Public health and church-based constructions of HIV prevention: black Baptist perspective

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Received on May 18, 2012; accepted on December 17, 2013

Abstract

The black church is influential in shaping health behaviors within African-American communities, yet few use evidence-based strategies for HIV prevention (abstinence, monogamy, condoms, voluntary counseling and testing, and prevention with positives). Using principles of grounded theory and interpretive description, we explored the social construction of HIV prevention within black Baptist churches in North Carolina. Data collection included interviews with church leaders (n = 12) and focus groups with congregants (n = 7; 36 participants). Analytic tools included open coding and case-level comparisons. Social constructions of HIV/AIDS prevention were influenced by two worldviews: public health and church-based. Areas of compatibility and incompatibility exist between the two worldviews that inform acceptability and adaptability of current evidence-based strategies. These findings offer insight into ways to increase the compatibility of evidence-based HIV prevention strategies within the black Baptist church context.

Introduction

In the United States, HIV/AIDS continues to significantly and disproportionately impact African Americans in comparison to other racial and ethnic groups. Given that the primary mode of transmission is sexual [1], we remain in need of effective and culturally relevant prevention strategies to reduce sexual risk. Despite recent biomedical advances in HIV prevention, behavioral risk reduction remains a critical HIV prevention strategy to reduce HIV in this population [2–5].

Five evidence-based behavioral strategies have demonstrated effectiveness in reducing risk for sexually transmitted HIV: abstinence [6, 7], monogamy [8–12], condom use [11, 13–17], prevention with people living with HIV/AIDS (PLWHA) [18–20], and voluntary counseling and testing (VCT) [21]. Although the evidence collected is from many populations and settings, little is known about the acceptability or potential utility of these behavioral strategies in black communities and their faith-based institutions.

Historically, the black church has been an influential institution in the black community [22–25]. In addition to catalyzing social, political and educational improvements, the black church has successfully partnered with public health researchers and practitioners to promote adoption of a range of health behaviors, including fruit and vegetable consumption [26–29], physical activity and weight loss [29, 30], and mammography screening [23]. Despite this ability to promote health [22] and shape members’ perceptions of health behaviors [31], the
involvement of black churches in sexually transmitted HIV prevention has been limited [32–35]. Challenges noted have included financial restraint [33, 34, 36], concerns with homosexuality and promiscuity and their association with HIV/AIDS [32–35, 37] time constraints [34], lack of understanding about the disease [38], difficulty with discussions about sexuality [34, 38] and low perceptions of risk for HIV/AIDS among churchgoers [32, 34, 35]. More recently, researchers have explored and validated black church interest and willingness to engage in HIV prevention activities [33–35, 39, 40]; however, HIV prevention can be broadly defined and little is still known about how to translate existing HIV prevention evidence to black church settings. A significant barrier to church engagement in HIV prevention might be that evidence-based behavioral strategies are not congruent with some common beliefs and cultural norms found in many Baptist churches, with predominantly black congregations. Evidence-based strategies of prevention require adaptation to make them transferrable to different racial/ethnic and cultural groups [34]. Sexual behavior and disease experience are shaped by social and cultural context. The social construction of diseases such as HIV is useful for understanding cultural and social experiences from the perspective of individuals, cultural groups, organizations and society at large. Hence, defining and integrating black faith-based institutions’ social constructions of HIV into existing behavioral strategies would be a first step to church engagement in HIV prevention activities.

The activities of black churches to prevent HIV/AIDS in black communities have increased in recent years. [35, 41, 42]. However, without more engagement of the black church in evidence-based behavioral strategies for preventing sexually transmitted HIV, both the field of public health and the black community are significantly hampered in advancing clinical and behavioral knowledge on how to reduce the disproportionate burden of this disease among African Americans. Black churches possess characteristics that are essential to promoting lasting behavioral changes that prevent HIV transmission. In addition to reach, capacity, and spiritual mandate, pastors and leaders of black churches are trusted and able to influence issues of sexuality, social behavior, beliefs about disease and rules for family life among church members [43]. By partnering these strengths with evidence-based behavioral strategies for HIV prevention, black churches have the potential to be an instrumental partner in reducing the spread of sexually transmitted HIV/AIDS.

**Purpose**

The purpose of this study was to define the social construction of HIV prevention by pastors, leaders and congregants of black churches in North Carolina. Principles of grounded theory and interpretive description were used to explore and characterize the symbolic and cultural meanings of HIV prevention with church pastors, leaders and congregants that could inform culturally congruent HIV prevention strategies. Findings from this study could lead to the design of church-based health promotion interventions that incorporate not only scriptural references and spiritual tools, such as song and prayer [44], but also a foundational understanding of the church’s sacred focus in relationship to the secular focus of most disease prevention interventions. Further, to engage black churches in equitable academic-community research partnerships that address HIV/AIDS, it is essential for public health researchers and practitioners to understand black churches’ cultural interpretation of HIV prevention in their own context.

