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A Contextualized Approach to Faith-Based HIV Risk Reduction for African American Women

Jennifer M. Stewart, PhD, RN¹, Christopher K. Rogers, MPH², Dawn Bellinger, MS², and Keitra Thompson, BA, BSN, RN²

Jennifer M. Stewart: jstewa44@jhu.edu

¹Johns Hopkins University School of Nursing Department of Community Public Health, 525 N. Wolfe Street, Baltimore, MD 21205, phone: 410.614.1443

²Johns Hopkins University School of Nursing 525 N. Wolfe Street, Baltimore, MD 21205

Abstract

HIV/AIDS has a devastating impact on African Americans (AA), particularly women and young adults. We sought to characterize risks, barriers, content and delivery needs for a faith-based intervention to reduce HIV risk among AA women ages 18–25. In a convergent parallel mixed methods study we conducted four focus groups (n=38) and surveyed 71 young adult women. Data were collected across 4 AA churches for a total of 109 participants. We found the majority of women in this sample were engaged in behaviors that put them at risk for contracting HIV, struggled with religiously based barriers and matters of sexuality, and had a desire to incorporate their intimate relationships, parenting and financial burdens into faith-based HIV risk reduction interventions (RRIs). Incorporating additional social context related factors into HIV RRI for young AA women is critical to adapting and developing HIV interventions to reduce risk among young adult women in faith settings.

Keywords

faith; African American; HIV AIDS; women; young adults

Young African American women continue to suffer significantly from HIV and AIDS disparities. Currently an estimated 1 in 32 African American women will contract HIV in her lifetime (Centers for Disease Control and Prevention [CDC], 2015c). Additionally, the incidence of HIV infection resulting from heterosexual relationships among African American women is eighty-seven percent (CDC, 2015d). Younger populations are particularly at risk accounting for an estimated one-fourth of the AIDS diagnoses (CDC, 2015b). More specifically, compared to all persons under 64 years of age, persons ages 15–24 account for one-fifth of newly diagnosed HIV infections (CDC, 2015a). Currently, the

Conflict of Interests

The authors declare that there is no conflict of interest with respect to the research, authorship, and/or publication of this article.

Research Ethics

This study was approved by the University of Pennsylvania Institutional Review Board. Written consent was obtained from all research participants.

rate of HIV/AIDS diagnoses for black women is an astonishing 20 times greater than that of white women (CDC, 2012). These statistics are particularly relevant for young African American women, with AIDS being a leading cause of death among women ages 25–44 (CDC, 2015e), many of whom acquired HIV in their young adult years.

Leveraging all available community and individual assets to mitigate the impact of HIV among young women is crucial. One potential approach is the use of faith settings to promote HIV awareness, prevention, and testing. The prominent role of spirituality and the Black church in the lives of African American women is well known (Pew Forum on Religious & Public Life, 2015). African Americans report high levels of spirituality on a number of measures including prayer, devotion to God, and church attendance. Approximately 94% of Blacks report an association with the Historically Black Protestant (HBP) church (i.e. the “Black church”), and 79% of women report attendance at a HBP church (Pew Forum on Religious & Public Life, 2015).

The Black church provides an easily accessible and trusted institution in the African American community (Stewart, 2008). It has remained a pillar of the African American community for several centuries and has promoted several health related interventions (Sutherland, Hale, & Harris, 1995; Campbell et al., 2007). Historically, however, the Black church has struggled with the inclusion of HIV prevention as a part of its mission in the African American community. Integration of HIV into faith settings requires taking steps to overcome organizational barriers and leveraging facilitators. These barriers have included conservative religious norms, HIV and homosexuality related stigma, the desire to promote abstinence only (Coyne-Beasley & Schoenbach, 2000; McKoy & Peterson, 2006; McNeal & Perkins, 2007; Bluthenthal et al., 2012), the pastors’ reported lack of knowledge and inexperience in discussing HIV related topics (Coyne-Beasley & Schoenbach, 2000; McKoy & Peterson, 2006; Smith, Simmons, & Mayer, 2005; Beadle-Holder, 2011; Stewart & Dancy, 2012), and some clergy’s beliefs that their congregations and communities are not at risk (Marcus et al., 2004; McKoy & Petersen, 2006; Baldwin et al., 2008; Eke, Wilkes, & Gaiter, 2010).

