Published in final edited form as:

J Health Care Poor Underserved. 2015 February ; 26(1): 211–222. doi:10.1353/hpu.2015.0017.

A Developing Framework for the Development, Implementation and Maintenance of HIV Interventions in the African American Church

Jennifer M. Stewart, PhD, RN

Johns Hopkins University School of Nursing, Department of Community Public Health

Abstract

The African American church has promoted the health of African Americans through supporting interventions that target a wide variety of diseases, and it is a crucial community partner in the development of HIV prevention interventions. Although research has described the development of church-based HIV interventions, there is a significant lack of frameworks and approaches available to guide the implementation and maintenance of HIV interventions within church-based settings. A developing framework of a comprehensive church-based intervention, derived from an ethnographic study about the development, implementation, and maintenance of an HIV/AIDS Ministry within an African American church is presented. This approach can provide guidance to support the development, implementation, and maintenance of HIV interventions in faith settings.

Keywords

Religion; African American; AIDS; HIV; implementation; sustainability

The rate of HIV and AIDS among African Americans is extremely disproportionate to the numbers of African Americans in the U.S. population. Although African Americans represent approximately 14% of the total U.S. population, nearly half of all new HIV cases are among African Americans.^{1,2} African Americans accounted for 56% of deaths due to AIDS in 2011, and their survival time after diagnosis is significantly shorter than survival time for other racial and ethnic groups.²

The African American church provides an important community-based organization to combat HIV and AIDS. African Americans are markedly more likely to attend a church, pray regularly, and report themselves as very religious, in comparison with other racial and ethnic groups.³ With 84% of the Black American population reporting a religious affiliation, the church is a viable venue for reaching a large number of Black Americans. The African American church has played a prominent role in social and political spheres of African American lives since its inception.^{3–5} Studies of the impact of religion indicate its positive influence on the health behaviors of many African Americans across the U.S.^{4,5} Church-based health promotion interventions have been shown to be effective in numerous health

problems including: weight reduction for urban African American women at risk for diabetes;⁶ hypertension prevention and weight loss for African American men and women;^{7,8} and in increased breast cancer screening among rural African American women.⁹ Few frameworks, however, provide guidance for the process of developing, implementing, and maintaining comprehensive HIV interventions in African American churches. There are far fewer church-based HIV interventions and almost none that address the full gamut of prevention, testing, care and support of HIV infected African Americans.

Many church leaders and congregants become more involved in HIV efforts once they recognize the impact of HIV on their congregations, and communities.^{10–14} Despite this recent trend, there is a striking lack of frameworks that address the constructs vital to the entire process from development to maintenance. Additionally, to date none of these programs have addressed the HIV continuum from prevention, to testing, to care of AIDS-infected congregants.¹

In order to move forward to HIV prevention, testing and care the church may need to make several changes within their organization. There are several models that deal with organizational change,^{15–17} particularly in health care settings. Key factors to consider in this process include a needs assessment, encouraging ownership of proposed programs, providing technical assistance, and taking into account the role of organizational culture and climate. Barriers to effective organizational change include lack of time, cost, and poor leadership.^{15–17} These findings provide information about potential factors that may affect a church's ability to make a change in favor of developing HIV programs and interventions. However, the process of organizational change within faith-based organizations, particularly African American churches is understudied. The role of religion and doctrine, the unique leadership structure of churches, and their historic negative stance on HIV pose formidable challenges.^{18–21} A foundation on which to build interventions to promote HIV risk reduction in African American Churches is needed to move forward in level of engagement in HIV and support capacity building.

The purpose of this paper is to help developing a framework of the process of development, implementation, and maintenance of a Church-based HIV program (see Figure 1). Strategies that can be used to promote development, implementation, and maintenance of comprehensive HIV programs that address prevention, testing, and care and support. This approach is informed by data from an in-depth, qualitative, ethnographic, naturalistic study of this process in an African American church in an urban setting.