**Methods**

Data for this qualitative study were collected in eight black Baptist churches in North Carolina, all members of the same church association. Seven focus groups were conducted with 36 congregants, and 12 church leaders (including 8 pastors) participated in individual, in-depth interviews. We choose to only sample Baptist churches because Baptist churches have congregational autonomy, such that individual churches may choose to incorporate HIV-related programs into their activities, without permission from any central authority. In addition,
more Blacks identify with the Baptist church than any other denomination [45].

Setting and participants
This study was conducted in two counties in North Carolina. According to the 2010 Census, one county was 25.9% Black, with a population of 359,638, and the other county was 55.6% Black, with a population of 51,853. From 2008 to 2010, both counties ranked above the state average HIV incidence of 17.6 per 100,000—20.0 and 41.0 average rates, respectively [46].

Recruitment was conducted both at the church level and within churches. Using criterion sampling as a guide [47], four churches in each county were randomly selected from a list of churches with the following criteria: (i) predominantly Black, (ii) Baptist denomination, (iii) did not have a ministry to specifically address HIV/AIDS, (iv) had a pastor who had been in service in that church for at least 1 year and (v) had average Sunday congregational attendance of <100 \( (n = 4) \) or \( \geq 300 \) \( (n = 4) \). Based upon organizational theory, we also used church size as a sampling criteria [48, 49].

Individual, in-depth interviews were conducted with church leaders \( (n = 12) \). Church leaders met study inclusion if they had decision-making authority or influence on church programming, by virtue of their position, and had served at least 1 year. At least one leader needed to be female, as women compose the majority of black Baptist church membership [46] and largely sustain church programs.

The study coordinator contacted each church’s pastor up to five times by phone to describe the study and request participation in an in-depth interview. During phone calls, the study coordinator scheduled an interview and asked the pastor for a list of up to five leaders who might participate in an in-depth interview. Each leader was also contacted by phone up to five times to describe the study and inquire about their willingness to participate.

We also conducted focus groups with the congregants of black Baptist churches \( (n = 7) \). Focus group participants met inclusion if they attended a predominantly black Baptist church within the county at least twice per month. Focus group composition included two groups of women ages 25–34, two groups of women ages 35–54, two groups of men ages 35–44 and one group of women of mixed ages. The age groups were purposefully sampled to reach those groups experiencing high HIV-related mortality. Participants were recruited through church announcements, bulletins and word of mouth. Participants for each focus group were drawn from a number of different churches to encourage dialogue among congregants with different church-related experiences. After congregants were identified, the study coordinator verified inclusion criteria and informed them of focus group logistics (date, time, location). Each participant also received a reminder phone call 1 day prior to the focus group.

Data collection method
Study procedures were approved by the Institutional Review Board for the protection of human subjects at the University of North Carolina at Chapel Hill. Prior to data collection, each individual participated in an informed consent process and completed a brief demographic survey. A trained member of the research team conducted the interviews and focus groups using a semi-structured guide that included intentional overlap of questions to allow for comparison of the findings. Topics included how participants and other members of the black church understand and describe HIV, the factors that fuel the spread of HIV in the black community, the role of the church in HIV prevention and participants’ perspectives of, and experiences with, five prevention strategies [abstinence, monogamy, condoms, prevention with positives (PwP) and VCT] within the church. Each interview and focus group was audio-taped and professionally transcribed verbatim for further analysis. Interviews and focus groups lasted an average of 52 and 79 min, respectively. Refreshments were provided at all focus group sessions.

Data analysis
Open coding by a trained research team member was used to examine the full range of responses
and to develop an initial codebook. Codes were sorted, compared and grouped into categories based on their similarities. ATLAS.Ti v.5.2 was used to organize and manage the data. Informed by the constant comparative method of Strauss and Corbin, we developed matrices to compare the conceptual categories between respondents, e.g. pastors/leaders versus congregants, rural versus urban, large versus small [50, 51]. Emergent codes were added to the codebook to identify ideas that emerged in the initial coding and comparison process. We used code reports and matrices for the final stage of interpretation. The primary researcher practiced reflexivity, or the process of recognizing analytic decisions, interpretations, and interests, and the extent to which these decisions may have been informed by her role as a member of the black Baptist community [52].

To ensure credibility of the data, the researchers documented all analytic decisions with memos, recording the researcher’s path of logic. The analytic decisions and process were discussed through debriefings with the research team [53]. Study findings were shared with two of the 12 church leaders and seven of the 36 congregants, as a form of member-checking to ensure that the findings represented the perspective of the participants.

