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Dissonance and Accord Between Black Faith Leaders' and Community Members' Perceptions of Structural and Institutional Barriers in HIV

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ABSTRACT

DISSONANCE AND ACCORD BETWEEN BLACK FAITH LEADERS' AND COMMUNITY MEMBERS' PERCEPTIONS OF STRUCTURAL AND INSTITUTIONAL BARRIERS IN HIV

By

JENNIFER PHILLIPS

07/22/2015

Historically, the Black church has acted as the leader and social service provider in the black community. Despite the church's successes in providing support to alleviate health disparities, the HIV/AIDS epidemic has remained largely ignored. Research has shown that rather than just providing information about high risk HIV behavior, underlying inequities also need to be addressed. This analysis contains data from four separate qualitative focus groups containing faith leaders and community members and preliminary quantitative data from community members. Responses from community members and faith leaders are compared and reported relating poverty, violence, HIV, and other inequities within their neighborhoods. The analysis focuses on the common themes of perceived barriers and future recommendations given by the community members and faith leaders. Community members and faith leaders both identified structural barriers and inequalities. With regards to HIV services, community members were concerned with confidentiality as well as availability and extent of services. Faith leaders discussed possible conflicts with church teachings and funding. Both groups acknowledged the impact of stigma. These findings highlight greater environmental factors that impact HIV services in black ministries, but also includes changes that could be addressed by ministries at the local level.

Key words: black church, HIV, low SES, homophobia

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BARRIERS IN HIV

by

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APPROVAL PAGE

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INTRODUCTION

Since its inception in 1787, the black church has served as the moral compass for the African American community (1). Although there is diversity between ministries and denominations, the black church is loosely defined as being a unified community in which many denominations come together in a collective conscious to serve and be led by African Americans (AAs) (2-4). Research suggests that the church is not only a space for worship but for centuries, has also acted as an educator, unifier and social service provider (1, 3-10).

The church has been actively involved in addressing multiple health disparities in the community (4, 9). Most notably, AAs experience higher rates of poverty, and diabetes, for example, when compared to other demographic groups in the United States (11, 12). The services that the church provides to address these concerns can include food donations, counseling, diabetes or cancer screening, and childcare among others (10).

When surveyed, over 80% of AAs agreed that the church had helped the condition of AAs (13). One study found that when AA males perceive that their church supports them in changing a specific health behavior, they show significant improvement in the health related behavior whereas those who perceive less support show less improvement (14). The literature shows that religious participation reduces mortality risks, increases psychological welfare and overall physical health for AAs (13, 15).

The influence and history of health ministries within the church enables it to be an ideal provider of culturally appropriate HIV and AIDS prevention programs (16). The CDC has made an appeal to black ministries to implement such programs due to African Americans making up

over half of the new HIV/AIDS cases in the United States even though they only constitute 12% of the population (11, 13, 17). Researchers believe that the ministries in especially low income, urban communities will be at an advantage due to their close ties and location in areas where prevalence can be at its highest (17, 18).

Black transgender women, heterosexual women and men who have sex with men (MSM) are disproportionately affected by HIV risk (19, 20), thus making them important groups for HIV ministerial interventions to target (19). Another target group is AAs that live in low-income, urban neighborhoods; they are at greater risk of contracting HIV due to the limited ability to find sex partners outside of their neighborhoods, increased rates of incarceration, drug abuse and IV drug use (20, 17).

Although HIV has highly affected the black community, the church has yet to take an active role in the prevention, education and awareness of the epidemic within its own congregations (21, 22). Black theorists believe that this lack of HIV prevention may be due to the association HIV has with homosexuality, drug use and premarital sex (23, 24). The church is known for facilitating an oppressive doctrine that suppresses both premarital sex and homosexual sexuality (9, 24-27).

HIV/AIDS related stigma has been noted as the primary source of apprehension in HIV/AIDS prevention program implementation within AA ministries (27).
Fear of stigmatization is the main reason for black MSMs to avoid HIV care or other health related services (28). MSMs report feeling isolated from their home ministry and although they still have the ability to thrive in lesbian, gay, bisexual and transgender (LGBT) communities,

they cannot go back to their childhood religious community without facing stigma (24). Racism is still experienced in the predominantly white LGBT communities, leaving black MSMs to choose between the homophobia at home and racism in LGBT culture (29).

