THE PERCEPTION OF AFRICAN AMERICAN FAITH-BASED ORGANIZATIONS REGARDING AFRICAN AMERICANS WITH HIV

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DEDICATION

This work is dedicated to my family; I love you. First of all, I want to thank my father, Elder Nathaniel R. Rodgers, for his support and prayers. This work is dedicated posthumously to my mother, Carol A. Demmings-Rodgers who gave me a love for reading and education. To my sister, Anita D. Williams, she has endured this long process with me. Next, thank you to my children, Reuben and Sable Otey, and my grandson Amare' DeShawn Otey. Their encouragement was expressed with lots of hugs and kisses and spending time together. I hope that I have set an example for you of the importance of an education and to never give up. Lastly, I want to thank my brother, Kevin and Alicia Rodgers, my nephew, Andersen Williams, and my niece Amber Rodgers and a host of extended family members.

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Tamara Dochelle Otey

THE PERCEPTION OF AFRICAN AMERICAN FAITH-BASED ORGANIZATIONS REGARDING AFRICAN AMERICANS WITH HIV

Shelby County has the fastest growing rate of HIV infection in the State of Tennessee and the majority of the people with HIV/AIDS are African Americans. 2011 CDC report stated Memphis had the fifth highest proportion of new HIV infections. The African American church is a natural and potentially powerful venue to facilitate health awareness. The purpose of this qualitative study was to explore the views of African American faith-based leaders (FBLs) toward offering HIV prevention services in FBOs.

The theoretical framework for this study was the Consolidated Framework for Implementation Research (CFIR). The fourth domain of CFIR, characteristics of the individuals, is concerned with organizational change which occurs on the individual level. CFIR provided a means to ensure effective implementations, data coding and analysis. Interpretative Descriptive (ID) design, which seeks to discover associations, relationships, and patterns within the described phenomenon, was used. The targeted population was African American Faith-based Leaders from areas known to have high rates of HIV/STIs. Purposeful sampling was employed to recruit participants. Data was generated through face-to-face, semi-structured interviews. The

researchers categorized and analyzed the data to form the concepts and themes identified using a coding scheme which was applied to all data.

Faith-based leaders revealed that they had a role in HIV prevention. The themes that emerged were their role to provide education on HIV, minister with compassion, teach Biblical doctrine, maintain a community focus, and partner with expert healthcare professionals. Perceived barrier concepts identified were lack of knowledge, denial, stigma, fear, keeping issues private, and the breakdown of family and community values. Findings suggest that FBLs had some knowledge of the health disparities and ongoing stigma concerning HIV remains a major barrier. The participants interviewed were open to HIV preventions on different levels to address HIV but needed more education.

Janice M. Buelow, PhD, RN, FAAN

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CHAPTER I

INTRODUCTION

Background and Description of Problem

The 2010 United States Census reports that African Americans comprise 12.6% of the total population and yet, African Americans account for 46% of the people living with the human immunodeficiency virus and acquired immune deficiency syndrome (HIV/AIDS) and as much as 45% of new HIV infections each year (Centers for Disease Control and Prevention [CDC], 2010a). The prevalence of HIV in African Americans is higher than for any other racial or ethnic group in the United States despite federal, state, and local efforts to reduce this disparity (Griffith, Pichon, Campbell, & Allen, 2010). Despite numerous HIV prevention programs and strategies, there has only been a minimal decline in HIV/AIDS rates within the African American community (Williams, Wyatt, & Wingood, 2010).

We have observed an epidemiologic shift of HIV cases from metropolitan Northeastern and Western areas to Southern urban and rural regions. The shift is exacerbated by poverty, insufficient knowledge of HIV transmission, and lack of access to HIV prevention services and care especially in Southern rural areas (Sengupta, Strauss, Miles, Roman-Isler, Banks, & Corbie-Smith, 2010).

Faith-based organizations (FBOs) are historically the core of social activities and a vehicle for presenting pertinent health information in the

African American community but they have been slow to respond to this epidemic (Griffith et al., 2010; Teti et al., 2011). Of the approximately 300,000 FBOs in the United States, only 10% offer some type of HIV-related services (Bluthenthal, Palar, Mendel, Kenouse, Corbin, & Derose, 2012; Derose et al., 2010).

The United States is known as a religious nation, but African Americans are markedly more religious than the United States (U.S.) population as a whole. According to the U.S. Religious Landscape Survey conducted in 2007 by the Pew Research Center's Forum on Religion and Public Life, 87% of African Americans report a formal religious affiliation. Eight out of ten African Americans (79%) say religion is very important in their lives, compared to 56% among all U.S. adults. More than half of African Americans (53%) report attending religious services at least once a week, more than three out of four (76%) say they pray on a daily basis, and nearly nine out of ten (88%) indicate they are absolutely certain that God exists (Sahgal & Smith, 2009).

There is a church approximately every mile in the majority of African American communities in the southern United States. FBOs, therefore, have the potential to make a significant impact in the community (Hicks, Allen, & Wright, 2005). The Centers for Disease Control and Prevention (CDC) and President Obama's National HIV/AIDS Strategy (NHAS) have called for new partnerships with FBOs to decrease HIV-related health disparities, reduce the spread of HIV/AIDS, and

provide information and services for their congregations and the surrounding community. Some of the NHAS priorities is to intensify HIV prevention activities in the neighborhoods where HIV is more heavily concentrated and to educate all Americans about the threat of HIV and how to prevent it (The White House Office of National AIDS Policy, 2010; Sutton & Parks, 2011).

Study Purpose

African American faith-based leaders have the power to provide health education, resources, and support to those with HIV/AIDS. Unfortunately, FBOs have not been commonly involved in HIV supportive services or prevention, and partnerships between healthcare professionals and FBOs to address HIV are rare (Bluthenthal et al., 2012). In order to subsequently build education and awareness programs focused on HIV in the African American community, we must better understand the common views and beliefs among African American faith-based leaders and their attitudes toward HIV education and awareness. The purpose of this study is to explore the views of African American faith-based leaders toward offering HIV prevention services in their FBO. Specifically, we will describe the perceptions of African American faith-based leaders regarding African Americans with HIV and their ability and willingness to identify FBO-based solutions to decrease the number of African Americans contracting HIV in the community where their FBO resides (Davidson, 2011; Francis & Liverpool, 2009).

Specific Aim and Research Purpose

The study will engage in meaningful conversation with African American faith-based leaders regarding their beliefs and attitudes toward HIV, those infected, and the blight upon the African American community. Shelby County has the fastest growing rate of HIV infection in the State of Tennessee. Youth between the ages of 13 to 24 represent 13% of new AIDS cases and 26% of new HIV cases in Memphis. The vast majority (83.5%) of the people living with HIV/AIDS in Memphis/Shelby County are African Americans (Williams, 2013). "The Memphis HIV disease incidence rate for non-Hispanic Blacks (55.6 per 100,000 population) is almost ten times that reported among non-Hispanic Whites (5.9 per 100,000 population) in 2010" (Memphis Transitional Grant Area 2012-2014, p 25).

The purpose of this study is to explore the views of African American faith-based leaders toward offering HIV prevention services in FBOs. The specific aims are to describe the leaders' (1) perceptions about the role of FBOs in HIV prevention, (2) perceptions about implementing HIV prevention services in FBOs, (3) perceptions of barriers to implementing HIV prevention services in FBOs, and (4) willingness and/or perceived ability to offer HIV prevention services in their own FBO.

Definition of Key Terms

We will define the numerous concepts or key terms used in this study. These concepts appear to be critical conceptual components in

HIV prevention interventions. They are *HIV prevention, stigma, HIV-related stigma, spirituality, religiosity, culture,* and *faith-based organizations*. Each concept will be defined and characterized.

HIV prevention consists of activities, programs, and services designed to prevent or reduce HIV transmission for persons who are not infected with HIV and persons who are HIV positive (The National HIV Prevention Inventor, 2009). *HIV prevention* has contributed to dramatic reductions in the number of new infections since the mid-1980s. An important sign of progress is the impressive declines in mother-to-child HIV transmission with current prenatal care standards (CDC, 2009). Researchers are still seeking more effective HIV prevention programs targeting the African American community (Williams et al., 2010).

Stigma was first identified as a sociological construct in the 1960's (Goffman, 1963). The term *stigma* refers to bodily signs considered to expose something unusual and bad about the moral status of an individual. There are three different types of stigma. The first type is individuals bearing some physical deformities. Next, there are blemishes of character such as intravenous drug use and sexual promiscuity. Finally, stigma is associated with race, ethnicity, and religion. Individuals possessing these traits can experience stigma and discrimination (Goffman, 1963). Discrimination is the manifestation of stigma. It is defined as negative reactions as a result of stigma that devalues and lessens the recipient's status in society (Nyblade, 2006).

HIV-related stigma is increasingly recognized as the single greatest challenge to slowing the spread of HIV/AIDS (USAID, 2010). It is defined as the stigma and discrimination experienced related to HIV/AIDS. HIV-related stigma can make individuals with HIV reluctant to disclose their HIV positive status or delay their treatment and care of HIV. It also causes individuals to refrain from being tested to learn their serostatus (whether an individual is HIV positive or negative). HIV-related stigma can impede governments from effectively addressing the epidemic, especially because the most at-risk populations are often the most marginalized groups in society (USAID, 2010).

The study of the African American community also necessitates defining the concepts *spirituality* and *religiosity*. The term *spirituality* has been used more recently to describe an individual's sense of purpose and meaning and personal connectedness to the divine or to the truth. It is personal and not related to an institution's context (Yi et al., 2006). *Religiosity* is defined as one's adherence to prescribed rituals and beliefs about God from an institution's standpoint (Mattis, 2000). Religiosity contributes to HIV/AIDS stigma as a barrier. Research has shown that individuals with high religiosity display significantly higher HIV-related stigma, believing that HIV/AIDS is a sin or curse and not deserving mercy. Therefore, spiritual individuals are more receptive to HIV issues than *religious* individuals (Muturi & An, 2010; Wooster et al., 2011).

The concept of *culture* is essential to health promotion and disease prevention research. Culture is defined as beliefs, ritual practices, art forms and ceremonies, as well as informal cultural practices such as language, gossip, stories and habitual activities of daily life. Culture consists of socially constructed symbols and activities that provide meaning and establish and reinforce expected behavior among group members (Barnes, 2005). By understanding the cultural characteristics of a given group, HIV prevention programs and FBOs will be more capable of meeting the health needs within the context of the targeted population's ethnicity and the congregation's culture, belief system, and resources (Bluthenthal et al., 2012; Williams et al., 2010).

Engaging FBOs in health initiatives among African Americans is not new but they are must becoming more common in some areas of the United States (Griffith et al., 2010).

> Faith-based organizations are defined by acting in accordance with one of these accepted parameters: (1) they are directly connected to a faith community, (2) they have a spiritually oriented mission statement, (3) they receive significant support from religious organizations, or (4) they are initiated by a religious institution. (IEL, n.d.)

FBOs are usually the last to leave impoverished African American neighborhoods, thereby shouldering much of the burden of meeting community needs (Derose et al., 2010). They have the opportunity to address HIV-related stigma by providing accurate information about

HIV/AIDS within the community and dispelling myths (Coleman, Lindley, Annang, Saunders, & Gaddist, 2012).

Literature Review

A review of the literature was conducted in order to assess the current state of knowledge surrounding the phenomenon of interest which is HIV prevention interventions in the African American community with faith-based organizations (Corbin & Strauss, 2008; Sandelowski, 2000). This will allow the evaluation of what is currently known about the phenomenon of interest, as well as what knowledge about the phenomenon is still lacking or incomplete, thereby informing the study's purpose and research questions (Corbin & Strauss, 2008; Sandelowski, 2000). This literature review's results were grouped together by categorizing the current research into the major themes they addressed: the African American Community and HIV, Lack of Effective Strategies to Reduce HIV in the African American Community, the Importance of Spirituality in the African American Community, Facilitators to HIV Prevention with FBOs, Barriers to HIV Prevention with FBOs, and Future Directions for HIV Preventions with FBOs.

Methods

Research studies were included in this review if they indicated that the targeted population included a portion of or the entire African American community, HIV/AIDS, stigma, HIV-related stigma, African American or Black church, and faith-based or religious organizations. To

ensure an extensive review, computer database systems (MEDLINE, CINAHL, OMNIFILE, PubMed, Web of Knowledge, Project MUSE, PsychInfo, Science Digest and search engine Google Scholar) were searched using the aforementioned key words. Inclusion criteria resulted in the final sample of 19 studies from various designs: qualitative, quantitative, and community-based participatory research. Studies were sorted by design, then grouped by their major themes.

The African American Community and HIV

While African Americans genetically are to a degree from African descent, there is much diversity and many subcultures in this group. Historical disparities in healthcare access, healthcare utilization, and generational poverty must be considered in examining why African Americans are at a greater risk for contracting HIV/AIDS (Wyatt, Williams, & Myers, 2008). Approximately, one in four African Americans lives in poverty, which includes a higher risk of homelessness. African Americans are more likely to be publicly insured or uninsured than European Americans (Laurencin, Christensen, & Taylor, 2008).

Intravenous drug use is an important primary risk factor for HIV/AIDS in African Americans. Intravenous drug abuse is reported to be the second leading cause of HIV infection in African American men and women. Illicit drugs are readily available in many low socioeconomic African American communities. In addition to needle sharing, substance abusers are more likely to engage in risky sexual behaviors while under

the influence of drugs. HIV positive substance abusers are less likely to maintain their medication regimen and increase the likelihood of carrying a resistant strain of HIV (Laurencin et al., 2008).

The current sexual context in the African American community differs from other communities. Reports indicate that 14% of African American men who have sex with women also have sex with men. Anticipated stigma repercussions secondary to sexual orientation have led many homosexual and bisexual African Americans men to socially identify as heterosexual, while secretly engaging in sex with men (Brooks et al., 2005). Moreover, African American women have problems with partner unavailability primarily due to incarceration, premature death, and homicide. Partner unavailability is a predictor of high-risk behavior because of its association with high levels of concurrent sexual partners (Williams et al., 2010; Wyatt et al., 2008).

Untreated sexually transmitted infections (STIs) are more prevalent in some African American communities. One's social environment can determine the probability of meeting uninfected or infected sexual partners. African Americans primarily choose sex partners within their own communities. Therefore, they face a greater chance of infection with each sexual encounter because of the higher rates of HIV infection within the African American community. African Americans account for one-third of all reported chlamydia cases, almost half of all syphilis cases, and two-thirds of all reported gonorrhea cases (Laurencin et al., 2008, p.

37). Inflammatory STIs (gonorrhea) and ulcerative STIs (syphilis) increase HIV susceptibility by three to five times. An individual infected with both HIV and these STIs has a greater chance of transmitting both to others (Laurencin et al., 2008; Williams et al., 2010).

The rate of incarceration among Black men is one for every fifteen; Blacks are five times more likely to be jailed than Whites. Incarceration has devastating effects on partner and family relationships and economic stability. Additionally, the prison environment is a high-risk setting for the spread of HIV and STIs due to unprotected sex, drug use and unsterile tattoos and piercings (Laurencin et al., 2008; Williams et al., 2010).

The majority of HIV transmission in the United States today occurs during sex or intravenous drug use. The infectiousness of HIV-positive partners depends on their viral load, their adherence level to safe sex practices (condom use), how long they have been infected, whether they are taking antiretroviral medications and whether they have STIs. The probability that an uninfected person will have an infected sexual or injection partner depends on both partners particular social and behavioral histories (Friedman, Cooper, & Osborne, 2009).

Serodiscordant is a label used to describe a couple where one partner is HIV positive and the other is HIV negative. Pre-Exposure Prophylaxis (PrEP) is a new HIV prevention method in which the serodiscordant partners who are HIV negative take a daily pill to reduce

their risk of becoming infected. PrEP research began in July 2012. The U.S. Food and Drug Administration approved the combination medication tenofovir disoproxil fumarate plus emtricitabine (brand name Truvada) for use as PrEP trials; it is taken daily in a single pill. When used consistently, PrEP has been shown to reduce the risk of HIV infection among adult men and women who are at very high risk for contracting HIV infection through sex or injecting drug use (CDC, 2013).

Lack of Effective Strategies to Reduce HIV in the African American Community

It was inconceivable 30 years ago when HIV became a major problem that HIV prevention would be more challenging than HIV treatment. We have learned that no simplistic solutions exist for HIV prevention especially in the African American community. Although HIV prevention programs have proven to be successful for some segments of the U.S. population, these programs continue to be ineffective in reducing the prevalence of HIV among African Americans. The CDC has initiated many projects targeting the African American community, including the following: (a) funding HIV testing for students who attend historically Black colleges and universities, (b) conducting epidemiological research designs that primarily focus on African Americans, (c) supporting community-based organizations that provide services to African Americans, (d) creating educational campaigns aimed at educating the public about the disease, and (e) developing and disseminating

evidenced-based interventions that were successful with other groups (CDC, 2007). Nevertheless, the rate of new HIV incidence continues to increase with African Americans still demonstrating disproportionate increases (Davidson, 2011).

Most research that links HIV-related stigma as a barrier to HIV prevention and facilitator of the HIV epidemic has been conducted in other countries and not in the United States. In China, individuals presumed to engage in high-risk behaviors are stigmatized. People living with HIV/AIDS (PLWHAs) in South Africa, who have been recipients of enacted stigma or discrimination, were less likely to disclose their serostatus to their intimate partner. Over 2,000 sexually active PLWHAs in France stated that HIV-related stigma and discrimination were coupled with increased unsafe sexual activity (Mahajan et al., 2008). The major challenge to HIV prevention, treatment, and support in Nigeria is HIV-related stigma and discrimination (Monjok, Smesny, & Essien, 2010). In order to develop effective prevention programs, rigorous research that demonstrates the relationship between stigmatizing attitudes and risky sexual behaviors is required (Mahajan et al., 2008).

HIV-related stigma and discrimination are intermingled with the other stigmatizing elements of the African American community (poverty, sexual promiscuity, sexual preference, gender, and race) creating multilayered stigmas. Thirty years after the first case of HIV was identified, stigma remains an issue and a barrier (Parker & Aggleton,

2002). The complexity of HIV-related stigma and the potential layering of pre-existing stigmas with African Americans must be addressed to begin the decline of HIV/AIDS in the African American community. These stigmas cause delays in health-seeking behaviors and facilitate disease transmission (Hood & Friedman, 2011).

The Importance of Spirituality in the African American Community

Historically, the church has served as a house of worship and a meeting place for social action. The African American pastors have been teachers, preachers, and politicians, and now we need them to become a change agent for health. The African American church is no stranger to health promotion programs and ministries. Some of them continue to take the lead in addressing the health of African Americans which is especially relevant given the large-scale health disparities (Francis & Liverpool, 2009).

The African American pastors and church leadership have a strong relationship with their congregants based on mutual trust. Therefore, advice on health issues communicated from the pulpit gets members' attention. These factors make the African American church a natural and potentially powerful venue to facilitate health awareness. Some public health and medical professionals have worked with the African American church to gain access to subpopulations in the African American community that are difficult to reach through other means (Francis & Liverpool, 2009).

The African American church is a cultural entity within the African American community. The spiritual songs, call-and-response sermons, fervent prayer style, and scriptural interpretation serve to translate and illuminate the basic issues of faith and life in every aspect of the human experience that is different from other faith traditions. The Bible is central to this culture. African American religiosity focuses both religious and secular events around prayer. The African American church is a more encompassing institution addressing economic, social, and political life than are European American religious organizations. This is mainly attributed to the fact that historically it has been the only institution controlled completely by African Americans (Pattillo-McCoy, 1998).

Spiritual and religious beliefs and practices are common in a majority of patients with HIV/AIDS especially African Americans. African Americans with HIV use positive religious coping strategies and they make remarks such as “I’m looking for a stronger connection with God” and “I’m seeking God’s love and care.” For this ethnicity, they value a religious affiliation that brings the byproducts of optimism, reduced alcohol use, self-esteem, life satisfaction, and enhanced overall functioning (Cotton et al., 2006).

African American Christian spirituality is based on themes of deliverance and freedom. The freedom aspired to and attainable through religion differs from the European American perception of freedom. In the African American Christian view, freedom is an endeavor signifying

both spiritual deliverance into God's kingdom and worldly deliverance from the material realities of racial oppression. Using the call-and-response style, the preacher and the congregation, in musical and verbal cooperation, make the journey toward freedom as one body (Pattillo-McCoy, 1998).