Results

Church leaders were primarily male (75%), married or living with a partner (75%), and most had a graduate degree (67%). Most focus group participants had at least some college (94.4%) and were married or living with a partner (52.8%). Most individuals in both respondent groups reported having at least some knowledge about HIV (91.7% and 86.1%), but a larger proportion of focus group participants reported knowing someone with HIV (33.3% versus 61.1%) (Table I).

Two worldviews

Based upon our interpretive analysis, respondents outlined two worldviews that were used to define and conceptualize HIV/AIDS prevention modalities within the participating black Baptist churches: a church-based perspective and a secular, public health perspective (Table II). The church-based perspective centers on the avoidance of sin, whereas the public health perspective centers on the core concept of avoiding disease. It is necessary to delineate the points of compatibility and incompatibility between these worldviews, as these points can define how to translate evidence-based prevention strategies into black churches, define appropriate audiences within the church to target and develop strategies for delivery. There is considerable convergence of views across respondent groups; however, we also specify those perspectives that are unique to a particular group.

Abstinence

Public health and church-based perspectives on abstinence

As a public health concept, participants described abstinence as the most reliable and effective method for preventing disease transmission. By avoiding sexual activity, individuals can effectively prevent any HIV transmission through sexual means. Female congregants more often discussed attributes that could support individuals in practicing abstinence included positive self-esteem, positive attention and affirmation, solid family foundations and networks, and positive responses to peer pressure. Each of these strategies was thought to support abstinence and reduce one’s risk for acquiring HIV. However, for pastors and leaders, abstinence encompassed more than avoiding disease through sexual activity, but avoidance of any behaviors that detract from one’s spiritual integrity—or sin. Abstinence was viewed as holistic behavioral discipline, extending beyond sexual activity, to other behaviors not broadly condoned within this church community, such as alcohol and drug use and profane language. In addition to avoiding HIV transmission, the holistic and more church-based practice of abstinence demonstrates that one lives a life more connected to God, understands the church-based value of life and spirit, demonstrates spiritual discipline and avoids a range of behavioral...
One pastor described abstinence from a holistic perspective:

[I]t’s not just teaching abstinence, it’s teaching discipline... You got not only to be disciplined of your genitals... You’ve got to build the whole person... I’m going to teach you how to have a healthy, holistic lifestyle... you’ve got to value your soul, the substance of who you are as a human being and you’ve got to value the substance of other people... [I]f the only thing I see in my relationship with you is two genitals coming together, then I missed a whole lot and I told you that the rest of you ain’t worth a crap. [I]t’s about life and do I value life and do I value the life of another person?

### Table I. Participant demographics

<table>
<thead>
<tr>
<th></th>
<th>Pastors and leaders n (%)</th>
<th>Congregants n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>9 (75)</td>
<td>5 (13.9)</td>
</tr>
<tr>
<td>Female</td>
<td>3 (25)</td>
<td>31 (86.1)</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>46.9 years</td>
<td>39.9 years</td>
</tr>
<tr>
<td><strong>Marital status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married or living with a partner</td>
<td>9 (75)</td>
<td>19 (52.8)</td>
</tr>
<tr>
<td>Divorced</td>
<td>1 (8.3)</td>
<td>5 (13.9)</td>
</tr>
<tr>
<td>Widowed</td>
<td>1 (8.3)</td>
<td>—</td>
</tr>
<tr>
<td>Never married</td>
<td>1 (8.3)</td>
<td>12 (33.3)</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Graduated from high school</td>
<td>1 (8.3)</td>
<td>3 (8.3)</td>
</tr>
<tr>
<td>Technical school or training</td>
<td>1 (8.3)</td>
<td>1 (2.8)</td>
</tr>
<tr>
<td>Some college</td>
<td>1 (8.3)</td>
<td>10 (27.8)</td>
</tr>
<tr>
<td>Completed college</td>
<td>1 (8.3)</td>
<td>12 (33.3)</td>
</tr>
<tr>
<td>Some graduate school</td>
<td>—</td>
<td>5 (13.9)</td>
</tr>
<tr>
<td>Graduate degree</td>
<td>8 (66.7)</td>
<td>6 (16.7)</td>
</tr>
<tr>
<td><strong>Work status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Working part-time</td>
<td>2 (16.7)</td>
<td>4 (11.1)</td>
</tr>
<tr>
<td>Working full-time</td>
<td>6 (50)</td>
<td>27 (75)</td>
</tr>
<tr>
<td>Taking care of home or family</td>
<td>—</td>
<td>8 (22.2)</td>
</tr>
<tr>
<td>In school</td>
<td>—</td>
<td>2 (5.6)</td>
</tr>
<tr>
<td>Retired</td>
<td>5 (41.7)</td>
<td>1 (2.8)</td>
</tr>
<tr>
<td>Unable to work due to illness or condition</td>
<td>—</td>
<td>1 (2.8)</td>
</tr>
<tr>
<td><strong>HIV knowledge</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Very little knowledge</td>
<td>1 (8.3)</td>
<td>3 (8.3)</td>
</tr>
<tr>
<td>Some knowledge</td>
<td>7 (58.3)</td>
<td>14 (38.9)</td>
</tr>
<tr>
<td>Very knowledgeable</td>
<td>2 (16.7)</td>
<td>12 (33.3)</td>
</tr>
<tr>
<td></td>
<td>2 (16.7)</td>
<td>5 (13.9)</td>
</tr>
<tr>
<td><strong>Ever tested for HIV</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>6 (50)</td>
<td>21 (58.3)</td>
</tr>
<tr>
<td>No</td>
<td>6 (50)</td>
<td>14 (38.9)</td>
</tr>
<tr>
<td>Unsure</td>
<td>—</td>
<td>1 (2.8)</td>
</tr>
<tr>
<td><strong>Know anyone living with HIV</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>4 (33.3)</td>
<td>22 (61.1)</td>
</tr>
<tr>
<td>No</td>
<td>7 (58.3)</td>
<td>12 (33.3)</td>
</tr>
<tr>
<td>Unsure</td>
<td>1 (8.3)</td>
<td>1 (2.8)</td>
</tr>
</tbody>
</table>

