

PERCEPTIONS AND SOCIAL CONSTRUCTIONS OF
HIV PREVENTION IN THE BLACK BAPTIST CHURCH

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ABSTRACT

MALIKA D. ROMAN ISLER: Perceptions and Social Constructions of
HIV Prevention in the Black Baptist Church
(Under the direction of Eugenia Eng)

Introduction. Although the Black church (i.e., the Black Baptist church) has long exerted incomparable influence upon the health behaviors of African American communities, few have engaged in evidence-based interventions for HIV/AIDS prevention or collaborated with public health professionals on implementation. Because no research has examined the compatibility of these innovations with theological and socio-behavioral perspectives of Black church clergy and congregations, this study: 1) examines social constructions of HIV/AIDS and efforts to prevent HIV by rural and urban black Baptist churches in North Carolina; 2) identifies, compares, and contrasts key considerations about introducing 5 evidence-based HIV prevention innovations (abstinence, monogamy, condom use, voluntary counseling and testing, and prevention with positives) to Black Baptist churches; and 3) explores relevant, participant-driven HIV prevention models.

Methods. This study used an exploratory qualitative design and methodological orientations of grounded theory and interpretive description. Data were collected using individual interviews and focus groups of respondents from 8 Black Baptist churches in North Carolina. A total of 1,117 interview

minutes were audio-recorded and transcribed verbatim; the 638 resulting pages of text were managed using Atlas.ti 5.2. Analytic tools included open coding, memo writing, case-level comparisons, model development, and validation of the theoretical schema.

Results. Case-level comparisons by church and by respondent segments revealed minimal distinctions. Respondents described social constructions of HIV/AIDS and its prevention in terms of 2 distinct worldviews, socio-behavioral and theological. Typical church responses to HIV/AIDS included silence, judgment, or maltreatment of persons living with HIV/AIDS. A combination of theological concepts, sin avoidance, and the socio-behavioral concept of avoidance of disease inform and enhance both the adaptability and acceptance of current evidence-based innovations. Participants also proposed non-evidence-based interventions.

Conclusions. Findings offered insights into: expanding the utility of evidence-based HIV prevention models within Black Baptist church contexts; specific modifications to those models to increase compatibility; and additional Black church-based models that will require additional research. Further research is needed to reconcile socio-behavioral interpretations of homosexuality, accountability, and the consequences of sin within church-based contexts.

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CHAPTER 1

Study Introduction and Rationale

Introduction

Since 1981, when Acquired Immune Deficiency Syndrome (AIDS) was first identified in the United States among populations of men who have sex with men (MSM), both AIDS and its cause, Human Immunodeficiency Virus (HIV), have become significantly concentrated among populations of color.[1] Blacks or African Americans, who have become most affected with the disease, experience more illness (49% of all new infections in 2005), shorter survival times, and more deaths than other racial and ethnic groups.[1] Among other appropriate venues for intervention, faith-based organizations (FBOs) have been shown to be worthy and essential partners for addressing the needs of those at risk for and suffering from HIV/AIDS. Studies have shown that FBOs, particularly in Black communities, are successful at shaping members' perceptions of health risk behaviors and linking them to valuable health promotion information and services.[2, 3] In their successful collaborations with researchers to address a wide range of health problems such as cancer, diabetes, and cardiovascular diseases, Black churches have shown that as FBOs they possess features that can be uniquely useful for HIV/AIDS prevention.[4-12] These features include reach, experience and capacity, spiritual mandate, sustainability, and moral

authority recognized by a large segment of the African American population.[13] However, despite these essential characteristics, a significant number of Black churches have yet to engage in HIV prevention activities.

Public health researchers have developed 5 evidence-based practices for reducing the spread of HIV/AIDS: abstinence, monogamy, condom use, voluntary counseling and testing (VCT), and prevention with positives (PwP; strategies for risk reduction and/or spread reduction engaged in by sero-positive people). Although each HIV prevention practice has drawn on bodies of evidence from biological, psychological, sociological, and public health sources, very little research has examined their compatibility with the theological underpinnings of Black churches, or how Black faith leaders adopt, adapt, or reject each of these practices according to their particular social construction(s) of the disease itself. Based on these premises, this study's goal is to document the social constructions of HIV/AIDS and its prevention among Black Baptist church leaders and congregants in North Carolina, as well as their views on the compatibility of the 5 evidence-based HIV-prevention practices with the theological perspectives of the Black Baptist church.

Study Rationale

This study uses an exploratory qualitative design informed by Rogers's Diffusion of Innovation Theory[14] to conduct a comparative exploration of the degree to which the characteristics of each of the 5 evidence-based innovations fit with the Black church's theological perspectives and social constructions of HIV/AIDS, including prevention. As a qualitative inquiry, it employs principles of

interpretive description and grounded theory with purposeful and maximum variation sampling. Data collection included in-depth interviews with church leaders and focus group interviews with congregants of Black Baptist churches, the largest denomination to which Black North Carolinians belong. Findings were applied to inform a conceptual model of participants' social construction of HIV/AIDS and HIV/AIDS prevention that includes their theological perspectives, and also to recommend future directions for facilitating compatibility and adoption of HIV prevention practices by Black Baptist churches.