Social conservatism is more prominent in the South causing HIV-related stigma to be more pronounced (The Center for HIV Law and Policy, 2008). The importance of religion in the South with its sexual prohibitions and sins really intensifies anticipated stigma. Since stigma is frequently experienced from religious organizations, southern people expect and anticipate the condemnation and feels of inferiority associated with stigma even before it can be seen. This is called anticipated stigma (Goffman, 1963).

The U.S. South has the highest numbers of adults and adolescents living and dying with AIDS. Of the 20 states with the highest rates of new HIV diagnosis; nine of them (60%) are in the South. At the beginning of the AIDS epidemic, most infections were in urban areas; however, currently in the South, HIV/AIDS numbers are increasing rapidly in rural areas as well (The Center for HIV Law and Policy, 2008).

Facilitators to HIV Prevention with Faith-Based Organizations

Hicks et al. (2005) conducted research in Washington DC with the African American community and faith-based leaders. Faith-based leaders were asked to identify factors that would enhance the development of

HIV preventions activities in their faith communities. Interviews of 14 African American leaders were conducted in person and by phone. The items identified to enhance HIV programs in FBOs included the following: (1) the pastor's understanding and support of HIV-related activities, (2) the ministerial health leaders' experience in faith-based programming and administration with the larger community, (3) how the community identifies people living with HIV/AIDS, (4) the existence of partnerships between public health and faith-based organizations, (5) an informed and educated congregation and community, (6) the identification of significant barriers in HIV-prevention program planning, and (7) the development of strategic plans for program enhancement. Partnerships with FBOs and public health organizations must begin with the education of the faith leaders by experts in the community. It was also recommended that faith-based leaders speak out against the stigma and begin conversations about sex (Hicks, et al., 2005).

Fulton (2011) studied African American churches that reside in predominately African American communities. The study examined whether the influence of liberal or conservative ideological orientation of an African American church would predict having HIV/AIDS programs. Bivariate analyses and logistic regression models were used for statistical measurements. Surprisingly, the results demonstrated that none of the variables measuring ideological orientation had a significant effect on HIV/AIDS program sponsorship. This differed from older studies which

showed that a congregation's liberal-conservative orientation significantly influences its social service activity. However, ethnographic research revealed that an African American congregation's commitment to social service provision determined whether they provided HIV programs independent of its liberal-conservative orientation.

This liberal-conservative orientation hypothesis was also tested with White congregations. The results confirmed that a White congregation's liberal-conservative orientation significantly predicted its likelihood of having HIV/AIDS programs. This analysis demonstrated that liberal-conservative ideology operates differently and generates different outcomes in White churches than it does in Black churches (Fulton, 2011).

Bluthenthal et al. (2012) explored congregational and community norms and attitudes regarding HIV, sexuality, and drug use through a qualitative case study of 14 diverse urban religious congregations in Los Angeles County. Interviews of clergy and lay leaders were audio-recorded from groups of four to six participants each. Results showed that congregational HIV activities are possible despite the presence of HIV-related stigma among the leadership and the members. The programs may contribute to the further reduction of stigma over time. Therefore, the correct attitude was to initiate HIV prevention interventions and not try to assess whether stigma exists in the congregation. It was more advantageous to establish the kinds of activities that are suitable to the

context of a particular congregation's culture, belief system, and resources.

One of the major strengths of the Foster, Cooper, Parton, and Meeks (2011) study was the collaboration between the research group and a well-organized rural Baptist ministerial group in Alabama. A ministerial liaison, who was very committed and knowledgeable about the HIV/AIDS epidemic, made this collaboration possible. A mixed method approach was employed, using both qualitative and quantitative designs. The study generated possible positive and negative influences of HIV/AIDS prevention by the participants. Potential positive influences included the following: having an HIV-positive relative or close friend, marriage to a healthcare provider or being a healthcare provider, having previously lived in a large metropolitan area, having concern for people and the need to help people, and previous participation in research projects.

Foster et al. (2011) suggested using healthcare providers such as nurses to educate the African American community about HIV/AIDS in the church setting or using of youth ministries as a vehicle to conduct HIV/AIDS prevention activities. Several potential negative influences were identified, including the following: the lack of knowing anyone HIV positive; the tension between addressing HIV/AIDS as a moral issue versus a health or societal issue; and how it fits with mission of church;

and fear of being viewed negatively by congregants or other church leaders due to the stigma associated with disease.

In the Moore, Onsomu, Timmons, Abuya, and Moore (2012) study, communication strategies regarding HIV among African American church leaders in a metropolitan cities and surrounding counties in North Carolina were explored. The various recommended modes of communication included the following: interpersonal communication, health fairs, health seminars, dissemination of printed information during the fairs or seminars, church bulletins, prayer breakfasts, sermons, various forms of media, workshops for pastors, and wearing red ribbons on the first Sunday in December, which is World AIDS Day.

After interviews were conducted and transcribed, Grounded Theory was used for the analysis, and the researchers were able to discover the themes that emerged from the data. Four main themes emerged: (1) disseminating information about HIV/AIDS through a combination of communication modes, (2) responsibility and obligation to create awareness about HIV/AIDS, (3) reducing stigma by example, and (4) preaching and teaching compassion. These African American church leaders accepted responsibility for helping to address HIV/AIDS prevention needs in the community and promised to fulfill this duty in a godly or loving manner. This study found that church leaders were not only HIV/AIDS prevention advocates, but one leader also acknowledged

his position as a role model for destigmatizing HIV/AIDS and related testing (Moore et al., 2012).

The purpose of the Teti et al., (2011) study was to identify and understand the barriers and facilitators to the development and implementation of effective faith-based programs from the perspectives of both religious leaders and community members. Grounded Theory was employed along with the Constant Comparative Method to guide the generation of theories and ideas from the data. Forty-six individuals were interviewed from specific groups: (a) clergy and religious leaders, (b) men who have sex with men (MSM), (c) male injection drug users, (d) female injection drug users, and (e) females with high-risk partners.

Several themes served to facilitate the provision of HIV-related services within faith communities: (1) the existence of faith-based health services, (2) the strength of networking across African American churches in the community, (3) outreach services, (4) recognition that providing support is part of their spiritual calling, and (5) being recipients of support from God, religion, or spirituality when in crisis. The major barriers included the following: limited capacity due to restrictions on how public funding could be used, lack of training and skills in obtaining and managing grants, lack of knowledge and skills to provide HIV-related services, and stigma associated with HIV/AIDS (Teti et al., 2011).

"*Your Blessed Health*" (YBH) is a community-based participatory research (CBPR) study with the goals of increasing HIV awareness and

knowledge, reducing HIV risk behavior, and fostering skill building among African American youth by strengthening the capacity of the faith community. The program was designed to respect the values and beliefs of faith leaders and treat HIV/AIDS as a public health issue rather than primarily as a sexual and moral issue for greater acceptance and sustainability. The YBH program also provided FBOs with a flexible menu of options from which faith leaders could adopt interventions to match their beliefs, doctrine, and cultures (Griffith et al., 2010).

The response of the medical and public health professionals to community sexual issues in Flint, MI appeared slow and inadequate which led to seeking assistance from community and faith-based organizations. At the time the Griffith, et al. article (2010) was written, 4,714 youth and adult congregants, pastor's spouses and other faith-based leaders from 42 congregations participated in the YBH training, activities and events. The YBH staff was successful in gaining the support of pastor's spouses, pastors, and other faith-based leaders who participated in the study. Faith leaders were able to discuss the importance of addressing HIV/AIDS awareness and they began to share this information with the rest of their faith community. Some of the faith leaders were able to influence their denomination. No statistically significant differences was noted in youths' knowledge, self-efficacy, or perceived support from adults post intervention. Although the primary goal of the YBH program was to reduce HIV risk behaviors and promote healthy sexuality among

adolescents, the actual outcome was that the faith-based leaders felt more comfortable and competent to effectively address HIV/AIDS with their congregants (Griffith et al., 2010).

The Coleman et al. (2012) study created a framework to guide the development and implementation of HIV/AIDS prevention programs in African American churches. Grounded Theory and constant comparative analysis were used to code the emerging themes generated from focus groups and interviews. The framework presented is the first to explain the process of implementing HIV/AIDS prevention programs in African American churches. It calls for the identification of individuals (members of the church congregation and church leaders) who are passionate about and devoted to addressing HIV/AIDS, and for churches to provide specific mechanisms (Health Ministries) through which these individuals can organize, strategies for HIV/AIDS program implementation.

According to Piot, Bartos, Larson, Zewdie, and Mane (2008), there are three crucial aspects that are essential to conducting effective HIV prevention interventions: (1) macrolevel social determinants of health, (2) the state of HIV/AIDS programming and funding relative to the needs of the community, and (3) the epidemiology of the local epidemic. While individual-level approaches have shown limited success in reducing risk behavior, behavioral interventions can be dramatically improved when coupled with structural interventions that have prevention strategies on multiple levels. At the macrolevel, the community leaders and faith

leaders must rally around issues related to HIV/AIDS in order to influence lawmakers. Many lawmakers are often unaware or in denial about the extent to which HIV/AIDS affects their constituents (Griffith et al., 2010).

In Williams et al. (2010), the majority of the participants received their HIV/AIDS education from informal sources such as brochures or television. Urban participants appeared to have more access to HIV/AIDS education sources than their rural counterparts. Most were interested in having HIV/AIDS prevention activities within their congregations (89.3%, $N = 50$). Of those sampled ($N = 33$), 58.9% had a health-related ministry at their church. Studies must draw upon the strengths and resiliency of the African American community and not solely on models in developing HIV prevention programs.

There have been successful collaborations developed with public-health and faith-based organization partnerships (Francis & Liverpool, 2009, p. 12). Several key elements were identified for producing successful HIV prevention interventions. They incorporate: (1) involving the faith-based community and the target population in design, implementation, and program evaluation; (2) recognizing that the pastor and their staff may have time constraints, requiring a liaison who is committed to HIV-related initiatives; (3) incorporating spirituality and compassion into prevention efforts; (4) ensuring that the program is culturally appropriate for the target audience; and (5) creating a sense of

ownership by the FBO to ensure wider program distribution and participation (Francis & Liverpool, 2009).

Several successful FBO HIV prevention programs were identified. The Churches United to Stop HIV (CUSH) program is a collaborative effort between the Broward County (Florida) Health Department and local community FBOs. The objectives of the CUSH program were to train faith-based leaders and congregations to develop HIV education programs, outreach, and referral services, and support to those infected and their families. Training manuals were created along with brochures and palm cards. Over a series of several meetings, they reviewed current local surveillance data, studied modes of HIV transmission, and discussed abstinence, condom use and distribution, premarital and extramarital sex, homosexuality, and substance abuse (Agate et al., 2005).

CUSH activities have underscored the importance of collaborations between public-health organizations and FBOs to connect science with the community. It provides early intervention services, HIV prevention training, HIV counseling and testing, and the creation of HIV ministries. The CUSH program has provided HIV prevention services to over 32,000 people and trained over 2,850 faith leaders (Agate et al., 2005).

The Metropolitan Community AIDS Network (Metro CAN) was created by the Metropolitan Interdenominational Church in Nashville, TN to serve African Americans who use cocaine and heroin and are at high risk for contracting HIV/AIDS. The program uses culturally relevant

interventions based on the National AIDS Demonstration Research (NADR) program and the National Institute on Drug Abuse (NIDA) Cooperative Agreement for AIDS Community-Based Outreach/Intervention Research Program. Metro CAN's program components include street outreach and risk reduction, HIV/STD testing and counseling, alcohol and drug coordination services that transition participants to treatment, ongoing long-term intensive case management, support groups, and spiritual nurturing activities (MacMaster, Crawford, Jones, Rasch, Thompson, & Sanders, 2007).

The Metro CAN program involved a non-experimental quantitative repeated measure design with data collection at the baseline, 6 months, and 12 months. Of the 163 individuals who initially started the program only 51 individuals continued through all 3 evaluation periods. Self-reported substance abuse significantly decreased and 72.5% were transitioned into substance abuse treatment. The largest decreases in sexual risk behaviors were among women with the greatest decline between baseline and 6 months along with condom use. The number of reported sexually transmitted infections declined during the 12-month data collection phase. HIV diagnosis increased during both the 6- and 12-month periods but this may not be indicative of a recent infection. The results of Metro CAN demonstrate the efficacy of faith-based interventions to reduce substance use and HIV/AIDS risk behaviors in the African American community (MacMaster et al., 2007).

Project BRIDGE was a three-year, federally funded, community-based participatory research (CBPR) project that guided a collaborative effort between the faith-based community, Windsor Village United Methodist Church, and university-based investigators from the University of Texas Health Science Center in Houston, TX. The BRIDGE project provided a structured program for youth in grades six through eight, one evening per week during the school year. The first goal of the project was to design, implement, and evaluate an ethnically appropriate curriculum to address substance abuse and HIV/AIDS prevention. The second goal was to increase the FBO's ability to sustain the implemented program and spread it to the community (Marcus et al., 2004).

The initial BRIDGE students were all African Americans between the ages of 13 and 14. After the study began, another group from a FBO was added as a comparison group in order to substantiate the research findings. This group had the same ages, race, and religion as the original group. Both groups' sizes were 27. An instrument tool was administered to both groups during the third year of the program` . Chi-square and *t*-tests were performed to determine if there were differences between the groups. There was no difference in HIV/AIDS knowledge. Ninety percent of the comparison group perceived a threat to contract AIDS whereas 100% of the BRIDGE students felt the threat. Significantly more (chi^2 = 6.71; p = 0.035) BRIDGE students agreed to treat individuals with HIV/AIDS with compassion than the comparison group. Also, the BRIDGE

group was more prone to discuss sexuality concerns with parents or guardians. There was no reported drug use among BRIDGE participants whereas the comparison group reported current drug use primarily marijuana (Marcus et al., 2004).

The successes of the project led the church to make BRIDGE an official ministry. They have more than 40 volunteers that have been trained to deliver the curriculum. The program is delivered to young people at the church and in an after-school program in the community. BRIDGE served as a foundation for future work between FBOs and scholars (Marcus et al., 2004).

The Balm in Gilead is a nonprofit, nongovernmental organization that develops educational and training programs to prevent diseases and improve individual health status. The program is the first faith-based initiative specifically designed to meet the unique needs of African American and African congregations in to addressing the HIV/AIDS crisis; they are based in Richmond, VA, and Tanzania, Africa. The Balm in Gilead's pioneering achievements have enabled thousands of churches to become leaders in HIV prevention by providing comprehensive educational programs and offering compassionate support to encourage those infected to seek and maintain treatment (Martin, Younge, & Smith, 2003; www.balmingilead.org).

The Teens for AIDS Prevention (TAP) program is a church-based intervention that trains youth members as peer HIV/AIDS educators who

then present HIV/AIDS prevention programs to other teens throughout the community. It was developed by the AIDS Ministries Program of Connecticut Inc. The program includes a 17-module curriculum that can be implemented during a weekend retreat or over several weeks. The curriculum has been translated into Spanish. TAP serves as a leadership-building program for the teens who participate. The most successful sites for TAP are churches with existing youth groups. Ten sites completed the program (Mertz, 1997).

Barriers to HIV Prevention with Faith-Based Organizations

The first generation of HIV prevention research focused only on safer sex with condom use. Researchers believed that the elevated HIV/AIDS rates were solely based on individual behavior and not the sociocultural context of health disparities, lack of health insurance, unemployment, and poverty issues. Another limitation was the assumption of homogeneity across racial/ethnic groups, which erroneously stated that HIV risk factors were universally the same (Williams et al., 2010).

A second generation of HIV prevention research focused on examining differences in race and ethnicity. During this period, public health researchers would classify groups based upon their race/ethnicity, believing it was a substitute for culture. Media resources, such as videos and music lyrics that included African American models or were written by African American artists, were used to demonstrate attention to

culture. However, to be culturally competent, cultural features must be communicated through the approach that conveys the message and through the people who visibly convey it. Lacking real cultural elements limits the success of the intervention models developed for the African American community (Williams et al., 2010).

Many research participants view organized religion as a powerful source for communicating stigma and cultural expectations around sex and sexuality. However, the church is both a discriminatory and supportive force in their communities. Some feel that churches are afraid to condone homosexuality and they are concerned about endorsing extramarital sex by prompting condom use. There is a very clear link between stigma and discrimination against gay and bisexual in some FBOs. Some congregations also spread inaccurate knowledge about transmission risk for HIV and STIs. Others are unable to communicate any issues of sex and sexuality (Lapinski et al., 2010; Nunn et al., 2012). Then, there are other church members who deny that HIV/AIDS exists in their congregation or community (Teti et al., 2011).

In the Foster et al. (2011) study, pastors were interviewed. Researchers identified several reasons why many pastors were not involved in HIV/AIDS prevention: (1) fear related to lack of knowledge of HIV or stigma associated with HIV, (2) tensions between how HIV/AIDS fits into the mission of the church, (3) lack of access to accurate and culturally competent prevention services, and (4) lack of educational

information for faith-based audiences (Foster et al., 2011; Nunn et al., 2012).

African American women shoulder a disproportionate burden of HIV/AIDS in this country. African American men are an undeniable component of Black women's vulnerability to HIV infection. Gendered power dynamics are present for all African American women regardless of their ages. For younger women, the problem centers on having no control over whether safe sex practices are used in dating or marital relationships, whereas for older women, it centers on maintaining relationships and family security no matter what they have to endure. Both situations result in women having no voice and engaging in unprotected sex (Newman, Williams, Massaquoi, Brown, & Logie, 2008, p. 839). Other themes include the influence of homophobia and AIDS-related stigma in supporting silence about HIV risk, and the power of poverty in constraining women's choices in relationships (Newman et al., 2008).

Recent surveys have noted that faith-based leaders were much more willing to engage in some level of HIV-related activities than in previous studies. However, barriers still exist including lack of pastoral experience and knowledge of HIV programs, low awareness about the level of need within the church and the broader community, resource constraints, and lack of strategic planning (Williams, Palar, & Derose, 2011).

Future Directions for HIV Prevention with Faith-Based Organizations

The next generation of interventions targeting African Americans must go beyond basic sex education and condom use and availability. New interventions must include African American culture, social determinants of health, ecological theories and implementation science. This will not only facilitate individual HIV risk reduction, but also support successful translation and implementation at the individual, social and community levels. At the individual level, social determinants of health, being poor, lack of health insurance, and perceptions of discrimination and mistrust of the medical system must be addressed. Evidenced-based interventions identified six core elements for successful programming: (1) gender specificity, (2) distinct target population, (3) theoretical foundation, (4) cultural and historical congruence, (5) skill-building components, and (6) well-defined goals (Williams et al., 2010).

To understand better the nature of roles congregations can play in the fight against HIV/AIDS, research is needed to understand the range of congregational responses, where congregations' capacities and assets are greatest, what challenges have risen, what strategies have been identified to overcome them, and how these issues vary across congregations of various denominations (Derose et al., 2010). The process of overcoming these barriers and attending to these concerns will be gradual and complex but they will not occur without significant contemplation, struggle, negotiation, and collaboration. The end result will be the

availability of HIV-related services provided within the context of a supportive faith structure (Teti et al., 2011).

Opportunities for HIV prevention tailored to the needs of urban African American women include strategies focused on community survival in hostile social and institutional environments, rather than basic HIV knowledge alone. The engagement of African American women in designing, implementing and disseminating HIV prevention research interventions will support culturally appropriate, gender-focused strategies to address the escalating HIV/AIDS epidemic among African American women. Gendered power theories and strategies can be successful for all ages (Newman, et al., 2008).

The marginalization of African American men who have sex with men (MSM) has significantly influenced their communication patterns with members within their group and others outside of the group. Researchers must determine the communication path African American MSM have to release information about their sexuality. This will assist researchers to understand how stigmatizing issues are discussed and how MSM's beliefs are communicated within the group. This knowledge will allow the identification of mechanisms to reduce stigma. People make decisions on whether or not to share private information based on weighing the rewards and personal costs. Choosing to disclose such information makes the person vulnerable to others because the person no longer controls the information (Lapinski et al., 2010).