*Categories not mutually exclusive.
Applying abstinence strategies in black Baptist churches

The congruence between the public health and church-based perspectives on abstinence offers little challenge to implementation. In addition, the church-based perspective broadened the behavior(s) of interest beyond sex and the rationale for practicing abstinence beyond avoiding disease. Though there is congruence between the two perspectives, participants noted significant challenges with

<table>
<thead>
<tr>
<th>Prevention interventions</th>
<th>Church-based perspectives</th>
<th>Public health perspectives</th>
<th>Points of compatibility</th>
<th>Points of incompatibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abstinence</td>
<td>Holistic behavioral discipline</td>
<td>Focus: Avoidance of sin</td>
<td>Self-esteem</td>
<td>Join the two perspectives</td>
</tr>
<tr>
<td></td>
<td>Life connected to God</td>
<td>Avoidance of sin, spiritual discipline</td>
<td>Positive attention</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Avoidance of sin, spiritual discipline</td>
<td>Value of life and spirit</td>
<td>Strong families</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Value of life and spirit</td>
<td>Unmarried</td>
<td>Responses to peer pressure</td>
<td></td>
</tr>
<tr>
<td>Monogamy</td>
<td>Marriage—1 partner</td>
<td>Reduce concurrency</td>
<td>No external partners</td>
<td>Messages for the unmarried</td>
</tr>
<tr>
<td></td>
<td>Relationship maintenance</td>
<td>Reduce total no. of partners</td>
<td>Address root causes of non-monogamy</td>
<td>Reduce no. of partners versus no or one partner in marriage</td>
</tr>
<tr>
<td></td>
<td>Spiritual accountability</td>
<td>Married and unmarried</td>
<td>Relationship maintenance</td>
<td>Accountability for sin among unmarried</td>
</tr>
<tr>
<td>Condoms</td>
<td>None</td>
<td>Protected sex—unmarried, PLWHA</td>
<td>None</td>
<td>Condom use among non-PLWHA, unmarried</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sero-discordant married</td>
<td></td>
<td>Accountability for sin among unmarried</td>
</tr>
<tr>
<td></td>
<td>Physical, emotional and spiritual support</td>
<td>Physical, emotional support</td>
<td>Physical, emotional support</td>
<td>Need for public disclosure and forgiveness</td>
</tr>
<tr>
<td></td>
<td>Confession and forgiveness</td>
<td>Condom use</td>
<td></td>
<td>Accountability for sin among unmarried</td>
</tr>
<tr>
<td></td>
<td>Correction-based</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Volunteer counseling and testing</td>
<td>Focus on counseling, spiritual support</td>
<td>Counseling</td>
<td>Counseling</td>
<td>Accountability for sin among unmarried</td>
</tr>
<tr>
<td></td>
<td>Testing</td>
<td>Risk reduction</td>
<td>Referral/partner for testing</td>
<td></td>
</tr>
</tbody>
</table>

This table outlines as follows:
How does the black Baptist church define HIV prevention?
How are the church-based and public health perspectives compatible?
How are the church-based and public health perspectives not compatible?
practicing abstinence. Nine of 12 pastors and leaders and all focus groups acknowledged a difficulty in the masses achieving on-going sexual abstinence. One pastor characterized the ‘depravity of man’, which respondents described as the difficulty of refraining from sex outside of a marriage context.