Many established black congregations within urban environments are predominantly made up of commuter members (17). When AAs were able to gain a higher socio-economic status (SES), many moved to the wealthier suburbs and needed to travel back to their urban communities to attend church (20, 30). Research suggests that though ministries have historically been led and attended by members in the community, they are now led by members of a different class who generally provide programs to suit their needs rather than the surrounding neighborhood's (17). This could increase stigma and social isolation for lower income AA members who are at greater risk for HIV and still live in the communities in which the ministries are based.

When interviewed about the epidemic, AA faith leader's primary recommendation for a reduction in HIV risk has been to increase education about HIV/AIDS (31). However, education may not be enough to lessen the burden of risk in the AA community (9). A growing body of research suggests that education about reducing risky behaviors has little effect on reducing HIV infection (9). It instead indicates that social and structural factors such as poverty, homophobia, stigma and violence are greater contributors to the racial disparity of increased risk of HIV infection among AAs (9, 32).

Furthermore, while the church continues to be a notable leader in the black community, there is a gap in the literature with regard to community members' reports about how effectively

the ministries in their neighborhoods are able to address HIV prevention (9). It is shown that when working with disenfranchised communities at risk for HIV, it is necessary to conduct needs assessments and receive program feedback from community members in order to ensure that the intervention designed for them is accurately catering to their unique needs (33, 34).

This paper will attempt to bridge the gap by exploring the perceptions of the black church's support of HIV services in the community. Data are analyzed from a previous study that interviewed community members and faith leaders. Both the faith leaders and community members either served or received services in the same marginalized urban neighborhoods in Atlanta, Georgia. This paper will focus on four different participant groups. Two focus groups included community members that lived within five disadvantaged zip codes. The other two groups were composed of faith leaders whose churches and outreach programs served the same aforementioned zip codes. Preliminary quantitative data including community members' responses on what services they are using from ministries in their neighborhoods are also analyzed.

Responses were compared from community members and church leaders on how the black church is helping to diminish poverty, violence, drug use, HIV and other inequities within their neighborhoods. The codes from the previous study were analyzed to find common themes between the pastoral leader's and the community member's responses. This analysis focuses on the common themes of perceived structural barriers and perceptions of HIV services given by the community members and faith leaders.

The theoretical framework of intersectionality is used to frame the analysis.

Intersectionality argues that multiple factors such as socioeconomic status, race, or sexual orientation can work together simultaneously to create a collective form of oppression experienced both on the micro and macro level (35). This is important in HIV related research because the populations at greatest risk for HIV experience multiple social and health inequities. Without this acknowledgement, HIV interventions could miss the complexities of underlying factors that are putting people at greater risk for HIV (35). Intersectionality is vital to public health research due to its applicability to historically oppressed populations and the multiple forms of health inequity that they experience (35).

METHODS

The analyzed data were part of a larger study that included 72 participants. Individual interviews included 41 participants and the four focus groups were composed of 31. Two staff members with extensive community experience conducted ethnographic investigations for the study. The data analysis team was comprised of the Co-Principle Investigator and six trained graduate students. The constant comparative method of analysis was used for coding the qualitative data. As part of this process, once the data were collected, the team immediately started conducting the analysis before the formal coding process of the data began. The cross-coding function of the web based mixed methods data software program Dedoose was used to identify preliminary codes within the data set. Three trained graduate students met twice over a period of three weeks to perform the final coding process. Various methods were used during the coding process to increase validity and inter-rater reliability. Students were given unmarked transcripts with a list of codes to code separately; students also created their own codes. Inter-

rater reliability was conducted by raters coding an un-marked transcript using the preliminary

codes. The transcript was then compared to the same transcript previously coded by the

qualitative investigator.