Development of Church-based HIV programs

A number of studies have focused on pre-development (descriptions of barriers and facilitators) and development of church-based HIV programs. The pre-development descriptive studies primarily explored the barriers to development of church-based HIV programs. The most prominent barrier found has been the desire for HIV messages to be in alignment with the religious belief of promoting abstinence.^{14,22,23} Other significant barriers included the pastors' reported lack of knowledge and inexperience in discussing HIV related

topics,^{22,23} stigma against people living with AIDS and against homosexuality,^{21,24,25} and some clergy's beliefs that their congregations and communities were not at risk.²⁶

Few studies addressed facilitators to development of HIV related interventions in African American churches. Of those that did, the following supports were found: (1) outspoken congregation members' desire to talk about HIV, STIs, and unintended pregnancies, (2) clergy who were willing to support HIV programming, (3) assistance from congregation-based nurses and health professionals as well as outside organizations, and (4) the close involvement of the congregation in developing and implementing the interventions.^{19,20}

Existing church-based interventions and programs are generally focused on HIV prevention, promotion of HIV testing, or providing support to HIV positive individuals. Comprehensive interventions that addressed all of these areas (including prevention, testing, linkage to care, and care and support of HIV positive individuals) were not well represented. The development studies were largely qualitative,^{23,24} used a community based participatory approach,^{25,27} and focused on the adult population.^{22,25} However, very few of the reports about development of interventions used a theoretical framework or model to guide the design of their programs.

Implementation and maintenance of Church-based HIV interventions

Proper planning for implementation has a significant impact on the health outcomes of the population and the sustainability of the interventions. Yet, few studies have looked exclusively at the implementation of church-based HIV interventions. Therefore, a framework, which provides direction in this phase, is essential. The literature specific to implementation of HIV risk reduction interventions in African American church settings is limited. The existing research on supporting factors for implementation emphasizes the importance of consultation with key stakeholders and the provision of options that allow for a tailoring of interventions to fit the unique religious culture of each church.^{25–27}

Maintenance of African American church-based HIV interventions is also seldom addressed. However, maintenance is vital in the effort to enhance public health impact. This gap in the literature makes it difficult to evaluate or sustain these programs in other faith settings. The framework presented in this paper may prove useful to maintaining and sustaining church-based HIV interventions. The African American church used for this study is unique in that its HIV/AIDS Ministry has been in place for over 20 years. In addition the church took a comprehensive approach to HIV risk reduction not often found in the literature by providing HIV prevention, testing, linkage to care, housing, care and support for HIV infected individuals in the congregation and surrounding community.

While other churches in the studies mentioned above focused exclusively on prevention or treatment, the church in this study addressed the HIV continuum. The framework presented will provide best strategies for development, implementation and maintenance of interventions or “programs/ministries” in African American church settings from the perspectives of the community members first hand. Here a note on terminology may be relevant. Congregants used the term “ministry” to represent the program they developed to

address HIV and AIDS. In an attempt to best describe this phenomenon from the perspectives of the participants we will use the word “ministry” forward.

Methods

Design and sample

In this qualitative ethnographic study, data were gathered via in-depth semi- structured interviews of pastors, lay leaders, and congregants (n=9), congregant surveys (n=50), observations (n=7), and review of documents (n=9) of the church and ministry over a year. Interview participants were those involved in the development, implementation, and/or maintenance of the HIV/AIDS Ministry in the church. To obtain the richest data, we intentionally chose a large church (with a membership of 8,854) that was predominately African American (97.5%) and located in an urban setting (where the median income was \$43,201) and which had an unusually long standing HIV Ministry. Prior to the beginning of the study approval was obtained from the University of Illinois IRB as well as a written letter of support from the pastor of the church.