Specifically, the aims of this study are to:

- 1: Examine social constructions of HIV and the prevention of it by the Black church
 - 1a: Develop a conceptual model reflecting Black church leaders' interpretation(s) of HIV/AIDS and HIV/AIDS prevention
 - 1b: Develop a conceptual model reflecting Black church congregants' interpretation(s) of HIV/AIDS and prevention
- 2: Identify, compare, and contrast key considerations for the introduction of various HIV prevention innovations (abstinence, monogamy, condom use, voluntary counseling and testing, and prevention with positives) to the Black church
 - 2a: Examine Black church leaders' perceptions of 5 key HIV prevention innovation models
 - 2b: Examine Black church congregants' perceptions of 5 key HIV prevention innovation models
 - 2c: Examine the applicability within the Black church of Rogers's Diffusion of Innovation characteristics to each of the 5 Study Rationales
- 3: Explore participant-driven HIV prevention models

In sum, health promotion research and practice have recognized the importance of religion and spirituality in the private lives of African Americans and that, throughout time, the Black church has occupied a place of central importance in Black communities.[3, 15] At the same time, engaging the Black church in HIV prevention continues to elude current public health research and practice despite the existence of several evidence-based intervention models.[16] Given the alarming increase of HIV/AIDS through heterosexual transmission within the U.S. African American population, it is incumbent upon the field of public health to consider that the current evidence base for existing HIV prevention practices may be incomplete or incompatible not only with how clergy and congregants of the Black church conceptualize the disease, but also with how its prevention fits their theological perspectives. Defining points of compatibility will be an important step toward engaging Black churches in adapting current evidence-based practices to improve their acceptability, as well as in developing new, effective practices that build on the Black church's theology and unique roles.

The next chapters offer a synthesis of the evidence for HIV/AIDS as a significant public health concern for Black Americans, and for the Black church as an appropriate and necessary partner in prevention. They include an in-depth exploration of the conceptual dimensions and their relationships to HIV/AIDS and HIV prevention from the perspectives of Black Baptist leaders and congregants. These findings are followed by a set of recommended strategies for engaging Black Baptist churches in HIV prevention activities, through modification of

current evidence-based interventions and through participant-driven interventions.

CHAPTER 2

Literature Review

This chapter begins with a synthesis of the literature on HIV/AIDS epidemiology as well as demographic trends that have resulted in the disproportionate burden of this disease upon African Americans in general, and particularly in North Carolina. Next, a review is presented of findings from prior research on a number of subjects: the 5 evidence-based practices that have been found to prevent sexual transmission of HIV/AIDS, the strengths of the Black church in addressing HIV/AIDS, and the impact of faith-based communities on HIV prevention. These are followed by a historical overview of the role of the church in the Black community and the role of the Black church as an agent of behavioral change, and finally by an overview of social construction and Diffusion of Innovation concepts, particularly Rogers's model of innovation attributes. The importance of examining the processes by which Black church leaders choose to engage in prevention activities is also considered.

Epidemiology of HIV and AIDS

Twenty-five years after public health officials gave a name to the rare cancers, pneumonias, and other illnesses affecting MSM in Los Angeles and New York, HIV/AIDS continues to threaten and alter the lives of those infected

and affected by the virus.[17] Despite numerous pharmacological and behavioral initiatives, the incidence of HIV infection remains stable or on the rise within specific populations.

In the United States, 1.2 million people were living with HIV in 2005 and an estimated 40,000 people have been newly infected each year for the past decade.[18] In 2005, of the estimated 43,198 total HIV diagnoses, 16,316 people died from AIDS-related complications.[19]

Along with the rest of the Southeastern United States, North Carolina (N.C.) follows a disparate trend of health conditions. Its reported incidence of AIDS is among the top 10 American states and territories, with 2,100 new HIV and/or AIDS diagnoses in 2003.[20, 21] With an infection rate of 25.2 per 100,000 persons, in 2003 N.C. experienced an increase in HIV/AIDS cases for the third consecutive year. By the end of 2003, an estimated 25,000 people in the state were living with HIV/AIDS.

As with many infectious and chronic diseases, groups who are disproportionately poor, disenfranchised, and vulnerable in N.C. are also disproportionately represented among its HIV/AIDS cases. The 2003 rate of HIV infection for non-Hispanic Black was 76.6 per 100,000, nearly eight times the infection rate for whites (9.6 per 100,000). For Hispanics, the rate was 25.4 per 100,000 (more than three times the rate for whites). Black males reported the highest rate of infection, at 104.3 per 100,000, but the greatest disparity existed between Black and white females. The HIV infection rate for Black females was

51.9 per 100,000, 14 times greater than for white non-Hispanic females at 3.6 per 100,000.[20]