For this paper, only the four focus groups were analyzed. The first two focus groups

contained faith leaders and the second two contained community members. The focus groups

contained a total of 31 participants with an average of 7-8 participants per focus group. The

sample age ranged from 18 to 64 with an average age of 40 years. For their time and

participation in the focus groups, the community members received $25 and the faith leaders

received $50. Each focus group was led by the project director and recorded by a graduate

student. Information collected from the community members showed that they were living in zip

codes 30314, 30310, 30318, 30312, and 30315. Fourteen of the community members identified

as African American, one identified as Native American and one identified as other. Ten of the

participants were male and six were female.

As with the community members, the faith leaders reported leading ministries in the zip

codes of 30310, 30315, 30318, 30314 and 30308. All of the faith leaders identified as African

American with eleven being male and four being female. Ten of the faith leaders were pastors.

The groups also contained one associate minister, assistant campus minister, ministry founder,

priest and assistant to the pastor. The faith leaders had an average of 14.6 years of service within

their respective churches with a range of 2 to 40 years. Five of the represented churches were

Baptist and three were non-denominational. The Episcopal, Catholic, Church of God in Christ

(COGIC), Full Gospel, Assembly of God, Pentecostal, and Methodist denominations were

individually represented once in the focus groups. Two of the ministers had campus ministries; two identified as gay and served predominantly LBGT populations. Two ministries did not serve out of a physical building but instead operated street-based ministries.

RESULTS

STRUCTURAL BARRIERS

The first common theme that was examined in all four focus groups was perceived structural barriers. These barriers were the perceived impediments to providing HIV services. Community members and faith leaders shared many of the same concerns about their neighborhoods. Both groups reported working and living in communities that were affected by violence, drug use, a lack of effective law enforcement, poverty and untreated mental health issues.

VIOLENCE

Both the community members and faith leaders expressed a fear of violence while in the community. People feared going to the corner store or walking down the street. When asked to describe the violence that occurred in their neighborhood, one community member stated:

"Like shootouts. Jumping on one another...They shoot in broad daylight. Or late at night they come by and shoot your house up."

Ministers also felt domestic violence was a prevalent form of violence in their neighborhood; women experiencing poverty faced homelessness if they left their abusive partners:

"It's hard to get them to say that they will remove themselves from the abuse…One said 'I been in a relationship with him nine years.' She never moved away…Still abused. Go to jail over each other and everything. Many of the young ladies…they are homeless because they have been victims of domestic violence. And they did move away but they had nowhere to go."

DRUGS

Community members reported a significant percentage of the neighborhood as being largely composed of gang members and people struggling with drug addiction. People reported feeling threatened and unprotected in their neighborhood because they refused to join gangs. Faith leaders also reported feeling threatened and indicated that this made it difficult to reach out to the members living in their neighborhood. One faith leader described his experience serving in his neighborhood as being difficult due to elected officials spending money allotted to help needy communities on other things. It was also reported that elected officials ignored the ministries' needs for safety and support, leaving the ministers open to threating actions from gang members if they attempted to intervene on neighborhood drug use:

"When you go into a community and you see people losing their lives…heroin addicts, kids

suffering and living up [in] such conditions and the money allocated to these communities is not

used for the purpose that they intended it for. And there's no accountability. And then the elected

officials that are supposed to be representing you to make sure that things is kinda in your favor,

they outside the ballpark. Then as a minister of the gospel, you have to really start testing your

faith for God. Because when people got guns in your face, your names all on the wall."

LACK OF EFFECTIVE LAW ENFORCEMENT

Faith leaders and community members reported feeling abandoned by police and political

leaders. Community members stated that criminals are commonly arrested and permitted re-entry

back into the community the same day only to steal and rob from members of the neighborhood

once again. Faith leaders described their churches or congregation members' cars being broken

into on numerous occasions. Community members reported that though police may arrest a head

gang member, the gang member that immediately takes his place might be even more violent.

Though the participants stated that they wanted to help stop the violence in their neighborhoods,

they expressed that people did not always feeling safe doing so. One participant talks about how

if people in the neighborhood call the police, gang members or criminals will know who called

due to the police visiting the caller's house. This makes the caller vulnerable to backlash from

the gang members or criminals once the police leave:

"I had a member of the congregation say 'Reverend, I would do it more often but they always

wanna come to your house. The police wanna come to your house. And those persons who are

involved in that kind of activity know who's doing the calling.'"

