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Congregational Involvement in HIV: A Qualitative Comparative Analysis of Factors Influencing HIV Activity Among Diverse Urban Congregations

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Abstract

Religious congregations can potentially reach disproportionately affected populations with HIV programming, however, factors that influence congregational involvement in HIV are not well-studied. Utilizing comparative case methods and in-depth qualitative data from a diverse sample of 14 urban congregations, we examine a range of attitudinal, organizational, resource, and demographic factors to systematically identify different case scenarios—i.e., combinations of characteristics—associated with the level and types of HIV activities in which the congregational cases tended to be involved. For example, White or mixed race congregations with active gay constituencies and an African-American congregation with a strong lay HIV champion were among the high HIV involvement case scenarios, compared to African-American congregations with a health emphasis but no lay HIV champion among the medium HIV involvement scenarios, and fundamentalist African-American and Latino congregations among the low HIV involvement

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scenarios. Two key factors that appeared influential across case scenarios included the existence of lay champions for HIV activities and the general theological orientation of the congregation.

Keywords

United States; HIV; religious congregations; case studies; qualitative comparative analysis

INTRODUCTION

In the U.S., HIV disproportionately affects African Americans and Latinos (1, 2). Given the long-standing role of many religious congregations as sources of influence, social support, and services for critical needs such as food, education, and health (3, 4), these institutions could play important roles in helping reduce disparities in HIV burden, services, and stigma (5–8). The 2012 National Congregations Study (NCS) found that 87% of U.S. congregations provided social services either formally or informally (9), an increase from 58% in 1998 and 82% in the 2006–2007 NCS (3, 10). Further, 75% of African American and 59% of Latino adults state that religion is “very important” in their lives, compared to 49% of whites and 36% of Asians (11). Thus, congregation-based efforts to address HIV-related needs, especially among African Americans and Latinos, could be effective. However, analyses of 2006–2007 NCS data suggest that only 5.7% of congregations had programs that provide support to people with HIV, whereas 57.5% had some other health-related program, such as blood pressure checks or groups to help people with substance abuse problems (12).

The reasons for relatively low levels of congregational HIV involvement as compared to other health programs are not completely understood. Congregational size (often a proxy for resources) has been associated with involvement in social services programs in general (12, 13), and HIV programs specifically (14). Using the 2006–2007 NCS, Williams et al. (12) found that the number of adult congregational members was the only factor related to a congregation offering a non-HIV health program, but having a statement welcoming gays was the only factor related to sponsoring an HIV program. Thus, attitudes and perceptions such as stigma and perceived need likely drive congregational decisions around engaging in HIV activities. For example, in a survey of congregations in New York State, 41% cited opposition to homosexuality or bisexuality, drugs, alcohol, and condom use as reasons for not engaging in HIV program activities (14). Similarly, analyses of survey data from congregations in one metropolitan area found religious denomination to be associated with the breadth of HIV activities, but this relationship was mostly mediated by other social and community service factors, such as congregational racial/ethnic composition, urbanicity, and general service and health programs (15).

Among congregations that are involved in HIV-related activities, the factors explaining why they engage in certain types of activities versus others are also understudied. In addition to congregation-based HIV prevention interventions (16–24), congregations have been involved in providing social and material support to people living with HIV and engaging in awareness and advocacy efforts to reduce community stigma and facilitate access to treatment, housing, and other basic needs (25–27). A recent study based on the first NCS to

differentiate among types of congregational HIV activities found that nearly 9% of congregations offered prevention activities, while approximately 7.5% of congregations offered care and support activities, were engaged in awareness raising, or provided donations to other organizations for HIV activities (28). Congregational factors in the survey associated with these HIV activities, however, appeared to be limited and vary by type of activity.

Moreover, there has been little attention to the way that such factors interact for different types of congregations to produce varying levels of involvement in different types of HIV activities. For example, while support from both clergy and lay leaders may help stimulate HIV activities in a congregation, it is not clear whether one, the other, or both are important for sustaining congregational HIV activities. Also unclear is the degree to which theological orientations, such as religious denomination or emphasis on evangelism, affect the extent and type of a congregation's HIV activities, and how those orientations interact with congregational stigma towards people living with HIV. Understanding the contingent factors affecting the involvement of religious congregations in addressing critical, yet often stigmatized community health needs such as HIV has important implications for identifying which congregations are likely to become involved, the extent and variety of their involvement, and how congregations might most effectively be engaged in addressing HIV among congregants and wider communities.