Although few studies have addressed facilitators in the development of HIV related interventions in African American churches (Stewart & Dancy, 2012), several studies have cited the characteristics of churches that have been successful in developing HIV risk reduction interventions. Those characteristics include: pastoral support, churches with clergy and/or congregants who were willing to organize HIV programming, churches that received buy-in and assistance from congregation-based nurses, health professionals and community-based organizations, churches with close involvement of the congregation in developing and implementing the interventions (Stewart & Dancy, 2012; Brown & Williams, 2005; Coyne-Beasley & Schoenbach, 2000; Harris, 2010; Khosrovani, Poudeh, & Parks-Yancy, 2008; McNeal & Perkins, 2007), and churches that utilized multiple communication channels to disseminate HIV/AIDS information (Moore, Onsomu, Timmons, Abuya, & Moore, 2012).

To our knowledge, the literature is limited regarding faith based HIV risk reductions specifically for young adult women. The majority of research has focused on adolescents and HIV interventions. Interventions available for the adolescent population were often

exclusively abstinence based. Although spirituality is known to moderate the prevalence of adolescent risk behaviors (Regnerus, Smith, & Fritsch, 2003; Gannon, Becker, & Moreno, 2013), the data are mixed on the role of spirituality on risk behaviors in young adults, necessitating further investigation on their risk behaviors within a faith context. The available research on the risks, barriers, and needs for young adult women in faith settings has remained limited. African American churches are receptive to HIV risk reduction interventions which are designed or adapted in alignment with their church's culture and their unique religious needs (Wingood, Simpson-Robinson, Braxton, & Raiford, 2011; Stewart, 2014; Wingood et al., 2013). However, an assessment of the needs of young adult African Americans is required to develop interventions that can address these issues. The purpose of this study was to illuminate the needs, barriers, and facilitators to a faith based HIV risk reduction intervention for young adult women ages 18–25.

Methods

Design

This is a cross sectional mixed methods study. We surveyed and then conducted 4 focus groups (n=38) with young African American women and church leaders. We then surveyed congregants (n=71) exclusively. Data were collected from those individuals that would be most closely involved in implementing any intervention or program for young adults in addition to the young women themselves. Thus, 2 of the focus groups were conducted with church leaders (n=18) ages 18 and older, 2 focus groups with church attending young adult women ages 18–25 (n=20), and surveys (n=71) were conducted with congregants 18 years or older. Focus group participants were also surveyed. There were a total of 109 participants across 4 churches.

Sample

A purposive sampling strategy was used to recruit churches not yet involved in delivery of HIV interventions, programs, or messages of any kind. Churches were recruited via 3 strategies: (1) recruitment from a local HIV/AIDS conference attended by the research team, (2) referrals from individuals attending other local African American churches, and (3) pastor referrals.

Once a potential church was identified we approached the pastor first to obtain consent to conduct the study within his or her church. Once participation was agreed upon the pastor recommended meetings and gatherings of the church leadership and young adults from which the research team could recruit individuals to participate in the focus groups. If the participants met the eligibility requirement we obtained consent and they were enrolled into the study.

For collection of survey data, the pastor allowed the research team to make an announcement during Sunday service regarding the study. Participants were screened for eligibility following Sunday service and permitted to take the survey once eligibility requirements were met and they consented to participation. Focus group participants were compensated \$40, and survey participants were compensated \$20 for their time. The

inclusion criteria for the selected churches were that each church had to have a reported Black or African American population of 60%, the pastor had to offer his or her support of the church participating in the study, and the church could not have offered any interventions, programs or initiatives related to HIV. Churches were excluded if they had less than 30 young adult African American women, and/or were unwilling to provide verbal support (from the pastor) for participation.