POVERTY

Both faith leaders and community members reported neighbors struggling with drug and alcohol addictions to the point that they were unable to provide for their basic needs. In addition, many members reported that within communities the only jobs people could often attain involved working for drug dealers or selling sex. Both groups expressed an overwhelming need to help their communities find stable jobs in order to alleviate poverty. When asked about employment opportunities available in the neighborhood, one minister said:

"You'd have to drive out of our community five, six, almost ten miles to get real decent employment. One of the issues I've had is that they built the facility near us and promised jobs to our community. Never came through. And so I guess I'm a little leery of people who come and say 'support this effort and we're gonna bring jobs.'"

Another minister describes his/her? experience serving community members experiencing poverty:

"Most of them are single parents, women that come, and we have food, clothing and different things that we try to serve them, because it's still a very poverty stricken community."

People reported that during colder weather, homeless members of the community would purposely try to get caught committing criminal acts just so they could spend the winter in jail with heat and meals. Community members reported that the widespread felony convictions in their neighborhoods contributed to an epidemic of chronic unemployment. Faith leaders reported that lack of education and job skills in addition to issues with permanent housing and transportation worsened the inability of many community members to find employment. When asked why helping people find employment was so challenging, one faith leader said:

"Because the ones who need them…[are] homeless. They don't have the attire necessary. They don't have the interviewing skills they need. They don't have the transportation to get there for the application. And even the applications that are online, they don't have access to the computer that they need to get the application, so that's the challenge that we're facing."

MENTAL HEALTH

Both sets of focus groups noted community members with mental health illnesses that were not receiving proper care. Faith leaders reported that many individuals use drugs while allowing their mental illness to go untreated. Participants reported that though mental health care was available, people too often did not take advantage of it because of common cultural stigmas related to having mental illness.

Drug addiction often takes precedence over mental health medication, leaving the person's mental health to deteriorate. Shortages of resources and support networks make it

difficult for them to maintain abstinence when drug abuse is also so prevalent in the community. One faith leader expressed their concern for members of the community trapped in the cycle of untreated mental illness and drug abuse:

"And some of them are so far into it, some of them are not even taking their medicine. Getting them into a program where they're taking it, they'll feel better."

Mental health issues and drug use were also thought to be an underlying risk for HIV exposure. Community members felt that in order to properly care for their disease, they would first need to receive treatment for their various mental health conditions and substance abuse issues. Both groups felt that mental health issues were an ignored underlying cause of several barriers. The majority of participants felt that without eliminating the stigma imposed on people seeking care for mental illness, people will continue to avoid seeking care. Participants also felt that the lack of job opportunities left people feeling depressed and hopeless:

"A lot of it is depression because people are not self-sufficient. They don't have what they need… So if we have more jobs where people can feel like men, feel like adults, that would go a long way for people taking pride in their neighborhood."

PERCEPTIONS OF HIV/AIDS SERVICES

The second common theme that is examined in all four focus groups is perceptions of HIV/AIDS services. Community members and faith leaders shared about their experience with receiving or giving services. The groups shared about openness in participating or implementing HIV/AIDS ministries. Both groups talked about what services they were either receiving or giving. Community members spoke about feeling excluded and unwelcome in ministries while both groups agreed that the church needed to reduce the stigmatized environment that is a part of the church community. Faith leaders also shared about their experience in seeking ministerial outreach service funding.

HIV/AIDS MINISTRY OPENESS

One of the faith leader's perceived barriers to providing HIV services was the community's lack of interest in their programs. Faith leaders felt that some community members would spend money given to provide for their basic needs on drugs. One faith leader expressed that people often just wanted money from churches instead of the programs that the church offered:

"But sometimes the people that we serve are looking for a dollar. We do have to spend ours to serve them. They don't see that…which if you give them money, they wouldn't do the things that they need to do with that money because they have to be revamped in order to use money again."