In this paper, we utilize comparative case methods and in-depth qualitative case data from a diverse sample of urban congregations well suited to address these questions. In particular, we examine a range of attitudinal, organizational, resource, and demographic factors among this congregational sample using Qualitative Comparative Analysis (QCA), a cross-case method based on Boolean logic algorithms (29–31), to systematically identify:

1. Different case scenarios (i.e., specific combinations of factors) associated with congregations involved in high, medium, versus low levels of HIV activity, and
2. The types of HIV activities in which these congregational cases tended to be involved.

METHODS

Conceptual Framework

As described elsewhere (32), our study developed a conceptual framework comprising four dimensions that influence congregations' willingness and capacity to adopt, implement, and maintain HIV-related activities: 1) *Norms and Attitudes*, the extent to which congregations and the communities in which they are embedded provide social and cultural support for HIV activities; 2) *Organizational Structure and Process*, the compatibility of HIV activities with roles and practices within the congregation and other organizations it may interact with; 3) *Resources*, the financial, material, and human resources that can be mobilized from within congregations or wider environments to support HIV activities; and 4) *Demographics*, the ethnic/racial, sexual orientation, socio-economic, and health composition of congregations and community settings.

Case Study Design and Data Collection

We used a comparative case study design to explore congregational dynamics in depth, incorporate multiple sources of data and perspectives within congregations, and compare HIV activities across different types of congregations (33, 34). Our study team included six highly experienced investigators from diverse disciplines (e.g., organizational sociology, social psychology, public health). Two experienced investigators were assigned to each case and co-led the case study data collection for that case, supported by research assistants. Our team- and case-based approach aimed to develop rapport critical to eliciting information on a sensitive topic within close-knit communities (35). We also integrated several community-based participatory methods to improve our understanding of congregational contexts and dynamics around HIV issues, including on-going involvement of a community advisory board (CAB) that consulted on all phases of the research from study design to case selection, recruitment, and analysis (32).

Congregational sampling and case selection.—Our study focused on the three geographic areas within Los Angeles County that, according to county health department surveillance data, had the highest cumulative number of HIV cases per 100,000 population. Through interviews with community experts and other local sources, a brief telephone screening questionnaire of congregations (with a response rate of 88%) (32), and discussion with the project's CAB, we identified a purposive sample of 14 congregations that reflected variation on extent and type of HIV activities (the main outcomes for our two research questions), as well as other key congregational characteristics described above, including racial and ethnic profile of the congregation, religious denomination or faith tradition, and congregational size and resources.

Data collection.—We collected data during multiple visits over roughly a one-year period. Our methods are described in detail elsewhere (27); briefly, they include: 1) qualitative, in-depth interviews with clergy and lay leaders (n=57; 3-6 per congregation), covering congregational background and dynamics, involvement in health and HIV activities, denominational and congregational policies regarding HIV and HIV-related issues, leader and congregation attitudes, and community characteristics and collaborations; 2) a congregational information form with basic information about congregational denomination, membership, resources, and programs or ministries; 3) observations of religious services, health and/or HIV-related activities, and the facility and neighborhood context; and 4) review of archival information about the congregation and its health and HIV activities. All research protocols were approved by [AUTHORS INSTITUTION'S] Human Subjects Protection Committee.

Data Analysis

Within-case Analysis.—Team members assigned to each case created single case summaries that incorporated data from interview notes and the other sources to develop an overall picture of each congregation's involvement in health and/or HIV. The case summaries were validated by presenting them to leaders of the congregation in on-site feedback sessions.

Thematic Analysis.—Study team members also worked in pairs to perform extensive coding of interview transcripts to identify prominent themes that emerged across the congregation cases. This thematic analysis employed both content coding (36–38) and inductive approaches (39, 40) to identify new themes and sub-themes. [For further details on these methods, see (27)]. The thematic results have been reported extensively in previous articles (27, 41–45), and subsequently used to generate variables for the comparative analysis described below.

Comparative Analysis.—For this paper, four members of the study team (three senior members who had led case study analyses and a methodology expert) utilized data from across our sources to conduct a cross-case analysis of the relationships between the extent of HIV activities within our diverse sample of urban congregations and factors identified from our framework and prior analyses. For our main outcome variable, the *extent of congregational HIV involvement*, we used a categorization from a previous analysis that differentiated among congregations with low, medium, and high HIV activity based on the frequency of activities and the degree to which activities primarily targeted HIV and went beyond the typical pursuits of religious congregations. That analysis also categorized congregational HIV activities into three broad types: prevention and education, care and support, and awareness and advocacy [for detailed description of each of these types of HIV activities, see (27)].