Conclusion

The HIV/AIDS epidemic is a deadly reminder of the health disparities that currently exist in the African American community. Health professionals, the community, and faith-based leaders must collaborate together to decrease the HIV/AIDS incidence in the African American community. Partnerships with the faith community should be strengthened through ongoing conversations on faith and HIV prevention with faith leaders, and academic and healthcare partners (Hicks et al., 2005). It will also be extremely beneficial for the researcher to present options for HIV prevention interventions that will coincide with the FBO's mission and beliefs. This describes how we must proceed and maintain the collaboration (Griffith et al., 2010).

The process from getting permission from faith-based leaders to have HIV prevention activities to actually implementing programs will have complications. Much care and patience will be required, and the change will most likely be slow and uneven (Lubkin & Larsen, 2006). To begin to reverse this situation, the silence about sexual health must be broken and the approach of institutions, communities, public health services, and medical agencies must change. We must create open discussions and build a culture where sexual health is viewed as a normal part of life. In order to change this culture, religious institutions and sociocultural dynamics in the community will have to be reshaped. Also,

the portrayal of individuals with HIV/AIDS must be presented in a nonstigmatizing manner in all forms of media (Hood & Friedman, 2011).

Explanations for African Americans higher HIV rates almost certainly relate to racial/ethnic oppression (discriminatory rates of arrest and incarceration, economic deprivation, and inadequate access to medical and social care), HIV-related stigma, and participation in risky behaviors. In order to administer culturally sensitive HIV prevention interventions, researchers must be able to understand how African American cultural traditions and themes can be used to decrease risk, and develop public policies or programs to support HIV prevention. There has been very little discussion of what these themes are within African American culture; how they interact within individuals, families, or larger groups; and how they can best be understood (Friedman et al., 2009).

Strengthening opportunities to conduct science-public health faith-linked research is very feasible within the context of religious doctrines. As we move forward in the context of the NHAS goals, more spiritual and faith-based interventions must be created to expand HIV prevention efforts for at-risk populations many of whom live in at-risk environments. We believe collaborations between researchers and FBO leaders can be a large part of decreasing HIV rates in the African American community (Sutton & Parks, 2011).

CHAPTER II

THEORETICAL FRAMEWORK

Health promotion is an interdisciplinary science with the aim of enhancing health and preventing disease. HIV is a preventable disease. The Healthy People 2020 goal is to prevent HIV infections, their related diseases, and death. After 30 years of HIV/AIDS research, successful interventions to decrease HIV incidence and prevalence in certain subpopulations and ethnicities are known. However, a gap exists between effective health promotion research and what is actually occurring in many Southern African American communities (DiClemente, Crosby, & Kegler, 2009; U.S. Department of Health and Human Services, 2011).

It is assumed that effective research will naturally and logically emerge into every setting and population (Glasgow, Lichtenstein, & Marcus, 2003). However, many diseases have a social etiology, meaning that the origin of the disease has sociocultural roots. The concept of risk environment describes how environments contribute significantly to behavior (DiClemente, Salazar, & Crosby, 2013). To meet these challenges, we will need to have substantially more evidence on how to implement recommendations in settings and locations serving minority and low-income populations facing health disparities (Glasgow et al., 2003).

A theoretical framework is a collection of interrelated concepts used to guide research and determine what things are measured and

what relationships are examined. Theoretical frameworks are important for descriptive studies, when the researcher does not really know much about what is going on in the phenomenon of interest and has the goal to learn more. There are three reasons why theoretical frameworks are critical: (1) no matter how little is known about a topic, and how unbiased the researchers believe they are, it is impossible for human beings not to have preconceived notions, even if they are of a very general nature; (2) the framework will guide what researchers notice in an organization or individual, and what researchers don't notice and explain the findings; and (3) a framework can indicate whether the information can be transferred to other settings (Borgatti, 1999). Nurse science researchers are identifying the importance of the role of implementation science to provide a framework to understand barriers, design interventions, and explore mediating pathways and moderators to actualize successful research into practice while demonstrating significant outcomes (Damschroder, Aron, Keith, Kirsh, Alexander, & Lowery, 2009; Damschroder & Hagedorn, 2011).

Consolidated Framework for Implementation Research

Implementation is defined as the consummation of all the processes from initiation to completion of an intervention. Implementation science is an emerging discipline whose purpose is to address the lag time between producing research and using it in practice. The CFIR is an organizing framework for building knowledge about *what*

works in a particular phenomenon, *where* and *why*. Empirically supported HIV prevention programs are available, but they are not being used in many Southern African American communities. According to the CDC in 2011, metropolitan Memphis had the fifth highest proportion of new HIV infections in the United States. It was estimated at 32.6 per 100,000 people. The metro areas with higher new HIV rates were Miami at 46.0, followed by Baton Rouge and New Orleans, LA, and Jackson, MS (CDC, 2011) .

In this study, we used some of the core concepts from the CFIR as our theoretical framework for data organization, analysis, and interpretation to build knowledge to assist in bridging the gap. Damschroder and Hagedorn (2011) created CFIR as a metatheoretical framework that synthesizes constructs from 19 healthcare-related theories about dissemination, innovation, organizational change, and implementation. Therefore, it has the potential to inform the development of theory-driven research and hypothesis testing.

The CFIR consists of 5 domains and 39 constructs to explain why or not organizations implement (or do not implement) research-proven interventions. A domain is defined as a field of knowledge containing the central concepts of the phenomena of interest (Pearsall, 1999). The five implementation domains of CFIR are: (1) the Characteristics of the Intervention, (2) the Outer Setting, (3) the Inner Setting, (4) the

Characteristics of the Individual, and (5) the Process of Implementation (Damschroder et al., 2009; Ilott, Gerrish, Booth, & Field, 2012).

A construct is defined as the building blocks to form an idea by bringing together various conceptual elements (Pearsall, 1999). The constructs of the CFIR were derived from multiple disciplines such as psychology, sociology, and organizational change. With 39 constructs involved in the framework, we will be using a menu-of-construct approach which will allow the flexibility to include only the constructs that apply to this study. It also enables systematic and comprehensive exploration and identification of potential explanatory themes or variables that may affect data analysis and interpretation of this complex phenomenon (Ilott et al., 2012).

The first domain, *characteristics of the intervention*, concerns the key attributes of an intervention that influence successful implementation. Too often interventions come to a setting poorly fitted to the situation, and because of the poor fit, they are resisted by the targeted population. The more complex and multifaceted the intervention is, the more challenging the implementation process will be. There are eight constructs in this domain: intervention source, evidence strength and quality, relative advantage, adaptability, trialability, complexity, design quality and packaging, and cost (Damschroder et al., 2009).

The next two domains are the *inner and outer settings*. Changes in the outer setting of the intervention can influence implementation. Often,

the changes are mediated through changes in the inner setting. The outer setting can include the external economic, political, and social contexts in the area where the organization resides; and the inner setting involves the organizations structure, politics, and cultural issues through which the implementation process will proceed. The line between the Outer and Inner Settings may be thin and frequent interaction between them can occur (Damschroder et al., 2009).

The *characteristics of the individuals,* which is the fourth domain of the CFIR, will be used in this study. This domain is concerned with the individuals who will participate in the study. Faith-based organizations (FBOs) are led by individuals who are positioned to play a critical role in the lives of their congregation and community. Even though this construct is titled characteristics of individuals, these measures are most appropriately aggregated to organizational levels of analysis. Organizational change begins on an individual level (Damschroder et al., 2009).

The targeted individuals for this study are African American faith-based leaders. The success of an intervention with a partnership between nurse science researchers and FBOs will ultimately be rooted in the actions and behaviors of the faith-based leaders. Little is known about the interplay between faith-based leaders and their ripple effect through their congregation and the community where the FBO resides. Individuals are carriers of cultural, organizational, professional, and individual

mindsets, norms, interests, and affiliations. Individuals have the power to make choices, and they can exert their power and influence on others with often predictable or unpredictable consequences for implementation (Damschroder, et al., 2009; Damschroder, n.d.).

There are five constructs in the fourth domain: individual identification with organization, individual stage of development, knowledge and beliefs about the intervention, self-efficacy, and other personal attributes. Each construct will be defined. The *individual identification with organization* construct is related to how individuals perceive their FBO and their relationship and degree of commitment to the FBO. These attributes may affect the willingness of the faith-based leader to fully engage in implementation efforts (Damschroder et al., 2009; Damschroder, n.d.).

The *individual stage of development* construct correlates to the current level of development of each individual faith-based leader. The level of individual development is determined by the progress that the faith-based leader makes toward skilled, enthusiastic, and sustained use of the knowledge or intervention being shared with them. Stage of change is an important measure because it is an indicator of what kinds of engagement and educational strategies will be required for effective implementation (Damschroder, et al., 2009; Damschroder, n.d.).

The *knowledge and beliefs* construct is concern with the current information the faith-based leader have about HIV in their African

American high-risk communities. Individual attitudes toward the facts, truths, and principles related to HIV are keys to implementation. The *self-efficacy* construct is defined as the individual belief in one's own capabilities to execute courses of action to achieve implementation goals. The more confident individuals feel about their ability to make the changes needed to achieve implementation goals, the higher their self-efficacy will be (Damschroder, et al., 2009; Damschroder, n.d.).

The *other personal attributes* construct adds other personal traits that are essential to implementation. These traits can include tolerance of ambiguity, intellectual ability, motivation, values, competence, capacity, and innovativeness. These traits have not received adequate attention by implementation researchers (Damschroder, et al., 2009; Damschroder, n.d.).

The fifth domain of the CFIR is the *implementation process*. The CFIR's primary aim is to nurture knowledge-building into why implementations succeed or end. There are four essential activities of the implementation process that are common across various settings: planning, engaging, executing and reflecting, and evaluating. These stages can be accomplished in any order and speed even stop-and-start, an incremental approach, or formally or informally to move toward implementation (Damschroder, et al., 2009; Damschroder, n.d.).

The CFIR represents a foundation for understanding implementation. At a macrolevel, the CFIR is used to organize and

promote synthesis of research findings using clear and consistent language and terminology that will further allow the capture of pertinent themes and concepts. The ultimate objective of the CFIR's effectiveness and validity for this study can be discerned by answering the following three questions toward the end of the analysis: (1) Is the terminology and language coherent? (2) Does the CFIR promote comparison of interview results? (3) Does the CFIR stimulate the development of new themes and concepts (Damschroder et al., 2009)?

Conclusion

In order to develop effective health promotion interventions, nurse scientists must understand and collaborate with frontline community leaders and grasp the realities of the community where future programs will take place. It is time to rethink HIV prevention interventions. We must combine the most effective theories and interventions, tailor-made for specific populations and settings. The CFIR will allow the researcher to see further; it is a road map for the research journey to assist with the accumulation of rich data, understand the complexities of the phenomenon, and provide a more predictable structure to ensure effective future implementation of HIV prevention intervention in the African American community (Damschroder et al., 2009; Rosenstock, Strecher, & Becker, 1988; Visser, Kershaw, Makin, & Forsyth, 2008).

CHAPTER III

METHODOLOGY

This chapter describes the research approach and methods that will be used to examine the perceptions of African American faith-based leaders regarding HIV. The chapter includes a description and rationale for the research approach, sampling methods and procedures, followed by a discussion of data generation, preparation, management, analysis, and interpretation techniques and processes. Finally, we will discuss the procedures that will be employed throughout the study to protect its validity (Merriam, 2009).

Background and Description of the Qualitative Descriptive Method

Qualitative research can be used to better understand phenomena or to gain new perspectives on existing phenomena that are difficult to quantify (Hoepfl, 1997). Data consisting of words and phrases to describe a particular occurrence are collected, analyzed and interpreted. The phenomenon is assessed and observed in terms of how it varies in different circumstances rather than by how big it is or numerical percentages as in quantitative research (Anderson, 2010).

Qualitative research has numerous strengths: issues can be examined in detail; the research framework can be easily revised as new information emerges from participants; and the human experience data that are generated can be powerful. Limitations include the volume of data, which can be time consuming to analyze and interpret, and the

researcher's presence can affect the participants' responses. Sample sizes are typically small and purposive and therefore not generalizable. However, they can be transferred to other settings and situations (Anderson, 2010).

In qualitative inquiry, the researcher must possess theoretical sensitivity and have insight into the phenomenon of interest to give meaning to the data and identify pertinent information. Strauss and Corbin (1994) believe that theoretical sensitivity can come from a number of sources: professional literature review search, professional experience, and personal experience. The researcher's role is to act as the human instrument of data collection. This is very effective because humans are able to respond to environmental cues, interact with the situation, collect information at multiple levels simultaneously, perceive the information holistically, process data as soon as they become available, provide immediate feedback, request verification of data, and explore unexpected responses (Hoepfl, 1997; Lincoln & Guba, 1985). The researcher must remain open to viewing the phenomenon however it naturally presents itself and be willing to move away from the original design if the data analysis warrants it (Sandelowski, 2010).

The specific design of the qualitative research depends on the purpose of the inquiry and the procedure that will deliver the most rigor and credibility (Hoepfl, 1997; Creswell, Hanson, Clark & Morales, 2007). Qualitative research designs include phenomenology, ethnography,

grounded theory, historical (narrative) studies, case studies, interpretive description, and participatory action research. The designs differ by the end product the researcher wants to achieve based on the research question, the unit of analysis (individuals or community), the level of structure, and the data collection process (Creswell et al., 2007). All qualitative methods attempt to determine how the social world is interpreted (Sandelowski, 2010).

Research Design

Interpretive descriptive (ID) methods, as described by Thorne (2008), will guide this study. ID is a qualitative research approach used to describe and interpret health-related phenomena. ID research is designed to allow nurse scientists to gain clinically applicable insight for the purpose of informing clinical reasoning and practice. ID was chosen for this study with the desire to describe subjective perceptions and attitudes of leaders from faith-based organizations (FBOs) in regards to the implementation of HIV/AIDS interventions in order to inform the development of faith-based interventions for this population (Hunt, 2009; Sandelowski, 2000; Thorne et al., 2008).

In research, the term *description* is used to explain studies whose purpose is to document something that is observed or someone's subjective experience. This term differentiates this kind of inquiry from studies designed to test something. By adding *interpretive* to *description*, we are extending description beyond documentation and into sense-

making (Benner 1994). ID seeks to discern associations, patterns, and relationships within the phenomenon being described (Thorne, 2008).

ID research questions should ideally be articulated in such a manner that they extend our reach beyond general qualitative description (typically reflected in such questions as *What is happening here? What are the dimensions of the concept? What variations exist?*) and into the domain of interpretive explanation (*How are phenomena similar or different from one another? How do they relate to one another? What patterns exist? And how do they operate?*). Out of necessity, ID questions must stop short of formal explanatory pretensions (causation, prediction, control, evaluation), for these become the domain of a much different form of inquiry (Thorne, 2008).

ID employs the *constructivism learning theory* and *naturalistic orientation* to inquiry. Constructivism is a theory to explain how knowledge is constructed in the human beings when information comes into contact with existing knowledge that has been developed by experiences. Naturalistic inquiry seeks to describe, understand, or interpret daily life experiences in their natural state (Hunt, 2009; Sandelowski, 2000; Thorne et al., 2008).

Qualitative inquiry is built on a set of assumptions about the human experience and the nature and production of the knowledge generated. ID assumptions are conducted in a naturalistic context respecting the comfort and ethical rights of the participants, focused on

the value of subjective and experiential knowledge as a fundamental source of clinical insight, maximize human commonalities that are expressed individually within a shared focus of interest, attend carefully to the time and context in which the expressions are portrayed, recognize that "reality" involves multiple constructed realities that may be contradictory, and acknowledge an inseparable connection between the knower and the known (Thorne, 2008).

ID studies are built upon relatively small samples, using such data collection methods as interviews and participant observation to articulate a coherent and meaningful account of the experiential knowledge. ID designs provide direction in the creation of an interpretive account that is generated on the basis of informed questioning and using techniques of reflection. Using the general principles of analytic framework regarding sample selection, data collection, analysis, and rigor, this study will produce credible knowledge that will contribute directly into our understanding of how African Americans faith-based leaders perceive HIV-related issues and how they perceive their role in the organization as it relates to offering the HIV prevention intervention (Thorne et al., 2008; Thorne, Kirkham, & MacDonald-Emes, 1997).

Rationale for Approach

The characteristics of ID research are categorized by the purpose of the research, the nature of reality (ontology), the nature of knowledge and the relationship between the researcher and the participants

(epistemology Hemachandra, n.d.). Interpretive description was chosen as the most appropriate design for this study for the following reasons:

1. The purpose of this ID design is to ask questions that are relevant to HIV/AIDS intervention implementation among faith-based leaders. The African American community has a high prevalence of HIV and the experiences of frontline leaders in this community are important to clinical practice (Griffith, Pichon, Campbell, & Allen, 2010).
2. It is possible that there are multiple realities for the causes of the lack of HIV Prevention Programs in African American FBOs. The realities of the perceptions of HIV can be explored and constructed through human interactions (ontology: Hemachandra, n.d.).
3. Phenomena can be best understood through the mental processes of interpretation that the participants have experienced through interacting with their social environment (epistemology: Hemachandra, n.d.).

Sample

Sampling Method: Purposive Sampling

After the research problem and questions have been formulated, the researcher's duty is to select the unit of analysis, which is the sample. The researcher must choose what, when, where, and who to observe. There are two kinds of sampling techniques: probability and non-probability. Probability sampling permits the researcher to generalize the

results and this is used in quantitative research. Non-probability sampling methods are used to solve qualitative problems. The most common nonprobabilistic method is purposive sampling, which is most effective when the researcher needs to study certain cultural domains from experts within the community (Merriam, 2009; Tongco, 2007).

Purposive sampling strategies are designed to enhance understanding of the experiences of selected participants for developing theories and concepts. The researcher selects *information-rich* cases which include individuals, groups, or organizations that provide the greatest insight into the phenomenon of interest or who work with the social processes under investigation (Frankel & Devers, 2000; Speziale, Streubert, & Carpenter, 2011). This study used purposive sampling with a population of African American faith-based leaders.

Inclusion/Exclusion Criteria

Inclusion criteria for participants included: (a) over the age of 18, (b) English speaking, (c) provides leadership in a FBO in Memphis, TN, (d) the FBO is located in a predominately African American community, and (e) the FBO is located in an area known to have high numbers of STIs and HIV. Data maps prepared by St. Jude Research Hospital in Memphis, TN reveal the following postal codes are predominately African American communities with high rates STIs and HIV: 38105, 38106, 38107, 38108, 38109, 38114, 38116, 38118, 38126, 38127, and 38128. Faith-based leaders whose organizations are located in an area considered to have

increased numbers of African Americans with HIV are eligible for the study. Faith-based leaders located outside of these Zip Code™ areas were excluded from this study (Merriam, 2009).

Setting

The interview will be conducted in the FBO's main office or in a private area elsewhere in the facility. The faith-based leaders may choose another private location if desired; they will be asked for their preference for the interview location during the initial screening. Privacy and confidentiality will be maintained. No physical risks are anticipated. While we do not expect any emotional risk, the participants voluntarily take part in this study and they may withdraw from this study at any time without penalty (Merriam, 2009).

Sample Size

Qualitative research samples must be large enough to ensure that most of the potentially important perceptions are uncovered, but having a sample that is too large becomes repetitive. In the majority of qualitative research, sampling will continue until data saturation is achieved, meaning no new information emerges from interviews (Mason, 2010). Estimating the number of participants required to reach saturation depends on several factors: the quality of data, the scope of the study, the nature of the topic, the amount of useful information obtained from each participant, the use of shadowed data, and the type of qualitative method used (Morse, 2000).

This ID study's scope was to determine the perception of HIV-related issues among African American faith-based leaders. The quality of data will depend on the participants. Some will be able to reflect on the topic and express themselves better than others. We will be reporting on the participants' experiences. They might also share the experiences of others which are called shadowed data (Morse, 2000).

According to Morse (2000), the quality of data and the number of interviews per participant determine the amount of usable data per interview question. For semistructured interviews with one interview per person, the researcher will obtain only a small amount of data per interview question. In order to ensure the richness of the data obtained, which is required for qualitative analysis, one needs a large number of participants (at least 30 to 60). However, phenomenological studies, requiring multiple interviews from each participant, will result in a large amount of data; therefore, fewer participants will be required (perhaps 6 to 10).

