Published in final edited form as:

J Relig Health. 2016 April ; 55(2): 631–640. doi:10.1007/s10943-015-0068-8.

Readiness to Implement HIV Testing in African-American Church Settings

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Abstract

HIV and AIDS continue to impact Black Americans at disproportionately high rates. Promotion of HIV testing and linkage to care is a national health imperative for this population. As a pillar in the Black community, the Black Church could have a significant impact on the promotion of HIV testing within their churches and surrounding communities. Churches, however, have varied levels of involvement in testing. Furthermore, little is known about how to assess a church's readiness to integrate HIV testing strategies into its mission, much less how to promote this practice among churches. This qualitative study used interviews and focus groups with pastors and church leaders from four churches with varying levels of involvement in HIV testing to identify key stages in the progression of toward church-based HIV testing and linkage to care. Findings showed that churches progressed through levels of readiness, from refusal of the possibility of HIV interventions to full integration of HIV testing and linkage to care within the church.

Keywords

African-American; HIV/AIDS; Church; Readiness; HIV testing; Implementation

Introduction

African-Americans are the racial/ethnic group most affected by HIV. Although African-Americans represent 14 % of the US population, they accounted for a staggering 44 % of new HIV infections in 2012 (Centers for Disease Control and Prevention 2011, 2012). African-American men represented 31 % and African-American women accounted for 57 % of new infections that year (Centers for Disease Control and Prevention 2011, 2012). Philadelphia has one of the highest rates of HIV transmission in the USA. Between 2007 and 2011, there was a total of 1740 newly diagnosed HIV cases in Philadelphia, with 66 % of the cases effecting African-Americans (Philadelphia Department of Public Health 2012). Furthermore, many African-Americans continue to receive a diagnosis of advanced HIV disease less than a year after diagnosis, suggesting that they have been HIV positive and unaware of their status for 5–10 years (Cohen et al. 2010; Marks et al. 2005, 2006). To

combat HIV's impact, early and routine HIV testing is vital to increase prompt diagnosis and linkage to care (The National HIV/AIDS Strategy 2010).

Community-based venues have become a recent strategy for engaging more African-Americans in HIV testing (Dorell et al. 2011; Kahn et al. 2003). It allows for larger numbers of individuals to be tested and can reduce the discrimination and mistrust associated with HIV testing in clinical settings (Halkitis et al. 2011; Nunn et al. 2011; Laveist et al. 2000). Community-based organizations have also produced some of the highest positive rates for new HIV diagnoses making them a venue with high returns on investment of resources (Kahn et al. 2003).

The African-American church, in particular, is a critical venue to involve in HIV testing for African-Americans. Research shows that 79 % of the African-American population attends church at least once a week (Pew Forum 2008; Chatters et al. 1999; Lincoln and Lawrence 1990). Use of the African-American church would dramatically increase testing behaviors and identification of positive individuals (Berkley-Patton et al. 2010, 2012). Given the significant impact of religion and the church on African-American lives, church-based HIV testing promotion can also facilitate a reduction in HIV stigma and routinize HIV testing among the African-American community (Holt and McClure 2006).

Although some African-American churches are already vital community partners in HIV testing, not all churches have been open to incorporating HIV testing into their ministries (Stewart and Dancy 2012). While great inroads have been made in African-American church involvement in HIV prevention and other risk reduction approaches (Pichon et al. 2012; Griffith et al. 2010; Lindley et al. 2010; Brown and Williams 2005; Hicks et al. 2005; McKoy and Petersen 2006), church-based HIV *testing* in comparison is by no means widespread (Berkley-Patton et al. 2013). Furthermore, there is a paucity of literature that examines characteristics of the churches that elect not to be engaged in HIV testing and linkage to care. A way of assessing readiness to implement HIV testing, as well as the differences between churches that are able to integrate testing and those that are not, is crucial to advancing scientific knowledge on implementation of interventions and public health. In short, researchers need an in-depth understanding of the varying levels of readiness to participate in HIV interventions that characterize different churches.