Significance of HIV/AIDS to African Americans

HIV/AIDS has impacted every race/ethnicity in the United States, but its effects on the African American community have been particularly strong and far-reaching. African Americans have been disproportionately affected at each stage of HIV, from infection to death.[1] According to the 2000 U.S. Census, African Americans comprised 12.3% of the country's population; however, in 2005 Blacks accounted for 49% of its new HIV/AIDS diagnoses.[1] By 2005 the rate of AIDS diagnoses among African Americans was 10 times that of whites, with African Americans accounting for 50% of the AIDS diagnoses in all 50 states and the District of Columbia.[1] Of the population under the age of 25 with an HIV/AIDS diagnosis, 61% were African American.[1, 22]

Not only have African Americans been diagnosed with AIDS at a greater rate, they have also disproportionately lived with and died from it. Of those living with AIDS in the United States, 44% were African American and only 66% of those were still alive after 9 years, compared to 75% of whites, 74% of Hispanics, and 67% of American Indians and Alaska Natives. African Americans have represented 40% of all deaths among people with AIDS[1, 22]. However, because the development of new treatments has helped to extend their life expectancy, their opportunities to transmit the virus have also increased.[22]

African American men have borne the heaviest burden of HIV in the United States. Among all American men living with HIV/AIDS in 2005, 41% were African-American.[1] Their primary modes of HIV infection were sexual contact with other men (48%), intravenous (IV) drug use (23%), and high-risk heterosexual contact (22%).[1] In 2005, African American men experienced 8 times the rate of AIDS diagnoses as white men. A key factor in the continued spread of HIV/AIDS among sub-populations of African American men has been lack of awareness of HIV status. In a study of African American MSM in five cities, 67% of those who tested positive were unaware of their sero-status.[1]

Among African American women aged 25–34 years, HIV/AIDS was the primary cause of death in 2001.[23] Due to late testing, and thus late medical intervention, the rate of AIDS diagnoses for African American women was 25 times the rate for white women.[21, 24] This tremendous impact indicates the urgency of developing and sustaining effective, efficient resources for HIV prevention specifically targeted to this group. Because HIV/AIDS impacts children as well as their mothers, prevention among African American women can greatly reduce transmission of the virus to them as well as perinatal transmission to their infants. The dire need for such intervention is evident: of the 90 infants diagnosed with HIV/AIDS in 2003, 62 were African American[21] and 91 of the 141 perinatally infected infants diagnosed in 2006 were African American.[1]

Analyses of modes of transmission show that, in 2003, the leading cause of HIV infection among African American women was heterosexual contact

(81.1%), a trend that continued in 2005.[1, 21] Not only were many of these women unaware of risky behavior by their partner or partners, they also engaged in unprotected sex with multiple partners, bisexuality, and IV drug use.[25] Among participants in an N.C. study, approximately 20% of African American MSM, both HIV positive and HIV negative, reported a female sex partner during the preceding 12 months.[26] In a study by Montgomery et al., 34% of African American MSM reported having had sex with women, but only 6% of African American women reported having had sex with bisexual men.[27]

Another key risk factor for sexually transmitted HIV in African American women is the prevalence of sexually transmitted diseases (STDs) in African American communities. In 2007, African Americans comprised almost 70% of all gonorrhea cases, 48% of chlamydia cases, and 46% of syphilis cases.[28] Prior research has shown that the presence of some STDs can increase the risk of HIV infection 3 to 5 times and increase the risk of spreading HIV as well.[29]

Risk Behaviors and Prevention Models

The need for prevention strategies is very apparent in North Carolina. Adimora et al. conducted a population-based, case-controlled study of Black men and women in N.C. who had been recently diagnosed with a heterosexually acquired HIV infection.[30] Case subjects in this study were more likely than control subjects to report concurrent partnerships during the preceding 1 and 5 years, more partners during their lifetime and in the past year, and a partner who had sex with others while in a sexual relationship with the respondent. Even among a subset of lower-risk respondents, case subjects reported more partners,

concurrent partnerships during the past 5 years, and a recent partner who was not monogamous during the relationship with the respondent. These findings indicate that each of the prevention models considered in the present study (abstinence, monogamy, condoms, voluntary counseling and testing, and prevention with positives) has the potential to reduce the spread of HIV/AIDS.

Until a cure for AIDS is discovered, HIV prevention through behavioral risk reductions is the only effective strategy available.[31-33] Sexual transmission, the primary mode of HIV infection around the world,[34] is also the primary mode in the U.S. for the African American population.[30] Prevention of sexual transmission can be directly accomplished through abstinence, monogamy, and/or condom use. Knowledge of one's HIV status through voluntary counseling and testing can be key to preventing further sexual transmission. There is also a need to reduce further sexual transmission through prevention as well as to provide support for those already infected.

One of the most popular and effective approaches to reducing sexual transmission of HIV is known as ABC (Abstinence/delay of sexual activity, *Be* faithful/reduce partners, and use Condoms). Each of these behavioral objectives has been clearly linked to reduced transmission of sexually acquired HIV. Although each component has supporters and detractors, they are related from both epidemiological and transmission perspectives and each contributes to HIV prevention. Abstinence is the only means of preventing sexual transmission of HIV/AIDS that is known to be totally effective (being faithful/reducing partners is only as effective as the commitment of each partner). Condoms, the most widely

promoted prevention technique, do reduce risk when used consistently and correctly. After campaigns based on these approaches, evidence of their effectiveness in decreasing HIV prevalence has been noted in several countries.[35, 36]. They are considered individually below.