We then reviewed the congregational case histories and qualitative themes identified in prior published analyses (41–45) to identify factors that emerged as explanatory variables. Indicators of these factors were coded for each congregational case and organized according to the four main dimensions of our conceptual framework, which were further grouped into related subcategories (see Table 1).

Under norms and attitudes, we derived several variables related to theological and spiritual orientations, as well as variables related to HIV and health. Theological and spiritual orientations included variables such as religious denomination, theological interpretation (e.g., taking a more contextual or historical versus literal or fundamental interpretation of scripture), orientations toward evangelism (from non-proselytizing to an imperative to convert and save others from damnation), and how faith motivates service to others outside the congregation (e.g., to help the poor or fix the world, to attracting others to one's faith by example of doing good, or explicitly using services as an opportunity to evangelize). Norms and attitudes related to HIV and health included such factors as clergy support of HIV activities, lay leader support of HIV activities, congregational stigma towards people living with or at risk of HIV, and the emphasis of the congregation on health issues prior to becoming involved in HIV.

Under organizational structure and process, we coded each congregation to the era in which it became involved in HIV according to Fauci's periodization of the epidemic, i.e., the early "dark ages" period (1981–86), the middle "pre-HAART" period (1987–96) and the later "HAART" period (1997–present) after the availability of highly active antiretroviral therapies (46). We also used results of a prior analysis that identified three *organizing models for HIV activities* within our case congregations, based on whether HIV activities

were contained within other health activities or were organizationally distinct (43), and another analysis that distinguished different forms of HIV collaborations with different types of external organizations (42).

Under resources, we included an indicator for *congregational size*. For demographics, we included the predominant *race-ethnicity* of the congregation. For both these dimensions, we considered other factors that emerged in our prior analyses, such as having congregational members with health professional expertise (resources) or the proportion of members that did not reside in the congregation's neighborhood (demographics), but we did not have sufficient data to code these indicators for all congregations.

We employed Qualitative Comparative Analysis (QCA) with this case-by-indicator dataset to systematically identify combinations of factors associated with the extent of HIV congregational activities. QCA, a technique based on Boolean logic algorithms, differs from standard linear statistical methods in that it allows for different combinations of factors (which we refer to as *case scenarios*, also referred to by others as *pathways* or *recipes*) to be associated with different values of an outcome (29, 31, 47). Thus, we developed separate QCA models for congregations that had high, medium, and low levels of HIV activities. We used the R statistical software package (48) to compute "crisp set" QCA algorithms, which require all indicators to be dichotomized. In addition, we constrained the consistency parameter (a measure from 0 to 1 indicating the degree to which cases that follow the same pathway also share the same outcome) to 1.00, in order to ensure distinct pathways across the high, medium, and low activity models. In such crisp-set models, the coverage parameter (a measure of the frequency of a given pathway to an outcome) is calculated simply as the number of cases in each pathway divided by the total number of cases in the model with that outcome (49–51).

As part of the QCA method, we performed a process of model refinement both to hone which variables to include in the analysis and to "calibrate" those variables, i.e., determine the proper categorization of values for an indicator (52). This process included conducting separate models of variables in each domain (i.e., theological and spiritual orientations, HIV and health-related attitudes, organizational structure and process) to identify factors that were either most commonly associated or appeared to differentiate sites with respect to having a particular level of HIV congregational activity. As a result, certain variables were combined or excluded for the final models (see rightmost column of Table 1).

Lastly, within each congregational case scenario identified in the QCA models, we analyzed the proportion of congregations having high, medium, and low levels of activity for each of the three types of HIV activities (care and support, prevention and education, and awareness and advocacy).

RESULTS

Congregational and Interview Participant Characteristics.

Table 2 describes key characteristics of the 14 congregations and 57 clergy and lay leaders interviewed. Six of the congregations were predominantly African American, 4 were Latino,

2 were white, and 2 were of mixed composition (i.e., no racial-ethnic group >70%). The congregations reflected varied faith traditions, including Jewish (Reform) and various Christian denominations (Catholic, mainline Protestant and Evangelical/Pentecostal), and ranged in membership size from less than 150 members to more than 8000. The leaders we interviewed included men (30) and women (27) and both lay (35) and clergy (22).