You always shoot for the standard but I also know the depravity of man and woman. If one is not married, then the goal is abstinence...I’m an idealist in a realistic work...the standard doesn’t change because of the inability of man to live up to it, but there are very few who are able. [Pastor]

Based upon their church-based beliefs, participants broadly ascribed to sexual activity as appropriate only within marriage; however, ‘depravity’ denotes human frailty and accepting the probability of individuals failing to meet the church-mandated standards of sex. To reconcile the challenge of individuals achieving long-term sexual abstinence, most respondents supported teachings on other prevention strategies as an interim plan to keep people physically healthy until they have achieved the spiritual marker of sustaining an abstinent lifestyle. Depravity creates the acceptable framework for churches to engage in HIV prevention strategies beyond abstinence. One pastor described:

Is abstinence achievable? Yes. Is it likely for duration? I think not. So what is the next best plan? Tell them to protect themselves and give them all the tools...[so] they will be able to live and keep others from dying.

Though participants acknowledged that the risk for HIV infection is present across the lifespan, abstinence was primarily conceived as a necessary preventive strategy for youth. Most respondents associated youth with high-risk sexual behaviors.

Public health and church-based perspectives on monogamy

Respondents discussed monogamy as sexual activity between only two partners, and reducing the total number of partners to reduce one’s risk for acquiring HIV. With an emphasis on the number and timing of partners instead of the context of the partnership, monogamy could be between married or unmarried individuals. Similar to abstinence, participants ascribed to a public health perspective of monogamy with a primary focus on avoidance of disease. However, the church-based concept of monogamy was broader and influenced by church beliefs of sexual activity within the confines of marriage. Hence, for most church leaders and congregants, monogamy from a church perspective was synonymous with marriage. A participant in one of the women’s focus groups described:

People have set in their mind this is God’s way...God’s way is you wait till you’re married, so anything outside of that is sin. Period. A lot of people in church feel that way.

Across all respondent groups, practicing monogamy was also indicative of spiritual accountability for avoiding sex outside of the confines of marriage. By engaging in only marriage-based sex, respondents viewed marriage as a protective factor for from HIV infection.

Applying monogamy strategies in black Baptist churches

In addition to promoting monogamy as sex between two people, respondents preferred that monogamy be taught as the structure for sexual partnership within the confines of marriage. However, given the depravity of man condition, monogamy strategies were seen as necessary for both the married and the unmarried. Church leaders and members expressed considerable concern with monogamy strategies for the unmarried, as it was viewed as permissive or condoning sexual engagement outside of marriage, and from a church perspective, non-marital sexual activity is considered a sin, even when it is monogamous. Despite this conflict, respondents discussed several strategies for assisting couples in maintaining monogamy. Several church leaders discussed the need to encourage marriage among single congregants, as a strategy to promote monogamy. Both leaders and congregants described
benefits to placing an emphasis on limiting the number of sexual partners, addressing the root causes of infidelity and teaching couples how to overcome challenges in their relationships without seeking additional sexual partners. One of the women’s focus groups described how to support monogamy in relationships:

[T]he importance of teaching people how to cultivate their relationships, understand what it says in the Bible...and what you need to do to sustain that relationship cause it’s not always good, it’s not always bad...If you’re teaching them how to sustain it through any cycle, good, bad, up or down, then this [infidelity] doesn’t become such an issue...[Female Focus Group, ages 25–34]

Although respondents primarily supported monogamy-based strategies within the church, messages that include a reduction in the total number of partners and target those who are unmarried neglect the church-based need to promote sexual activity within the confines of marriage and create spiritual accountability for sexual activity outside of marriage.

Public health and church-based perspectives on condoms

Condoms were described as an effective HIV prevention strategy when used correctly and consistently. However, some leaders noted concerns about condom effectiveness, either due to condom design or individuals inability to use them correctly or consistently. Condoms were the only prevention strategy for which no respondents had a church-based perspective or utility for avoiding sin. Although respondents largely believed that condoms can prevent disease transmission, condom use was inconsistent with respondent’s church-based desire to avoid sex outside of marriage. Condoms were also viewed as helping individuals to circumvent spiritual accountability for non-marital sex:

[Y]ou can’t go passing out condoms...It doesn’t justify the means because there’s consequence...I think that when you do it wrong and God has condemned it and said that the only bed that is not defiled is the marriage [bed] and if you go ahead and do it anyway there is some consequence. And that’s not a fear but it’s more or less the reality of sinning. [Pastor]

All leaders and congregants described several perceptions associated with condoms that conflict with church-based beliefs around sex within the confines of marriage. Condoms represented condoning and promoting sex among the unmarried, as well as having multiple partners. When asked how condoms contribute to HIV prevention, one pastor described:

For the church it’s taboo. To some it would be like condoning sexual activity. If you’re not going to condone it [sex] then you don’t have to talk about condoms...to talk about [condoms], people would ask, ‘Pastor, are you condoning [sex]?’ [Pastor]

In addition to the messages associated with condom promotion for church members, several leaders and congregants indicated that churches may face backlash from parents who are uncomfortable with their children receiving condom promotion, and from larger religious associations or organizations with whom churches are affiliated.