Abstinence/delay of sexual activity. Both decreased numbers of lifetime sexual partners and higher ages of sexual debut have been associated with lower HIV prevalence[37]. According to U.S. Demographic and Health Surveys from 1989 to 1995, the age of sexual debut increased by less than one year and the proportion of single women aged 15–24 who reported sex during the previous year decreased by approximately 33%.[36] These effects immediately followed the reduction in HIV incidence observed in the late 1980s and early 1990s.[36]

Faithfulness/partner reduction decreases both the possibility and probability of transmitting HIV and other STDs. Partner reduction takes various significant forms, including mutual monogamy within or outside the context of marriage, reducing the total number of sexual partners, and reducing the number of concurrent and/or casual partners.[38, 39] Several studies indicate that partner reduction is central to the large-scale HIV incidence reduction noted in several countries, including Uganda and Thailand.[36, 38-40] Uganda's adult prevalence, which declined from 15% to 5%, has been largely attributed to casual partner reduction among men and women[35, 38] and its nationally promoted “zero-grazing” policy that emphasizes faithfulness to a single partner.[41] According to Global Programme on AIDS surveys, the proportion of Ugandan men reporting

one or more casual partners decreased from 35% in 1989 to 15% in 1995; among women the decrease was 16% to 6%. Even among high-risk groups, the proportion of men who reported three or more non-regular partners decreased from 15% to 3%.[35, 36] Reports from Thailand noted a decrease in casual and commercial sex partnerships concurrent with the prevalence declines experienced by the country as a whole. In the United States and Europe, decreased HIV prevalence among MSM has been associated with partner reduction.[38, 39]

Condom use is proven to reduce heterosexual transmission of HIV.[42] When used correctly and consistently, condoms can reduce HIV incidence by at least 80%.[40] The international organization UNAIDS concludes that “the male latex condom is the single, most efficient, available technology to reduce the spread of HIV and other sexually transmitted infections.”[43] Many studies have indicated that correct, consistent condom use by heterosexual couples in which one partner is HIV positive significantly reduces the risk of HIV transmission; the European Study Group on Heterosexual Transmission of HIV found no seroconversion among couples reporting consistent condom use but significant seroconversion among inconsistent users.[44] Thailand’s reduction in HIV prevalence has been closely linked to the implementation of a “100%” condom approach that requires brothel owners to enforce condom use in every paid sex act.[39, 41] In Ghana, where condom use has been reported at rates over 90%, AIDS rates declined from the world’s highest (in the 1980s) after the implementation of a multi-level HIV prevention campaign.[41] Ghana’s

Demographic and Health Surveys indicate that women's reported use of condoms increased from 1% to 6%, and was 16% among men.[35] The 1989 and 1995 WHO Global Programme on AIDS surveys indicated that condom use by urban women increased from 7% to 20%, and among urban men from 15% to 30%.[36] Uganda also reported one of the highest levels in Africa of condom use by non-regular partners.[36]

Voluntary counseling and testing (VCT) has been clearly identified as a key prevention strategy to encourage behavior change and reduce sexual transmission of HIV.[45] Considering that approximately 25% of those infected with HIV are unaware of their infection[46], the need for widespread, frequent testing is dire. It has been surmised that people unaware of their serostatus account for more than half of the new HIV infections each year.[46] Testing can be a protective and informative tool for those who are already infected as well as for their uninfected partners. Research indicates that those who know their HIV status are more likely to make behavioral changes that reduce the risk of further transmission.[31, 34] Voluntary participation in testing also leads to early diagnosis of HIV infection, which benefits both the infected and the uninfected. People who are diagnosed early have the opportunity to enter medical care, receive antiretroviral therapy, and reduce the negative sequelae of infection, including advanced immune system suppression and opportunistic infections. Reducing one's viral load through early medical treatment also reduces the risk of further HIV transmission.[31, 47] The benefits of VCT are not only clinical, but

also offer those infected with the opportunity to engage in supportive counseling, access necessary information and education, and build support systems.[45]

Prevention with positives (PwP). Most HIV prevention research and strategies have focused on helping the uninfected to avoid infection. While this help is essential to reducing further spread, the ability of those already infected to prevent further spread has been largely ignored.[48] Some studies indicate that PwP requires the same inputs, resources, costs, and time frames as prevention efforts that target the uninfected; however, changing or reducing the risky behaviors of HIV-infected individuals has a greater effect. Although the total number of new infections has remained stable in recent years, the number of people living with HIV/AIDS continues to increase.[49]

Because of numerous advances in treatment, more people with HIV are living longer, higher-quality lives. The latter may include sexual activity, which has been a difficult topic for many to approach. As the number of people living with HIV increases and their management of the disease improves, their role in preventing further transmission is becoming more central. Studies have indicated that approximately 33% of people living with HIV/AIDS continue to engage in unprotected intercourse, which places them at risk for co-infection or other STDS and places their uninfected partners at risk for infection.[49] Social support, which is a major strength of FBOs, has been shown to have positive effects on sexual risk behaviors.[49]