Our congregational sample was purposefully selected to include a diverse extent of HIV-related activities, from very few and infrequent activities to very many and recurring activities. As shown in Table 3, there were relatively equal numbers of congregations in each level of HIV activity according to our definitions for HIV activities overall as well as for prevention and education activities in particular. In contrast, for care and support activities, more than half of the congregations were categorized as low activity. For awareness and advocacy activities, there were similar numbers of high and low activity congregations, with slightly fewer medium activity congregations.

QCA Models by Level of HIV Activity.

Table 4 presents three separate QCA models, one for each overall level of HIV activity: High, Medium, and Low. The rows within each model indicate the congregations identified by the QCA algorithms as having a distinct combination of values on factors in the analysis. For each of these combinations of factors—or “congregational case scenarios”—the first column gives a descriptor of the predominant racial/ethnic composition and salient case characteristics of the congregation(s) within that set.

The QCA model for the High Activity congregations identified three distinct congregational case scenarios in our sample. The first scenario listed consists of 3 congregations of predominantly White or mixed-race composition with an active gay constituency. The second scenario was a bi-ethnic congregation with an active gay constituency, and the third was an African-American congregation with a strong lay HIV champion.

Across the three high HIV-activity congregational scenarios, all cases shared the same values on 5 factors (indicated by bolding in the table): all had a lay champion or champions promoting HIV activities, a relatively liberal theological orientation, a “call-to-service” ethic motivated as an expression of faith or an example of doing good deeds (rather than primarily a vehicle for evangelism), and involvement in HIV activities that started earlier in the epidemic and without a prior emphasis of the congregation on general or non-HIV health issues.

Only the White/mixed-raced congregations with an active gay constituency exhibited relatively low stigma of people living with or at risk of HIV. These attitudes were more mixed in the other two cases, although the high levels of HIV activity over time had helped to substantially lower HIV stigma and improve acceptance of people living with HIV within the congregations. The African-American congregation was the only high-activity case without a senior clergy personally involved in HIV efforts, although the senior clergy in this case was supportive—and proud—of the HIV champion’s and ministry’s work.

The QCA model for the Medium Activity congregations identified two distinct congregational case scenarios within our sample. The first case scenario consisted of 4 African-American congregations, while the second case scenario consisted of one White congregation. These two case scenarios shared values on just two factors: congregations in both had relatively liberal theological orientations and shared a “call-to-service” ethic. They differed on almost every other factor. Two of the African-American medium-activity congregations had senior clergy personally involved in HIV efforts, but no lay champions and high to mixed levels of HIV stigma among congregants. The White congregation did not have a senior clergy personally involved in HIV activities, but did have a long-time lay HIV champion (supported by one of the main general service groups within the congregation) and relatively low HIV stigma. The African-American congregations also all had a general emphasis on health improvement prior to their HIV activities, which were begun later in the epidemic. The White medium-activity congregation was more similar to the high-activity congregations in having started its HIV activities earlier in the epidemic without a prior congregational emphasis on health issues.

The QCA model for the Low Activity congregations identified three distinct congregational case scenarios. The first scenario consisted of two Latino fundamentalist congregations, the second scenario consisted of one African-American fundamentalist congregation, and the third scenario included a Latino congregation that acted as a center for a large immigrant community in the local area.

Congregations in all three low-activity scenarios did not have senior clergy or lay champions involved in HIV activities, and exhibited high or mixed levels of HIV stigma among congregants. All also had a prior emphasis on general or non-HIV health issues (often addressing substance abuse), and the few HIV activities in which they had been involved had occurred more recently in the epidemic. The Latino and African-American fundamentalist congregations, as the description suggests, espoused a theology involving a more literal interpretation of the Bible and engaged in community outreach primarily to proselytize new members. The third case scenario—the Latino immigrant congregation—was differentiated from the two fundamentalist congregations by exhibiting a call-to-service for community outreach motivated by a Catholic ethic to serve the poor and the residents in its local parish area regardless of whether they are formal congregational members. Yet, the congregation also had a bent toward Charismatic Catholicism that, while not fundamentalist, adopts religious concepts such as a personal relationship with God, and prayer practices, such as faith healing, similar to Pentecostalism and other evangelical movements.

QCA Case Scenarios by Type of HIV Activity.