Data collection

Data collection began with interviewing the pastor who referred us to other key stakeholders that participated in the development, implementation, and maintenance of the HIV/AIDS Ministry. Specifically, interview participants included the pastor, pastor emeritus, associate pastor, lay leaders and HIV Ministry leadership (both past and present) that had key involvement in the process. Of these participants, the pastor emeritus, and two lay leaders were involved in development (remaining developers were deceased or unreachable due to relocation). The remaining participants with the exception of the current pastor (who was only involved in maintenance) were all engaged in both implementation and maintenance. We ended the interview process when we had met with all the available individuals with insight about the HIV/AIDS Ministry.

During the interview phase, we concurrently began to attend church services, forums, HIV/AIDS Ministry meetings, and other pertinent events for non-participant and participant observations. This was followed by a review of accessible documents, including the church and ministry history and doctrine, mission statements, training manuals, brochures, bulletins and newsletters. Finally, we approached a random sample of congregants for a brief survey about their knowledge of the HIV ministry to obtain their ideas about maintenance.

Interview questions, observations and the review of documents focused on the multiple domains of intervention development, implementation and maintenance. Specifically, we asked participants about the barriers and facilitators at each stage, as well as their beliefs, attitudes, norms, and acquired knowledge;^{28,29} what internal and external challenges they faced; and lessons they learned.

Analysis

Analysis began with the transcripts of audio-recorded interview data. The interview data and data collected from notes on the observations were analyzed in accordance with Auerbach

and Silverstein's grounded theory coding method.³⁰ We began with the transcripts, memos, and field note texts, which were narrowed down to the text specifically in relation to development, implementation and/or maintenance. This text was searched for repeated points from which themes were gleaned. Through a detailed and iterative process, these themes were further narrowed down to form theoretical constructs pertaining to the research concerns and integrating the narratives and words of the participants. Following initial analysis, an outside prepared researcher also confirmed results. This multi-staged analytic approach was taken to ensure that the story of the development, implementation, and maintenance of the HIV Ministry was described in depth in the words of the participants.

Results

The HIV Ministry of this church, as mentioned earlier, is unique in that it has been in place for over 20 years. The records revealed that females comprised approximately 72% of the current ministry membership. The HIV Ministry provided multiple HIV and AIDS related services including monthly HIV/AIDS educational sessions and forums. It also provided HIV testing 2–3 times per year with immediate linkage to care for positive results. The HIV Ministry also conducted HIV related outreach events and trainings in the surrounding community and other churches and offered housing and counseling for HIV and AIDS infected individuals. Lastly, they provided condoms and educational brochures at a resource booth every month following church service with hands-on, skill-based guidance on how to prevent contraction of HIV. Overall, several themes emerged that distinguished each stage of development.

Phases of development, implementation, and maintenance

Development—The development phase refers to the preliminary planning process that the pastor, church leaders, and congregants underwent to create the HIV Ministry. This ministry was initiated in partnership with the pastor emeritus and several church leaders. The three key themes that emerged which supported the development of the HIV Ministry included: promoting leadership support, building necessary infrastructure/resources, and promoting education.

Leadership support—Leadership support was crucial in the development phase. Pastors have significant power and impact in their churches and often in the surrounding community as well. The support of the church leaders is also important, as they lead implementation of programs. During the development of the HIV Ministry, the pastor gained more knowledge of HIV and AIDS and saw the potential which addressing HIV could have in serving the needs of the congregation, their families and communities.

The pastor of the church assembled a leadership team that devoted their volunteer efforts to the development of the HIV/AIDS Ministry. Many of these individuals credited the pastor as being the “visionary” and a “pioneer” in supporting the ministry, stating that it would not have been developed without his support and belief in its importance... One individual stated, “I think that the church needed and wanted to do it [develop the HIV/AIDS Ministry], but the Pastor Emeritus wanted to do it most.” Support from both the pastor and

church leaders was critical because they implemented the day-to day activities to develop and later implement the HIV Ministry.