In this study, we sought to understand churches that are resistant to the integration of HIV testing, as well as churches that are open to implementing testing. We also examined churches that facilitate HIV testing through partnerships with outside organizations and those that have embedded HIV testing within their churches independently. We focused on two research questions: (1) What factors support church readiness to implement HIV testing, and (2) what factors served as barriers to implementing HIV testing in churches. Understanding the factors that shape these differing levels of commitment to intervening in the spread of HIV will shed light on effective ways to promote widespread HIV testing.

Methods

Research Design

A qualitative research design was used to explore the factors that contributed to readiness to engage in HIV. This method allowed for an in-depth study of the process as well as the barriers and facilitators to African-American church-based HIV testing. The product was an in-depth understanding of a “continuum of readiness” ranging from resistant to a fully integrated HIV testing effort within the church. The data were collected from interviews with pastors ($n = 4$), and focus groups with church leaders ($n = 39$) across four churches.

Setting and Sample

Churches were selected from an urban community in Philadelphia. We purposely chose churches that resided in one of the top two zip codes with the highest incidence of HIV. Churches were matched on certain demographic characteristics including size of the membership and age of the church. To qualify as a predominately African-American congregation, pastors had to report a Black or African-American population of 60 %. This purposive sampling strategy yielded participants from the Baptist, Church of God in Christ (COGIC), Pentecostal and non-denominational religious organizations.

The churches also differed widely in their involvement in HIV testing. Church 1 did not have HIV testing and was largely unwilling to address HIV in any fashion. Church 2 did not have HIV testing, but was responsive to the possibility of integrating HIV testing into their setting. Church 3 conducted HIV testing in partnership with an outside organization. Lastly, Church 4 had HIV testing embedded into the church. This meant that HIV testing was a part of the mission statement of the church, was conducted by trained church members and the pastor on a weekly basis, and was part of the church’s reputation in the surrounding community.

Data Collection

Data collection occurred during the period from December 2012 to June 2013. In order to be eligible for the pastor interview, the participant had to identify as the head pastor of the church, be over the age of 18, and be willing and able to provide informed consent. In order to be eligible to be interviewed as church leaders for the focus group, participants had to be identified by the pastor as church leaders that would have input on the promotion of HIV testing, or directly involved with HIV testing. They also had to be age 18 or over and able to provide informed consent.

The study employed a purposive sampling strategy. Churches were recruited via four strategies: (1) recruitment from a local HIV/AIDS conference attended by the research team with flyers, (2) referrals from individuals attending other local African-American churches, (3) pastor referrals, and (4) street outreach via approaching churches in the zip codes with the highest HIV incidence.

A semi-structured guide was developed for both the interviews and focus groups and sought information on the social, organizational, and individual level barriers and facilitators to

readiness for church-based HIV testing and treatment. The interview guide included, for example, questions such as: What steps would you need to take or what steps did you take to be ready to integrate HIV testing in your church? Tell me how leadership attitudes and religious values impact readiness to offer HIV testing in the church? Tell me how discrimination impacts HIV testing in the church? What barriers and facilitators did or do you face in preparing for HIV testing in the church?

Following IRB approval from the University of Pennsylvania, pastors were approached, informed about study, and screened for study participation. If the church met the criteria for participation, the pastor was asked to provide written consent for participation in an interview.

Upon completion of the interview, the pastor identified and facilitated introductions to church leaders who were also asked to participate in the study. Once informed about the study's purpose and after providing written consent, the church leaders were asked to participate in a focus group that took place in their church at a mutually agreed upon day and time. The principal investigator or research staff conducted all interviews and focus groups. Focus group size ranged from 6 to 11 participants and lasted 90 min on average. Interview and focus group participants were all compensated \$40 for participation. All interviews and focus groups were audio recorded and transcribed. Once transcription was complete, all identifying materials were stripped from the transcribed documents.

