in African-American churches (Fig. 1).

Because barriers to African American church-based HIV testing exist at multiple levels, the framework proposes the social, organizational, and individual level factors that influence church-based HIV testing. A multi-level framework that examines the reciprocal nature of the relationships of the pastor, church leaders, parishioners, and the environment in which the church resides is critical. The framework not only examines this process but also explicates the nature of support for development of church-based interventions to promote HIV testing and referral efforts.

The framework described here presents three levels that impact church-based HIV testing. These multi-level factors are also impacted by church-specific contextual characteristics such as demographics, size, and denomination. The combination of these factors can influence a church’s approach and viewing of HIV testing. In other words, the impact of church demographics on the social, organizational, and individual factors work together to systematically influence an African American church’s readiness to adopt HIV testing.

The refined framework proposes that at the social level, factors such as social and racial discrimination and availability or access to care have impact. At the organizational level, leadership attitudes, capacity to support testing, and religious norms are key. Lastly, at the individual level, low perceived risk, general HIV knowledge, and mental health indicators such as stress, anxiety, or fear about results also impact church-based HIV testing. Because these levels all play a significant role, each deserves more detailed explanation.

Social factors

The World Health Organization (WHO) defines social factors as those things that effect how humans interact and relate to others.²⁴ There are several social level factors that impact HIV testing. Discrimination and access to testing

FIG. 1. Conceptual framework.

services were most important in this study. Experiences of discrimination can be amplified among African Americans due to a combination of racial, and/or social discrimination as well as the historical ramifications of medical maltreatment among African Americans.

Discrimination. Discrimination refers to the perceived experience of substandard treatment based solely on social and racial positioning. Social and racial discrimination was reported by the participants as experienced in clinical settings where HIV testing was offered and reinforced in the more general daily experiences of discrimination felt among African Americans. Too often, such experiences contribute to decreased healthcare utilization, and present a barrier to HIV testing, disclosure, and adherence to treatment for positive individuals. In this study, discrimination served as a significant barrier to HIV testing in clinical settings, contributed to feelings that these environments were cold and uncaring, and promoted greater utilization of the church as a preferred HIV testing site. Participants stated that the church played a socially supportive role in minimizing the effects of racial and social discrimination associated with decisions to get tested for HIV.

One participant, for example, stated, “a lot of people come here [to the church] because they don’t want to go to a clinic. The clinics weren’t designed for us. It’s very cold, not caring. Its like ‘okay you’re positive. Here are your papers, just go over there.’ But here you get warmth. Treating people different is not an issue for us.”

Discrimination had a significant role in decisions to get tested for HIV among African American church-going individuals as well as non-church going individuals in the surrounding community. Because of the widely-held view of the church as an institution where members of the African American community can go for social support, it seems to many to be a “safe place” to get tested for HIV. In short, as a pillar of the community, the African American church can provide an environment conducive to promotion of HIV testing, follow up and linkage to care.

Access and availability to care. Access refers to the availability, quality, and accessibility of HIV testing sites in communities at greatest risk. Access to HIV testing impacts routine HIV testing in a profound way. All of the churches that participated in this study were located within predominately African American communities with the highest incidence of HIV infection in the city. Many of the clinical HIV testing sites were located in the center of the city and not easily accessed by these populations. Thus, the churches provided HIV testing for the numerous African Americans that resided close to the church. In addition, the church provided testing availability during convenient days and hours of the week including Saturdays, Sundays, and evenings.

Being able to access testing services easily during nontraditional days and hours is important for promotion of testing. Easy access to transportation to the testing site is also pivotal. Because many churches are situated in communities at risk, they become convenient testing venues for church members and the larger community. As one participant stated, “To me, it’s an access point for getting tested in case you can’t go to the hospital or you feel uncomfortable... You’d be surprised how many people come here from different denominations, people that don’t even go to church, different faiths, all that.”

Providing wider availability of HIV testing locations that are trusted, respected, available during convenient times, and situated in high-need communities is an effective way to promote access. Clearly, the location of the church serves as a major facilitator in reaching at-risk communities for HIV testing. In addition, churches often have enough volunteer staff and church members to facilitate linkage to care by physically bringing HIV-positive individuals to an affiliated health care provider. In sum, the critical nature of access suggests that African American churches are poised to play a formidable role in increasing HIV testing within African American communities.

Organizational factors

An understanding of the organizational structure of the church provides the context for supporting meaningful and

sustained change. This study is unique in that it focuses on the pastor whose support is vital, and the church leaders, who are integral for promotion or intervention implementation. Enlisting the support of these leaders strengthens the acceptability and sustainability of HIV related interventions. However, other organizational factors—such as leadership attitudes, capacity, and resources available to support HIV testing, and religious norms—are also important factors to understand in order to promote church based HIV testing.