Applying condom strategies in black Baptist churches

As monogamy was conceptually synonymous with marriage, condoms were viewed as necessary for HIV prevention among the unmarried. Employing condom strategies for the unmarried requires an acceptance of the depravity condition and a focus on avoiding disease. Only one church leader saw no utility for condoms for HIV prevention, and all focus groups with church members supported church-based education about condom use, endorsed as a secondary message to abstinence. The greatest point of incompatibility was that condoms did not attend to respondent’s church-based need to avoid sex outside of marriage and promote spiritual accountability.

Despite the conflicts over behaviors associated with condoms, respondents offered three levels of
condom-focused prevention within the black church: openly teaching and promoting condom use within the church, making referrals to condom distribution sites, and discreet distribution of condoms through specific church auxiliaries devoted to men and youth. Respondents, primarily leaders, also emphasized PLWHA as appropriate end-users of condom strategies as a way to prevent further transmission, particularly in marriages with serodiscordant partners.

Public health and church-based perspectives on PwP

From a public health perspective, PwP consisted of physical and emotional support, and condom use to prevent further transmission. All respondents discussed the importance of helping PLWHA avoid further transmission of HIV and protect them from further STI infection, much of which hinged upon condom use. Similar to the public health perspective, leaders and congregants described social, emotional, spiritual, and resource support for PLWHA and their families, as consistent with the role of the black church to provide comfort and care to all in need. Provision of support services was often discussed as connected to church practices of confession and forgiveness. Confession, primarily through the form of testimonials, was encouraged for PLWHA as a means to obtain Divine forgiveness for the behaviors that might have facilitated infection, solicit support from the church to avoid risky behaviors, and ultimately to gain acceptance from other church members. Respondents acknowledged that disclosing one’s HIV status within the church can be challenging. Two female focus group participants described:

Participant 1: It’s very rarely people that are in church will openly confess [Affirmations.] that they have HIV/AIDS . . . because they are not in an environment where it’s comfortable . . . People are comfortable coming up and saying I was diagnosed with cancer. Please pray for me. I was diagnosed with diabetes. Please pray for me . . . it’s not an atmosphere to come up and just say that

[you are HIV-infected] because you don’t know how you’ll be treated.

Participant 2: I think people are probably more comfortable coming and saying I smoke crack than to say, [Laughter.] that I have HIV because it’s just like Oh well if you smoke crack you can get over that but if you have AIDS . . . we can’t touch you or, you know, that kind of thing.

Despite the challenges with disclosure, most participants believed testimonials could facilitate further empathy for PLWHA and understanding of the condition:

I wish those who have been touched by AIDS, themselves or family members, would share. I use my two uncles who died of AIDS as a way of bringing fertile ground out of something that’s very tragic with our family. I’m very open about sharing, hoping that other people will be open . . . we’ll come to the conclusion that people who die of AIDS are just like us who need love and support as well as family members who need love and support and understanding . . . [I’m] being transparent enough to make people feel like, I’m not out here by myself. [Pastor]

Testimonials were also thought to encourage other individuals living with illness to seek support. Church members and leaders also described the role of the church in PwP as providing guidance on modifying risk behaviors from a church-based perspective. One focus group described the need for the church to correct risk behavior in addition to providing support to PLWHA:

What was the right way? What was the wrong way? . . . when people see what they do it kind of helps them to take an inventory of themselves and say I don’t need to do it like that . . . I’m not saying we’ve got to be beating up on people . . . What I am saying is this: the love of God also corrects, so we need to be correcting . . . we don’t need to just overlook that [behavior] . . . we need to talk about what
Applying PwP in black Baptist churches

All but one participant agreed that the church should promote PwP strategies. Though most respondents supported both a public health and church-based approach to PwP, the need for public disclosure and forgiveness in the church-based perspective presented a critical incompatibility. Both confession and forgiveness were linked to respondent’s need to hold individuals accountable for sexual activity outside of marriage. Respondents also noted that one challenge to providing direct services is the lack of visibility of PLWHA within congregations. Only a third of pastors and leaders indicated that they knew a PLWHA. Among focus group participants, 22 of 36 (61%) indicated knowing a PLWHA. Although none of the pastors and leaders and few of the focus group participants attended churches with HIV/AIDS ministries, respondents did acknowledge that some churches may have ministries that help PLWHA in the context of other services (feeding all who need it/are sick, providing housing assistance).