Mason (2010) analyzed PhD databases from universities in Great Britain and Ireland in August 2009 which stated they used qualitative research interviews as the method of data collection. They examined how many participants were interviewed based on the qualitative design. The ID method was not studied, but grounded theory and phenomenology were used. They documented the range along with the measures of central dispersion used for each method. The mean number of interviews

for grounded theory was 32, and the mean for phenomenology was 25 (Mason, 2010).

Thorne (2008) states ID studies can be conducted on almost any sample size. The majority of research studies used sample sizes ranging from 5 to 30 participants for the purpose of capturing thoughts and patterns within subjective perceptions and generating explanations capable of informing clinical understanding. Although the size of the sample will not be determined *a priori*, we estimate this study's sample size will consist of approximately 30 African American faith-based leaders based on Thorne (2008), Morse (2000), and Mason's (2010) recommendations.

Recruitment

Community-based recruitment was used to select a purposive sample for the study. Memphis, Shelby County local phone books and online websites will be used to obtain potential participants based on the FBO's Zip Code™. If an adequate size sample is not obtained from our purposive sample, snowball sampling will also be used. Study participants will be asked if they are aware of any other faith-based leaders who might consider participating in the study. This strategy produces a secondary pool of possible participants. Leaders selected from the secondary sample must also have a FBO located in the targeted Zip Codes™ (Wilmot, 2005).

The recruitment process will be documented to demonstrate that no bias was be used in the selection of the sample. The reasons for refusal from potential participants will be noted. If the reasons for refusal are related to the research question or the recruitment process, revisions to this plan will be considered and may be implemented (Wilmot, 2005).

Initial contact will be made by a letter with a postcard. The recruitment letter will clearly explain the purpose of the study, the expectations of each participant, the voluntary nature of the study, and how confidentiality will be maintained. Potential participants can return a refusal message with the postcard provided if they do not want to be contacted. Follow-up communication will be made with a telephone call. The phone calls will be made to facilities and we will request to speak with the FBO's leader (Merriam, 2009).

Ethical Considerations

The researcher will ensure that recruitment, data generation, and data analysis phases of the study will protect the human participants. The researchers and co-investigators (e.g., dissertation committee) have successfully completed the human subject protection course at the Indiana University Purdue–University Indianapolis campus prior to the beginning of this study. No activities were performed until approval was been granted by Indiana University's Institutional Review Board (IRB). IRB approval was granted on May 3, 2013 (Merriam, 2009).

All identifying information obtained from the participants will be maintained separately from the data collected. Confidentiality will be maintained as follows. Each participant will be assigned a number and each transcript will only have the participant's assigned number attached to it. The audio recordings and printed transcriptions of audio recordings will be kept in a locked file cabinet in the researcher's locked office. They will be heard and viewed by the investigators for study purposes only. No physical risks are anticipated. While we do not expect any emotional risk, the participants voluntarily take part in this study and they may withdraw from this study at any time without penalty (Merriam, 2009).

Data Generation

Instrumentation

In qualitative research, the goal of data collection is to generate information regarding participants' experiences in their own words while the specific research questions guide the study. There are three types of qualitative interviewing that are based on structure: highly structured, semi-structured, and unstructured. Highly structured interviews strictly adhere to predetermined questions which may not allow the researcher to assess participants' true perspectives and feelings of the study's phenomenon. In semistructured interviews, the questions consist of both flexible and controlled questions that are open-ended. This format permits the researcher to respond and interact with the participants as new ideas and themes emerge. The unstructured interview is usually

combined with participant observations; the researcher is learning enough about the phenomenon of interest to formulate questions for subsequent research (Law et al., 1998; Merriam, 2009).

For this study, semistructured interviews will be employed and interview questions will be developed based on the research questions and study aims. These questions will serve as the initial means of generating data during the interviews. Probes, which are questions that follow up something that has already been asked, will be used as needed to learn more details, for clarification, or for examples. The research will remain focused on the data and avoid interrogating participants. If the content of the interview is changed based on emerging themes from the participants, new concepts and questions will be added to the list. The researcher will check off each item during the interview and review the list prior to the close of the interview to ensure that all pertinent topics were addressed. Each participant will be expected to participate in one interview that is anticipated to take approximately 30 minutes (Merriam, 2009).

Before beginning the discussion, participants will: (1) be invited to ask any questions they have about the study, (2) give verbal consent to perform the interview, and (3) grant permission to audio-record the interview. Identifiable information is any information that can be used to identify, contact, or locate an individual, either alone or combined with other resources. A form will be used to collect the following demographic

data from participants: gender, age, race, address of the FBO with Zip Code™, years of ministry in Memphis, and size of FBO. The identifiable information collected to make contact with the leader will be kept separate from the interview data. The interview data collected for each faith-based leader will identified by a number. We anticipate that approximately 30 leaders will participate in this study (Merriam, 2009).

The interview will be conducted in an open format, allowing participants to give information during the interview and receive information from the researcher after the interview is complete. The initial questions will be more general, and then other questions will be created throughout the discussion. To facilitate comparability across interviews, the researcher will develop an interview guide consisting of a list of questions to be covered. During the interview, the researcher can assist the participants to explain their views more fully by asking probing questions (Merriam, 2009).

Interview Questions
1. Tell me your thoughts about the HIV/AIDS epidemic in your community.
2. How has the HIV/AIDS epidemic affected your congregation?
3. How does your community address the epidemic? Are there any programs that you are aware of?
4. Does your church currently offer health-related programs? Will you describe them?
5. Some faith-based organizations offer programs to help stop the spread of AIDS/HIV in their congregation. What are your thoughts about faith-based organizations providing such services?
6. What would your church need in the way of resources or support to offer such programs?
7. How do you think your church members would feel about you adding HIV prevention activities to your church programs? How do you know?

8. Tell me about the beliefs and attitudes regarding human sexuality in the school and church where you grew up.
9. Were human sexuality issues addressed during your graduate education? (If they attended seminary) Tell me about how you were taught to counsel members experiencing difficult situations.
10. Talk about what you believe your responsibility (if any) is toward those affected by HIV.
11. In what ways are you and your FBO involved in the community with nonmembers? Describe the types of programs you have and how often you perform them.
12. Does your FBO meet with other FBOs in the community? Do you discuss community problems?
13. Have you ever attended a workshop or seminar regarding HIV/AIDS? Tell me what encouraged you to seek out more information or why you think you have not been interested in seeking out more information.

Procedure

Interviews will be digitally recorded with the participant's permission. The audio data will be transcribed verbatim in English by the researcher. The audio recordings and printed transcriptions of audio recordings will be kept in a locked file cabinet in the researcher's locked office. They will be heard and viewed only by the investigators for study purposes. The demographic information collected will be stored separately from the collected data in a locked office. Field notes will be taken at each interview regarding the site, the participant's mood and emotions noted during the dialogue and facts that could not be obtained from the audio recordings. Field notes will be added later to the transcribed interview (Sandelowski, 2010).

Data Management

Data management is the method by which the researcher organizes data for easy access. An *audit trail* is a transparent description of the steps taken from the start of the research until reporting of the outcomes. This includes data collection decisions and steps taken to manage, analyze, and report data. An audit trail provides evidence of the rigor established in the research. For this study, data management will include an audit trail (Sandelowski, 2010; Wolf, 2003).

A folder will be created for each FBO leader using Microsoft Windows™ and Microsoft Word™. Each folder will contain the participant's transcript, field notes, and any analytic documents pertaining to that transcript and interview. Each line of the transcribed interview will be numbered to assist with analysis. The researcher will check all transcripts for accuracy. Initially, the field notes will be written in a reflective journal and later they will also be transcribed verbatim. The field notes documented during data generation will be added to each participant's transcript in the appropriate places using the track changes function in Microsoft Word™. This system will allow for management and easy retrieval of each participant's study materials (Sandelowski, 2010; Wolf, 2003). The researcher will relisten to the audio recordings and reread the transcript to support descriptive validity. Then, the researcher's field notes and reflections will be added to each transcript in

order to maintain interpretive validity (Tavakol, Torabi, & Akbar Zeinaloo, 2006).

Each analytic session will be documented: the date, a brief summary of data analysis activities, decisions regarding coding, conclusions drawn, and the rational for conclusions. The same coding techniques will apply to all data. Total immersion in the data must be produced prior to coding, classifying or creating linkages. The total immersion process involves synthesizing, hypothesizing, and recontextualizing the data rather than simply sorting. ID in nursing requires the researcher to be intimately familiar with each interview in order to produce knowledge to inform the phenomenon of interest. The analysis must be grounded in the data generated (Thorne et al., 1997).

In summary, data management strategies will be used to ensure that the data are arranged to make them most amenable to analysis. Transcripts will be checked for accuracy by researchers when completed by transcriptionist. Management will be achieved additionally by organizing the transcripts using color codes representing categorical information: age range, size of FBO, gender, and Zip Code™ of FBO. These processes will ensure the descriptive and interpretive validity of the final analysis (Sandelowski, 2010; Wolf, 2003).

Data Analysis

We have chosen the Consolidated Framework for Implementation Research (CFIR) to guide the data analysis of this qualitative research

study. In order to ensure the translation of the data collected from research into practice, CFIR has the potential to offer useful insights into informed, theory-driven research. Researchers are able to select constructs from the CFIR that appear relevant to their study and use them to guide assessments, data coding and analysis, and assist with explaining research findings. The characteristics of individual domain of the CFIR will be used to guide the coding and analysis of this study (Damschtoder, et al., 2009).

Data analysis is the process of making sense out of the data and involves consolidating, reducing, and interpreting what the participants have said and what the researcher saw and heard. It is a complex process of moving back and forth through the data with the goal of answering the study's research questions (Merriam, 2009). Our goal is to discover the perception of African American faith-based leaders on HIV/AIDS-related issues.

Codes are signifiers applied to portions of data that are relevant to the research questions. Coding occurs in three levels. Level I codes are organized in segments according to the responses to each question. Each transcript will be examined for statements and quotations that answer the research questions and that coincide with the CFIR constructs (Ilott et al., 2013; Sandelowski, 1995; Tavakol, Torabi, & Akbar Zeinaloo, 2006).

In Level II, the researcher condenses the Level I analysis into broader codes, key concepts and themes. Each construct will be examined

for patterns and frequency of occurrence. The statements and quotations will be replaced by more general labels to facilitate comparison. For Level III, data synthesis and analytic descriptions are produced and repeated until the final report is reached. This will involve determining the relationships among the groupings and inductively forming a cohesive narrative that addresses the study aims (Hsieh & Shannon, 2005; Ilott et al., 2012; Sandelowski, 1995; Tavakol, Torabi, & Akbar Zeinaloo,, 2006; Thorne et al., 1997).

To ensure validity for qualitative researchers, Maxwell (1992) developed five categories to judge the validity of qualitative research: descriptive validity, interpretive validity, theoretical validity, generalizability, and evaluative validity. *Descriptive validity* refers to the accuracy of the data. The data must accurately reflect what the participant has said or done. The reporting of the data must also reflect the same accuracy. The transcription must be an accurate account of what was said. Descriptive validity forms the foundational bases for the study; without an accurate account of the data, everything else is irrelevant (Glaser & Strauss, 1967; Maxwell, 1992; Thomson, 2011).

Interpretive validity is defined as how well the researcher reports the participants' meaning of events, objects or behaviors (Maxwell, 1992). The interpretations are not based on the researcher's perspective but rather that of the participant. *Theoretical validity* addresses the theoretical constructs that the researcher brings to or develops during

the study. It seeks to evaluate the validity of the concepts and the theorized relationships among the concepts in context with the phenomenon of interest (Auerbach & Silverstein, 2003; Thomson, 2011).

Generalizability refers to the ability to reproduce the study's conclusion with a similar group and can also be termed transferability. *Evaluative validity* moves away from the actual data, itself and tries to assess the evaluations drawn by the researchers (Maxwell, 1992; Thomson, 2011).

Issues of rigor and credibility in qualitative research are important. Trustworthiness and transferability can be accomplished through an audit trail where the specific analytic decisions are presented and contextualized within the larger picture. According to Emden and Sandelowski (1999), credibility occurs when complexities are made visible through the analytic process and are articulated with an openness and tentativeness about the final research outcomes. In other words, a premature conclusion will not be made (Thorne et al., 2008).

Conclusion

Because African Americans are the largest racial/ethnic group affected by HIV/AIDS despite numerous prevention studies, a qualitative descriptive approach is most suitable to investigate this phenomenon. This will assist the healthcare community in developing effective primary HIV prevention interventions. Purposive sampling will be employed to recruit FBO leaders. Data will be generated through face-to-face

interviews and analyzed using qualitative descriptive techniques to identify new concepts and themes. Documentation will be maintained throughout the study to form an audit trail and to protect descriptive and interpretive validity. The final interpretation will be presented in a manner that answers the research questions and remains faithful to the data.

In every data set, there are numerous interpretive possibilities but in ID the researcher's interpretation must reflect the research question. A good interpretive conclusion may vary slightly from the research question, but if so, it will be because the data led to this finding (Thorne, et al., 2008).

CHAPTER IV

RESULTS

The purpose of this interpretive description study is to explore the views of African American faith-based leaders (FBLs) toward offering HIV prevention services in faith-based organizations (FBOs). The majority of the participants were recruited through purposive sampling (n = 24) and the remainder by snowball sampling (n = 6). Locating addresses and contact information for most FBOs was difficult for several reasons: lack of websites or email addresses, traditional telephone books not listing ZIP Codes™; and no staff present onsite during the week to contact by phone. In the ZIP Codes™ identified for the study, only Christian FBOs were readily identifiable. Thus, all study participants were from Christian denominations.

Initially in early December 2013, 20 FBLs were contacted by mail, yielding six interviews. Thirty additional FBLs were contacted by mail in January 2014, resulting in 17 interviews. The second group of mailed letters to potential participants yielded more results due to the holidays (Christmas and New Year's Day). Additional interviews were obtained through FBLs calling other leaders, resulting in seven new African American participants. Interviews were completed by April 2, 2014. Interviews lasted from 15 minutes to one hour. A schematic design of the

process, from research questions to data analysis and interpretation, was produced to illustrate the protocol of the study (see Figure 1).

The Memphis African American Community

Shelby County, Tennessee, is located in the lower southeast corner of the State of Tennessee overlooking the Mississippi River. It borders Crittenden County, Arkansas and Desoto County, Mississippi. Memphis is the largest city in Tennessee by physical size and population, and is the County Seat of Shelby County (Clay & Schmidt, 2000). The 2010 total population for Shelby County was estimated at 927,644 persons, 52.1% African American and 40.6% European American (U.S. Census Bureau, 2010).

Many of the characteristics described in the literature review that place the African American community at-risk were found in Memphis. Thirteen (43%) of the 30 African American faith-based leaders interviewed told us that the people in their ZIP Codes™ are overwhelmed with intravenous drug use, sexual promiscuity, unprotected sex, and health inequalities associated with chronic diseases. Several FBLs commented that they know that some of the young people at their FBOs are sexually active and some are pregnant. A few of them stated they have encountered men who have sex with women and men (bisexual); the ethnic concept is called “men living on the down low.” One pastor commented, “people are not conservative in the community.”

One of the FBLs is a police clergyman and he made the following comment regarding the Memphis community;

> We are working to serve the community, to educate them about safety, crime prevention, gang violence, you know, women abuse, a lot of different categories from a clergy policemen standpoint. One of the biggest targets is gang violence in Memphis, to try to, you know, restore the young men back to the right track by putting them in church, educating them, and, you know, just being a big brother, a father.

The HIV/AIDS epidemic has disproportionately affected particular populations of Memphis and Shelby County. Populations that have been more infected are non-Hispanic Blacks, African American men who have sex with men (MSM), young people aged 15-24, Hispanics, incarcerated people living with HIV/AIDS (PLWHA), and the homeless (Memphis Area Ryan White Planning Council, 2012). According to the 2012 Centers for Disease Control and Prevention (CDC) Surveillance Report, Tennessee's sexually transmitted disease frequencies are high among reported cases and rates by states. Tennessee rated twelfth for chlamydia, tenth for gonorrhea, and twenty-third for primary and secondary syphilis when compared with other states and territories. Sexually transmitted infections (STIs) can increase the risk of transmitting and acquiring HIV. The rates are disproportionately higher among populations who lack access to medical care (Memphis Area Ryan White Planning Council, 2012).

Measured by the federal government's household income scale, in 2010 the poverty rates for African Americans (33.6%) and Hispanics (43.10%) in Memphis were higher than the overall poverty rate (28.30%) in the metropolitan area (Memphis Area Ryan White Planning Council, 2012). The rate of poverty among African Americans in every age category is higher than the rate for European Americans in those same categories. The poverty rate among female head of household families is high with 35% living below the poverty level. These high poverty rates can be attributed to unemployment, low wage service jobs, and lower educational levels. The rate of all adults 25 years old and over without high school diplomas is 19 percent. The overall European American poverty rate in Memphis (11.9%) is much lower than the rate in the state of Tennessee (17.9%) and the national rate (15.9%; Delavega, 2013; Memphis Area Ryan White Planning Council, 2012).

Sample Characteristics

For this study, the sample consisted of 30 interviews with African American faith-based leaders from ZIP Code™ exhibiting high levels of HIV in Shelby County, Tennessee who met the other inclusion criteria. This group was not representative of all FBLs but was a nonprobability sample. The majority of the faith-based leaders (24) were male (80%) and the other FBLs (6) were female (20%). One interview involved a couple who serve as pastor and co-pastor of the same church, making the sample technically 31 participants, though these two leaders were lumped

together as one for purposes of analysis. Another couple also interviewed together, but they are in pastoral ministry at different churches, so they were analyzed as two separated respondents.

The mean age of the faith-based leaders was 54 years with an overall range of 38-72 years. Collectively, they influence 12,952 congregants weekly. Participants had Christian affiliations as follows: non-denominational (n =15), Church of God in Christ (n = 8), Baptist (n = 5), and Methodist (n = 2). A list of the ZIP Codes™ with frequency table where each FBO resides can be found in the Appendix, Table 1. Nine of the participants report seminary or Bible college attendance (29%). The mean number of years the FBLs have been the head of their FBO in Memphis is 16 years with an overall range of 2-33 years. Demographic information was maintained by the author in a Microsoft Access database.

I interviewed African American faith-based leaders whose FBOs reside in at-risk areas as outlined by all of the inclusion criteria except one exception. For this study, an at-risk HIV area is defined as having more than 50 persons diagnosed with HIV living in the area. The ZIP Code™ 38131 is a small area in Shelby County with a population of 1 per the 2010 U.S. Census Report (U.S. Census Bureau, 2010). It is composed of businesses near the Memphis International Airport. The FBO included in the study that is an exception to the inclusion criteria is located in a strip mall within this area. This area is surrounded by ZIP Codes™ that are at-

risk (38111, 38114, 38116, and 38118). Since the FBO's leader and membership were from the adjacent at-risk areas, this interview was included in this study.

Initially, the only data mapping of at-risk ZIP Codes™ for HIV in Memphis was created by St. Jude Research Hospital with rates from 2006-2010. At the time of data collection for this study, December 2013 – April 2014, the Shelby County Health Department published the latest information of HIV rates by ZIP Codes™. The results demonstrated more areas that met the study's definition of an at-risk area which is greater than 50 confirmed HIV cases. This updated information allowed the inclusion of one FBL from ZIP Code™ 38018. No participants were interviewed from areas not determined to be at-risk (Shelby County Health Department, 2012).

Rates and frequencies are used by epidemiologists to describe a disease in the population. Frequencies are the total number of events that occurred in a defined period of time. Rates are the number of events divided by the average population at-risk of that event in a specific time period. Rates tell us how fast the disease is occurring in a population. The frequencies and rates of a certain disease can be compared with other populations at the same defined time periods (Gordis, 2008). The Appendix Map 1 presents the at-risk HIV ZIP Code™ in Memphis for children to young adults, ages 10-24 years old (2006-2010). Table 2 contains the total numbers and rates of people living with HIV or AIDS

from each of the ZIP Code™ where the study's FBOs reside (Shelby County Health Department, 2012).