Faith-Based Organizations and HIV Prevention

Faith-based organizations have been defined both as “places of worship and their members as well as any organization affiliated with or controlled by these houses of worship.”[50] People affiliated with FBOs “share similar convictions or practices that involve a belief in a higher power or order; a larger organizing principle for life and the universe; or a system or code that links values and actions to the idea that there is a reason and purpose for human existence.”[51] By some estimates, more than 80% of the world’s population identifies with some type of religion.[51] In the United States, FBOs have an extensive history of providing health, human, and social services including child welfare and child care, medical care, housing, transportation, and counseling.[52]

With the onset of the HIV/AIDS epidemic, various segments of society have been named as essential partners in addressing the needs of those infected with the disease as well as those affected by it. Initially, FBOs were slow to respond to those in need because in the conservative religious view, HIV is a punishment or curse in retribution for immoral acts such as premarital and extramarital sex, IV drug use, and homosexuality.[51] Moreover, FBOs have been seen as highly resistant and major obstacles to prevention messages about HIV, particularly messages related to nontraditional sexual practices, sex outside of marriage, and sex education in schools.[37] Researchers have found that it can be difficult to move FBOs in Black communities to address issues in general, including teen pregnancy,[53] safer sex,[53] HIV,[51, 53] sexual orientation,[51] and even cancer.[53] This reluctance also applies to HIV/AIDS.[54]

Many have attributed the Black church's lack of response to HIV/AIDS to its view of the disease in the early years of the epidemic as a "white gay" disease, not relevant to the Black community[51] as well as to the stigmas associated with the primary transmission behaviors.[55] In addition, Black churches have not traditionally supported condom use[50] and distribution[56] and needle exchange,[56] have stigmatized HIV as an immoral disease,[57] and have limited discussions about sexuality and gender relations.[50]

Despite traditional resistance to addressing HIV prevention through FBOs, current research shows that FBOs have become and will continue to be essential partners for effectively addressing the needs of those at risk for HIV.[54, 57, 58] Through direct community contact and by extending their core tenets, FBOs can effectively promote primary behavior changes via premarital abstinence and fidelity within marriage. According to one member of a faith community: "Religions, denominations and churches cannot conquer AIDS alone, but it also will not happen without us." [59] From the early years of the epidemic, FBOs have provided much of the care infrastructure in developing countries, including support and counseling.[37]

Although research institutions and medical communities do much to promote intervention messages and advance knowledge about clinical and behavioral prevention, FBOs possess characteristics that are essential to promoting the kinds of lasting behavioral changes that prevent HIV transmission. Indeed, MAP [Medical Assistance Program] International describes churches as "the largest, most stable and most extensively dispersed non-governmental

organization[s] in any country.”[37] When it convened for the U.N. Special Assembly on HIV/AIDS in June 2001, the United Council of Churches developed a statement about the necessary role of FBOs in addressing the atrocity of HIV/AIDS.[13] The statement identified four resources offered by FBOs: *reach*, *experience/capacity*, *spiritual mandate*, and *sustainability*.

Reach. Usually, FBOs are immersed in local structures and intertwined with a community’s cultural and social environment. They may also reach a larger proportion of a country’s population than any other type of institution.[55] Their reach and involvement equip FBOs to actively engage in community mobilization to respond to HIV/AIDS via normative social and cultural channels. Most FBOs maintain organizational structures at every level, from local to national or even international divisions, that employ extensive networks of people, institutions, and infrastructures. Particularly in rural areas, these organizations enable FBOs to mobilize people and resources for the benefit of populations not effectively reached by other means.[37, 50] Organization through multilevel structures facilitates the distribution of information and initiatives. Such structures have allowed FBOs to reach and support people who may be marginalized, disenfranchised, or beyond the reach of government campaigns for other reasons.[37, 51, 60] Because behavioral change requires multiple points of entry, both to and for targeted populations, as well as sustained exposure to messages or forms of intervention, FBOs have captured audiences through organizations that have regular followings and by establishing consistent contact with followers.[50]

Experience/capacity. By the nature of their calling, FBOs tend to have both histories of intervention in human needs and structures designed to help address human needs. Although the role of FBOs as barriers to HIV prevention has been widely acknowledged, some have always been involved with prevention and treatment as well. Faith communities' contributions to development and implementation have helped to create a holistic approach to HIV/AIDS.

Spiritual mandate/call. A primary mission of FBOs is to address the spiritual needs of people in need; in fact, FBOs are designed to assist such people in coping with issues they cannot deal with alone.[51] Members also feel compelled to love their neighbors, which includes assisting those who are ill, hurt, or bereaved. The religious bases of FBOs promote fidelity, respect for life, and committed relationships, and oppose stigmatization and discrimination—all of which contribute to reductions in HIV transmission. With their emphases on faith, idealism, and compassion, FBOs can both secure and mobilize large numbers of volunteers who are driven and sustained by their call to help those in need.[37]

Sustainability/staying power. The presence of FBOs in communities of need is well established. Such communities have maintained their presence through periods of war, conflict, natural disaster, and political oppression.[51] Accordingly, members of FBOs have demonstrated long-term voluntary commitment rooted in their deep spiritual beliefs; typically, they show more commitment than members of political, social, or economic institutions.