Building Infrastructure: establishing collaborations and partnerships—Steps that were taken to garner necessary resources for the development of the HIV Ministry included seeking out information and collaboration from local AIDS Service Organizations (ASOs), the local department of public health, and congregation and locally based health care providers and psychologists. These individuals and organizations were able to provide educational materials, trainings, HIV testing kits, condoms and other necessary resources, as well as consultation on the logistics of development. It was also at this stage that the team decided that these efforts would be solidified in the development of a HIV Ministry. By creating this infrastructure within a ministry context, the church began the process of planning for the long-term maintenance of the ministry as a part of the church for the long term instead of a temporary program.

Collaborations and partnerships were essential. Steps were taken to adapt and/or modify materials to fit within the faith context and to build a team of congregants that would be trained to lead and later implement the program. The church already had substantial space to accommodate any HIV related forums or events and donated financial resources to begin development of the HIV Ministry.

Promotion of education—Obtaining education about HIV and AIDS demystified the disease among the leadership and congregation. Both the pastor and the leadership team sought extensive education about HIV and AIDS during the development phase. They reached out to experts in the field of HIV and AIDS including, but not limited to, researchers, physicians, nurses, psychologists, members of the department of public health, and individuals infected and affected by HIV and AIDS. One participant stated, “We got doctors, we got nurses, social workers, people that have HIV and developed a 20-hour training. We didn't know much on our own.” Becoming educated about HIV and AIDS by these individuals demystified the disease and helped to dispel myths, which reduced levels of HIV stigma among the leadership and church community.

During the process of education they also found that many of the congregants who were previously silent were able to comfortably disclose their HIV status and receive the subsequent support of their church. Education contributed to another essential step in the development of the HIV Ministry, which was affirmation of individuals within the church living with HIV and AIDS. This led to openness to individuals regardless of sexual orientation, behavior, or drug use.

The leadership team developed a comprehensive required training that was completed by the pastor, leadership team and any future members of the leadership prior to participation as a HIV leader in any capacity. This 20-hour training process was conducted on every Saturday over a two-month period. Each session was four hours long and mandatory. Sessions began by covering the definition of HIV and AIDS, the history and virology of HIV/AIDS, immunology and components of the immune system, HIV testing, stages of HIV infection, current HIV medications, and treatment plans. This was followed by education about

transmission, the infection process, HIV/AIDS prevention, and HIV/AIDS and its effects on women and children. The next session covered the social and psychological aspects of AIDS and the last session included training in pastoral and spiritual care of individuals with HIV/AIDS. This required training was later made available to the larger congregation in a more general form *via* educational forums and seminars.

In sum, the process of development required input and agreement on multiple levels of the organization: the pastors, church leaders, and congregants. As the church began to transition to implementation of the HIV ministry, the congregation provided unified support of the HIV ministry and its mission.

Implementation

The primary factors that supported the implementation were capacity building and enlisting the support of the congregation.

Internal and external capacity building—Planning for implementation included building on the infrastructure that was created in the development phase. First, the education, resources, and key outside contacts were made available to the larger congregation. In this phase, key opinion leaders in the church—both members of the HIV Ministry as well as members of other ministries within the church—voiced active support of the HIV Ministry. This support included forging intra-church collaborations with the women's, men's, and youth ministries. An associate pastor was also assigned to facilitate long-term church funded financial support and integration into the congregation.

The HIV Ministry actively engaged funding agencies through applying and obtaining funding from the city and foundations to provide additional financial support to fund housing, provide medication, employment, linkage to care and support groups for HIV and AIDS infected individuals. This was an indicator that intrinsic buy-in had been established and not imposed on the church. The impact of the HIV Ministry was expanding, and the availability of resources magnified their commitment to HIV and AIDS

Congregational support—As the HIV Ministry was gaining more exposure within the church, the support of the congregation was essential. Because the support of the pastor, church leaders, and other key opinion leaders within the church had already been garnered, much of the congregation was willing to support the implementation of the HIV Ministry as well. This openness to change and innovation helped to allay some of the concerns on the leadership's part as to whether or not the development and implementation of the ministry would cause congregants to leave the church. One interviewee said, “I think we all felt that we were doing something that was important” and summed up the “congregation's attitude” with the phrase, “Somebody has to care.”