Inclusion criteria for the church leaders included age 18 or older, pastor confirmed individuals in leadership positions, church membership for 6 months or more, and able to speak and read English. Exclusion criteria included in a leadership position for less than 6 months. Inclusion criteria for the young adult women included member of the selected church for 3 months or more, between the ages of 18 and 25, able to speak and read English. All participants self-identified as Black or African American. Data for this were collected between November 2012 and May 2013.

Focus Group Guides

In-depth, semi-structured focus group guides asked questions about HIV related risk behaviors, barriers and facilitators to the implementation of HIV interventions, and needs and preferences for an HIV risk reduction intervention for young adult women. Sample questions included: Tell me about some of the things young adult women in churches do that might put them at risk; What makes it difficult to have an HIV intervention or program in your church; What things would you like to see included in an HIV intervention or program at your church. All focus groups were conducted by an African American member of the research team at a mutually agreed upon time and private location within the church. Focus groups were audio recorded and professionally transcribed. Any identifying materials were then stripped from the transcribed documents. We used NVivo 9 for qualitative data management.

Survey

A paper survey was administered to the congregation by several members of the research team. This 38-item survey consisted of several items from validated scales as well as items developed by the investigators. Overall, it measured religiosity, HIV related risk behaviors, intervention needs, barriers, facilitators, content and delivery

Specifically we used all 20 items from the Intrinsic Extrinsic Religiosity scale (Gorsuch & McPherson, 1989; $\alpha=.83$) to examine religiosity and 12 items from the behavioral risk assessment tool (BRAT) developed by the CDC (Wisconsin HIV Prevention Evaluation Work Group, 2000) to examine HIV related risk behaviours. We also used 11 items based on the needs assessment to support HIV Ministries in churches developed by the *Balm in Gilead*—a non-profit organization in the state of Virginia in the United States—which has focused on equipping churches to address HIV and AIDS for over 20 years (Balm in Gilead, 2010). These items were measured on a 4-point scale with a low of 1 (low need) to 4 (high need). Five items were also developed by the investigators, which mirrored the qualitative items, and also included questions about potential topics of interest for the intervention and additional barriers, facilitators to HIV interventions for young women in church settings.

Items were constructed using a 5-point Likert scale (1- strongly agree, 5 strongly disagree). We developed these items based off of a review of the faith based HIV literature, extensive work and consultation with the population of interest.

Analysis

A convergent parallel design (Creswell, Klassen, Plano Clark, & Smith, 2011) was used to investigate risks, barriers, facilitators, content and delivery needs for faith based HIV risk reduction for African American young adult women. A convergent parallel design was employed in order to merge quantitative and qualitative data that were collected at the same time (Creswell et al., 2011). This design allowed for a fuller understanding of participants' experiences than employing either methodology exclusively. Qualitative and quantitative data were analyzed separately as outlined below. Findings were then mixed or merged to give a final interpretation of data. This gave us an in-depth and synergistic view of the phenomena of interest and the ability to see how the results converged or diverged.

Qualitative Approach

Qualitative inquiry has the potential to enhance the depth and relevance of findings. Listening to community members' desires for HIV risk reduction brings to light perspectives on these issues that researchers may not otherwise be aware of. The points of view represented by the voices that appear in the findings sections are essential to hear in order to shape interventions that resonate with this particular population.

We used a qualitative hybrid thematic analysis approach to analyze the data. This approach incorporated both a data-driven inductive approach (Boyatzis, 1998) and a deductive a priori template of codes approach (Crabtree & Miller, 1999). This approach complemented the research questions by allowing for themes to emerge directly from the data using inductive coding. The two focus groups with the church leaders and the two with the young adult women were analyzed separately by two coders, however, the same procedure was employed. Two coders from the research team independently pulled data from structural and content codes for thematic analysis. Both scrutinized the data line by line to systematically generate initial codes related to our research interest across the data set. The coders collated the codes into potential themes gathering all data relevant to each potential theme. From there, the coders and all research team members involved in qualitative data collection engaged in ongoing analysis to refine the specifics of each theme generating clear definitions and appropriate names for each theme. Inter-coder reliability was assessed throughout the coding process by comparison of codes independently generated by each coder, identifying discrepancies, and coming to consensus via research team discussions. Lastly, the two coders extracted quotes that related to and illuminated the research question.