Table 5 decomposes the level of HIV activity for the congregations in each case scenario by type of HIV activity. The greatest differences in types of HIV activities pursued by congregations occurred among the case scenarios in the high-activity QCA model (top three rows). The White/mixed-race congregations with active gay constituencies were the only case scenario in which all congregations exhibited high levels of HIV care and support activities. The other two congregations were engaged in notable care and support activities but at a more moderate level.

In contrast, only one of the congregations in this first case scenario (the mixed-race congregation) and the African-American high-activity congregation had high levels of HIV prevention and education activities. Congregations in all three case scenarios exhibited high levels of HIV awareness and advocacy activities. This activity was the only type for which the bi-ethnic congregation was highly engaged, although its substantial if more moderate activities in the other two types of HIV activities kept it within the high level of activities overall.

In the medium-activity QCA model, the African-American congregations again showed a strong emphasis on HIV prevention and education activities, which distinguished them from the White medium-activity congregation. Congregations in both case scenarios tended toward moderate levels of awareness and advocacy and low levels of care and support. It should be noted, however, that the White congregation's earliest and most sustained HIV activity was for care and support, which provided a springboard for many of its activities in prevention/education and awareness/advocacy. Not unexpectedly, all the congregations in the overall low HIV activity QCA model exhibited low levels across each type of activity.

DISCUSSION

Results across the QCA models for our sample indicate that lay champions are a central factor in religious congregations achieving and sustaining high levels of HIV activities. While clergy can initiate and directly support HIV activities, as in the two high-activity case scenarios with active gay constituencies, the African-American high-activity congregation never had senior clergy who played such a role. The medium-activity case scenarios were mixed on these factors—the first case scenario included some congregations with senior clergy personally involved in HIV issues, but none with lay champions; the second case scenario included a lay champion but without any clergy personally involved. Neither HIV lay champions nor personally involved senior clergy were present in the low-activity congregations. This finding suggests that lower-activity congregations may be able to reach higher levels of HIV activity with the support and direct involvement of senior clergy, but committed lay champions may be necessary for congregations to become among the most involved in HIV issues.

A non-fundamentalist theology and non-evangelistic service motivation also appear to be important for congregations to become highly involved in HIV issues, whether or not HIV stigma is low within the congregation. This was the case for all congregations in the high-activity and medium-activity scenarios. The two case scenarios in our sample that adhered to a fundamentalist theology and evangelistic community service both had low HIV-activity. A fundamentalist theology may not only limit the engagement of a congregation with HIV issues; other analyses indicate these theological orientations may likewise condition the types of HIV activities a congregation is comfortable in adopting [e.g., abstinence-only sex education versus condom use (27, 28, 41)].

The fact that all the high-activity congregations in our sample initiated their HIV activities in the early period of the epidemic may result from the accumulation of initiatives over the length of their involvement in HIV issues, yet also signifies the long-term journey it often

takes a congregation to build and sustain a portfolio of activities in HIV or other service areas (27, 45). All high-activity congregations reported from one to three HIV activities that have persisted since the beginning of their involvement, including regular group support meetings or retreats for people living with HIV, pantries of food and sundry items for HIV+ individuals, material or volunteer support for specific community HIV service organizations, and sustained engagement in certain HIV awareness and education events, such as AIDS walks or congregational programs for World AIDS Day. At the same time, even the high-activity congregations in our sample experienced fluctuations in HIV involvement, for example one congregation in the first case scenario whose core activities continued but experienced a drop-off in initiatives after the lapse of its HIV ministry for several years before undergoing a resurgence during the period of our study.

None of the high-activity case scenarios had a prior emphasis on general or other health issues prior to becoming involved in HIV. This result indicates that a prior health emphasis is not necessarily a prerequisite to HIV involvement. At the same time, all but one congregation in the medium- and low-activity case scenarios had such a prior health emphasis, suggesting it may be one “gateway” for introducing HIV activities within a congregation. Other published analyses from our study illustrate how, among the medium-activity African-American cases in particular, (re)framing HIV as a health rather than moral issue helped align HIV activities with the health improvement agenda of the congregation and overcome initial stigma to HIV and unease with addressing the disease (41), similar to findings from other studies (53–57).