All of the faith leaders expressed interest in starting HIV/AIDS ministries but felt that their congregations did not support them. They expressed that they feared losing members if they started to preach about safe sex practices or HIV prevention. Leaders revealed that though a few

HIV positive congregants were outspoken about their status, most chose not to disclose their status to other church members. All of the focus groups participants had experienced losing family, community and church members to AIDS; they shared that although people may acknowledge the deaths, they will often not speak about how they died:

"You bring it up in ministry talks and people get quiet. Deadly quiet. Like 'pastor, don't talk about that!'"
"They don't wanna deal with it. People clam up. We have a health ministry. They don't wanna deal with it. We have health fairs. We don't wanna talk about HIV. We don't wanna talk about getting tested"

Faith leaders reported that the black church has historically spoken out against premarital sex and homosexuality. Many of them felt that speaking in favor of certain HIV prevention practices would be condoning traditionally condemned behaviors. Faith leaders reported that the black church has historically spoken out against premarital sex and homosexuality.

Community members reported a lack of supportive services from the churches in their communities. Though they found HIV/AIDS screening beneficial, they collectively agreed that HIV screening alone was not enough to help the community decrease the health disparities. One participant was asked about the usefulness of HIV screenings…

"With the screening, it's like...for years, they have came through the community and did the

screening...But we would like to see them do more about providing medicine for the people that's

sick...You can go down to the health department across from Grady and get screened for AIDS.

Every day, for free...Try to provide shelter for these people. Provide jobs so they won't lower

they self to do stuff to try to get money, that what causes the AIDS and diseases and stuff."

MINISTRY SERVICES

Faith leaders reported that the church provided more services than were reported by the

community members. Within the focus groups, community members described having

knowledge of food bags, hot meals, clothing and a small amount of job help. Faith leaders

reported HIV testing and education, food bags and hot meals, youth programs, housing, utility

and mortgage help, health fairs, social events, drug addiction treatment referrals, Christmas tree

lighting, job referrals, condom distribution, health fairs and clothing. Community members

stated that they received additional services, however, they were from non-profits instead of their

local churches. Members were not aware of these additional programs that the churches reported

offering. Community members often recommended that churches help them find jobs and stable

housing, hold youth activities and provide safe places for families to congregate.

The preliminary quantitative data showed that out of three hundred and eighty two

community members surveyed, seventy churches in the same zip codes were providing services.

Within the last three months, survey participants reported receiving food, clothing, shelter,

healthcare, spiritual guidance and counseling, church service, MARTA passes, referrals to others

programs, mail services, hygiene kits and showers, diapers, I.D. services, brotherhood programs, free haircuts, housing, bail money, money and HIV testing.

Neither the qualitative nor quantitative data from community members showed that ministries within their zip codes were providing the recommended job referrals and youth and family activities that are suggested from the community members. However, the quantitative data suggests that community members receive a larger variety of services than what was reported in the focus groups.

FEELINGS OF EXCLUSION

Furthermore, some community members felt that they were not welcome at their local churches. Community members and faith leaders reported that congregations often do not consist of actual residents of the neighborhoods but instead are longstanding church members that left the community for better opportunities and now reside in middle to upper class suburbs located throughout metro Atlanta:

"The people that I see coming to the churches in my community of English Avenue, they don't live over there. They have cars. We don't have cars. They don't come and stay over there. I don't see them walking down the street."

When a community member was asked why they felt people drove from the suburbs to the churches in their neighborhood they said:

"I think they basically come there just to make themselves feel better. Just looking at the neighborhood, just riding through, just to feel how well off they have it. I don't wanna feel uncomfortable being around people like that. I was brought up that you should be able to come to church just as you are. And a lot of people feel uncomfortable."

Though several participants proclaimed that they felt unwelcomed and judged by church congregations, the faith leaders themselves declared that they had non-judgmental congregations that include trained church volunteers who treat people receiving services with respect and compassion. Several community members shared that though church volunteers and congregation members were allowed to use the bathrooms, those receiving services were not allowed to use the bathrooms. One member of the community stated that as a result of this type of treatment, she would be unlikely to seek assistance from the ministry in the future. When asked why they did not feel comfortable visiting their neighborhood church, another community member said:

"Because I guess the people that they have handling the food and pantry and clothes, they don't give you a good feel of that church...give you the sense of 'oh we're here to help you.' It's like 'oh, ya'll need our help.' So you wouldn't wanna go to that...you be like if this how the organization, the community is acting...the people who helping run the church acting...how's the pastor?...They won't even let you use the bathroom. "

Both participants and Faith Leaders gave opinions about how their local churches could improve their communities. Community members were asked questions relating to what their church would need to change for them to increase their attendance at programs. Church leaders were also asked questions about what they felt their churches could change to increase attendance or better serve their communities.