Public health and church-based perspectives on VCT

Respondents viewed VCT as necessary to help individuals become aware of their HIV status and learn how to reduce their risk. One male focus group compared HIV testing with other health screenings:

Participant 1: I got tested for my cholesterol. It made me eat better.
Participant 2: We have high blood pressure testing... It will kill you too.

Unlike the public health perspective of VCT, respondents viewed counseling and testing as conceptually distinct programs. There was consensus across respondents that the church has a role in making individuals aware of their HIV status, but some respondents deemed only the counseling component of VCT as a natural extension of the church’s function and role. The underlying rationale for this perspective was largely rooted in logistical concerns with implementation of VCT, including a lack of sufficient experience within the church with administering HIV testing.

Applying VCT in black Baptist churches

Respondents were open to church-based testing through collaboration with a medical establishment, both to provide the medical expertise and to maintain confidentiality for those being tested. As one women’s focus group discussed:

Maybe if you bring a nurse that works at [a local hospital] [affirmations] or [another local hospital]... If you bring somebody in like that then I can see it working, but not just Joe Blow from the congregation. You need to get somebody that’s from the outside and knows absolutely nothing about your congregation that’s going to keep those things confidential.

Formats for implementing VCT within black churches included highly visible campaigns and pastor-led initiatives to private, off-site testing events, where individuals could be accompanied by their pastor for counseling and spiritual support. Campaigns for public testing, particularly featuring pastoral involvement, were thought to enhance the normalization of testing and encourage individuals to participate. Private, off-site VCT opportunities were championed for their ability to counter the stigma associated with HIV testing and the fear of disclosing that one had engaged in risk behaviors (i.e. sex outside of marriage). Respondents also supported VCT as a part of pre-marital counseling offered through the church. One pastor stated ‘Before you get in a committed relationship, part of premarital counseling, maybe the pastor can share [VCT], for the most loving thing is for both individuals to make sure that they are clean and clear’. The perspectives of VCT were largely compatible, but neither risk-reduction counseling nor testing addresses the need for spiritual accountability for engaging in risk behaviors.
Discussion

As a spiritual institution within a broader society, the black church conceptualizes HIV prevention from both church-based and public health perspectives. Each prevention strategy had public health utility that focused on preventing HIV transmission, and except for condoms, also resonated with participant’s church-based principles and culture. In some instances, pastors and leaders differed from congregants in their conceptualization of compatible HIV prevention (i.e. promoting marriage among single congregants to achieve monogamy, emphasis on condom use as appropriate among PLWHA); however, most leaders and congregants supported comprehensive HIV prevention, beyond abstinence-only, delivered through the church. These findings are consistent with recent studies in which churches indicated interest in, support of, and acceptance of the responsibility for conducting HIV prevention activities within the church [33, 35, 39, 54–59]. However, there exists a range of potential strategies and formats for engaging in HIV prevention, and these findings provide specific cultural insight and language that can help tailor prevention strategies for black Baptist churches, which has been limited in the literature from this perspective.

The level of congruence between the abstinence perspectives can facilitate church-led abstinence-based HIV prevention programs, similar to those found in other studies [56, 60–62]. However, given that many pastors and leaders conceptualized abstinence more broadly than refraining from sexual activity, church-based HIV prevention strategies may gain traction as part of a broader health promotion context [63]. Monogamy, within the context of marriage, and condom use within sero-discordant couples were also a compatible fit for this sample. However, based upon these findings, confession and forgiveness for PwP present significant conceptual incompatibility and practical challenges. First, confession and forgiveness assume all PLWHA became HIV-infected by not following church standards for sexual activity; however, individuals do become infected within the context of marriage. Second, participants acknowledged that sexual activity occurs outside of marriage, but only indicated a need for confession and forgiveness for those who subsequently become HIV-infected. Third, public forms of confession, without the appropriate support in place, can fuel stigmatization of PLWHA. Although these concerns exist, other work indicates that creating more openness and connection between PLWHA and congregational leaders and members can facilitate more empathy and decrease further stigma [56, 62, 64]. These findings would indicate the need for more work around stigma within the church setting to encourage effective support mechanisms for PLWHA. In one sample of congregations already engaged in care and support activities for PLWHA, churches most commonly provided pastoral spiritual support, prayer and counseling [56]. This level of activity is closely aligned with respondent’s church-based emphasis on counseling within VCT and providing support for PwP. In addition, respondent’s idea of partnering with external organizations to conduct VCT has been the trend for other faith institutions that successfully offer HIV testing [56, 63].