These dynamics are likely intertwined with the course of the HIV epidemic and the period in which the congregations became involved in addressing HIV. For example, the African-American medium-activity congregations all became involved more recently in HIV (since the early 2000's) as the epidemic became more recognized in communities of color. These congregations tended to be highly involved in HIV prevention and education activities, which may reflect a focus on ensuring that individuals receive testing and treatment and were connected to other support services that had become available in the general community by that period. An African-American and a mixed-race congregation were the only high-activity cases in our sample that were also among the most involved in prevention and education activities. In contrast, only the high-activity congregations were amongst the highest in care and support activities, which may reflect the lack of HIV medical treatments and community services available when these congregations became involved.

Similarly, while many congregations in our sample engaged in various awareness and advocacy activities, only the high-activity cases were highly involved in such efforts. This may be explained by the accumulation of HIV activities over time noted above serving as a base to sustain advocacy and awareness work, as well the heightened activism that marked the earlier periods of the epidemic (58–60).

The combination of features that characterized the high-activity congregations in our sample—a strong lay HIV champion, direct involvement or support of senior clergy, early involvement in the HIV epidemic, or even an active gay constituency within the membership—are likely rare among religious congregations more generally. Thus, it may be unrealistic

to expect that many congregations can or want to become highly involved in addressing HIV. On the other hand, several congregations in our sample were in scenarios that sustained moderate levels of HIV activity, and even congregations in the low-activity scenarios typically had been engaged in at least several HIV activities. A more realistic expectation given the nature of congregational settings in the U.S. might be that, in line with NCS data (12, 28), only a small proportion of religious congregations will engage in some HIV activities, and that those involved in some HIV activities will usually be involved at moderate levels, tailored to the interests and capacities of the congregational leaders and members.

Understanding the factors differentiating these congregational scenarios may help identify the most important barriers that prevent congregations from starting or increasing their involvement in addressing HIV. For example, the White medium-activity congregation had much in common with many of the high-activity scenarios, including a long-time lay champion who initiated HIV activities earlier in the epidemic, supportive clergy, and relatively low HIV stigma. However, the perceived need for HIV services within the congregation and its local community was not as urgent as in the high-activity congregations. Moreover, the “embedding” of HIV activities within an established general service group within the congregation helped provide stability to HIV efforts but also entailed accommodation within competing causes and activities of the group (43).

As noted above, fundamentalist theologies appeared to be a limiting factor in HIV involvement, as the only congregations with these orientations were the two fundamentalist case scenarios in the low-activity model. For this reason, the congregation in the Latino immigrant scenario appears to be the low-activity case within our sample that would be most likely to move to a moderate level of HIV activity. Given our other results, this would depend on a lay champion emerging or the senior clergy becoming personally involved in expanding the response of the congregation to HIV. Even if the senior clergy did not become personally involved in HIV issues, clergy can play key roles in encouraging and supporting lay leaders taking the initiative. For example, a congregant interviewed in one of the fundamentalist congregations expressed interest in starting a group for HIV-infected members, but did not think it possible without sufficient support from the clergy.

At the same time, the results of this analysis should not lead one to underestimate the impact of religious congregations becoming or remaining involved in even low levels of HIV activities. Within our low-activity category, there was still a range of activity among congregations and, in some cases, openness to further engagement. In addition to the amount of direct HIV-related services that congregations can provide, even low levels of HIV activities, if visible within the congregation, may help reframe HIV as a health issue and promote reduction in stigma of those affected by HIV (41). Given the likely large numbers of congregations that match the profiles of cases in our low- and medium-activity scenarios, this may represent an important outcome for many communities.

In applying the results of this study to congregational involvement for other critical public health problems, it is important to keep in mind how the attitudes and beliefs of specific congregations might relate differently to specific health issues, such as the current opioid

crisis. For example, all the high HIV activity congregations in our sample began their involvement in HIV activities earlier in the epidemic and without a prior emphasis on health issues. Their impetus was specifically related to a concern for those affected by the HIV epidemic in the congregation and community, particularly given the high levels of stigmatization and marginalization experienced by those affected by HIV at the time. To the extent that members or communities of such congregations are affected by the opioid crisis and the individuals affected become stigmatized and marginalized, these congregations might be similarly prompted to develop work in this area. Most of the other congregations in our sample had a prior emphasis on other health issues, with all but two offering or incorporating help for substance abuse in their various programs (e.g., sober living homes, 12-step recovery groups, youth prevention programs). Thus, while less involved in HIV, many of these congregations may be well positioned and predisposed to addressing the opioid crisis. As we found for HIV, theological orientations may influence the type of assistance that congregations offer; for example, the community service of fundamentalist congregations in our sample tended to be predicated on evangelism, which may have limited appeal, depending on the communities in which a congregation is situated. Likewise, the dynamics we found of senior clergy able to play important roles in initiating or supporting a new congregational effort, but lay leader champions being critical to sustaining the effort, would be applicable to other health issues.