CONFIDENTIALITY

Faith leaders in both focus groups opined that the black church needed to improve its relationship with community members by increasing confidence and trust. Participants reported that they would be hesitant to seek HIV/AIDS services from local churches due to a lack of confidentiality. They were afraid that church members would talk about them and their potentially positive status. The community members felt that if their neighborhood churches became more confidential, they would be more open to receiving services from them. When asked why they may not want to go to their church for HIV testing one member of the community said:

"Because the majority of the time the people at church be hypocrites. They the ones who talk about you first before anything else go wrong, and that's how your business get out there."

Faith leaders also felt that their churches would attract more members from their neighborhoods if they were able to establish a reputation of being more confidential…

"We have a responsibility as leaders in the church to withhold certain information. To breach

that confidentiality is to go against our own calling. But I wouldn't go to [our]church either.

Because we don't know how to keep our mouths shut."

STIGMA

Faith leaders wanted to provide greater resources for HIV/AIDS prevention. Speaking

out about stigma and mistrust in the church during sermons was recommended. Despite possible

backlash from church members, church leaders felt they needed to take the lead and start

addressing the stigma that is often a part of church teachings.

Community members reported that people often choose to not seek care for their HIV

disease because seeking care could expose their status and therefore isolate them from the

community. Both groups believed that the church needed to increase confidentiality while

reducing the climate of shame and stigma surrounding LGBT or single, sexually active members

of the congregation. One faith leader speaks here on the power of stigma in the church:

"A lot of the stigma came from the church, because the church…for so long…thought that its

main goal was to identify what the church called sin. So that was the label or the banner that we

carry. And the church still carries that… Now we are learning a new way or a new conversation.

We still have some of the same old concerns, but we have another way of approaching it. I say

it's gonna take a while. It's gonna take a lot of education."

FUNDING

Both faith leader focus groups also reported that a lack of funding kept them from properly serving their neighborhoods. There was an interest in partnering with more non-profits including universities in order to increase the efficacy and quantity of services. Faith leaders expressed a desire to work with universities and health care workers to put together programs to help congregations and communities with education and care:

"And every time we tried to do something, our hands were tied because there was no money, because a couple of mega churches get good grant writers. They hire the best grant writers and soak up all the money. And then you ask them to help you, and they just simply tell you 'refer them to us.'"

"Emory had…a 15 million dollar grant that they received a few years back. I tried to set up an appointment with the person that was administering the program. And I couldn't get to first base. I could not get to first base. The only time that I was able to access any kind of services was through a board member at Morehouse."

DISCUSSION

These findings highlight the broader framework in which HIV prevention services are delivered within this community. Structural barriers which were identified by both faith leaders and community members include lack of employment, lack of housing, violence and drug addiction. These findings mirror the literature in that they suggest that HIV risk is linked to an interplay of other health disparities and social problems (36). Multiple components such as low

SES, ethnicity, HIV risk and substance abuse may exist simultaneously for communities and therefore may need to be addressed as a whole during intervention planning strategies (36).

If members of the community are too afraid to walk down the street because of violence then it may be unreasonable to expect them to participate in community activities located in the same violent neighborhoods. If people are trading sex so they may obtain safe housing or basic needs, it may also be overreaching to expect an increase in condom use once they receive HIV education. Interventions guided by the theoretical framework of intersectionality may prove to be a more effective strategy for reducing HIV risk then the more traditional method of using HIV education alone (35, 36).

Although the findings from the focus groups are not necessarily generalizable to the larger population, they provide a more in-depth perspective to faith leaders and community members within these Atlanta neighborhoods. The data analyzed was part of a larger study that covered a robust amount of topics and information. This paper did not analyze all of the responses and information given by the participants but focused only on the key themes commonly identified by all of the focus groups. Some of the themes that were not shared between the two different groups included ministry descriptions, survival methods and income.