Table 2

People Living with HIV/AIDS and Rates (per 100,000 population) by ZIP Code™, Shelby County Residents, as of December 31, 2012 (Shelby County Health Department, 2012)

Zip Code™ Where FBO Resides	Number Living with HIV or AIDS	Rate Living with HIV or AIDS
38018	71	2026
38105	194	3137.2
38106	323	1186.6
38107	244	1378.7
38108	190	1014.5
38109	393	843.5
38111	242	579.8
38114	293	1089.1
38115	309	789.7
38118	308	742.8
38126	122	1663.5
38127	315	696.2
38128	235	523.9

Emergent Themes

The final interpretation of data rendered from this interpretive description qualitative study is presented in the form of emergent themes. Statements from each interview were placed in theme categories based on the study's aims. The research questions are as follows: (1) What do the participants believe the role of faith-based organizations in HIV prevention should be? (2) What are the faith-based leaders perceptions about their role in implementing HIV prevention services? (3) What barriers to implementing HIV prevention services in faith-based organizations do faith-based leaders perceive? (4) What are the

participants' current activities and future plans with regard to offering HIV prevention or related services in their faith-based organizations?

Coding began after several interviews were completed. The themes are organized by research questions; themes not directly related to the *a priori* research questions will be discussed separately. Themes are displayed in tables, and summarized in a narrative.

Research Question 1

The first specific aim concerns what the participants believe the role of faith-based organizations (FBOs) in HIV prevention should be. In other words, what are the FBOs' insights and attitudes regarding their responsibility in fighting HIV as an organization? The four main themes, along with their associated subthemes that emerged during the interviews (see Table 3) will be discussed.

Table 3

Research Question 1 Themes

Main Theme	Sub-themes	Frequency
Provide education	General information	$n = 15$
	Prevention strategies	$n = 4$
Offer ministry	Ministering	$n = 11$
	Compassion	$n = 15$
Teach Biblical doctrine	Precepts	$n = 17$
	Biblical sexuality	$n = 11$
Maintain a community focus		$n = 14$

Theme 1: Provide education. One of the major themes that emerged as the FBO's role in HIV prevention is to provide education. In

describing the organization's educational roles, FBLs narratives focused on two inter-related sub-themes: (A) general information, and (B) prevention strategies. Each of these sub-themes captures different aspects of the FBL's beliefs and feelings.

Sub-theme A: General information. Many FBLs expressed that the FBOs role is to provide general information on HIV regarding transmission, testing, and where to go for treatment and support. One of the faith leaders stated;

> In my opinion, the church, historically, has always been the cornerstone for the community, not only from a spiritual level but also an educational level. And I think the church is still very relevant in the Black community. And we probably hold the greatest potential to reach the most people. So because of that I think the church needs to play a major role in that.

Other leaders commented, "The church does have responsibility to try to educate and inform" and that the church needs "to create programs where people will have an opportunity." One leader mentioned that the scripture states "My people are destroyed for the lack of knowledge." Another stated, "It's bad when you deal with something you don't understand what you're dealing with. But when you get an education about it and know what your opportunities and resources are, you can cope."

One leader remarked on how such education should occur. To "become more educated, me and my staff first" must receive it, "because I feel that if the leadership is more educated, then we will be able to offer

more services to the people." Another leader observed that budget issues need to be considered. "Budget-wise ... Right now, my thing in dealing with the Board is pushing my education department." Yet another leader stated:

> But I think the big issue is education, education, education. And I think that the churches have, I mean, a prolific opportunity … We've got to get under the burden for helping to relieve this epidemic … it's a major issue in our community.

One faith leader conveyed that the FBOs role is to dispel HIV stigma and misconceptions through education:

> Initially, we were very much afraid because little was known. But the more education and we learned that you can't get it by touching people, and the disease has a very limited life outside of the body. The more educated you become about it, then it eases your fears, you know.

Another FBL reported "There are misconceptions of people with HIV and AIDS. It's not going to 'rub off' on you. A lot more teaching needs to come from the church in that area."

Sub-theme B: Prevention strategies. HIV prevention in this section concerns educational activities and programs designed to prevent or reduce HIV transmission. One pastor stated that "FBOs need to try to do anything they can to try to prevent it and to cause a cure to come into existence." Another faith leader remarked:

> It's a great concern with the pastors in this area that we address those issues of HIV and AIDS and what can we do to keep the people informed, as well as provide preventive measures that would help bring this -- this problem to the forefront.

Yet another leader commented;

> I told my staff that we have got to move from the 19th century ministry into the 21st century ministry, which means that we have got to change our curriculum. So one area that I have engaged in and asked my staff to engage in is our young people improving their lives, and that's part of the curriculum for them is to deal with not only the sexual revolution that they're in but this technology revolution that they're in.

Theme 2: Offer ministry. Another frequently reoccurring theme was the role of FBOs to offer ministry to persons with HIV/AIDS and their affected families. While FBLs were describing their organization roles to offer ministry, two sub-themes emerged: (A) ministering and (B) compassion.

Sub-theme A: Ministering. To minister is defined as attending to the needs of others through prayer and emotional support (Pearsall, 1999). Several FBLs commented on the role of FBOs in offering ministry. One said, "I believe the church and the pastor's God-given assignment is to minister to the needs of the people, and the people need this." Another commented:

> And God has tasked us with an awesome assignment to minister hope and healing to those who find themselves suffering in any way. So it is a responsibility that as a pastor, I feel like this should be a priority for the church.

Other faith leaders emphasized more specific aspects of the roles of FBOs to minister. For instance, one said:

> All souls are important. I believe, regardless of what a person may have, whether it's HIV or even some other type

> of sickness or a disease, it is our job to try to minister to that person the same way the people that had leprosy in the Bible.

Another commented that upon meeting “people that are sick with HIV, bring them into the church. Let's minister to them. Let's pray over them. Let's give them the information they need.” Finally, yet another FBL said:

> And Jesus told them to "Go to the church and show yourself." When people have HIV, if they come in here, let's not shun them away, because in these doors are healing and deliverance are in these doors. That's why these doors are open.

Sub-theme B: Compassion. Compassion is defined as showing concern for the suffering of others (Pearsall, 1999). According to one leader, the FBOs role is to be “sympathetic and empathetic to what they’re going through.” Several FBLs further delineated the FBOs role. A participant said, “We have responsibility to help the lost and the hurting. They need care; they need love; they need time, need attention. That’s a great opportunity to show the compassion of Christ.” One FBL further explained, “And so regardless of how they contracted it or what have you, we have a responsibility to love people and to meet their needs.”

Another leader added, “Well, I think certainly we have a responsibility. They're people. And you have to show compassion, you have to show tenderness.” One pastor expounded, “I think it's a huge responsibility. I think our example goes back to how Jesus treated people in the Bible, He showed love regardless. We have to show people God's love, regardless.” Yet another leader emphasized, “We need to open our

doors and a heart of compassion because everybody is suffering. They need your compassion; they need your love; they need your spiritual guidance." Finally, one leader clarified, "If we are to be Christ-like, which is what a Christian is, then we have to do what Christ would do, and that's embrace them with love and help them in the healing process."

Theme 3: Teach the Biblical doctrine. The most frequently reoccurring theme for Research Question 1 is the FBOs role to teach Biblical doctrine. There were two sub-themes noted as FBLs described this role; they are Biblical: (A) precepts and (B) sexuality.

Sub-theme A: Precepts. Precepts are the commandments or directions given as a rule of action and conduct (Precept, n.d.). All of the study's participants were from Christian denominations. Leaders expressed how FBOs must model and teach Biblical beliefs. For instance, one leader said, "It is our job as the church to teach what the Bible says, first of all, and then what our doctrine says, which should line up with the Word." Another FBL added, "faith-based organization's role is to preach true prevention, the standard of righteousness" and "to make people aware of what God's Word and Will is." FBOs are "to keep their voice according to the Lord and abstain from all appearance of evil and "teach that disobeying God's Will and Word has consequences." A pastor explained, "Faith-based organizations need to embrace their prophetic role to provide Biblical issues to this issue."

Several FBLs commented on the need of FBOs to consistently educate on the conversion process. A pastor clarified it as follows:

> We convert people but we don't tell them there's a conversion. To convert someone means I change. Conversion means I continue on. And until we can get people to understand that once you've been converted, there's a conversion that comes with it.

One leader said, "Lifestyle change requires a new way of thinking." Another pastor expounded, "And since the world has classified same-sex marriage as an alternative lifestyle, we have to understand the lifestyle that Jesus Christ has given us to make sure that they know the difference between right and wrong." One participant commented, "The preaching and teaching most of the time end up talking about people's health and, you know, living Godly and holy will certainly keep you away from a lot of sin." A FBL explained,

> And so God, you know, just like what Jesus done for us. While we were yet sinners, Christ died for us. He didn't say, "you old filthy, nasty sinner. I don't want anything to do with you." So even though we're against how sin comes about, we're not saying that we're not there to provide bandages and aids for those that are suffering with those ailments.

Finally, a participant added, "It's a lifestyle, and we've got to teach our people how to live within that lifestyle."

Sub-theme B: Biblical sexuality. Biblical sexuality refers to the FBOs interpretation of the Bible's references to sexuality. One FBL said, "A faith-based organization's role is to teach sexuality issues as the Bible proscribes." A pastor continued, "We try to advocate sex is only good and

sex is only authorized within the confines of marriage." Another leaders added: "If sex is done outside of marriage, it is wrong, it is sinful, it is ungodly." "Faith-based organizations must teach what the Bible and doctrine says abstinence and monogamy." And a FBL proclaimed, "A faith-based organization's role is to teach against homosexuality as a lifestyle." Finally, one leader stated, "we are to hold the position of the Bible that sexual sin is wrong and has consequences and marriage is honorable."

Theme 4: Maintain a community focus. There are many FBOs that currently do not have any communication or programs to enhance the community where the FBO resides. Some of the leaders we interviewed conveyed their desire to stay focused on the community. One FBL said, "A faith-based organization's role is to be involved with the community to make them aware naturally then spiritually." Another faith leader stated, "we're open to the community. It's (HIV) not really being kept in the forefront as to this is a problem. We need to address it, and the faith-based community can help with it." Yet another pastor said, "We need to open our doors and a heart of compassion because everybody is suffering." A FBL explained:

> We've got to bring information to you. That means that even though my doors may be closed today, I need to open my doors up one day next week to bring awareness to the fact that we've got a problem.

Finally, yet another leader exemplified, “We have a responsibility to do whatever we can to help the entire community, and those patients are a part of the community.”

Three FBLs stated that the education programs offered at FBOs should have a community focus. The first FBL offered, “I think that the ministry should be an all-around basis, because I always have said, when you go out the door, you need to have some valuable information on what's really going on outside the door.” A second added:

> It's really getting to the point where churches need to address it because it's so prevalent in our community. And whatever we can do as a church body to make them aware spiritually of what devastation it can bring. Education is always the key.

Finally, a third pastor commented, “My thought is something needs to be done. Sometime education is not enough. We need to, I guess, handle in the community, go out and talk to individuals.”

Research Question 2

The second research question addresses what are the faith-based leader’s perceptions are about their role in implementing HIV prevention services. The focus is the personal roles of FBLs in helping their parishioners not to contract HIV. Five main themes are identified; the first theme has associated sub-themes. Table 4 displays the main theme and subthemes that developed through during the interviews.

Table 4

Research Question 2 Themes

Main Theme	Sub-Themes	Frequency
Be an educator	Essential facts	*n* = 17
	Mental health issues	*n* = 4
	Prevention measures	*n* = 11
Engage the community		*n* = 14
Promote the faith perspective		*n* = 19
Minister with compassion		*n* = 22
Partner with expert professionals		*n* = 17

Theme 1: Be an educator. One of the major themes that emerged is for FBLs to personally take on the role of an educator in implementing HIV prevention services. This teaching role as interpreted by research participants can be divided into three inter-related sub-themes: (A) essential facts, (B) mental health issues, and (C) prevention measures.

Sub-theme A: Essential facts. What factors and behavior modifications are necessary to prevent or reduce exposure to HIV? These topics are termed essential facts in HIV prevention. Several faith leaders commented on their role to be a source of information for their congregants concerning HIV. One FBL stated, “Our job as in calling as a pastor is to edify and educate, so to help them learn of their situation they're facing.” Another participant expounded, “I think there are still just so many misconceptions with our culture, I just really think that it starts with the pastors if it came from the head it would spread amongst the congregation then into the community.” Several FBLs believe that they

“will be more effective at teaching this to congregants than the health ministry.”

“A faith-based leader’s role is to educate themselves and find out new technologies.” Another pastor clarified, “We certainly believe in studying, as well as taking advantage of educational offers that are out there.” We have “to give current information.” A pastor explained, “Faith-based leaders need to know their congregants demographics to address this issue properly.”

Additional comments were made concerning specific topics to teach. One leader stated, “A Faith-based organization’s role is to teach about marriage. In the Black community, 70% of them didn't grow up with a father. They have no concept of what marriage is, what a real father should be.” They must also “educate youth about the dangers out in the streets.” Another pastor elucidated, “The bedrock of the church today is not to entertain but it is to inform. And the shepherds have to understand, it's not a show but it is to present salvation.”

Sub-theme B: Mental health issues. A person diagnosed with HIV has not only physical health problems to contend with but also mental issues such as depression, frustration and anger. Some FBLs believe that the location or setting of the HIV programs will facilitate conversation and assistance with mental issues. One pastor said, “I think a lot of people battle with questions and want answers and solutions, but they do it in a private manner, you know.” Another added, “We try to be sensitive

to it and to deal with that person on an individual basis." Yet another FBL stated, "This is a serious matter; faith-based leaders must deal with it on an individual basis." A leader expounded, "We actually need some type of sit-down discussion, where some question and answer can be done and where individuals can interact." "They wanted to discuss with them privately." A FBL offered the following comments:

> We can refer them to places or get them set up with counseling and information that will help them establish a safe zone of people that they can actually, not only get them help medically but get help mentally, because that's a big problem that I see with dealing with HIV and AIDS. The mental aspect of what they're dealing with because of the way that people treat you sometimes gets to be more tantamount than the physical aspects of it.

One FBL has an ideal to assist the community with mental issues.

> It would require us to explain and clarify why it's so important that this issue (HIV) needs to be discussed. And I think once they see those that have been impacted and affected in our community, I think it will help them get over any hurdles, mentally and emotionally about this issue.

According to several FBLs, there are a few problem areas that keep African Americans from asking questions about HIV in public. They are as follows: (1) "The church have not allowed for people to be open." (2)"The pulpits are too silent about it (HIV)." (3) Even when expert healthcare professors are ask to conduct an educational seminar, "no one asks any questions due to stigma." They feel that most people would prefer these discussions privately. These FBLs believe that having opportunities for private discussions decrease the mental stress, alleviate psychiatric symptoms and

promote the emotional well-being of PLWHA (Freeman, Patel, Collins, & Bertolote, 2005).

Sub-theme C: Prevention measures. Some FBLs voiced that they felt a personal role in HIV prevention. One leader stated, “As far as the congregation overall, I try to keep abreast as to what's going on and the preventive measures that are needed.” Another added, “I have a lot of young people and I know that they are sexually active, so I have to keep them informed.” A FBL commented, “As people receive information, they are more cautious on prevention.” Finally, a pastor proclaimed, “God gives us the freedom to make good choices” so having accurate information is essential to make the correct choices.

Theme 2: Engage the community. A few of the FBLs expressed a role to personally be involved in the community. For example, one pastor said, “Faith-based leaders need to develop programs to help impoverished neighborhoods.” Another FBL added, “Faith-based leader’s role is to go outside the church and know the community where the faith-based organization resides.” A leader stated that we (FBLs) are “to be the voice in the Black community and offer assistance. If we don’t address it the information will not get out there.”

Theme 3: Promote the faith perspective. Another theme that was noted by FBLs is to keep faith concepts in HIV prevention. One pastor commented, “Faith-based leaders have a great responsibility to teach the world about God’s laws and statues.” Another stated my “position is that

the root cause is sin," and "to help them understand that they can be healed supernaturally through faith in Jesus Christ." A leader added, "Faith-based leader's job is to minister to the total man" and remember that "all souls are important."

Several expressed potential problems that could occur with keeping the faith. One leader stated he didn't "have a problem with programs allowing the church to operate freely, unrestricted." A pastor proclaimed, "Faith-based leaders need to address homosexuality, and rape and child molestation." Finally, one FBL emphasized, "Number one, a faith-based leader's role is to teach abstinence."

Theme 4: Minister with compassion. FBLs stated that they have to be the primary example for the congregation on how to lead and minister with compassion. One leader stated, "Faith-based leader's role is to treat all people as a person and serve them and point them in the right direction." Another pastor expounded, "First, faith-based leaders must reach their hearts then reach their minds." A different FBL added, "Shepherds are commanded to love one another just as He loved us." Other leaders believe that they "are to offer help to those wanting deliverance" and "those who are suffering with sexual issues." "Faith-based leaders need to tell them we've all made mistakes but we can do this together." They need to "deal with this difficult issue with compassion" and "show the affected more love and attention."

Theme 5: Partner with expert professionals. FBLs were asked what current health programs they currently have at their FBO. It appears to be a growing trend among FBOs to sponsor health fairs (70%), but only four of these health fairs disseminate HIV information (14%). The FBOs in Memphis appear to be aware to some extent of the health disparities that exist in their communities, and sponsoring health fairs assists with primary and secondary health prevention in these high risk areas (U.S. Department of Health and Human Services, 2011).

Several FBLs considered that successful HIV prevention programs will require the assistance of expert healthcare professionals. One pastor stated, "The faith-based leader's role is to design sessions for expert presentations to offer direction and testing." Hopefully, a pastor commented, the "expert professionals will donate their time." Another leader felt that most FBLs are "unsure about the depth of HIV prevention teaching they personally can do at FBOs" because of their "role to teach the Bible." One participant considers that "in-depth discussions need to occur at the Health Department" or with "expert professional assistance." Additional comments are: "FBLs role is to meet needs of members; if sources are unknown, FBL will refer and seek help," "FBLs need information to make referrals for those in need for medical care," and "When FBLs and health care professional's roles are done, we both win."

Research Question 3

Research Question 3 reports the FBLs perceived barriers to implementing HIV prevention services in FBOs. Barriers are structures blocking access or something that obstructs. The answers given by FBLs were related to why they would not be able to institute prevention measures because of the barriers they described. The six main themes with associated sub-themes will be discussed (Table 5).

Table 5

Table 5 Research Question 3 Themes

Main Theme	Sub-Themes	Frequency
Lack of knowledge	HIV basics	*n* = 18
	Sexuality issues	*n* = 7
Negative attitudes about HIV	Stigma	*n* = 21
	Fear	*n* = 11
	Avoidance	*n* = 15
	Racism	*n* = 1
Denial		*n* = 21
Issues kept private, secret, and in the closet		*n* = 27
Breakdown of family and community values		*n* = 16
Religious concerns		*n* = 4

Theme 1: Lack of knowledge. One of the major themes that emerged as a barrier to implementing HIV prevention programs at FBOs is the lack of or inadequate knowledge regarding the essential facts of HIV. Lack of knowledge is a state of being uninformed concerning the facts of a subject or concept, untrained and unlearned. These lack of

knowledge barriers can be sub-divided into the following categories: (A) HIV basics, and (B) sexuality issues.

Sub-theme A: HIV basics. HIV basics include what are HIV and AIDS, how is it transmitted, how do you find out if you are infected, and how do you access treatment. One pastor commented, “The issue is many people are not educated, number one, enough.” Another added, “Churches are not educating their young people ages 9-30 years. A leader continued, ”There is a “lack of knowledge regarding people at risk for HIV and how it is transmitted.” Some FBLs have “misconception about the origin of HIV”; one FBL commented that HIV was a “man-made virus.” Several leaders agreed there is a “lack of knowledge concerning how an early diagnosis will not progress to AIDS.” Finally, a pastor said, “It's a tragedy, and I think because of the lack of education, it spreads.”

Sub-theme B: Sexuality issues. Biblical sexuality mandates teaching abstinence many FBLs state. “It is taboo to teach about prophylactics,” and “condoms are against doctrine.” A leader discussed the barrier.

> You see the dilemma there as a pastor? As a pastor, it would be almost impossible for me to stand in front of the congregation to teach Christianity from a holistic perspective and a holy perspective and yet give you prophylactics, saying, you know, “I know you may do it anyway, but here’s just in case.” Now, it creates a dilemma in the church and it looks as if the church is being hypocritical.