Several steps were taken to ensure the trustworthiness of the qualitative data. Credibility was ensured by making visits to each church, and attending church services to develop a familiarity and understanding of the culture of each church. Thick detailed descriptions of the phenomena under study in the words of the participants were used. Upon completion of interviews and focus groups, member checks were done via provision of a summary of what was discussed during the session and asking if it accurately reflected what was said. Lastly,

during debriefings, the PI and research staff discussed beliefs, assumptions, and biases and how that might affect data analysis as results were iteratively and collectively found and confirmed as a group (Guba, 1981).

Quantitative Approach

We used SPSS 20 for quantitative data management. We summed the scores on the IERS and BRAT scales using the predetermined cut-point based upon the scoring system provided by the instruments to rank levels at high, moderate, or low. Items on the needs assessment and those generated by the investigators were analyzed individually with a focus on specific questions relating to intervention development.

Quantitative data were analyzed using descriptive statistics (i.e., frequencies, percents, means, and standard deviations). We analyzed the total sample (n=109) as well as separated out the data to analyze the total number of young adult women between the ages of 18–25 surveyed (n=25), the total number of church leaders (n=18), and total number of congregants (n=71) exclusively. This allowed us to compare findings across these different populations. At this point the qualitative and quantitative data were integrated. Each portion of the data were weighted equally. We used two primary strategies to merge the two sets of results: (1) identification of content areas represented in both data sets and compared, contrasted, and synthesized the results in a research team discussion and table, and (2) identified differences within one set of results based on dimensions within the other set and examined the differences within a display organized by the dimensions. We then discussed as a research team how the data merged, diverged, related to each other, and/or produced a more complete understanding (Guba, 1981).

Results

The majority of the quantitative sample was 18–25 (45.8%), female (84.4%), and single (48.6%). The majority were highly religious (90.3%) and reported that God had a significant influence on the way they acted (62.5%). The majority of the qualitative sample was also female (84.2), single (65.8%), and highly religious (76.3%). A reported 30 out of 38 focus group participants (78.9%) also reported that God had a significant influence on the way they acted. The church leaders' focus group was over the age of 56 (55.6%). Including the 20 women ages 18–25 that participated in the focus groups, there were an additional 29 women that participated in the survey only for a total of 49 women in that age range.

Risks

The majority of women 18–25 were sexually active (63.3%). The remaining portion (18 out of 49) had been abstinent for at least 6 months. Of the 49 young women who were sexually active, 61.9% had 1–3 partners in the previous 6 months, and 46.7% never used condoms when having vaginal sex.

Despite these facts, the majority of the total young adult women surveyed (62.5%) strongly agreed that their chances of getting HIV were small but felt that they should wait until marriage to have sex (55.6%). Fortunately, the majority of these women had also been tested for HIV in the previous year (59.7%). The qualitative data confirmed the aforementioned

results as several of the women stated that they were engaging in sexual activity. One young woman said, “In the church the reality is that it’s [discussions of HIV prevention] needed. Because there are a lot of young people in the church that are sexually active.” Another young woman stated, “I feel as though you can push abstinence and you can push safer sex, but safer sex is gonna actually get across cause 9 times out of 10 they’re having sex.” In the focus groups with church leadership, several individuals in each focus group mentioned that they assumed that many young adult women were engaging in unprotected sexual behavior but were undecided on how to address it. One church leader stated, “There are things that our young people are doing; [as young as] sixth-graders. There’s a lot of things going on we’re not blind. There is some teaching that needs to go on we need programs to come in and add that teaching to the scriptures.”