Leadership attitudes. The support of the church leadership was instrumental in this study in promotion of HIV testing. Initial support began with the pastor, was transferred to the church leaders, and trickled down to the congregants. Some participants expressed initial apprehensions about incorporating HIV testing into the church. Those churches without testing were very concerned about how leadership would view HIV testing uptake. In churches without testing, participants almost unanimously reported a need to address HIV in the church setting. However, they did not know how to broach the subject. Within the churches with testing, the pastor was the initiator of these efforts.

Within a church with testing in place, for example, one church leader participant stated “the good thing is our Pastor has a good influence in this community in regards to HIV and AIDS so it’s a trickledown effect. He has the face, he has the knowledge, and now he brings it to us and we’re able to have more knowledge and we’re able to take what he gives us and establish what we need to do for HIV in this community.” In other words, pastors have a prominent role in both their churches and their communities. Leveraging this to the benefit of promoting HIV testing has significant implications for the African American community.

On the other hand, within a church without testing, one participant stated, “This isn’t a one-man decision. Several leaders would have to come together to support it and figure out what role we’d have.” While another participant stated “to speak for the church we have to have direction from leadership before you make a stand for the church on HIV.”

These contrasting quotes illuminate the importance of supportive leadership attitudes in the integration of HIV testing. It also shows the need for dialogue to begin between pastor and church leaders about their attitudes towards HIV testing. A good point of entry is to encourage promotion of HIV testing with the pastor first, and encourage dialogue between the pastor and church leaders to begin to embrace this as an important issue to address in their community.

Capacity. Capacity, in this study included the available space, financial, and human resources needed to support testing. Of primary focus in this study was a space to test that is private to ensure the confidentiality of the individual being tested. Churches often had the space to accommodate HIV testing as well as a strong base of volunteers willing to facilitate testing. The primary barriers in regards to capacity often were related to redesigning this available space to support privacy and confidentiality, and supporting continual funding for purchase of HIV testing kits. Churches with testing in place were able to address these barriers easily. One participant in a church with testing stated, “We have the manpower, the trained persons, the confidentiality, the space. It makes it feasible.” However, in churches without testing in

place, finances to support testing were the most salient barriers. One participant expressed concerns about availability of private space, for example, but not about available volunteers, saying “um...volunteers. We do pretty good here as a church and with working together on different projects, so I think if we had the finances, and the private space we could do it [HIV testing]”.

As that last quote indicates, churches overall are well positioned in terms of manpower to accommodate HIV testing. The structure and culture of the church promotes the voluntary service of congregants. In this way capacity-related issues serve as facilitators to HIV testing for church settings. However, churches will have to make efforts to redesign space in order to protect client privacy and obtain the financial resources necessary to support HIV testing.

Religious norms. Religious norms, or patterned standard ways of interpreting and acting on religious beliefs, have a significant impact on HIV testing.¹⁴ In selecting churches with a range of HIV testing involvement, the study discovered various ways in which religious norms evolved. Religious norms often went through a process of transformation as churches transitioned from resistance to HIV testing to willingness to embrace testing practices. Religious norms and culture had to shift from viewing HIV as a result of morally and spiritually reprehensible behaviors, to viewing HIV as a health and/or social justice issue. From this perspective, churches with HIV testing were able to reframe religious norms to reduce HIV-related stigma and promote compassion. They were able to find religious and biblical support for pursuing a caring and compassionate approach towards HIV as a part of their spiritual purpose.

As one participant stated, “it has to be a growth. We started to hear, and started to learn and then started to grow. Okay, yes, there are certain behaviors but how do I respond with the grace of God? You as a Christian, your heart goes out to someone with HIV, so okay you stop and think. Are you ministering with love? Are you helping in love?”

Because of the spiritual beliefs that support the church’s role as an organization that cares for individuals, religious norms can be shifted to promote HIV testing, care and support of HIV positive congregants and community members. Many participants saw their efforts in HIV testing and risk reduction as a spiritual calling, further integrating these practices into the framework of the church.

Individual factors

Exploring the role of social and organizational factors is not enough to gain a comprehensive view of factors associated with the decision to get tested for HIV in a church setting. Social and organizational level factors provided the context for individual behavior in this study. Participants clearly articulated the role that individual-level factors played in decisions to get tested for HIV, both in terms of the experience of volunteers as well as in terms of the experiences of people tested. Individual level factors should also be considered in the development of church-based HIV testing promotion interventions.

Low perceived risk. Low perceived risk (the belief that one is not at risk for contracting HIV), served as a barrier in

promotion of testing. One participant, for example, stated, “you think it can’t happen to you. I think a lot of times in our own communities why people don’t respond in a way that you would think or a way you would hope [to offering HIV testing] is a lot of time they are misinformed or uninformed you know what I mean? HIV and AIDS, the whole thing.” The participants in this study, however, had the benefit of hearing perspectives from individuals who chose to get HIV testing and those who declined. Church leaders involved in testing often became advocates in promotion of HIV testing in their church, while in the community, and at work. In order to overcome the barrier of low perceived risk, participants provided information and education about HIV, which persuaded individuals to get tested.