There were two areas of dissonance between the two groups. Within the focus groups, community members reported ministries providing a few resources such as food and clothing where the faith leaders claimed to provide greater variety. Some of the community members same service recommendations for ministries were the same services that the faith leaders claimed to already be providing. For example, the community members wanted ministries to

help with finding employment and reported that ministries offered no employment referral programs. This finding is inconsistent with the faith leader focus groups in which several ministries reported providing job referrals. The preliminary quantitative data taken from community members living within the same zip codes shows that members are in fact receiving a greater variety of services. The potential discrepancy in the reporting of services could be related to the smaller number of participants that were included in the focus groups. It also is possible that there is a lack of communication between the ministries and community participants about services that are provided in their neighborhoods.

The dissention between community members and faith leaders could be that community members are expecting services that the ministries simply cannot provide. Previous literature suggests that pastors and leaders of churches may not have the resources to direct or design all of the HIV-related initiatives (7, 34). The compensatory model explains that through the organizational structure of the black church, the AA community is able to take part in education and activities that are denied them in greater society; however, intersectionality is also experienced in black ministries (13). Many historical AA ministries have been forced to relocate, cut ministries and outreach services due to lack of funding or city rehabilitation. Historical black churches are often located in poor urban communities making them vulnerable to the same violence, poverty, deterioration and demolition of buildings that businesses face in their communities (37). Friendship Baptist Church, the oldest black church in the nation, recently sold their 130 year old church building to the city to make way for the new Falcons stadium in Atlanta, Georgia (38). They opted for the much needed funds of 19.5 million in lieu of their

historic building because of their now increased ability to provide a greater variety of outreach services to their community (38). Due to lack of funding opportunities in church communities, community members cannot look to their ministry as a one stop shop for resources. Though historically the AA community treated their neighborhood ministry as such, it is unrealistic to expect the AA church to aid in all the health and social disparities that the AA community faces when they often have the same struggles.

Community members and church leaders need to increase communication and work together in order to bridge the gap of awareness and service utilization. Due to the lack of communication funding and resources, involving community members in program implementation and evaluation could help improve program implementation and effectiveness. Creating a community outreach committee where universities, non-profits and community members could share ideas and collaborate on future projects could better fulfill the needs of the community the churches are interested in serving. There is a lack of literature that shows program outcomes for faith-based HIV programs. There is a need for additional church interventions that include both implementation and evaluation in order for more empiric recommendations to be made for future dissemination.

Another point of incongruity was the welcome received during formal church services and ministry outreach. Community members cited that faith leaders and ministry congregations treated them and others receiving their services with prejudice and judgment. Faith leaders sin-driven approach to ministering could shun the very people who are at greatest risk for HIV and need the ministries services the most. Research has shown that using a fear-based approach to

HIV prevention is not as successful as a compassionate, educational approach (7). Churches struggle with providing services for issues that may have historically been seen as immoral, such as sex before marriage or drug use (7, 24-27). There are special challenges that ministries may encounter when aiming to serve neighborhoods with a heightened sensitivity to cultural stigmas such as mental health treatment and premarital sex (7). In order to better serve these members of the community, stigma reduction within the congregation and faith community must be addressed (39).

One successful intervention found that though many faith leaders understood how HIV could be transmitted, they lacked understanding of how HIV could not be transmitted (27). Faith leaders who reported understanding that HIV could be spread through unprotected sex but also were unsure on whether or not it could be spread through actions like casual non-sexual contact had more HIV related stigma beliefs then those who reported a more thorough understanding of HIV contraction (27). This particular intervention found that more thorough educational approaches to HIV/AIDS education reduced stigma-related beliefs for faith leaders and their congregations (27).

Another intervention found that because stigma directly affects a community's ability to prevent HIV risk, interventions primarily focusing on stigma reduction could improve the communities overall HIV prevalence (39). This minority and faith-based intervention used theory along with community engagement to develop a multi-pronged program (39). In collaboration with their local health department, the intervention found that reduction in HIV related stigma among minority church congregations could be implemented successfully (39).