Data Analysis

The analysis of the data was managed through the use of the qualitative software package, NVivo9 (NVivo 2012). We use an inductive approach to our content analysis. Our initial aims were explored in depth. Conventional content analysis was used to analyze the data (Mayring 2000). Content analysis focuses on the characteristics of language as communication with attention to the content of contextual meaning of the text and is designed to provide a subjective interpretation of the content of text data through the systematic classification process of coding and identifying themes or patterns. It is particularly valuable because it draws on the actual subjects' own words and ideas to generate the themes and patterns. This approach yielded greater understanding of the differing characteristics of the churches and their corresponding stages of readiness.

We began this iterative process by immersing ourselves in the transcribed data. The interviews and focus group transcripts were read repeatedly, and the portions of the text most relevant to our research aims were highlighted. The highlighted text was then re-read word by word to derive codes. Thus, initial coding was derived directly from the text. The codes captured the key thoughts and concepts most salient to the question of readiness to incorporate HIV testing into the church setting. These codes were then sorted and compared to one another across churches. We further narrowed down the codes to identify a theme unique for each church. This generated a key principle that was reflective of the church's characteristics and readiness as described by the participants.

Results

Sample Characteristics

The churches represented a diversity of denominations including Baptist (Church 1), nondenominational (Church 2), Pentecostal (Church 3) and Church of God in Christ (COGIC) (Church 4). Pastors ranged from age 44–61 (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 (see Table 1). All participants self-reported as Black or African-American. The pastor identified the church leaders as being in leadership positions for: health and HIV-related ministries, programming for adults and youth, and/or roles in financial support of ministries and programs. Churches were similar in membership with an approximate high of 250 members and a low of 150.

Themes

Overall, in the churches with HIV testing in place, church leaders and pastors spoke in great detail and accuracy of HIV as a disease and related HIV knowledge. There was also more reporting of feelings of compassion toward people infected with HIV and AIDS and a focus on love rather than condemnation. Churches without HIV testing focused more on the obstacles to integrating it into their church, which included a desire for more training and education, and several statements that were interpreted as potential indications of association of HIV with homosexuality, stigma against homosexuality and fear. From our combined conversations, we were able to glean the most important themes in regard to readiness across churches.

Level 1: Negotiating Roles—The first stage of readiness, level one, was best exemplified by Church 1, which was definitively opposed to implementing HIV testing in their church. The key reason for their opposition was a lack of clarity for how to negotiate the roles and procedures for implementation of a secular, health-related intervention within a religious context.

There was a prevalent theme of uncertainty and a struggle with conflicting feelings on discussion of sexuality in church. They were not persuaded that as an entity focused on spirituality that they should play any role in HIV-related issues. They were also unsure of who within the church would lead these efforts if they chose to participate. Members of this church were apprehensive about the appropriateness of talking about health issues related to sexual behavior and how it could quite possibly contradict their religious teachings. Practical concerns, however, also drove their opposition. Their primary obstacle was lack of clarity about how church leaders and congregants would negotiate their roles. Would church leaders, for instance, be directly involved in HIV testing? Would the pastor provide approval or a dialog on HIV? What part would he play? One participant stated, “I’m not so sure what it would involve. I’d need more information to know how’d we’d fit in.” Similarly hesitant and looking for more support, another participant stated, “This isn’t a one-man decision. Several people would have to come together to support it [HIV testing] and figure out what role we’d have.” This gentlemen’s strong apprehension points to another barrier to implementing HIV testing in this church.

Level 2: Seeking Education—Church 2 represents the second stage of readiness, level 2, which was supportive of integrating testing. Unlike Church 1, this church was open to beginning church-based HIV testing. However, they felt they first needed additional knowledge on HIV and HIV testing. Much of the leadership felt HIV testing would not compromise religious beliefs, but they wanted additional information on how to make this goal a reality. One participant stated, “yeah its feasible but we need to know everything from A to Z; teach us so we can teach the other people.” The pastor stated,

I think the biggest barrier is knowledge and education, having an understanding. I mean the church has to be significantly undereducated in a number of areas. Do you follow what I mean? So I find this to be very much the case for HIV. [The myths] I guess have traveled down the line. We’re just used to just passing stories down. And it goes down the line through ten people and it’s something completely different. So I wouldn’t be surprised if there are a lot of people in my congregation who still think you can get it by touching someone or something like that.