Throughout this phase, the notion of the importance of HIV education continued to be reinforced as essential to the support of the Ministry. Additionally, the church leadership and general congregation began to transition to viewing themselves as pioneers in this endeavor, which added to their enthusiasm and commitment to the HIV Ministry. Finally, a driving commitment to and compassion towards individuals living with HIV and AIDS was noted,

as many congregants reported during the implementation phase that they, in fact, had close friends or family that had been affected by the disease.

Maintenance

The two key factors that supported the maintenance of the HIV Ministry included integrating the ministry into the church culture for the intent of long-term maintenance and establishing a sense of responsibility for the ministry among church leaders.

Integration—Integration included reframing the doctrine to emphasize compassion and social justice, normalizing the HIV Ministry into the church routine, and continual reinforcement and public support by the leaders. Many African American churches have experienced difficulty in bringing their religious beliefs and doctrine into alignment with support of HIV and AIDS efforts. This church, however, chose to place the emphasis on the role of Jesus in encouraging compassion, love, and acceptance of all individuals. This promoted inclusiveness within the church. By reframing religious doctrine to emphasize social justice, compassion, and service to the underserved the religious culture shifted from reinforcing stigma and judgment to integrating the ministry and providing support for long-term maintenance.

The church also worked to integrate the ministry by continually normalizing their activities and integrating them into the church routine. This included frequent seminars and workshops sponsored by the HIV Ministry, posters, and a monthly resource booth as a part of the weekly routine. By the maintenance phase, the pastor originally involved in the development and implementation had retired and been replaced by a new pastor who also promoted the HIV Ministry's integration by regular reinforcement of their activities and publically voicing his support. These included announcements by leadership at weekly church services and integrating HIV prevention, care and support messages into weekly sermons and Bible studies. Most strikingly, the pastor even allowed the congregation to witness him being tested for HIV at one service.

All these efforts created a very visible and strong presence of the HIV Ministry, which is now well known throughout the community, city and state. The new pastor summed up the success of the maintenance process at this church by saying, “The HIV Ministry has been a continual tradition at the church. It has been a model program. It is in line with the teaching of the church over the years. The core values were already set in place before I got here. The hardcore work had already been done. So it's a part of the culture now. It's expected.”

Ownership—The established team of HIV Ministry volunteers assumed leadership of the ministry and its progression and maintenance. They were allowed to have authority over the day-to-day workings of the ministry, were provided with funds from the church budget to plan events and other activities to support the ministry. As part of multiple ministries within in the church, the HIV ministry followed the same policies and procedures as other ministries, further establishing the ministry as a part of the culture and mission of the church. One participant stated, “I think the ministry is a very active and thriving ministry. We have worked as a congregation to own it and embrace those members that are struggling with understanding or accepting their loved one that has been diagnosed.”

Discussion

Approximately 79% of African Americans report regular church attendance.³ In addition, the majority of African Americans report religion as very important in their lives.³ This provides evidence of the number of individuals that could be reached through the church and the significant impact the church could have on HIV related behaviors. Though African American churches are vital to the fight against HIV and AIDS in the African American community, there is a gap in available frameworks that can be used to promote development, implementation, and maintenance of comprehensive HIV interventions within the African American Church. The framework presented in this paper provides the strategies needed to engage African American churches in urban settings and promote the sexual health of their congregation and surrounding communities for the long-term. Scientists often develop interventions and programs in isolation from the communities that implement them. We should consider, however, the knowledge to be gained from community members and organizations that have had a long-standing role in program development and maintenance and look for ways to support and extend the reach of their work.