Another pastor further clarified, “The church has a dilemma to how the disease is contracted.” Several FBLs believe that when “faith-based organizations have discussions about the causes of AIDS, it means the

FBO agrees with the lifestyles that caused it." Other leaders' comments on this issue reflect this sentiment. One said, "Talking about condoms and sex outside of marriage will open the door for everything." Another added, "Discussing sexuality, sexual behavior, was taboo and not to be discussed in the church." However, a pastor stated, "The longer and the more we ignore it, the more we're putting our youth at risk, because we have to discuss it." One FBL stated it was not discussed in church so he "learned sexuality from friends and they did not teach a healthy lifestyle."

Some FBLs who received higher education stated sexuality was not addressed. One FBL stated, "No seminary preparation was given for discussing sexual issues." Another added, "We were not taught to deal with man-with-man or women-to-women sexuality; we just knew it was wrong." Finally, a pastor expounded, "Whenever you start talking about sexuality in the church, most Christians, believers, or church-goers quite naturally feel a little awkward discussing that issue. But if we are honest, it's an issue that we all have to face and we struggle with."

Theme 2: Negative attitudes about HIV. Another major theme that emerged as a barrier is negative attitudes associated with HIV/AIDS. An attitude is the way a person views something or tends to behave towards it. The negative attitudes about HIV identified as barriers are: (A) stigma, (B) fear, (C) avoidance, and (D) racism.

Sub-theme A: Stigma. Concepts as well as people can be stigmatized. Historically, the subject of "sexuality was taboo and not discussed in church." A participant stated, "The church did not address it in the old regime or the next regime; now they are starting to but it's late." Another leader continued, "It's like the elephant in the living room. Everybody knows it's there but nobody wants to talk about it." One pastor commented that "in the community, it is looked on as taboo" also.

"Stigma has decreased some but still there." And yet another pastor added, "But right now, with it taking such legs and running the way it is, it's a very alarming thing." One FBL described his experience.

> Unfortunately, I even know pastors who again they shun away from it. They don't want to address it or to be involved with it, even refusing to do certain funerals because of that. And it breaks my heart. I think the Lord Jesus would embrace them, just as He did on one occasion, ten lepers.

One leader commented that "HIV is a taboo subject similar to death."

Sub-theme B: Fear. HIV/AIDS-related fear is synonymous with phobias and anxiety concerning issues associated with HIV/AIDS. As one pastor stated, "There's a very dark veil of ignorance that goes with or associated with both of those". Another added, "I feel that the pulpits are being silent on it because of ignorance, of fear, of not knowing what to do when you do decide to take up the issue." One participant continued, "A lot of fear exists for a person with AIDS similar to people in the Bible with leprosy." Meanwhile, one pastor proclaimed, "Some people don't want the information; they have a fear of knowing if they are HIV

positive." One faith leader commented that "by offered HIV screening at our first health fair, it might have scared a lot of people."

Another FBL stated there is a "fear that same sex marriage will dominate the church." One African American participant remarks expressed fear of research.

> It's just like years ago, when they were experimenting with the Black men. And then wasn't telling nobody until the nurse came out and told what was going on. And what is the primary effect of syphilis? Sterilization. If you sterilize the Black man, he can't produce no kids. And I still think . . . exactly, how they do their statistics? I think that they need to readdress this because if we don't get tested, how do they know how much HIV exist in our community?

Some pastors' fears related to FBO teachings regarding hell:

> I think that's what's probably a big major problem in the African American community because we was always scared. You know, we were scared to talk about sex because everything was related to hell and you were going to hell if you had sex. But we never had the facts about anything, and so, you know, when you mess around here and try something, it felt that like whatever your tried, it ain't as bad as they said it was going to be. So a man took his chances, whether he's going to go or not.

Sub-theme C: Avoidance. Avoidance is defined as staying away from, shunning, or evading persons or a stigmatized group. When people want to avoid someone, they will go out of their way not to be in close proximity to that person or group; many times it is very obvious. As one FBL explained, "If people are not educated, and the congregation knew someone had HIV/AIDS, they might fear they would catch it." Another pastor commented, "People are afraid to be around persons with

HIV/AIDS." One participant remarked, "In the African American community, people with HIV are somewhat an outcast."

Many FBLs feel that "avoidance of HIV positive will cause a decrease in church attendance." When the word spread about HIV positive people in our church, "it would jeopardize my church's existence. I know HIV prevention is needful but in the long run I will be hurting myself." One pastor described his experience.

> To say that one is HIV positive, it puts a stigma; it puts up a red flag. No one wants to associate with you; no one wants to have any contact with you. And in the church, the church is very affectionate when it comes to touching, hugging, sharing, things like that. And to find out a person would be HIV positive, I could understand the stigma and the reasoning for not coming out and saying they are positive.

One FBL commented on his observations when one of his members disclosed his HIV positive status:

> At the moment that he let them know that he has full-blown AIDS, I've seen I'd say sixty to seventy percent of them, they deal with him in a totally different way. They try to stay away from around him or they don't conversate with him as much as they used to. . . It's a 60/40 split. Some of them draw closer to them. And it's a tricky thing because people, they don't understand it. I mean, you know, the people with HIV have a tendency of associating it with a homosexual disease.

There is also an "avoidance of people who are homosexuals or who have been assaulted by one." As one FBL claimed, "No one wants to be seen with homosexuals."

Sub-theme D: Racism. Racism is defined as the belief that all members of each race possess characteristics or abilities specific to that

race, and they can be distinguished as inferior or superior to another race. Racism produces prejudice, discrimination, or antagonism directed against someone of a different race based on the belief that one's own race is superior (Pearsall, 1999). Here is one FBL comments on racism:

> But for whatever reason, it seems to me that the Black community is always singled out when an epidemic comes. I don't know the reason for that. Look at how this country has evolved. . . We've got a Black president now, and nothing can get done because racism has shown its head. And I believe if we dig deeply into a problem that they say is in the Black community, we'll find out that racism plays a vital part in HIV.

Theme 3: Denial. The action of declaring something to be untrue is called denial. Several levels of denial can be noted. First, several FBLs deny that anyone in their congregation has HIV; their responses when asked if their congregation has been affected by HIV/AIDS were quick and short: "No, not at all;" "No one in my congregation has HIV;" "No;" "No, we have not had any families with HIV/AIDS;" and "No, I don't."

Second, some FBLs do not believe HIV is the priority problem in their community. A FBL stated, "Faith-based organization ministries are not in pursuit of anything concerning HIV." Another leader added, "Sexuality is not considered as an important issue as poverty and school funding." Another continued, "Churches are not concentrating on this deadly disease." One pastor expounded, "The community did not believe the data concerning high rates of HIV" and "people do not take this problem seriously." Then, "some people will do what they do regardless

of the information given." A leader conjectured, "Most people don't think it will happen to them." More clarification offered by another FBL:

> I think it's high, and I think our culture sort of remains in denial about a lot of things with HIV and AIDS. There's help out there ; there's medication, and I think it's just a misconception of, you know, the disease in general.

A couple of FBLs stated that they had never attended educational offerings on HIV because "it was not close to him at that time" and they "never felt a prompting to gain information on HIV."

One FBL feels that people believe that a Christian's life must be perfect without sins or faults but this is without merit. So, they deny premarital or extra marital relationships. Therefore, they are unwilling to acknowledge weakness in their morality. One pastor clarified:

> Most of the people are handling it with fear for the simple fact that because we are known as a faith-based or a religious organization, people are not willing to admit to relationships outside. So, in order for me to admit that there could possibly be AIDS in my family or even within me, I have to admit that I have not been perfect. So, that's where people get a misnomer. They think you have to be perfect, but the Lord asks you to be faithful because He understands perfectness doesn't come through you; it comes from Him.

Theme 4: Issues kept private, secret, and in the closet. HIV positive African Americans will not voluntarily disclose their serostatus. Stigma is the primary reason for this behavior (Lichtenstein, Hook, & Sharma, 2005). Whatever it takes to keep their status a secret will be done. Then to complicate the situation, many African Americans refuse to discuss sexual issues in FBOs and even within the family structure.

One FBL stated, “HIV has affected our community, and we know it has affected our church even though some may be secret about it.” Another leader remarked, When “we have this secret life that we're not willing to discuss with the world, we do a disservice to our people.” And a pastor continued, “The church has not allowed people to be open. It is swept under the rug, pushed back in the closet, and not talked about.”

“The Black church may be vocal about civil rights but not vocal on STDs or sex outside of marriage.” Yet another pastor commented, “Sexuality issues are kept in the closet and not discussed.” One FBL exemplified “Youth have a tendency to engage in sexuality; TV promotes it; we don’t talk enough about it.” Another leader exemplified, “HIV positive persons hide they’re status and everyone else is not aware but we know they are in the community.” One participant said, “People don’t tell their medical situation.” In one pastor’s opinion, “Homosexuals keep their lifestyle a secret.” An additional comment, “The African American community shrinks back and shy away from this.” F
inally, a FBL exclaimed, The situation is “difficult to deal with, not a lot of freedom; it’s a hard place.”

Theme 5: Breakdown of family and community values. Family and peer relationships have shown to significantly predict high-risk sexual behaviors and drug use in adolescents. Family availability and monitoring are critical protective factors for reducing high-risk behaviors. When family conflict and low levels of communication exist, it is

associated with increased sexual behaviors and drug use (Bhana, McKay, Mellins, Petersen, & Bell, 2010).

One pastor stated, “African American culture has changed in most homes.” Another added, “Family values are no longer taught.” “Being promiscuous is no longer frowned upon; it’s a societal norm.” More leaders continued, “We see an influx of newborns and single parents in the community;” and “the church is not addressing this community problem.” One FBL expounded:

> But a lot of things, you know, regarding sexuality, regarding what you’re talking about should start at home with the mother and father, but a lot of time, there is no mother and father, especially in our community. I think, what is it, sixty-five or seventy percent of families now are raised by single women. So, there’s just not a father present, and sometimes the mother is so overwhelmed, she may not deal with that until the child gets pregnant or catch a disease.
>
> But today, you know, kids are on their own. Mom and daddy are probably, if two parents are in the house, they’re working two jobs, most of the time they’re not at home; and if they are at home, they’re asleep. So, we’ve got this problem.
>
> And then you had a certain time you had to be back to the house. Now, you know, kids, they come and go and they stay out as late as they want to and leave when they’re ready. So you can see the difference in the culture; it has changed. And I think that’s where the problem lies in the culture. The culture has made a transition that is unbelievable, because they were just some things we were just not allowed to do.

Theme 6: Religious concerns. Religious concerns are issues unique to FBOs. Denominations are religious groups that operate under a common name, tradition, and identity. The following comments are

representative of the interviewed FBL's apprehensions related to religion, denominations, and HIV.

> And with violence and sex came AIDS. It's going to take this nation as a whole and the religious establishments to combat it. We need to cross over these, what we call denominational lines. And align ourselves to fight this battle. That's the only way we're going to win.
>
> The biggest barrier I ran into in the ministry is Memphis. It's the Bible belt, and it's denominational driven. Because of the territorism that they have in there. It's hard because people think that you're trying to steal members.
>
> Well, the fellowship, honestly, has been limited. I reached out but because denominational differences, sometimes there's a barrier there. Not that you don't try. But for the most part, we've reached out and we've had some fellowship. The problem is that they have not continued. That's my heart really. I'd love to, you know, to have a community where we can come down and sit down and the community where we can come down and sit down and the community be the big picture, not our denomination.

One FBL continued, "HIV is increased and that means there are some things not being taking care of." Another FBL added, "Community collaboration is crazy because some faith-based organizations are territorial." Further clarification given by another pastor, "Faith-based organizations do not collaborate with faith-based organizations outside of their denomination; collaboration does not cross denominational lines."

Research Question 4

The fourth research question speaks to the participants' current activities and future plans in regards to offering HIV prevention or

related services in their FBOs. In other words, what is their perception of wanting to help their congregation and/or community through HIV prevention activities? Five main themes have been identified (see Table 6).

Table 6

Research Question 4 Themes

Main Theme	Frequency
Currently offer non-HIV health programs	*n* = 24
Currently offer health programs that address HIV	*n* = 6
Plan to offer non-HIV health programs	*n* = 4
Plan to offer health programs that address HIV	*n* = 26
FBL or Staff have training in HIV issues	*n* = 5

Theme 1: Currently offer non-HIV health programs. Nineteen FBLs currently have health programs at their FBO that do not address HIV. Some FBLs have more than one health program (*n* = 9). Health fairs and symposiums are held annually by several FBOs (*n* = 6). Some FBOs offer health screenings annually (*n* = 2) and others more frequently (*n* = 3). FBOs' health ministries occur weekly to monthly (*n* = 5). One FBO has a regularly scheduled health fitness program. A handful of FBOs offer community services in the form of food and clothing (*n* = 5). Many partner with other community health organizations for a variety of services including utility payment assistance, neighborhood watch or improvement projects, and youth programs (*n* = 6).

Theme 2: Currently offer health programs that address HIV. Six FBOs currently have some form of HIV prevention activities and two of

them offer more than one event. Five FBOs offer HIV information during their health fairs and two of them added HIV testing to their health fairs. One FBO's health ministry provides support to HIV positive people and their families on a regular basis. Other FBOs partner with community health organizations and expert healthcare professionals to deliver HIV prevention programs (n = 3).

Theme 3: Plan to offer non-HIV health programs. Some FBLs have decided other health concerns are priority not sexually related health issues (n = 4).

> As we expand, we are still looking in the nutritional direction more than anything else, because we have more than just AIDS as a problem. Obesity probably is the biggest problem. I guess the biggest thing I see is diabetes running rampant, especially in the Black community.

> We deal with issues unfortunately such as crime, poverty, low attendance in the church, and that has not been a primary target, to just deal with that one segment, HIV positive. You know, again, by this being a very low income area, we address the immediate needs, which would be poverty, low income, and low education. But primarily, I could tell you, it is crime.

Theme 4: Plan to offer health programs that address HIV. Nineteen FBLs spoke of offering HIV prevention programs in the future and some spoke of expanding the programs they currently have. Several stated that financial resources such as grants would be required to implement HIV prevention services (n = 6). Others stated they need the assistance of healthcare professionals and community organizations to increase health programs with HIV (n = 6).

Theme 5: FBL or staff have training in HIV issues. Six FBLs and one staff member have received training in HIV issues. Some received training through their non-religious occupation (n = 4). Two FBLs received some indirect training in seminary: one in counseling and the other one through a class that discussed dealing with sexuality in the church.

Other Different Themes Not Related to the Research Questions.

There were several significant themes that were not related to the research themes but still pertained to the community. One pastor is a member of the Memphis City Beautiful project. Their purpose is to keep the physical property of his community beautiful and clean in order to attract residents that are also concerned about keeping the community clean. Another FBL has opened a coffee shop business in a high traffic area of the community. He explained, "We're deliberately in a commercial zone, between two bars because we have a strong desire to build relationships with folks that are not just members with the expectation that some will join God's kingdom."

Because of the high crime and drug infected community where one leader resides, he has returned to higher education to pursue a paralegal degree: "Not to be a lawyer, but to get a ground rules base of what the real law is so that we can help community members with everyday legal issues that they deal with." Another FBL has a charity in a high crime area in another location from the church: "We have to deal with everything,

the crime. We have to deal with neighborhood watch. All these things play into it, because you can't do one without the other."

FBLs were asked to talk about their beliefs and attitudes regarding human sexuality in the school and church where they grew up. Most of the comments stated that sexual issues were not taught in the home or at church. One pastor stated, "I told my staff that we have got to move from the 19th century ministry into the 21st century ministry." This move would require FBO's to make curriculum changes. Content of HIV prevention should include how to address conversations about sexuality, drug abuse prevention, and sharing needles in the home (MacMaster et al., 2007). We cannot allow these issues to remain silent from FBOs or home discussions any longer; the lives of too many African Americans are at risk because of the lack of knowledge.

Summary of Findings

In this chapter, I explored the perceptions of African American faith-based leaders regarding offering HIV prevention programs at their FBOs. Research aim questions were addressed by presenting themes that emerged during data analysis. Additional non-research themes were also considered. Demographic characteristic frequencies were discussed.

Regarding Question 1, faith-based organizations have a role in HIV prevention to offer ministry and provide education. Also, FBOs need to teach Biblical doctrine and maintain a community focus. For Research Question 2, they noted the FBLs role in implementing HIV prevention

services. The themes that emerged were to be educators, engage the community, promote the faith perspective, minister with compassion, and partner with expert healthcare professionals.

About Research Question 3, the faith-based leaders listed the barriers they perceived that would block HIV programming at FBOs. The major barrier concepts cited were lack of knowledge, denial, stigma, fear, keeping issues private, and the breakdown of family and community values. Regarding Research Question 4, I noted participants' current activities and future plans in regards to offering HIV prevention programs at FBOs. Eighty percent (24) of the interviewed FBOs currently offer health fairs or other health programs. Only 25% (6) of the 80% currently offer HIV prevention material. Five FBOs had members who were trained in HIV issues. Other themes revealed FBOs activities in their communities to enhance the lives of the people who reside there. One FBL stated:

> If you can change the way a man thinks about a subject, you might be able to help him, but if you can't change his thoughts, you know, we all do what we think. When we think we're thirsty, we go drink. When we think we are sexually in need, we go looking. And so if you change our thoughts, then you can change our habits.

CHAPTER V

DISCUSSION

This chapter presents a summary of the views of African American faith-based leaders (FBLs) toward offering HIV prevention services in their faith-based organization (FBOs). It includes the significant conclusions drawn with each research question and the application of those findings to nursing practice. Also, it provides a summary of the findings in light of the literature review, the limitations of the study, the potential for future research with FBOs and HIV prevention programs, and implications for public health nursing practice.

Discussion of Findings

African American FBOs became the targeted population for this study because they are among the few organizations that have remained in the lowest socioeconomic predominately African American communities in Memphis. In their roles as leaders of worship and religious activity, the participants have the potential to influence 12,952 people weekly. Therefore, they hold the "greatest potential to reach the most people" in these communities. The purpose of this study was to explore the views of African American FBLs toward offering HIV prevention services in their FBOs.

Findings will be discussed based on the study's research questions. Interpretive description (ID) qualitative methods enabled understanding of the FBL's perspectives. ID facilitated the discovery of associations,

relationships, and patterns among the collected qualitative data. The fourth domain of the Consolidated Framework for Implementation Research (CFIR), the Characteristics of the Individual, formed a theoretical framework to interpret findings related to the study aim questions. I will discuss the important findings revealed in this study (Damschroder et al., 2009).

Research Question 1: FBO role in HIV prevention

I identified four themes within this Research Question 1: to provide education, minister, teach Biblical doctrine, and maintain community focus. During the interviews, we found that African American FBOs did acknowledge that the problem of HIV existed, contrary to what was reported in the literature. Previous research findings stated that African American churches generally resisted acknowledging the problem of HIV/AIDS in their FBOs (Moore et al., 2012). However, many FBLs were unaware of the extent of new HIV infections in Memphis.

It is possible that because the interviews addressed HIV, these faith-based leaders acknowledged that the problem existed, but did not really understand its gravity, which would resonate with Moore et al. (2012) conclusions relating to resisting knowledge. However, most of the FBLs were not necessarily resisting knowledge. They seemed undereducated on the topic. Further, most of them requested more information. In understanding overall lack of knowledge, it is important to delineate between resisting knowledge and poor understanding. If FBLs

and FBOs are resisting knowledge then recruiting and training them will be a much different problem. On the surface most seemed willing to learn but more exploration of this topic will be necessary to determine the best training programs or interventions for each FBO.

With regard to ministering, all those interviewed stated that their job as a leader within a faith-based organization was to minister to all the members of their congregation and to show compassion. This theme is complicated because those interviewed also referred to the precepts of the Biblical view of sexuality and sexual relations. The stigma related to HIV in the general population and more specifically in the African American community (Hood & Friedman, 2011) might complicate their ability to minister to both those already diagnosed and those who are at high risk, thus also complicating their ability to educate. According to Griffith et al. (2012), African American FBOs are not equipped to balance their moral mission and interpretation of Biblical doctrine with complex health issues like HIV/AIDS. The evidence from current research has proven that the most effective prevention interventions are HIV testing and treatment. The next step does not involve arguing over doctrinal interpretations and teachings. Healthcare partners must explore the feasibility of integrating HIV testing and linkage to care with faith-based organizations (Pichon, Williams, & Campbell, 2013).