An additional participant stated, “I’m not a doctor. And I don’t know... I would want someone’s hand in this who is knowledgeable, who is experienced and can tell me. I’ve never sat in front of a person who told me they’re HIV positive—short of my cousin—but not from a standpoint of being a church leader.” This remark reflects a dilemma shared by many in the church. Though they felt comfortable with discussing HIV around the family dinner table, they were unsure how to have an open discussion about HIV in church. As the participant explained, “I don’t know what that feels like. And I would want someone of experience in this particular area to tell us what to look for and what are some of the concerns people have, someone to help us along the way in learning and educating ourselves and others.” This church was able to get past the barriers faced in Church 1 through support and direction from the pastor. The primary barrier they faced was in feeling undereducated about HIV and HIV testing so that they could deliver accurate messages.

Level 3: Faith-Based, but not Church-Placed—Church 3 represents the third level of readiness. This church had testing in place through a partnership with an outside organization. The pastor and a small group of community leaders created a community-based organization CBO to provide HIV testing and linkage to care as well as other services to the surrounding community. Although HIV testing was not done within the church, some of the members were trained as certified and volunteered in the affiliated organization as HIV testers. The leadership in this church felt that having testing offered close to the church but not within the church would aid in the comfort of individuals in the neighborhood being tested while still maintaining an integration of faith elements.

The primary theme at this church regarding readiness was providing spiritually focused care and support via a church and CBO partnership. In knowing that the church was involved in HIV testing, both the CBO and the church provided a “safe zone” for getting tested and referral. One participant stated, “getting tested outside is very cold, [they] don’t care about us. In the church setting they show some love.” Another participant stated, “this area is one of the highest affected but this church is a safe place for the community. It’s a safe place to go which draws more people to get tested.” Another participant stated, “it’s giving back to

the community. Through my experience of testing here it's turning the tide. It's something where you're really giving back to the community."

This is an option in church-affiliated HIV testing. Testing can be done within an outside organization rather than in-house. However, in this church's case, they used the advantage of a different affiliated environment to expand their services and promote comfort.

Level 4: Activism and Influence in the Community—Church 4 represents the final level of HIV testing integration. In this church, testing was performed by the pastor and church leaders, whom were HIV testing certified. The church made an emphasis on HIV activism and influence on the surrounding community. This approach increased the reach and availability of HIV testing in their surrounding urban settings. In other words, this church's approach generated a local movement toward the eradication of HIV in their community.

This church was well positioned to make the greatest impact on HIV testing. They offered weekly testing, several HIV testing-focused events, and lead an annual community March for the Elimination of AIDS. The congregants and pastor took on the role of HIV activists and revealed their influence on not only the norms of the church but also the norms of the surrounding community. One church leader said, "Our pastor has a good influence in the community in regards to HIV and AIDS so it's a trickledown effect." Another participant stated, "We give them [people in the community] signs [about HIV and AIDS]. At this stage we are enlisting everyone as activists, put it in your windows, put it in your cars, make HIV testing a conversation piece. So they can become activists that way too." The pastor stated, "the Black church is... an anchor... a strong anchor in that it is the site where it [HIV testing] really needs to be done more and needs to be empowered to do it on a continuous basis. The churches...because actually it's still the trusted voice in the African-American community, is still where Black people feel that they're going to be taught the truth. And so we... we tell them the truth."