Community based participatory research is recommended for HIV interventions due to the need to gain trust from the community and understand the genuine needs of the community members at risk (39). Without this key component in interventions, health workers and faith leaders may provide the community with something that is unnecessary and ineffective (39, 34). The community member's reports indicate that the interlocking systems of privilege and oppression that lead to HIV risk may not be addressed by one health behavior change or one health service given by a church ministry. It is recommended that faith leaders continue to assess the specific needs of their community while collaborating with the people they aim to serve so that they may ensure more effective outreach services.

Table 1. Faith Leader Roles

Denomination	Role in Church	Years Affiliated with Church	Percentage of AA members
Baptist	Associate Minister	40	95
Episcopal	Priest	2.5	100
Catholic	Asst. Campus Minister	5	100
Assembly of God	Assistant to Pastor	3	60
Baptist	Pastor	18	99
Baptist	Founder	13	90
Non-denomination	Pastor	14	99
COGIC	Pastor	19	100
Non-denomination	Pastor	15	98
Full Gospel	Pastor	15	80
Baptist	Pastor	4	99
Methodist	Pastor	2	100
Pentecostal	Pastor	25	90
Non-denomination	Pastor	7	98
Baptist	Pastor	36	99

Table 2. Faith Leader Role Averages

Denomination	Role in Church	Years Affiliated with Church	Percentage of AA Members
Baptist = 5 (33.3%)	Pastor = 10 (66.67%)	Avg years of affiliation = 14.6	Avg Percentage of AA Members = 93.8%
Non Denomination = 3 (20%)	Assoc. Minister = 1 (6.67%)		
Episcopal = 1 (6.67%)	Asst. Campus Minister = 1 (6.67%)		
Catholic = 1 (6.67%)	Founder = 1 (6.67%)		
COGIC = 1 (6.67%)	Priest = 1 (6.67%)		
Full Gospel = 1 (6.67%)	Asst. to Pastor = 1 (6.67%)		
Assembly of God = 1 (6.67%)			
Pentecostal = 1 (6.67%)			
Methodist = 1 (6.67%)			

Table 3. Faith Leader Demographics

Zip Code (last 6 months)	Gender	Age	Race/Ethnicity
30314	Female	63	B-AA
30314	Female	27	B-AA
30314	Male	28	B-AA
30308	Male	48	B-AA
30308	Male	59	B-AA
30318	Male	49	B-AA
30310	Male	54	B-AA
30315	Male	51	B-AA
30315	Male	45	B-AA
30318	Female	60	B-AA
30310	Male	52	B-AA
30318	Male	64	B-AA
30315	Female	60	B-AA
30315	Male	49	B-AA
30318	Male	63	B-AA

Table 4. Faith Leader Demographic Averages

Zip Code (last 6 months)	Gender	Age	Race/Ethnicity
30308 = 2 (13.3%)	Female = 4 (27%)	Average age = 51.5	Black (African American) = 15 (100%)
30310 = 2 (13.3%)	Male = 11 (73%)		
30314 = 3 (20%)			
30315 = 4 (26.7%)			
30318 = 4 (26.7%)			

Table 5. Community Member Demographics

Zip Code (last 6 months)	Gender	Age	Race/Ethnicity
30314	Female	48	B-AA
30312	Male	57	B-AA
30310	Female	44	B-AA
30310	Female	28	B-AA
30310	Male	22	B-AA
30315	Male	18	B-AA
30314	Male	46	B-AA
30318	Male	48	B-AA
30314	Male	39	O- Human
30310	Female	24	B-AA
30314	Female	52	B-AA
30314	Male	41	B-AA
30314	Male	39	B-AA
30318	Female	50	B-AA
30318	Male	41	Native American
30314	Male	45	B-AA

Table 6. Community Member Demographic Averages

Zip Code (last 6 months)	Gender	Age	Race/Ethnicity
30310 = 4 (25%)	Female = 6 (37.5%)	Average age = 40.1	Black (African American) = 14 (87.5%)
30312 = 1 (6.25%)	Male = 10 (62.5%)		Other - Human = 1 (6.25%)
30314 = 7 (43.75%)			Native American = 1 (6.25%)
30315 = 1 (6.25%)			
30318 = 3 (18.75%)			

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