Another educational area identified, prevention strategies creates a conundrum for those who base their decisions solely on traditional

Biblical teachings. Derose et al.,'s (2010) research found that even though prevention activities remain contested within many FBOs, many FBLs vary in the strictness of their adherence to traditional Biblical teachings and policies. One intervention in Michigan titled *Your Blessed Health (YBH)* demonstrated flexibility in the format of each FBO site according to the FBLs comfort level and material consistent with the culture and doctrine of the organization. YBH pastoral evaluations showed an increase in FBL confidence and ability to discuss HIV/AIDS at the conclusion of the study. It is important to help FBOs progress from operating with barriers to HIV prevention and move to facilitating prevention efforts (Griffith et al., 2010).

Fulton (2011) suggested that those congregations already committed to social services would be the congregations most likely to provide education regarding HIV. Other research in this area has shown that it is possible to have HIV related activities despite the presence of stigma (Bluthenthal et al., 2012). Although most of this study's FBOs are either in the process of considering or actually being involved in HIV/AIDS prevention programs on a limited scale, their knowledge of and acceptance by the community render them suitable participants in HIV preventions programs (Kloos et al., 2003). However, given the complexities related to HIV, the stigma associated with HIV, and a general lack of knowledge by FBOs, training for these pastors becomes imperative before serious educational efforts can take place. Hicks et al. (2005)

suggested that barriers are related to lack of knowledge and in their study found that pastors were asking for education regarding HIV to support HIV-related activities. This will decrease stigma and fear among FBLs.

Research Question 2: Perceived FBLs role in implementing HIV prevention programs

In this research question, five themes emerged. According to Aim 1, the FBO should provide education, ministry, and teaching of Biblical perspectives. FBLS expressed that their role is to personally carry out those duties; they will be the educator, minister, and teacher. The FBLs sensed that they must lead; these duties should not totally be given to someone else in the organization. Two themes were unique to this aim. FBLs believed that they should (1) engage the community and (2) partner with expert healthcare professionals.

On the subject of engaging the community, the FBLs discussed the need to reach out to the community. In order to do this, the literature suggests that knowledge of the communication patterns not only within a faith-based organization and but also between FBOs in the community (Moore et al., 2012) is important. These levels of communication were not evident in the interviews. This communication difficulty may be due to denominationalism or territorialism exhibited by FBOs in the same area. In 2010, the Religion News Service of the Huffington Post published an article titled *The Black Churches: Working Together across Denominations.*

One of the leaders of a national religious organization for Black churches commented that from his experience, there was no communication between the denominations even though they had common interests and common agendas. Another FBL stated that all the denominations are primarily absorbed in trying to sustain themselves. He also felt that no single denomination had the resources to take on education or to take on social justice by itself (Banks, 2010).

In the interviews, the FBLs suggested a partnership between experts and themselves regarding HIV (Moore et al., 2012). One study addressing such partnerships identified both positive and negative possible outcomes between partners. The tension between regarding HIV/AIDS as a moral issue and seeing it as a public health issue was evident in the interviews, and comes as no surprise. Positive outcomes are associated with connecting a person diagnosed with HIV/AIDS and a health care professional, as well as helping people in general (Foster, 2011). To address the first outcome, recommendations to build such a relationship are to ensure that the program is culturally appropriate to incorporate spirituality and to ensure that the FBO has a sense of ownership of the program (Francis & Liverpool, 2009). Partnerships are shown to be valuable when they are successful.

According to Damschroder, 2009, partners (FBOs and healthcare professionals) must develop a baseline of common knowledge and learn about the other's services, resources, organizational cultures and work

constraints. Without common knowledge, partners will rely on stereotypes and misconceptions and cause an unhealthy, counter-productive outcome. Integrity and trust are essential to any successful partnership. The FBLs must be confident in their ability to execute and implement changes even in an environment where stigma lingers and people have long-standing distrust in research. Such knowledge and support will earn them a reputation of integrity and competence among their congregation. Developing partnerships with academia and healthcare professionals will strengthen FBOs resolve to participate in HIV prevention (Damschroder et al., 2009: Damschroder, n.d.).

Those interviewed acknowledged the need to engage the community. Community engagement is a lofty goal that requires advocacy skills. Griffith et al. (2010) suggested that community leaders and faith-based leaders must rally around such issues as HIV and even influence lawmakers. However, these skills take training and knowledge. In this study, while FBLs talked about community involvement their discussion has not yet taken them to the level of advocacy. While they talked about being the voice of the Black community, they did not verbalize how this would happen. This hesitancy might be related to individual stages of leadership maturity. The levels of leadership maturity exhibited by the participating FBLs in this study ranged from low to moderate with a few high scores, whom Damschroder (2009) calls "champions."

Damschroder (2009) states that the main distinction between champions and opinion leaders is that champions actively support the intervention through to completion. An opinion leader is an influential person who is capable of persuading others but who may or may not complete the desired task. We interviewed only a few FBL champions that had already begun to address HIV in their FBOs and their communities. Moore et al.'s (2012) study found that church leaders could not only be HIV/AIDS prevention advocates but they are also positioned to serve as role models for destigmatizing HIV/AIDS and related testing. As advocates or champions, FBLs can be responsible for ensuring that everyone in their FBO has the opportunity to receive HIV education and participate in potential testing and other HIV programs. FBL champions can spread their influence to include the FBOs located in close proximity regardless of their denominational affiliation.

Research Question 3: Faith-Based leaders perceived barriers

Research Question 3 addressed the barriers FBLs perceive will prevent them from sponsoring HIV preventive measures at their FBO. In this aim, the six broad themes included lack of knowledge, negative attitudes about HIV, denial, HIV issues kept in the closet, breakdown of family and community values and religious concerns. These same barriers seem to have existed in the African American community over more than 30 years since the appearance of HIV. Organized religion is often seen as a source of stigma and fear (Lapinski et al., 2010; Nunn et

al., 2012). It would seem that if organized religion is one source of fear and stigma, then they are likely not educated. Stigma and fear are both related to lack of knowledge but also interfere with the ability to gain knowledge. As stated earlier, a tension exists between HIV, the general belief of how it is spread, and the mission of the church. This tension is one reason persons who are affected or may be at-risk would not want to disclose their status and thus stay hidden in the closet. This community appears to continue in a sort of limbo, unchanged, not advancing, with little to no advocacy of prevention strategies for HIV (Foster et al., 2011; Nunn et al., 2012).

Research Question 4: FBOs current activities and future plans

Derose et al. (2010) stated that future studies should try to understand the ranges of FBO responses to join the fight against HIV/AIDS. The current study demonstrated that the majority of the participants were open to HIV prevention programs. Only four of those interviewed felt that other health related problems in the African American community like hypertension and diabetes were higher in importance than HIV. These four FBLs did not plan to implement any HIV prevention activities in the near future. In light of the responses elicited in the interviews, overcoming all of the identified barriers will be gradual and complex and it will not occur without struggle, negotiation, and collaboration. Ideally, the end result will be culturally and ethnically tailored HIV prevention programs provided in at-risk areas within a

supportive faith structure that will include trained FBLs and their staff (Derose et al., 2010).

Relevance to Public Health Nursing Practice

The HIV epidemic in affected communities has long been recognized and supported through public health interventions. Despite these efforts, African Americans remain disproportionately affected by new cases of HIV, poor access to care, and higher mortality and morbidity rates than other racial/ethnic groups in the United States. Non-traditional public health partners for HIV/AIDS prevention which includes faith-based organizations and their leaders are increasingly being solicited to assist in shifting this disproportionate trend in African American communities. The first National HIV/AIDS Strategy announced by the White House in July 2010 stated that faith communities have a vital role in conjunction with the government, scientists, and public health officials to achieve the goals of reducing HIV incidence and reducing HIV-related disparities (The White House Office of National AIDS Policy, 2010). The Strategy identified two actions as important for FBOs to play a major role in: (1) to developing programs for FBOs to promote non-stigmatizing support for people living with HIV/AIDS (PLWHA); and (2) reducing the number of new infections by increasing the number of African Americans who know their HIV status. Through education, FBO congregants will learn the importance of early diagnosis and serve as information resources for linkage to care for those who test positive (The White

House Office of National AIDS Policy, 2010; Sutton & Parks, 2011). This study has identified some FBLs who state their willingness to participate in HIV prevention programs.

Successful public health programs and initiatives must be based on an understanding of the targeted populations' health behaviors and the environment in which they occur (Glanz & Bishop, 2010). This current study demonstrated that African American faith-based organizational environments have long standing stigmas and associated lack of knowledge. Stigma and privacy issues also occur in the family unit; FBLs stated sexual issues were not discussed in FBL's homes. Most of the interviewed FBLs churches were located in an area of low socioeconomic level with poor access to care, and lack of transportation. For this reason alone, public health interventions in Memphis might be developed based on the information obtained from this study.

The possible benefits of having FBOs with HIV prevention programs in at-risk Memphis communities would be increased testing; more consistent follow-up care; and mental, spiritual, and emotional support (Pichon, Williams, & Campbell, 2013). Advantages will be apparent in the inner setting (the FBO itself) and in the outer setting (the low socio-economic community). This will eventually lead to an increase of knowledge in the community, decreases in the rate of new HIV infections in Memphis and improved continuity of care among PLWHA (Damschroder, 2010).

Limitations

Participating FBLs were all from Christian organizations and primarily non-denominational churches rather than members of a historically Black church. Not all at-risk ZIP Codes™ in Memphis were represented in this study. Only six FBLs were female. We did not return to the participants with transcribed interviews to establish credibility of the data (though to ensure data validity, recorded data were transcribed by a professional transcriptionist). Regardless of the limitations revealed in this study, several significant themes related to the establishment of HIV prevention programs in at-risk African American communities emerged.

Future Research

The U.S. Department of Health and Human Services' Agency for Healthcare Research and Quality (AHRQ) 2013 Health Disparities report states that the spread of HIV can be linked to various socioeconomic factors like poverty, risky sexual behaviors, sexually transmitted co-infections, people with unknown serostatus, stigma, and substance abuse (alcohol, injected drugs, and associated behaviors). It disproportionately affects African Americans in the United States (U.S. Department of Health and Human Services, 2013). The present research verifies this report. All of the socioeconomic links with HIV were found in at-risk ZIP Code™ in Memphis. Research demonstrates that changes in HIV infection rates are directly related to changes in behavior by at-risk individuals, and community programs can assist in influencing behavior changes (U.S.

Department of Health and Human Services, 2013). Future implications for conducting HIV prevention programs in FBOs in Memphis are to: (1) develop and implement HIV prevention interventions and literature to match FBOs' missions; (2) create abstinence training curriculum in FBOs; and (3) establish partnerships with healthcare professionals in academia and public health.

Currently a few community organizations in Memphis address the problem of HIV/AIDS in the African American community, but my research shows that only four of the FBLs interviewed are presently participating. What is the correct tool to open more doors for engaging in HIV participation? We believe that continual dialogue between FBL "champions" who are engaged in this effort and healthcare professionals serves as a vital part of the solution. Memphis New HIV rates in Memphis are among the highest in the country. Therefore, HIV prevention is important to all of the citizens of Memphis Shelby County, Tennessee especially healthcare professionals, politicians, school administrators and teachers, community leaders, parents, and students.

Conclusion

Is AIDS in our churches? Many of the FBLs interviewed cannot accept that reality even though we are living in a one-world society that frequently wrestles with pandemics due to international travel. The fear and stigma that still grip these communities are unacceptable, and they keep people from seeking care, and knowing their serostatus. They

separate families and friends, and cause some to live paralyzed with fear. Education can play a key role in decreasing stigma and fear. It can also effect change when laws and public policy cannot in significant areas like among family, friends, and community residences. Academics and healthcare professionals can be ideally placed to disseminate information that challenges the HIV-related stigma in the Memphis community (Catanzaro, Meador, Koenig, Kuchibhatla, & Clipp, 2007).

Collaboration can initiate, maintain, and strengthen partnerships between healthcare professionals and FBOs (Miedema, n.d.). To successfully break the cycle of stigma within the African American community, prevention programs must be designed using knowledge of the current myths and misinformation circulating. Stigma is a pervasive and destructive barrier that reinforces existing divisions in Memphis. The benefits of educational partnerships will become apparent quickly and the long-term goals can potentially involve increased testing and support for PLWHA (Miedema, n.d.).

Prior to the start of this study, we questioned whether FBLs would allow us to interview them regarding HIV. With a history of engagement with African Americans, we knew that FBLs were reluctant to publicly discuss this subject. We were pleased that thirty FBLs engaged in conversation with us. All of them expressed willingness to discuss it again and potentially participate in HIV prevention programs in the future if they align with their mission.

In summary, this research shows us several things about FBOs and FBLs in Memphis and Shelby County. We discovered the necessity of teaching FBOs HIV basics and assisting with the communication between FBOs, especially those within the same community. Pastors have the ability to create or open opportunities for HIV prevention programs. The programs should include teaching people how to talk about sexuality issues in church, the community, and most importantly the home. FBLs felt compelled to ensure that all HIV prevention material would reflect the faith message of their doctrine. Researchers must address the identified barriers FBLs perceived as hindering FBOs from implementing HIV prevention services.

This interpretive description qualitative research study explored the perceptions of African American faith-based organizations regarding African Americans with HIV. The Consolidated Framework for Implementing Research helped to describe the relationships among the individuals involved, their readiness to change, their belief in the ability to change, and how these factors could influence implementation of an intervention (Weiner, 2009). While themes varied according to individual values, the underlying conclusion of the interview data demonstrated FBLs' knowledge of the health disparities that exist in the African American community, as well as ongoing stigma concerning HIV which serves as a major barrier in the Memphis African American communities.

Leadership is needed from African American FBLs because of their influence in the community and FBOs.

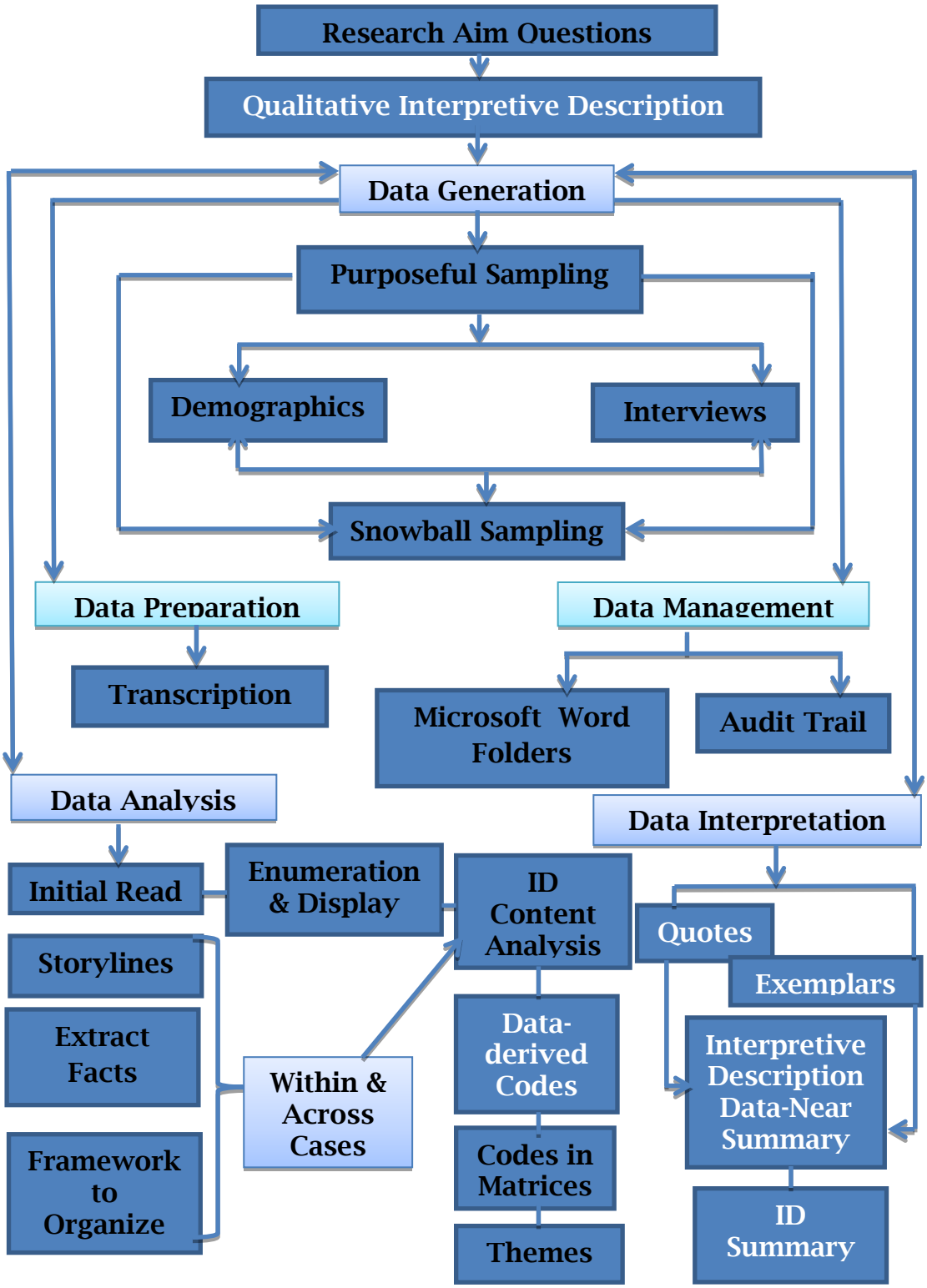
Appendix A
Table 1

STUDY DEMOGRAPHICS FREQUENCY TABLE		
AGES	30 – 39	2
	40 – 49	9
	50 – 59	12
	60 – 69	6
	70 – 79	1
GENDER	Male	24
	Female	6
	Couple	1
SAMPLING METHOD	Purposive	22
	Snowball	8
FBO MEMBERSHIP SIZE	< 50	5
	50 - 99	7
	100 – 199	6
	200 – 299	7
	300 – 399	2
	> 500	3
ZIP CODE WHERE FBO RESIDES	38018	1
	38105	1
	38106	4
	38107	1
	38108	2
	38109	3
	38111	1
	38114	3
	38115	3
	38118	3
	38126	3
	38127	1
	38128	4
	38131	1
Denominational	NonDenominational	15
Affiliation	Church of God in Christ	8
	Baptist	5
	Methodist	2