Ken Casey, leader of the WVI Hope Initiative, has identified an additional characteristic that makes FBOs essential partners in addressing HIV/AIDS: moral authority, defined as a set of fundamental assumptions that guide people's perceptions of the world.[61] This ideal empowers FBOs to maintain a type of jurisdiction over certain areas and communities that other institutions do not. Religious leaders are typically recognized and respected as moral authoritarians, particularly about issues of sexuality, social behavior, beliefs that explain the basis of disease, and rules for family life.[50] Such well-established authority makes religious leaders and institutions particularly useful for creating and disseminating messages about HIV risk.

Evidence of the strength of authority that FBOs can wield is evident among those who believe that messages about alcohol consumption lead to a lower prevalence of HIV among members of specific religious faiths. Because people who consume high levels of alcohol are more likely to participate in risky behaviors and thereby increase their risk for HIV, religions that have little to no tolerance for alcohol consumption may decrease risky behavior by and risk of HIV transmission among their members.[50] FBOs also have the authority to affect the social stigmas associated with HIV/AIDS. Just as open discussions among government authorities have helped to abate stigmas toward and negative perceptions of those infected with HIV/AIDS, similar discussions by faith leaders can influence stigmas toward and perceptions of the epidemic for those who turn to them as moral authorities.[37]

Effective HIV prevention programs have been endorsed by the local community, are relevant to local social and cultural contexts, and create protective and encouraging environments for behavioral change.[62] The conceptual and cultural connections among individuals, groups, and FBOs hold corollary to these findings: individuals associate with FBOs based on cultural identification, familial history, shared belief systems, social norms, and role expectations. Ideally, each person chooses to affiliate with an FBO that reinforces his or her cultural and social identity and worldview. Such shared belief systems and perspectives lend further credence to messages delivered by FBOs regarding behavioral, social, and even political decision making.

HIV Prevention Activities by FBOs

While effective campaigns against the further spread of HIV cannot be solely attributed to the involvement of FBOs, global HIV/AIDS initiatives in which religious leaders were involved early in the planning and implementation have had significant impact upon the epidemic. One of the greatest success stories has taken place in the country of Uganda: according to national surveillance surveys, the capital city of Kampala experienced a decrease in its HIV prevalence among pregnant women from about 30% in 1992 to approximately 10% by the end of 1999. Other regions of the country also experienced declines in prevalence.[36] Perhaps not coincidentally, as of 2001, a church leader was in his sixth year of chairing Uganda's National AIDS Commission.[63] Encouraging results have also been noted in Thailand, where Buddhist and Christian groups

have decreased the stigmatization associated with HIV by introducing home-based care services.[63]

In the United States, several groups have convened to consider faith communities' roles in and levels of commitment to addressing HIV/AIDS. The American Association for World Health established an interfaith declaration that defined its membership and outlined its responses to HIV/AIDS. Generally, the work of U.S.-based FBOs has ranged from food preparation and delivery to housing and child care. The Balm in Gilead (founded in 1989) has been at the forefront of HIV/AIDS prevention. This group initiated the Black Church Week of prayer for the Healing of AIDS, which has become the largest AIDS awareness program targeting the Black community in the United States[52]. In 1994, this body also developed the African-American Clergy's Declaration of War on HIV/AIDS, to represent Black churches' commitment to addressing HIV/AIDS.[64]

A partial list of the ways FBOs have been and can be involved in HIV prevention is given in Table 1.

Type of Activity	Source
Food and meal services	[52, 64]
Food banks	[64]
Prayer	[52]
Pastoral care and counseling	[37, 52, 64]
Homeless shelters for HIV-positive women and their children	[64]
Day care center	[52, 64]
Hospices	[37, 64]
Housing	[52, 64]
Support services – infected and affected communities	[37, 64]
Care and support for orphaned children	[37]
Training of care providers	[64]
Support groups	[52, 64]
Substance abuse ministries	[52, 64]
AIDS education programs	[52, 64]
Peer educator programs	[37]
Financial assistance	[52]
Emergency lodging	[52]
Mental health services	[52]
Respite care	[52]
Locating missing persons	[52]
Income generation and vocational rehab for PLWHA and dependents	[37]
Alternative employment or income-generation for girls and women vulnerable to or trapped in sex-trafficking	[37]
Voluntary counseling and testing	[37]

Table 1: Types of Faith-Based HIV Prevention Activities

Black Churches and Religious Affiliation as Agents of Behavior Change

The Black church is one of the most central and influential institutions in Black communities.[3, 9, 10, 65] Research has shown the influence of faith and faith-based organizations upon social and behavioral change; the same ability to create change is found in the Black church, an institution that has played a unique role in shaping the behaviors of its members throughout its history of community involvement and engagement. Most relevant to the context of health, studies have shown that churches in Black communities are successful at

promoting health,[10] shaping members' perceptions of health behaviors,[11] creating social support, and serving as a source of information about services that are valuable and important to members.[2, 3, 51]

As one of the most religious population subgroups in the industrialized world, Blacks are particularly sensitive to church influence in their decision-making. This is largely because, in addition to its primary focus of spiritual address, the Black church has historically promoted education as well as Black business development, political activism, social development, cultural development, and health initiatives.[3, 55, 56] The latter have traditionally included feeding programs, free health clinics, recreational activities, and child care programs.[56] These efforts to address issues of importance in Black communities have substantiated the ability of Black churches to facilitate positive behavioral directions and changes in their members.