Barriers and Facilitators

Barriers—The most salient barrier to integrating HIV risk reduction for young adult women into faith settings was the conflict between delivery messages regarding abstinence versus safer sex with an emphasis on condom distribution. While 77.8% of the total sample (n=90) believed an abstinence based program would be a very good or good idea to integrate into their church, several participants in the young adult focus groups noted the difficulty in staying abstinent. One young woman stated, “I think staying abstinent is really hard for a Christian woman. Especially if your partner doesn’t want to be. Every day you going in that house and they say they accept it but they really don’t.” Despite this fact, 68% of the young adult women still reported that an abstinence based program would be a very good or good idea to integrate into their church. Church leaders, on the other hand, emphasized that abstinence was the most important approach to take but could be integrated with safer sex messages. For example, one church leader stated, “The action to take is abstinence. That’s what God expects is abstinence. But along with that I want there to be an understanding of how to protect yourself also, if you make a decision to do something that we didn’t teach you.”

There have been several studies indicating the difficulty of integrating HIV risk reduction into church settings due to doctrine and unspoken church rules (Brown & Williams, 2006; Stewart & Dancy, 2012). However, in this sample 62.7% of surveyed participants disagreed that a safer sex program would be against the churches’ rules. The young women felt that it was primarily the discomfort in talking about the reality of sexual practices and HIV risk that contributed to the lack of programming. One young woman stated, “People want to be ignorant to the fact. That’s a barrier. People are not comfortable talking about it [sex] — from truths coming out. But the pro is the help that could be offered and the knowledge that could come out of it.”

Church leaders on the other hand did recognize the potential challenge in incorporating HIV risk reduction into faith settings, particularly if it was being taught from the pulpit in a public setting versus a private one and regarding condoms specifically. One leader stated, “Most of the barriers would be the scriptures but for the most part teaching and showing of condoms. It would go against teachings in the word that we’re preaching. Privately I could

tell you [about condoms] but from a pulpit no. You'd need to be able to have confidence to talk to me or the youth leaders privately."

While congregants as a whole reported that the pastor would agree to support an abstinence program (55%) and to a less extent a safer sex program (37.3%), the qualitative results diverged from this finding. One young woman stated, "Everything about sex is kept a secret. It's a barrier cause older people don't know how to talk about it. Like even with my parents. They gave me the basics but I had to learn a lot of things on my own. That's why a lot of the youth they don't know stuff. We don't know stuff so we need someone to help us out so we don't just jump in there and do it."

Facilitators—The primary facilitators were a readiness and awareness of need, and the role of the church as an ideal location to integrate messages about the promotion of health. Results indicated that 44.6% agreed that their church was ready to implement an HIV intervention or program for young adult women. In addition, 51.4% agreed that there was a need for an HIV intervention in the church. Young women also confirmed the need for faith based HIV risk reduction programs stating, "We need people in church to spearhead this."

It was also clear that the integration of the promotion of sexual health seemed to be a natural progression of the churches' spiritual work. For example, young adult woman stated, "Because a church is like a hospital, it's like a place where people can come and get well and get knowledge on HIV so they're not ignorant. That's what we're supposed to be."

Content and Delivery

Participants gave several suggestions on the content and delivery of the intervention. Demonstration of condom usage was recommended by the young adult women. In addition, the majority of surveyed congregants felt that condoms and safer sex messages would be acceptable to cover (56.7%). Those that were in leadership, however, noted the difficulty in teaching about correct condom use and safer sex. To speak or teach condom use was akin to encouraging the young adult women to engage in sex prior to marriage, which was expressly discouraged. The pastor at one church stated it most clearly in saying, "We're not trying to give a free pass—just go out there [and have sex]. There needs to be a conversation where they understand we're not encouraging that."

Standard HIV prevention education was also requested as an element of a faith based HIV program by young women. One young adult woman stated, "We need to know what it is and how to prevent HIV from happening." In addition, participants stated they wanted information regarding where and when to get tested for HIV, and how to live as an HIV positive woman. "We need to know about the medications you need if you are HIV positive and steps you take to, you know, to keep healthy."

Interestingly the young women also requested that several additional topics be woven throughout the HIV risk reduction program, including issues surrounding the impact of HIV on pregnancy, negotiating safe sex and abstinence, and relationships as a single parent. For example, one participant stated, "Being a teen mom, there's a lot of young ladies our age with kids. So, STDs, HIV testing and education, pregnancy, and how a STI can affect the

baby coming out...how to have relationships and ask who they've [your sex partner] been with. We need to talk about all that." Church leaders, focused more on the safer sex aspect of education and appeared to be more comfortable with someone from outside the church giving those messages. Thus, several church leaders supported the idea of having someone from outside the church provide information and written materials with one saying, "they may not tell me about it but if we could put the outside person and material in front of them they could say 'if you're going to have sex then it should be safe sex'."