Limitations.

As with any observational study, we are limited in our ability to draw conclusions about the direction of causality among the factors identified. The small sample of cases within one geographic region also may constrain the generalizability of our findings. However, our sample of 14 congregations is larger than many case-based studies of congregational HIV activities and was purposely selected to include a diverse range of urban congregations in terms of demographic composition, organizational characteristics, and level of HIV activity (27, 44). In addition, the in-depth case data and use of Qualitative Comparative Analysis (QCA) are well-suited to identifying combinations of factors associated with different levels of congregational HIV activities and understanding the contingent dynamics of congregations' involvement in addressing a critical yet often stigmatized community health issue such as HIV.

CONCLUSION

Religious congregations offer several strategic advantages for reducing HIV disparities, particularly within African American and Latino communities, but relatively few congregations address HIV as compared to other health issues. Our in-depth study of a diverse sample of urban congregations and use of systematic cross-case QCA methods suggest that different combinations of congregational demographics (race-ethnicity and sexual orientation), theological and service orientations, clergy and lay leader attitudes and roles, and the historical period when a congregation became involved in HIV are associated with, and may help determine, levels of HIV involvement and types of activities. In addition, two key factors that appeared influential across case scenarios included the role of lay champions for HIV activities and the general theological orientation of the congregation.

Understanding how these factors interact to shape congregational involvement can help HIV prevention and services organizations determine the most promising strategies for engaging with religious congregations.

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Highlights

- Religious congregations can reach populations disproportionately affected by HIV
- Case studies of 14 diverse urban congregations explored factors shaping HIV activity
- QCA methods identified case scenarios of unique combinations of congregation factors
- Two factors were influential across cases—lay champions and theological orientations
- Dynamics are applicable to congregational involvement in other health issues

Table 1.

Conceptual Framework Dimensions, Factor Indicators, and Factor Values

Factor Indicators	Factor Values	Final Calibrated Values (<i>dichotomized</i>)
Norms and Attitudes		
<i>Theological and Spiritual Orientations</i>		
Religious denomination	Catholic, Evangelical/Pentecostal/Non-denominational; Mainline Protestant, Baptist, Jewish Reform	
Theological interpretation *	Contextual, Literal	Literal vs Contextual
Relationship of spiritual & other needs	Holistic, Multiple needs, Spiritual healing	
Evangelism orientation	Non-proselytizing, Sharing the good news, Saving souls	
Community service orientation *	Expression of faith, Evangelism by example, Preconditioned on evangelism	Call-to-service (Expression of faith and Evangelism by example) vs Preconditioned on evangelism
<i>HIV and Health-Related Attitudes</i>		
Clergy support of HIV activities *	Personally involved, Supportive, Tolerant	Personally involved vs Supportive or Tolerant
Lay leader support of HIV activities *	Presence of one or more HIV champions	Lay champion(s) vs none
Congregational stigma of people living with or at-risk of HIV *	Low, Mixed, High	Low congregational stigma vs Mixed or High
Congregational health emphasis *	Established involvement in health issues prior to involvement in HIV	Health emphasis prior vs none
<i>Organizational Structure and Process</i>		
HIV epidemic time period in which congregation began involvement in HIV *	Early (1981-86, "dark ages"), Middle (1987-96, pre- HAART), Later (1997-present, HAART)	Later period start vs Early or Middle
Organizing models of HIV activities within the congregation	Embedded (HIV activities contained within other health activities), Parallel (organizationally distinct), Overlap (organizational distinct but share members/ activities)	
HIV collaborations with external organizations	Total HIV collaborations; Percent characterized by a <i>to, from, or with</i> relationship; Percent with faith-based, or with other health and social support organizations	
<i>Resources</i>		
Congregation size (monthly attendance)	Small (150 members), Medium (151-500 members), Large (501 members)	
<i>Demographics</i>		
Predominant race-ethnicity of congregation *	African-America, Latino, White, Mixed Race	African-American vs other Latino vs other

* Indicates factor included in final QCA analysis.