As noted earlier, church-based HIV interventions, programs and ministries are often developed without a guiding framework or framework. However planning for maintenance from the beginning stages of development and implementation is critical to long-term sustainability. Although not explicitly stated by participants, integrating HIV efforts into an HIV Ministry within the church involved planning and the engagement of key stakeholders. Promoting compassion approaches were pivotal to engagement of the key stakeholders as many individuals revealed they had members of their family or friends living with HIV and AIDS.

Though some frameworks and approaches in the research literature have described factors contributing to development of HIV interventions, the Church-based HIV Development, Implementation and Maintenance Framework identifies key factors that influence the implementation and maintenance of HIV programs in African American churches. This includes promoting intra-church collaborations, enlisting the support of the congregation, intentional integration of medical knowledge about prevention, testing, and care into the culture of the church, and fostering ownership of this initiative among church leaders and volunteers.

Consistent with the literature, this framework also shows that programs and interventions that take into account the church's preferences and structure early in the process is key.^{23–25} A community-based participatory research (CBPR) approach that engages the key stakeholders throughout the process, having a team within the church that is invested in supporting the program or intervention, engaging in internal and external collaborations to support the process, providing education to dispel HIV myths and stigma, promoting affirmation of HIV and AIDS infected individuals among pastors, church leaders and congregations, and framing HIV and AIDS messages within a faith context are the key factors that play important roles in the development and implementation of church-based HIV programming.^{19–25}

Limitations of this study include that it was a non-randomized study of a single church, which limits generalizability. Additionally, a portion of the data consisted of information that was collected via retrospective self-report and may be biased. However, the richness of data that was garnered over a period of time focusing on the HIV Ministry from development to maintenance may provide a foundation future studies may build upon.

Future research should seek to test the proposed framework in the African American church or focus on the development, implementation, and maintenance phases individually. Increasing the study of how evidence-based HIV prevention interventions are implemented in church settings on a broader scale is also important. Additionally, the lack of research about maintenance and sustainability of church-based HIV programs warrants further study. With the significant role the African American church can play in public health, particularly for African Americans, it is vital to have models to guide development of effective interventions that have the potential for long-term sustainable impact on the HIV epidemic. The Church Based HIV Development, Implementation and Maintenance Framework contributes to a continuing and necessary dialogue about the development, implementation and maintenance of church-based HIV interventions and ministries.

Acknowledgments

This research was supported by Award Number (5T32NR007964), Health Disparities Training Grant from the National Institute of Nursing Research and the Johns Hopkins Center for AIDS Research (1P30AI094189).

References

1. Center for Disease Control and Prevention. HIV among African Americans. National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, Division of HIV/AIDS Prevention; Atlanta, Ga: 2011. Available at: <http://www.cdc.gov/hiv/topics/aa/index.htm>
2. Kaiser Family Foundation. Black Americans and HIV/AIDS. Kaiser Family Foundation; Menlo Park, CA: 2013. Available at: <http://kaiserfamilyfoundation.files.wordpress.com/2014/05/6089-11-black-americans-and-hiv-aids.pdf>
3. Pew Forum on Religion and Public Life. U.S. Religious Landscape Survey. Pew Forum on Religion and Public Life; Washington, DC: 2008. Available at: <http://religions.pewforum.org>
4. Lincoln K, Taylor R, Chatters L. Correlates of emotional support and negative interaction among older Black Americans. *J Gerontol B Psychol Sci Soc Sci*. Jul; 2003 58(4):S225–33. <http://dx.doi.org/10.1093/geronb/58.4.S225>. [PubMed: 12878656]
5. Chatters LM, Taylor RJ, Bullard KM, et al. Spirituality and Subjective Religiosity Among African Americans, Caribbean Blacks, and Non-Hispanic Whites. *J Sci Study Relig*. Dec 1; 2008 47(4): 725–737. <http://dx.doi.org/10.1111/j.1468-5906.2008.00437.x>. [PubMed: 21052481]
6. McNabb W, Quinn M, Kerver J, et al. The PATHWAYS church-based weight loss program for urban African-American women at risk for diabetes. *Diabetes Care*. Oct; 1997 20(10):1518–23. <http://dx.doi.org/10.2337/diacare.20.10.1518>. [PubMed: 9314627]
7. Oilman MJ, Thomas JC, Taylor KB, et al. Short-term impact of a church-based approach to lifestyle change on cardiovascular risk in African Americans. *Ethn Dis*. Winter;2000 10(1):17–23. [PubMed: 10764126]
8. Sutherland M, Hale C, Harris GJ. Community health promotion: The church as partner. *J Prim Prev*. Dec; 1995 16(2):201–16. <http://dx.doi.org/10.1007/BF02407340>. [PubMed: 24254754]
9. Erwin DO, Spatz TS, Stotts RC, et al. Increasing mammography practice by African American women. *Cancer Pract*. Mar-Apr;1999 7(2):78–85. <http://dx.doi.org/10.1046/j.1523-5394.1999.07204.x>. [PubMed: 10352065]