Yet low perceived risk remains a barrier to HIV testing. Counseling and education on what constitute risk may impact an individual’s perception of their level of risk. It is important that this information comes from someone they perceive as knowledgeable and trustworthy in order to increase the perceived credibility of the messages about the need for routine HIV testing.

HIV knowledge. In general, there were some misconceptions of what HIV is, how it is transmitted, and some conspiracy theories among those participants in churches without HIV testing in place. These participants stressed their need for HIV education. There was also a strong desire to reinforce what was already known about HIV across all churches, regardless of their level of engagement in HIV testing. Churches without testing in place needed to dispel myths with training and knowledge. Those with testing in place needed additional information to keep up-to-date and to give correct information during testing, counseling, and advocacy.

One participant in a church without testing in place stated “I think the biggest barrier to dealing with HIV in church is knowledge and education, having an understanding. I mean the church has to be significantly undereducated in a number of HIV areas.” In other words, churches in general need education to overcome barriers to involvement in HIV testing.

Our study found that education on HIV, testing, risk reduction, and linkage to care in African American churches is needed. For those churches that already had HIV testing in place, there were responses from participants that indicated high levels of HIV-related knowledge. During interviews and focus groups, participants reported on HIV incidence and prevalence in their community, ways of transmitting HIV, symptoms, and populations at highest risk in their zip codes. However, there was still a desire for more extensive knowledge related to HIV. More significantly, for those churches without testing in place, it may be most valuable to provide a basic HIV education in order to dispel myths and promote willingness and comfort in integrating HIV testing into their church.

Mental health. Mental health-related indicators were reported to play a role in decisions to get tested for HIV, where to get tested, and responses to a positive result. Participants who engaged individuals that refused testing initially, reported that the fear and stress associated with a potential positive result was a formidable barrier. On the other hand,

the idea of getting tested in a church setting also had a comforting effect for individuals who preferred to hear a positive result within a setting that could provide immediate spiritual counseling and support.

Participants stated that the church was uniquely positioned as an institution that catered to the physical body as well as the mind and spirit. This promoted use of the church as a HIV testing site. As one participant stated, “I think that makes it [the church] a safe place. It’s such a touchy subject even today and to have somewhere, even if you come to church or not, that you feel comfortable with...which hopefully can draw more people to be tested. I think the counseling is very important to go along with the testing because sometimes people really aren’t ready for that information.”

Such statements from participants in this study supports the view of African American churches as uniquely positioned institutions that can address both mental health issues as well as physical ones. Because so many African Americans report that religious beliefs impact their behaviors and that the church is often utilized as a source of social support, integrating promotion of mental health into HIV testing efforts seems to be a natural fit for the church.

Discussion

The African American church is a valuable partner in promotion of HIV testing and linkage to follow-up care. Previous studies have indicated their important role in HIV prevention^{25–27} and the effect on the African American community around a variety of other health issues.⁹ Although other studies have developed frameworks for HIV prevention in faith settings,²² availability of frameworks to better understand HIV testing and linkage to care in faith settings is limited.

In alignment with other studies looking at HIV prevention or testing, the framework here incorporates the role of organizational factors such as pastoral leadership, religious norms, and HIV knowledge.²⁵ Although HIV stigma is often a significant issue of concern in faith-based HIV efforts, it was not a salient theme among the participants. It is possible that HIV testing is an easier entry point for African American churches to become involved in. A focus on elucidating the role of HIV stigma in HIV prevention versus HIV testing is a valuable direction for future research in this area.

The potential to integrate mental health promotion into church-based HIV testing adds to and builds upon other findings as well. The fear, stress, and anxiety associated with a potentially positive result may need to be explored further as a primary mental health-related barrier to HIV testing in church settings. This has significant implications to practice as it supports the engagement of health care professionals both within the church and in partnership with it. Further research can focus on how to leverage the skills of congregants for long-term sustainability of HIV testing and counseling, as many African American churches often have a strong base of volunteers who are also health professionals willing to serve in HIV testing in their churches.

This framework also considers the impact of discrimination and access to care. Few frameworks have taken this multilevel approach in church-based HIV risk reduction. Integrating in the role of social level factors in particular is an important area to explore further particularly in low income

communities or communities with high rates of HIV. This framework can provide a foundation for this exploration and also be used to develop interventions to promote HIV testing and linkage to care.

The results are limited by the small sample size and may not be applicable to other church settings. Because each church is not representative of African American churches as a whole, we cannot assume the findings will be applicable to African American churches in other geographical locations, for example. Despite these limitations, this framework provides a valuable starting point for development of multi-level interventions to promote churches' involvement in HIV testing and linkage to care.

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