It may also be important to note the ramifications of lack of financial resources on sexual behaviors as many participants naturally began discussions of money and poverty in relation to HIV. One young woman stated, "You got other things to worry about too. Bills, money, financials, the stress of becoming an adult. Sometimes it gets overwhelming. Small things rack up you need things resources. It's hard to become an adult it's a shock like a smack. Juggling school and work with sex and relationships. Then HIV? It gets to be a lot."

For the structure of a HIV risk reduction intervention or program the majority of young adult participants recommended a monthly small and private group led by an approachable faith leader their age or slightly older. A young woman stated, "You should have a mixture of persons in your age range and someone slightly older who has been there and had some experience with HIV." They also emphasized that the groups should be engaging and interactive saying, "it should be every other month and always fun....maybe have incentives and giveaways to pull people in from the community. They might be coming from that but at the same time they're getting health information and spiritual information." Not surprisingly young adult women wanted to integrate their sense of spirituality into the intervention with one saying, "I would like to see information on HIV and spirituality. What God says about it."

Discussion

Overall, young adult women in church settings remain at risk for HIV. Both young women as well as their pastors and church leaders recognize the need to address sexuality and HIV within the church. Young adult women had a desire to discuss HIV and sexuality, but church leaders expressed a great deal of discomfort in speaking about it in public formats. As a whole, previous studies have indicated that individuals who report a religious affiliation and/or church attendance have exhibited lower levels of risk (Rasic, Kisely, & Langille, 2011). However, recent studies have indicated that religious young adults and non-religious young adults exhibit similar levels of risk behaviors (Hawes & Berkley-Patton, 2014). This indicates the need to incorporate HIV risk reduction interventions in a variety of sites indiscriminately.

Church leaders reported a greater acceptance of abstinence-based approaches within the church and great reservations in discussing HIV or sexuality. However, the majority of the congregants along with young adult women felt that discussions about HIV were needed and would be welcomed. This indicates some potential ambivalence towards HIV and safer sex messages in the church as a whole. Other investigators have indicated that safer sex interventions have not been readily accepted by churches (Wingood et al., 2013). However

our findings indicate that safer sex interventions may garner more acceptability in private settings rather than from the pulpit.

Interestingly, many of the young women indicated the importance of several other factors that they associated with HIV risk including parenting, negotiating sexual relationships with other partners, and financial stressors. Parenting provides an additional layer of complexity in the adaption and development of faith based HIV risk reduction interventions. It could have implications for reinforcing protective behaviors for the sake of one's children, as well as provide opportunities for HIV risk reduction messages to be delivered by mothers to their children and adolescents. Parenting is also a segue into relationship dynamics as young women may be sexually engaged with the father of their child(ren) and/or other partners. Previous research has indicated that the father of their child(ren) was the only sexual partner that women were willing to forgo condom use with (Nelson, Morrison-Beedy, Kearney, & Dozier, 2011). The importance of skill building in the area of negotiating safer sex has been indicated in previous HIV risk interventions (DiClemente & Wingood, 1995; Jemmott, Jemmott, & O'Leary, 2007). However, negotiating abstinence for young adult women often remains unaddressed. Abstinence may be a critical component in faith based HIV risk reduction interventions for young adult women as well.

The link between socioeconomic status and HIV has been found in several studies (Ickovics et al., 2002; Adler, 2006; Arnold, Raymond, & McFarland, 2011), and was spoken about by the young women in this study as well. Developing interventions that address the link between social factors, socioeconomics, and HIV are critical to the advancement of HIV risk reduction interventions for young adult African American women.