In addition to being an impetus for change, church affiliation is also a buffer against risky behaviors and other factors associated with poor health outcomes including tobacco use,[66] alcohol use,[66] drug use[66] violence,[66] early sexual initiation,[66, 67] and avoidance of birth control[67]. One study found a significant relationship between religious service attendance, importance of religion, denominational affiliation, and lower levels of sexual involvement and more positive attitudes toward using condoms.[66]

In order to influence behavior, an institution must possess characteristics that are of value to and that promote a positive identity for its members. The Black church's behavioral influence is largely rooted in its source of authority and

the relational support it inculcates among its members. Since slavery, the Black church has been a source of support, social organization, and identification for Black Americans. The social and emotional support found in church can also counter the isolation experienced by ill people[56], which is particularly relevant to prevention efforts directed at people who are HIV-infected. The Black church's ability to create social networks and to define affirmative norms and values though those networks and accompanying social support emphasizes a variety of efforts, including health promotion activities.[56, 68] By using social networks to define norms and values, Black churches also provide venues for the creation of community-level socio-cultural changes.[68]

Through church-based health promotion programs, public health and medical researchers have linked with Black churches to access populations that are traditionally difficult to reach.[56] By collaborating with churches in Black communities, the unmet health needs of many Black Americans have been and can continue to be addressed. The need to intervene in the health of African Americans is evident: they have lower life expectancies, are less likely to have health insurance, make fewer primary care visits, have lower birth weights, experience higher infant mortality,[3] show high rates of obesity,[8, 11] and are more likely to lead sedentary lifestyles.[11] Close bonds between African Americans and their churches create multiple opportunities to use a demonstrated venue as a means to reach a historically neglected and underserved population.[69, 70] The effects of the church as a source of health promotion may be particularly beneficial for the Black women who largely

comprise the Black church. Women have been shown to be more likely to participate in and value church experiences generally, as well as more likely to participate in church-based health promotion programs.[69]

To counter the health disparities experienced by this community and to facilitate behavioral change, researchers have successfully collaborated with Black churches for church-based health promotion (defined by Ransdell as “large-scale effort by the church community to improve the health of its members through any combination of education, screening, referral, treatment and group support”). The literature shows evidence of the church’s effectiveness as a tool for health promotion, especially about fruit and vegetable consumption,[3, 5, 7] diabetes prevention,[71] physical activity awareness,[4] weight loss,[8] cancer prevention,[72] colorectal cancers,[10] cardiovascular disease,[11, 12] and mammography use.[9] The health issues addressed, however, have largely been noncontroversial.[55]

A list of health promotion activities undertaken by Black churches appears in Table 2.

Health Issue	Project Name	Effect	Reference
Fruit and vegetable consumption	African Methodist Episcopal Church and Medical University of South Carolina partnership	Program awareness significantly related to fruit and vegetable consumption	[4]
	Body and Soul	Increased fruit and vegetable consumption	[5]
	North Carolina Black Churches United for Better Health Project	Increased fruit and vegetable consumption	[6]
	Healthy Body Healthy Spirit	Significant changes in fruit and vegetable intake and physical activity	[7]
Physical activity awareness	African Methodist Episcopal Church and Medical University of South Carolina partnership	Program awareness significantly related to physical activity and fruit and vegetable consumption	[4]
Weight loss	WORD	Increased weight loss	[8]
Mammography use	Los Angeles Mammography Promotion in Churches Program	Maintained mammography adherence and reduced non-adherence	[9]
Colorectal cancer ^s	WATCH	Improved fruit and vegetable intake, recreational physical activity, FOBT	[10]
Cardiovascular disease	Project Joy	Significant improvements in body weight, waist circumference, systolic blood pressure, dietary energy, dietary fat, sodium intake	[11]
	Lighten Up	Significant short-term reductions in weight and systolic blood pressure	[12]

Table 2: Selected Black Church Health Promotion Activities

To affect behavior changes that facilitate HIV prevention, Black churches would need to educate members about risk reduction for transmitting or acquiring the virus. These goals can be accomplished by assisting congregants in knowing their serostatus, abstaining from sexual contact, using condoms consistently and

correctly, reducing their number of sexual partners, changing from high-risk behaviors to low-risk behaviors, and/or engaging in mutual monogamy.