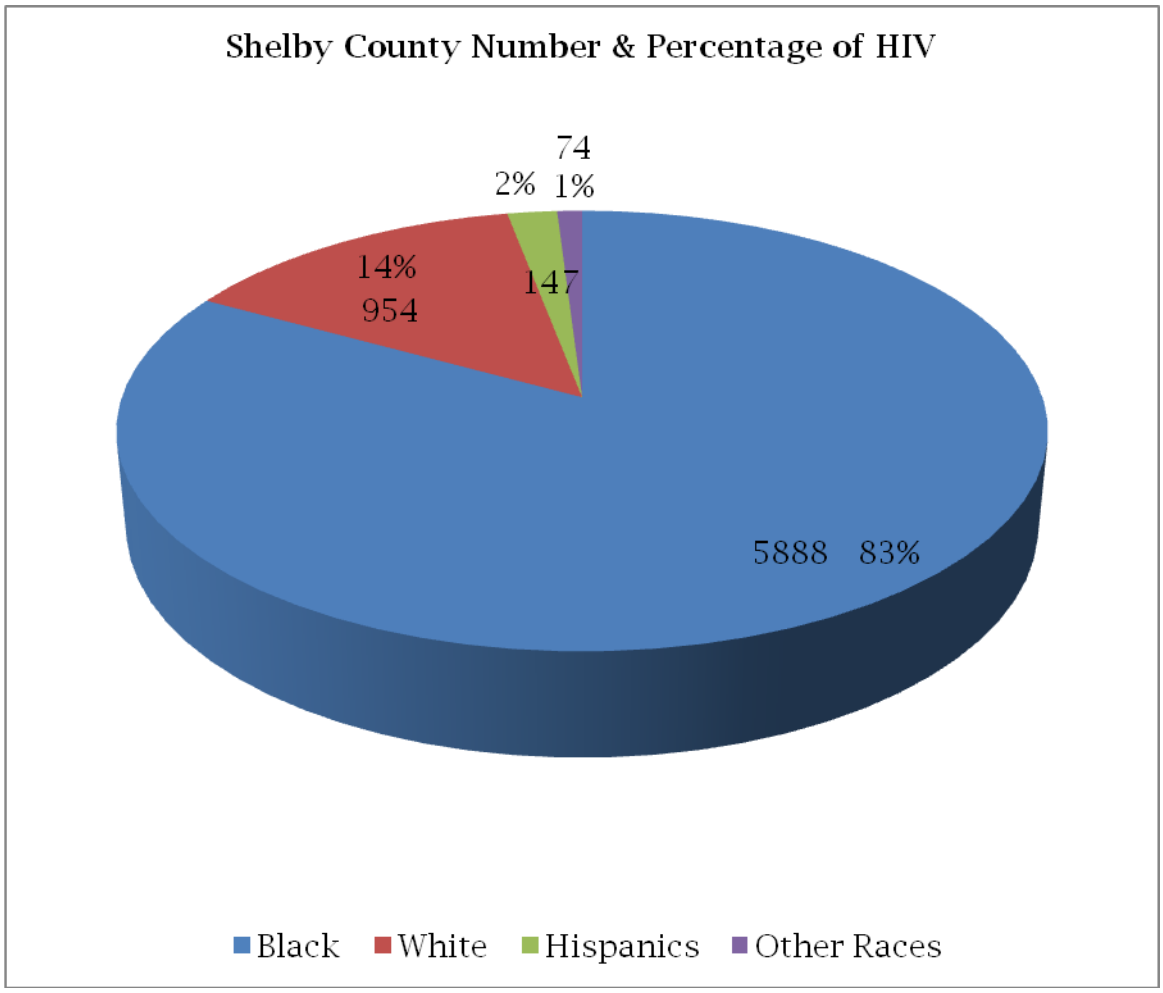
Appendix B

Figure 1

Summary of Data Generation, Analysis, and Interpretation Process



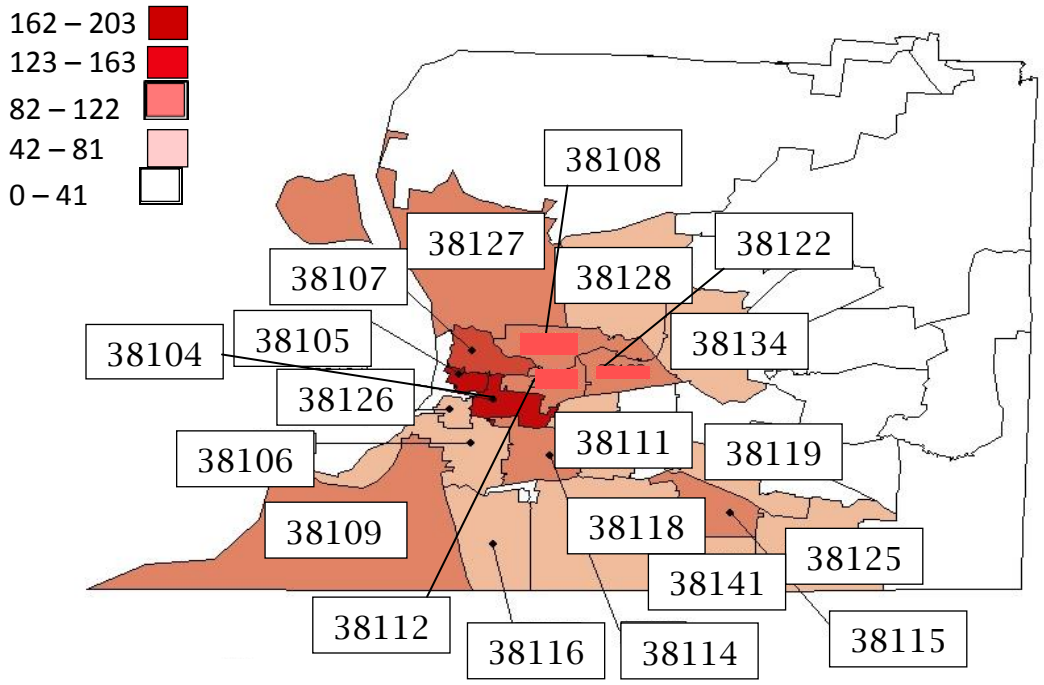
Appendix C
Graph 1



http://shelbycountytn.gov/DocumentCenter/Home/View/17347

Appendix D
Map 1

HIV/AIDS Rates, African Americans ages 10-24
Shelby County, TN, 2006-2010



St. Jude Research Hospital

2006 – 2010 African Americans

Rates per 100,000 by ZIP Code ™

Raw Count Data provided by Shelby County Health Department

U.S. Decennial Census 2010

Appendix E

INDIANA UNIVERSITY

esearch Administration

To: JANICE M. BUELOW NURSING

From: IU Human Subjects Office
Office of Research Administration – Indiana University

Date: May 07, 2013

RE: **EXEMPTION GRANTED**

Protocol Title: The Perception African American Faith-Based Organizations Regarding African Americans with HIV

Protocol #: 1304011158

Funding Agency/Sponsor: None

IRB: IRB-01, IRB00000220

Your study named above was accepted on May 03, 2013 as meeting the criteria of exempt research as described in the Federal regulations at 45 CFR 46.101(b), paragraph(s) (2) . This approval does not replace any departmental or other approvals that may be required.

As the principal investigator (or faculty sponsor in the case of a student protocol) of this study, you assume the following responsibilities:

Amendments: Any proposed changes to the research study must be reported to the IRB prior to implementation. To request approval, please complete an Amendment form and submit it, along with any revised study documents, to irb@iu.edu. Only after approval has been granted by the IRB can these changes be implemented.

Completion: Although a continuing review is not required for an exempt study, you are required to notify the IRB when this project is completed. In some cases, you will receive a request for current project status from our office. If we are unsuccessful at in our attempts to confirm the status of the project, we will consider the project closed. It is your responsibility to inform us of any address changes to ensure our records are kept current.

Per federal regulations, there is no requirement for the use of an informed consent document or study information sheet for exempt research, although one may be used if it is felt to be appropriate for the research being conducted. As such, these documents are returned without an IRB-approval stamp. Please note that if your submission included an informed consent statement or a study information sheet, the IRB requires the investigational team to use these documents.

You should retain a copy of this letter and any associated approved study documents for your records. Please refer to the project title and number in future correspondence with our office. Additional information is available on our website at http://researchadmin.iu.edu/HumanSubjects/index.html.

If you have any questions,

please contact our office at

the below address. Thank

you.

1| c/o IU Human Subjects Office | (317) 278-7189 | irb@iu.edu

Appendix F

Tamara D. Otey MSN, RN
PhD Student
Indiana University School of Nursing

Date, 2013

Dear Sir or Madam

My name is Tamara Otey. I am a PhD student at Indiana University School of Nursing under the supervision of Dr. Janice Buelow, Associate Professor and Department Chair, Indiana University School of Nursing. You are invited to participate in a research project entitled:

The Perception of African American Faith-Based Organizations (FBO) Regarding African Americans with the human immunodeficiency virus (HIV). The purpose of this survey is to determine the views of African American FBO Leaders regarding African Americans with HIV. This study has been approved by Indiana University's Institutional Review Board (IRB).

The following descriptive study was developed to ask you a few questions regarding your views and beliefs on people with HIV and your willingness to provide spiritual support for them and their affected families. It is our hope that this information can begin to ease the HIV related stigma in our community. There are no identified physical risks from participating in this research. You will be asked to participate in an interview. Interviews will be audio taped with the participant's permission. No identifiable information will be collected. The taped data will be written down word for word in English by me. The audio recordings and printed transcriptions of the audio recordings will be kept in a locked file cabinet and locked in a locked research office. They will be heard and viewed only by the investigators for study purposes only.

Participation in this research is completely voluntary and you may refuse to participate without consequence. The interview will take approximately one hour to complete. You will receive no compensation for participating in the research study. Neither the researchers nor the University has a conflict of interest with the results.

Further information regarding the research can be obtained from the principal researcher Dr. Janice Buelow at jbuelow@iupui.edu or Tamara Otey (901-827-7152) at tdotey@iupui.edu. If you wish further information regarding your rights as a research participant, you may contact the Human Subjects Office at (317) 278-3458 or (812) 856-4242.

Thank you for your consideration. Your help is greatly appreciated.

Your signature below indicates that you have read the above information, are at least 18 years of age and agree to participate in The Perception of African American Faith-Based Organizations Regarding African Americans with HIV.

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Curriculum Vitae

Tamara Dochelle Otey

EDUCATION:

	Institution	Degree	Date Awarded
DOCTORAL	Indiana University	PhD in Nursing Science	2015
MASTER	Union University	MSN	2003
UNDERGRADUATE	University of Memphis	BSN	2000
PROFESSIONAL DIPLOMA	Jewish Hospital School of Nursing	RN Diploma	1984

APPOINTMENTS:

I. ACADEMIC

Institution	Rank/Title	Dates
University of Memphis Loewenberg School of Nursing Memphis, TN	Clinical Assistant Professor	2005-Present
	Clinical Skills II Coordinator	2010 - 2013
	Director of Simulation	2010 - 2011
	2219 & 3019 Clinical Coordinator	2006 – 2009
Methodist Hospital School of Nursing	Instructor	2002 - 2004

II. NON-ACADEMIC (i.e. Administrative, Hospital or Corporate Appointments)

Institution	Rank/Title	Dates
Methodist Healthcare Memphis, TN	Oncology Clinical Educator	2004 - 2005

Home care & Hospice Coordinator Supervisor for Methodist Hospitals: University, North, South, and Germantown	1997 - 2002
Home Care Coordinator for Methodist Hospitals University and North	1993 - 1997
Staff RN, Methodist Home Care Services	1988 - 1993
Staff RN, Family Birthing Unit, Methodist North Hospital	1987 - 1988
Staff RN, Cancer Care Center, Methodist University	1985 - 1987

LICENSURE, CERTIFICATIONS, SPECIALTY BOARD STATUS (as applicable for discipline):

Credential	**Inclusive Dates**
Registered Nurse, Active, Tennessee, State Board of Nurses	2014-2016

PROFESSIONAL ORGANIZATIONS:

Organization	**Role**	**Inclusive Dates**
Sigma Theta Tau International Honor Society of Nursing Beta Theta Chapter-At-Large Memphis,	Member	2003 - Present
National League of Nursing	Member	2006 - Present

TEACHING:

Course/Title	**Cr.**	**Format**	**Role**	**Term**	**Enrollment**
UNDERGRADUATE University of Memphis					
4127 Community Health Nursing	3	Didactic	Instructor	S 14	5

4129 Community Heath Nrsg Practicum (2 Sections)	2	Clinical	Instructor	S 14	5 / 9
3206 Nursing of the Adult I: Common Health Alterations Practicum	3	Clinical	DEU Instructor	S 14	7
3118 Clinical Skills II (2 Sections)	1	Clinical	Instructor	F 13	12 / 12
3119 Medical-Surgical Nursing Practicum (2 Sections)	3	Clinical	Instructor	F 13	9 / 7
3118 Clinical Skills II (8 Sections)	1	Clinical	Instructor	S 13	11 /11 /10 /10/ 10 /9 /12 /12
3118 Clinical Skills II (7 Sections)	1	Clinical	Instructor	F 12	13 /11 /11 /12/ 12 /11 /12
3118 Clinical Skills II (7 Sections)	1	Clinical	Instructor	S 12	10 /11 /9 /10/ 11 /11 /12
3119 Medical-Surgical Nursing Practicum (2 Sections)	3	Clinical	Instructor	S 12	7 / 8
3118 Clinical Skills II (6 Sections)	1	Clinical	Instructor	F 11	13 /10 /11/ 8 / 8 /10
3118 Clinical Skills II (3 Sections)	1	Clinical	Instructor	S 11	12 /10 /14
3118 Clinical Skills II (3 Sections)	1	Clinical	Instructor	F 10	9 /11 /11
3018 Clinical Skills I (4 Sections)	1	Clinical	Instructor	S 10	9 / 8 / 9 /8
3019 Introduction of Medical Surgical Nursing Practicum (4 Sections)	2	Clinical	Instructor	S 10	9 / 8 / 9 / 8
3018 Clinical Skills I (4 Sections)	1	Clinical	Instructor	F 09	8 / 9 / 10 /10

3019 Introduction of Medical Surgical Nursing Practicum (4 Sections)	2	Clinical	Instructor	F 09	8 / 9 / 10 /10
3019 Introduction of Medical Surgical Nursing Practicum (4 Sections)	3	Clinical	Instructor	S 09	5 / 6 / 5 / 4
3019 Introduction of Medical Surgical Nursing Practicum (3 Sections)	3	Clinical	Instructor	F 08	7 / 9 / 5
2219 Foundations of Nursing Practicum (3 Sections)	3	Clinical	Instructor	S 08	7 / 8 / 6
2219 Foundations of Nursing Practicum (3 Sections)	3	Clinical	Instructor	F 07	8 / 8 / 9
4129 Community Health Nursing Practicum	2	Clinical	Instructor	U 07	7
2219 Foundations of Nursing Practicum (4 Sections)	3	Clinical	Instructor	S 07	7 / 8 / 8 / 7
2219 Foundations of Nursing Practicum (3 Sections)	3	Clinical	Instructor	F 06	8 / 10 / 9
3219 Expanding Family Nursing Practicum	3	Clinical	Instructor	U 06	8
2219 Foundations of Nursing Practicum (3 Sections)	3	Clinical	Instructor	S 06	
2219 Foundations of Nursing Practicum (4 Sections)	3	Clinical	Instructor	F 05	

Methodist School of Nursing N6 Management of Care	13	Clinical	Instructor	F 04	8
N4 Nursing Care of Adult II	10	Didactic	Co-Instructor	F 04	38
N3 Nursing Care of Adult I	10	Didactic	Co-Instructor	F 04	40
N5 Maternal Child Nursing	13	Clinical	Instructor	U 04	8
N3 Nursing Care of Adult I	10	Didactic	Co-Instructor	U 04	45
N1 Introduction to Nursing	7	Didactic	Co-Instructor	U 04	60
N4 Nursing Care of Adult II	10	Didactic	Co-Instructor	S 04	45
N1 Introduction to Nursing	7	Didactic & Clinical	Co-Instructor	S 04	52
N4 Nursing Care of Adult II	10	Didactic	Co-Instructor	F 03	44
N3 Nursing Care of Adult I	10	Didactic & Clinical	Co-Instructor	F 03	62
N3 Nursing Care of Adult I	10	Didactic	Co-Instructor	U 03	60
N1 Introduction to Nursing	7	Didactic & Clinical	Co-Instructor	U 03	75
N4 Nursing Care of Adult II	10	Didactic	Co-Instructor	S 03	37
N1 Introduction to Nursing	7	Didactic & Clinical	Co-Instructor	S 03	95

N3 Nursing Care of Adult I	10	Didactic & Clinical	Co-Instructor	F 02
N1 Introduction to Nursing	7	Didactic & Clinical	Co-Instructor	U 02

SERVICE:

I. ACADEMIC SERVICE:

ACTIVITY	COMMITTEE	ROLE	DATES
University of Memphis			
Loewenberg School of Nursing	Technology Committee	Member	2010 - Present
	Transforming the Curriculum Committee	Member	2012
	Simulation Task Force Ad Hoc committee	Chair	2010 - 2011
	Task Force on Strategic Planning	Member	2010 - 2011
	Undergraduate Curriculum Committee	Member	2005 - 2009
	Faculty Counselor for STTI Beta Theta Chapter-at-Large	Faculty Counselor	2006 - 2008
Methodist School of Nursing	Test Review Committee	Secretary	2002 - 2004

PROFESSIONAL ACTIVITIES

Presentations

1. Church Health Center, Congregational Health Promoters Class, HIV/AIDS Content Speaker, October 22, 2013
2. Church Health Center, Women's Health Conference Speaker, STI and HPV, October 26, 2013
3. Church Health Center, Aides for HIV/AIDS to Guide, Network, and Educate Lives (A.N.G.E.L.) Training Speaker, September 14, 2013

4. Church Health Center, Congregational Health Promoters Class, HIV/AIDS Content Speaker, July 23, 2013
5. Church Health Center, Aides for HIV/AIDS to Guide, Network, and Educate Lives (A.N.G.E.L.)Update Dinner Speaker, May 6, 2013
6. Church Health Center, Congregational Health Promoters Class, HIV/AIDS Content Speaker, April 23, 2013
7. Temple of Deliverance's Sisters Taking A Righteous Stand (S.T.A.R.S.), The Wonderful World of Human Sexuality, STI, & HIV Speaker, February 2, 2013
8. Church Health Center, Hickory Hill, Women's Issues Speaker, February 2. 2013
9. Church Health Center, Congregational Health Promoters Class, HIV/AIDS Content Speaker, October 12, 2012
10. Church Health Center, Aides for HIV/AIDS to Guide, Network, and Educate Lives (A.N.G.E.L.) Training Speaker, March 29, 2012
11. The Wonderful world of Human Sexulaity and HIV/AIDS/STI Lessons. Kingdom Life Gospel Church. Port Harcourt, Nigeria, West Africa. August 15, 2011.
12. Sisters Taking A Righteous Stand (S.T.A.R.S.) Conference Topic: Menstruation, Sexual Education, HIV/AIDS and STDs Prevention. Temple of Deliverance COGIC. October 16, 2010
13. HIV / AIDS Update. Progressive National Baptist Convention - Southern Region Jackson, MS. June 23, 2010
14. Always Sisters Forever Brothers - Memphis Chapter Topic: Why remain Pure? September 19. 2009
15. Youth Conference Topic: Whose Body is it anyway? 2 sessions scheduled. Temple of Deliverance COGIC. May 23, 2009.
16. Interdisciplinary Orientation: Pain Assessment. Methodist Healthcare. May 10 & June 7, 2005
17. HIV/AIDS/STD prevention. Evangelist Temple COGIC February 16, 2005
18. Surgical Oncology Orientation: PEG tube Maintenance, Feeding, and Care. Methodist Healthcare Cancer Center January 12, 2005
19. HIV/AIDS/STD prevention. Temple of Deliverance COGIC. October 9, 2004
20. HIV/AIDS Prevention for African Americans. YO Memphis (Youth Opportunity Movement). June 22, 2003
21. Taking Care of Person's with Cancer at Home. F.A.C.E.S. (Families Adapting to Cancer through Education & Support). Sponsored by Methodist Healthcare Cancer Care Center. April 8, 2000

Outreach

1. International Studies - Dominican Republic Mission - LSON faculty and students - October 8 - 14, 2008.

2. International Studies - Dominican Republic - LSON Faculty and Students - March 3 - 8, 2008.
3. Nigeria Medical Mission Trip. September 14 - 26, 2004. Temple of Deliverance Church of God in Christ (COGIC). Team Leader.
4. Nigeria Medical Missions Trip. October 20 - 29, 2007. Temple of Deliverance Church of God in Christ. Team Leader.
5. Nigerian Medical Mission Trip. June 17 - July 16, 2008. Temple of Deliverance Church of God in Christ. Team Leader.
6. Nigeria Medical Missions Trip. March 7 - 20, 2010. Temple of Deliverance Church of God in Christ. Team Leader.
7. Nigeria Medical Mission Trip. August 2 - August 19, 2011. Temple of Deliverance COGIC. Team Leader.
8. Nigerian Medical Mission Trip. August 1 - 17, 2012. Team Leader.
9. Nigerian Medical Mission Trip. August 7 - 16, 2013. Team Leader.
10. Nigerian Medical Mission Trip. July 29 – August 13, 2014. Team Leader.

Creative Activities

"Sista, Let Keep It Real," Reducing HIV in African American Adolescent Females Through Community Involvement. July 21, 2003, August 1, 2003, and August 22, 2003 - Memphis Urban League; Memphis Shelby County Central Library & the Youth Diagnostic Assessment Center - Union University MSN Scholarly Project/Interactive CD-ROM on HIV/AIDS Prevention.