One participant stated that the church had "a ready volunteer base. That's an asset. And the church is a community-based asset. The church has relationships with others that can be pulled together around the common cause, generally through the pastor's involvements or through the involvements of members who may be in different kind of services and jobs in the city. The church has all of these resources, connections in the wider community that make it suitable. It's right there. [The church] Doesn't have to come into the commitment. We're already in. Folks have different views about the church, but yet if the church comes together and the church starts doing something for the cause of African-American people, the community will listen to their voice more so than listen to anybody else about HIV/AIDS."

This approach provided a way of reaching individuals in the surrounding community on a greater scale. In essence, congregants became HIV/AIDS activists that engaged at risk populations via the church as they go about their daily lives.

Discussion

In this study, we explored the salient themes at each stage of readiness for integrating HIV testing into church settings. This process began with negotiating roles, followed by the need for HIV education, partnerships with CBOs, and an integrated mission to reach the community. In alignment with other studies of barriers to HIV prevention and testing in churches, we found that barriers were focused on the religious implications of addressing HIV and the need for comprehensive education (Smith et al. 2005). Participants in our study added to the potential barriers their concern for protection of confidentiality.

With the prominent role of HIV stigma in studies of African-American churches (Brown et al. 2003), it was interesting to note the role churches had as “safe spaces” for HIV testing. In fact, community members actually felt more comfortable getting tested for HIV in church settings than in clinic settings. As a significant community institution that has 21,000 churches located throughout the USA (NAACP 2012), it is imperative that African-American churches leverage the trust of the community to become vital access points for HIV testing and referral.

Looking in depth at a church that was against HIV testing represents a gap in the literature, as many previous studies have worked with and presented churches that were willing to get engaged in HIV efforts. Our findings can provide recommendations to how to promote increasing church involvement in HIV. By beginning with reframing religious doctrine to support discussions of HIV, initiating a dialog between leaders and the pastor about their potential roles, and providing comprehensive HIV-related education and training, we may be able to develop strategies to promote engagement.

In taking a more naturalistic approach in the exploration of stages of readiness and common themes or levels of readiness, we were able to learn from the church communities and their recommendations for “best practices” in implementing HIV testing. This knowledge may assist in the development of culturally sensitive tools, which allow for the rapid assessment of whether certain African-American churches will be receptive and successful in integrating HIV testing into their venues. The role of the congregants as community educators and advocates has vital implications for community-based efforts to ameliorate the effects of HIV in African-American communities. Studies that further explore the role of congregants as peer educators in their church and surrounding community in regard to HIV are an important future direction.

This study is limited by its small sample size. However, the qualitative study design allowed for an in-depth exploration of the factors that support readiness for implementing HIV testing in African-American church settings. The implications are of value as church and the surrounding community members are often at risk for HIV. The ability to use churches as testing sites will expand the availability of testing, making it more routine and less stigmatizing.

In addition, this study can contribute knowledge on how to intercede at each level to promote moving HIV testing forward. Further research is needed to develop assessments and measures of church readiness in order to efficiently assess churches. Examining factors

that contribute to readiness to implement HIV testing quantitatively can provide scientific information on which churches to engage in HIV testing and which churches may be the most effective to use of time and resources. This is essential to developing strategies to engage African-American churches in promoting the integration of HIV testing and other risk reduction interventions into their cultural framework.

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Table 1

Participant demographics

	Church 1 (<i>n</i> = 12)	Church 2 (<i>n</i> = 11)	Church 3 (<i>n</i> = 12)	Church 4 (<i>n</i> = 8)
<i>Characteristic (%)</i>				
Gender				
Male	41.7	45.4	25	37.5
Female	58.3	54.5	75	62.5
Age				
18–25	16.6	24.6	0	0
26–35	10.9	8.2	11	40.8
36–45	18.2	13.1	27.8	39.2
46–55	20.0	36.1	5.6	0
>56	47.3	18.0	55.6	20
Residence				
Urban	69.1	68.9	44.4	59.1
Suburban	21.8	19.7	44.4	41.9
Rural	3.6	9.8	11.1	0
Religiosity				
High	80.4	45.9	76.5	84
Moderate	19.6	45.9	17.6	17
Low	0	8.2	5.9	0