Existing evidence based interventions should be adapted to include the role of spirituality in many young adult African American women's lives, navigating sexual relationships with their children's father or other partner, how to negotiate abstinence, the role of social conditions and poverty on HIV risk, and medical management and diagnosis of HIV. Many faith settings are home to several health care professionals who can be instrumental to initiating programs and interventions to reduce HIV risk for education and awareness.

For young African American women, spirituality is still an important part of their lives and can influence their decisions regarding sexuality and HIV related risk behaviors. Health care practitioners can play an instrumental role in delivering culturally sensitive care and interventions that address the importance of spirituality in mitigating HIV risk. Integrating principles of faith can be an important approach to HIV risk reduction interventions. In addition, HIV risk reduction for young adult African American women should be situated within the context of their complex and multi-faceted lives. In other words, HIV risk reduction interventions for young adult women should also include topics related to pregnancy, single parenting, and economic stability that leads to financial security.

Based off of the findings several detailed recommendations for faith based HIV interventions for young adult women can be made. First, small, private groups co-led by their peers and an older woman with health care experience is an ideal approach. This would abate the conflict that many participants indicated in the ability for the church to both

maintain their public encouragement of abstinence and their private realization that many young women may be putting themselves at risk sexually. Second, interventions for young adult women must be religiously tailored. Because of the desire that both church leaders and young women expressed in regard to the importance of spirituality on their lives, a faith based intervention would resonate in a greater way with this population.

Third, it is essential to take a contextualized approach to HIV prevention for young adult women. This includes shaping messages within a social determinants of health perspective which addresses the ramifications of poverty, interpersonal relationships and networks and drug use on HIV risk. Lastly, young women indicated the need for more comprehensive HIV education. This includes more detailed information regarding diagnosis and management of HIV and AIDS.

An additional consideration is that of multi-tiered intervention approaches for African American churches at the leadership, target population, and congregant levels. At the leadership level it may be important to provide interventions focused on providing information regarding the importance of HIV prevention for young adults in the church and addressing doctrinal barriers may be of greatest use. Results indicated the need for HIV prevention messages but also the importance of not preaching safer sex messages from the pulpit. Because of some of the more conservative stances expressed by the church leadership one can assume that more private, detailed conversations on HIV and sexuality may best be done in small group settings with the target population and congregation.

Findings can be used in a variety of future research directions. Using the recommendations to develop and implement a faith based intervention for young adult women that encompasses their spiritual values, provides more in depth HIV education, and addresses the social determinants of sexual health could be a valuable approach. In addition, the design of multi-tiered HIV interventions for churches is an important consideration. Lastly, addressing the role of young adult men in the church and conducting further work on this population could be vital in the development of faith based interventions for young adults.

Health professionals can have a vital role in these interventions. Engaging nurses and nurse practitioners embedded in faith settings or local community based organizations in the implementation of faith based HIV risk reductions could fill some of the needs that many churches expressed in this study. Through the provision of education regarding HIV as a disease, testing, treatment, and adherence to care for young adult women, nurses can provide comprehensive preventative and self-management services to this vulnerable population.

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Table 1**Participant Demographics by Church**

	Church 1 (n=28) n (%)	Church 2 (n=23) n (%)	Church 3 (n=27) n (%)	Church 4 (n=31) n (%)
<i>Characteristic</i>				
Gender				
Female	23 (82.1)	19 (82.6)	23 (85.2)	27 (87.1)
Male	5 (17.9)	4 (17.4)	4 (14.8)	4 (12.9)
Age				
18–25	10 (35.7)	10 (43.5)	12 (44.4)	17 (54.8)
26–35	3 (10.7)	2 (8.7)	3 (11.1)	0 (0)
36–45	3 (10.7)	4 (17.4)	5 (18.5)	5 (16.1)
46–55	7 (25.0)	3 (13.0)	1 (3.7)	4 (12.9)
>56	5 (17.9)	4 (17.4)	6 (22.2)	5 (16.1)
Religiosity				
High	27 (96.4)	21 (91.3)	25 (92.6)	25 (80.6)
Moderate	1 (3.6)	2 (8.7)	2 (7.4)	5 (16.1)
Low	0 (0)	0 (0)	0 (0)	1 (3.2)