10. Agate LL, Cato-Watson D, Mullins JM, et al. Churches united to stop HIV (CUSH): A faith-based HIV prevention initiative. *J Natl Med Assoc.* Jul; 2005 97(7 Suppl):60S–63S. [PubMed: 16080459]
11. Lindley LL, Coleman JD, Gaddist BW, et al. Informing faith-based HIV/AIDS interventions: HIV-related knowledge and stigmatizing attitudes at project F.A.I.T.H. churches in South Carolina. *Public Health Rep.* Jan-Feb;2010 125(Suppl 1):12–20. [PubMed: 20408383]
12. Marcus MT, Walker T, Swint JM, et al. Community-based participatory research to prevent substance abuse and HIV/AIDS in African-American adolescents. *J Interprof Care.* Nov; 2004 18(4):347–59. <http://dx.doi.org/10.1080/13561820400011776>. [PubMed: 15801550]
13. Tesoriero JM, Parisi DM, Sampson S, et al. Faith communities and HIV/AIDS prevention in New York State: Results of a statewide survey. *Public Health Rep.* Nov-Dec;2000 115(6):544–56. <http://dx.doi.org/10.1093/phr/115.6.544>. [PubMed: 11354338]
14. McNeal C, Perkins I. Potential roles of black churches in HIV/AIDS prevention. *J Human Behav Soc Environment.* 2007; 15(2–3):219–32. http://dx.doi.org/10.1300/J137v15n02_13.
15. Heward S, Hutchins C, Keleher H. Organizational change—key to capacity building and effective health promotion. *Health Promot Int.* Jun; 2007 22(2):170–8. Epub 2007 May 11. <http://dx.doi.org/10.1093/heapro/dam011>. [PubMed: 17495992]
16. Durlak JA, DuPre EP. Implementation matters: a review of research on the influence of implementation on program outcomes and the factors affecting implementation. *Am J Community Psychol.* Jun; 2008 41(3–4):327–50. <http://dx.doi.org/10.1007/s10464-008-9165-0>. [PubMed: 18322790]
17. Stetler CB, McQueen L, Demakis J, et al. An organizational framework and strategic implementation for system level change to enhance research-based practice: QUERI series. *Implement Sci.* May 29.2008 3:30. <http://dx.doi.org/10.1186/1748-5908-3-30>. [PubMed: 18510750]
18. Beadle-Holder M. Black churches creating safe spaces to combat silence and stigma related to AIDS. *J African Am Stud.* 2011; 15(2):248–67. <http://dx.doi.org/10.1007/s12111-011-9159-0>.
19. Stewart JM, Dancy BL. Factors contributing to the development of an HIV ministry within an African American church. *J Assoc Nurses AIDS Care.* Sep-Oct;2012 23(5):419–30. Epub 2011 Dec 31. <http://dx.doi.org/10.1016/j.jana.2011.09.008>. [PubMed: 22212914]
20. Brown EJ, Williams SE. Southern rural African American faith communities' role in STI/HIV prevention within two counties: an exploration. *J HIV/AIDS Soc Serv.* 2005; 4(3):47–62. http://dx.doi.org/10.1300/J187v04n03_05.
21. Harris AC. Sex, stigma, and the Holy Ghost: The black church and the construction of AIDS in New York City. *J African Am Stud.* 2010; 14(1):21–43. <http://dx.doi.org/10.1007/s12111-009-9105-6>.
22. Khosrovani M, Poudeh R, Parks-Yancy R. How African American ministers communicate HIV/AIDS related health information to their congregants: a survey of selected black churches in Houston, TX. *Mental Health Religion Culture.* 2008; 11(7):9. <http://dx.doi.org/10.1080/13674670801936798>.
23. Hicks KE, Allen JA, Wright EM. Building holistic HIV/AIDS responses in African American urban faith communities: a qualitative, multiple case study analysis. *Fam Community Health.* Apr-Jun;2005 28(2):184–205. <http://dx.doi.org/10.1097/00003727-200504000-00010>. [PubMed: 15778632]
24. Leong P. Religion, flesh, and blood: re-creating religious culture in the context of HIV/AIDS. *Soc Relig.* 2006; 67(3):295–311. <http://dx.doi.org/10.1093/socrel/67.3.295>.
25. Berkley-Patton J, Bowe-Thompson C, Bradley-Ewing A, et al. Taking it to the pews: a CBPR-guided HIV awareness and screening project with black churches. *AIDS Educ Prev.* Jun; 2010 22(3):218–37. <http://dx.doi.org/10.1521/aeap.2010.22.3.218>. [PubMed: 20528130]
26. Merz J. The role of churches in helping adolescents prevent HIV/AIDS. *J HIV/AIDS Prev Educ Adolesc Children.* 1997; 1(2):10. http://dx.doi.org/10.1300/J129v01n02_05.
27. Coyne-Beasley T, Schoenbach VJ. The African-American church: a potential forum for adolescent comprehensive sexuality education. *J Adolesc Health.* Apr; 2000 26(4):289–94. [http://dx.doi.org/10.1016/S1054-139X\(99\)00097-X](http://dx.doi.org/10.1016/S1054-139X(99)00097-X). [PubMed: 10734276]