Table 2.**Congregation and Interview Participant Characteristics**

Congregations (n=14)	Frequency
Predominant race or ethnicity ^a	
African American	6
Latino	4
White	2
Mixed ^b	2
Congregation size ^c	
Large (501 members)	6
Medium (151-500 members)	5
Small (150 members)	3
Denomination	
Catholic	3
Evangelical, Pentecostal, or Non-denominational	4
Mainline Protestant	4
Baptist	1
Jewish (Reform)	2
Interview Participants (n=57)	Frequency
Race/ethnicity	
African American	22
Latino	15
White	18
Asian	1
Other	1
Gender	
Female	27
Male	30
Role	
Clergy	22
Lay	35

Adapted from Derose, Mendel, Palar et al., 2011 (27).

^aThe predominant race/ethnicity comprises 70% of regular participants (except for “mixed”).

^bNo individual race/ethnicity comprises > 70% of regular participants.

^cMeasured in terms of the number of reported congregational participants that attend services monthly.

Table 3.
Distribution of Congregations ($n=14$) on Extent of HIV Activities, Overall and by Type of HIV Activities

Extent of HIV Activities	Definition	Overall HIV Activities	Type of HIV Activities		
			Prevention & education ^a	Care & support ^b	Awareness & advocacy ^c
High activity	Activities are frequent, target HIV, include multiple types of activities above and beyond what congregations traditionally do	6	5	3	5
Medium activity	Activities are more frequent than once a year and may target HIV, but are an extension of what congregations already do	4	4	3	3
Low activity	Activities are infrequent (once a year) or not targeted specifically to HIV	4	5	8	6
<i>Total Number of Congregations</i>		<i>14</i>	<i>14</i>	<i>14</i>	<i>14</i>

Adapted from Derose, Mendel, Palar et al., 2011 (27).

^a e.g., HIV educational workshops and materials, programs to promote abstinence.

^b e.g., Pastoral care of people with HIV and their families, support of local AIDS services organizations.

^c e.g., Pastors preaching about HIV, congregants raising funds and participating in AIDS walk, special worship services for World AIDS Day.

Table 4.

QCA Model Results: Case Scenarios of Religious Congregations with High, Medium, and Low Levels of Overall HIV Activity

Congregational Case Scenario	Senior clergy personally involved in HIV	Lay champion for HIV	Congregation low stigma of PLWH & at-risk	Literal theology	Call-to-service community outreach	Health emphasis prior	Later period start in HIV	# of Cases
HIGH Overall HIV Activities								
White or mixed race with active gay constituency	Yes	Yes	Yes	No ^c	Yes	No	No ^f	3
Bi-ethnic (Latino & White) with active gay constituency	Yes	Yes	No	No ^d	Yes	No	No	1
African-American with strong lay HIV champion	No ^a	Yes	No	No ^d	Yes	No	No	1
MEDIUM Overall HIV Activities								
African-American with health emphasis	Yes(2), No(2) ^a	No	No	No ^c	Yes	Yes	Yes	4
White with lay HIV champion	No ^a	Yes	Yes	No ^c	Yes	No	No	1
LOW Overall HIV Activities								
Latino fundamentalist	No ^b	No	No	Yes	No ^e	Yes	Yes	2
African-American fundamentalist	No ^b	No	No	Yes	No ^e	Yes	Yes	1
Latino part of large immigrant community	No ^a	No	No	No ^d	Yes	Yes	Yes	1

Note: PLWH = people living with HIV.

^aSenior clergy supportive^bSenior clergy tolerant.^cMainstream Protestant, Jewish Reform, or liberal non-denominational theology.^dCatholic theology.^eEvangelism-based community service.^fOne congregation not founded until later period, but senior clergy had started in HIV issues since earlier period.

Table 5.

Congregational Case Scenarios Involvement by Type of HIV Activities

Congregational Case Scenario	Overall HIV Activities	Type of HIV Activities			# of Cases
		Care & Support	Prevention & Education	Awareness & Advocacy	
White or mixed race with active gay constituency	●	●	●	●	3
Bi-ethnic (Latino & White) with active gay constituency	●	●	●	●	1
African-American with strong lay HIV champion	●	●	●	●	1
African-American with health emphasis	●	●	●	●	4
White with lay HIV champion	●	●	●	●	1
Latino fundamentalist	●	●	●	●	2
African-American fundamentalist	●	●	●	●	1
Latino part of large immigrant community	●	●	●	●	1

Color key:
 ● = High activity ● = Medium activity ● = Low activity

Note: Pie-shading of circles indicates proportion of cases comprising higher or lower levels of activities.