Although respondents in this study were clear that their first priority was to their spiritual goals and church-based beliefs, their recognition of depravity and desire to prevent disease made monogamy teachings among the unmarried, condom use among PLWHA and the unmarried, VCT, and PwP acceptable, even within the church context. Depravity allows churches to create a contingency plan for sex that is premarital or extramarital. The rationale for this approach is similar to other public health risk-reduction or harm-reduction approaches that emphasize intermediate protective strategies that create balance between the desired behavioral outcome and an individual’s current behaviors (e.g. sexual risk reduction programs, needle exchange programs for intravenous drug users, use of lower tar cigarettes among smokers, etc.) [62, 65–67]. The challenge of depravity is that it operates as a conceptual guide to HIV prevention among churches, but may prove difficult to put into practice. The church-based focus on avoidance of sin introduces a need for spiritual accountability that is not
necessarily addressed by current public health prevention interventions. Prevention approaches, such as reducing the number of sexual partners and condom promotion, focus on risk-reduction. The risk-reduction approach presents a challenge for integration and implementation, given church-based beliefs on the appropriate parameters for sexual activity and a desire for spiritual accountability for adhering to those standards. This tension between supporting prevention and being responsive to church-based beliefs is similarly found in other studies [35, 55, 56]. Interestingly, despite condoms having no utility for avoiding sin, almost all respondents supported their use within the church setting. This suggests that avoidance of disease can supersede the focus on avoidance of sin, particularly when framed as a temporary contingency instead of the long-term standard. Ultimately, translating existing public health prevention interventions into the church context will require a balance between teachings on spiritual accountability and employing HIV prevention strategies as a safety net to sexual risk behaviors.

Previous studies on HIV prevention within the black church have largely focused on the attitudes and opinions of pastors and church leaders [33, 38, 39] while overlooking the influence of congregants’ perspectives on shaping church contexts for HIV prevention programming. However, this study is among the first to document the perception and support for comprehensive church-based HIV prevention by congregants. In light of the growing sense of engagement in HIV prevention among black churches, these timely findings indicate broader organizational support for preventive activities and outline opportunities to integrate both necessary perspectives. Although churches in this study were broadly supportive of prevention interventions within the church, their discussions were targeted at heterosexual partnerships. Given many church views on the parameters for sexual activity, homosexuality remains a difficult area for many black churches to address [33, 56, 62, 64, 68, 69, 70]. This challenge has implications in particular for Black men who have sex with men, who remain at highest risk of HIV [71]. Further study is needed to determine how an integration of the public health and church-based perspectives can be applied to same-sex partnerships.

This study is not without limitations. First, none of the churches sampled for this study actively engaged in HIV prevention. However, the participant views provide the practical context within which prevention interventions are considered and applied. Second, as a qualitative study we did not sample the churches or participants within the churches to be able to generalize these findings to all black churches. This study was designed to explore the topics in-depth with a small, purposive sample of individuals who could share their informed perspectives. In addition, participants described their views of church-based beliefs and standards, which may not reflect actual Baptist doctrine and theology. Third, although we sampled to be able to make comparisons across size of church and urban/rural location of churches, we found striking similarities across the groups indicating that the same factors that inform the understanding and preferences for addressing HIV are likely present across most black Baptist contexts. Fourth, though currently 71% of HIV in North Carolina is sexually transmitted, HIV transmission does occur via intravenous drug use or other unidentified risk behaviors [72]. In this study, we only explored preventive interventions for sexually transmitted HIV. The literature suggests that some churches are engaging in broader HIV prevention efforts including addiction services and policy advocacy [54]. Another opportunity for church engagement in HIV prevention is through linkage to care and treatment, which may not present the same challenges as risk reduction approaches. Further exploration of how broader prevention strategies fit within a church-based perspective is warranted.

Significant evidence substantiates the impact of HIV upon the black community and affirms the need for black church engagement in prevention. Multiple studies have outlined the challenges and facilitators to church-based HIV prevention [33, 35, 36, 38, 39, 54], as well as the need to adapt interventions for minority communities [40, 72–74]. Current evidence-based intervention strategies are effective for preventing HIV, but may lack the
salience for adoption within the black church environment. A major challenge to church engagement in prevention is deeply rooted in the cultural dissonance between church-based conceptualizations of HIV prevention, and the pragmatic approach of public-health-derived models. This study provides the language, associated meanings and cultural insights necessary to bridge evidence-based HIV prevention strategies with the black Baptist church’s sacred environment. This measure of cultural insight should inform message content and delivery to effectively prevent HIV/AIDS within this ethnic sub-population [40]. Integrating the synergies between the church-based and public health perspectives, and balancing the focus on avoidance of sin and avoidance of disease, can allow churches to maintain their spiritual priorities and accountability while engaging in HIV prevention activities.

Conflict of interest statement

Research reported in this publication was supported by the National Institute Of Allergy And Infectious Diseases of the National Institutes of Health under Award Number T32AI007001. The content is solely the responsibility of the authors and does not necessarily represent the official views of the National Institutes of Health.

References

Public health and church-based constructions