28. Mehan, H.; Wood, H. The reality of ethno-methodology. Wiley Inter-science; New York, NY: 1975.
29. Dorr-Bremme DW. Ethnographic evaluation: a theory and method. Am Educ Res Assoc. 1985; 7(1):65–83.
30. Auerbach, CF.; Silverstein, LB. Qualitative data: an introduction to coding and analysis. NYU Press; New York, NY: 2003.

Author Manuscript

Author Manuscript

Author Manuscript

Author Manuscript

Figure 1.
Church based HIV Development, Implementation and Maintenance Model (CHDIM).

<u>Development</u>	<u>Implementation</u>	<u>Maintenance</u>
Building Infrastructure - Resources - Outside agency connections - Development/adaption of HIV and AIDS materials for faith based context	Capacity Building - Build on existing infrastructure - Support involvement of key opinion leaders - Actively engage collaborators via forums, and workshops etc.	Integrate - Reframe doctrine to emphasize compassion and social justice - Normalize HIV Ministry activities (integrate into church routine) - Continual reinforcement and public support by leaders
Leadership Buy-In - Create a leadership team - Provide leadership with HIV/AIDS education - Promote affirmation of individuals living with HIV and AIDS	Congregation Support - Openess to change and innovation - Ongoing educational opportunities to dispel HIV related stigma - Commitment and passion	Ownership - Allow HIV Ministry to have authority - Promote ministry as a model program

Figure 2.