Because of the level of identification that the African American population has with church as an institution, the level of moral authority inherent in churches over topics of sexuality and sexual behaviors, and the presence of social networks based on or promoted by churches, Black churches are well positioned to establish and promote healthy sexual norms. This ability is apparent in the zero-grazing policy promoted by community-based, faith-based, and governmental entities in Uganda to promote fidelity and partner reduction.[73] Churches promote fidelity and thus can create many opportunities to promote one of their central tenets while addressing a dynamic specific to the largely sexually driven epidemic of HIV in the Black community.

Why Social Construction Matters

The approach of this study is deeply rooted in principles of qualitative research, which illustrate the experience of social phenomena as interpreted through the lens of life experience for individuals, cultural groups, organizations, and society at large. Understanding and perception are specific to the context of people's lives, what processes and experiences mean to them, how they interpret their interactions with the world, and the symbolic and cultural meanings they assign to each of these.[74] Researchers are best able to understand insiders' perceptions in their natural contexts, as various contexts inform insiders' perspectives, experiences, and responses.

The understandings of HIV held by the Black church as an organizational unit, its leadership, and congregants, as well as how all of these interpret and respond to the issue of HIV, can be filtered through numerous orientations that include culturally shared interpretations as well as beliefs about disease origin, disease process, appropriate prevention, treatments or cures, understanding of roles, locus of control as it relates to infection, and even terminology. These influences on social construction require a great deal of untangling and deconstructing, particularly of the complex issues around sexual practices, which in turn carry deeply ingrained expectations for sexual behavior and the dynamics surrounding it.[75]

Every culture, including Black church culture, has its own learned patterns and interpretations of how illness is experienced, explained, and managed.[75] Social construction also influences unaffiliated individuals' understandings of societal norms and how these intersect with the diffusion of health innovations.[76] Before Black churches can be expected to be viable partners in addressing the public health crisis of HIV/AIDS, it is essential to understand African American cultural interpretations and experiences of HIV in the context of the Black church.

Diffusion of innovations. Since the 1940s, social science researchers have formally observed how individuals or other units of adoption launch new behaviors or initiatives. Everett Rogers, who is generally credited with the development of the diffusion model, defined diffusion as the process by which an innovation is communicated through certain channels over time among the

members of a social system.[14] This model has been applied across disciplines, beginning with agriculture and continuing through marketing, business, political science, anthropology, nursing, pharmacology, and public health.[77] When applied to interventions, Diffusion of Innovations can help change the perceived attributes of an innovation, utilize the appropriate communication channels for each stage of the innovation-decision process, and identify and utilize opinion leaders and other change agents.[78] Most research on adoption of innovations attempts to explain patterns of adoption in space and time, establish determinants or correlates of adoption in individual actors, and explain the process by which innovations come to be adopted.[79] Eventually, all the attributes of an innovation are examined to determine their applicability within specific contexts, to develop scales that can predict the likelihood of their adoption and quantify their influence on the rate or likelihood of adoption, and to determine their relative contribution to the adoption of a specific innovation.

Extended public health applications. While Diffusion of Innovations has shown multidisciplinary applicability, its use within the field of public health has varied. Components of the model have been used to examine the relationships between adoption and medical practices, family planning techniques, technological advances, screening modalities, water practices, and many others. Roger and Singhal summarized the model's applicability by studying innovation decision processes, adopter categories, opinion leadership, homophily, communication channels, and innovation attributes.[80] Examinations of

innovation attributes, specifically, have helped to justify and expand the model's utility in the public health arena, as per a focus of this study.

Suther et al. used innovation attributes to assess whether and to what extent the perceptions of genomic medicine by primary care providers (PCPs) influenced their adoption of its use.[81] These researchers were able to determine PCPs' perceptions of the relative advantage, compatibility, complexity, trialability, and observability of genomic medicine; in addition, they used these criteria to develop scales to predict PCPs' likelihood of adopting genomic medicine as a practice.

In another study from the nursing literature, Ting-Ting Lee used qualitative inquiry to explore how nurses adopt the use of computers in patient care and documentation.[82] To assess nurses' perceptions of this technology, Lee interviewed nurses who were using a computerized nursing care plan and assessed their responses in comparison with Rogers's innovation attributes. Based on this comparison, Lee was able to determine how innovation attributes contributed to the nurses' understanding and use of the innovation (computers) and also to identify considerations relevant to adoption in this context (patient care and documentation by nurses). In Lee's application, the model was theoretically expanded to further inform innovation adoption.

Diffusion of Innovations has not only been useful in explaining how public health professionals adopt new behaviors and modalities, it has also been useful in understanding how lay people adopt health behaviors. In a study conducted by Armstrong et al., women were assessed via a survey for their perceptions of

genetic testing for breast cancer, their level of innovativeness, how they learned about genetic testing, and how they made the decision to be tested after genetic counseling.[78] By assessing the characteristics of the women who engaged in testing according to Rogers's innovation attributes, the researchers were able to determine that participation in genetic counseling was most associated with the women's tendency to learn about and adopt innovations, and with the perceived compatibility of the test with the women's personal values and needs.

In their examination of the adoption of substance abuse policies, Pankratz et al. used factor analysis and the innovation attributes to develop a scale to measure Safe and Drug-Free Schools coordinators' perceptions of the Principles of Effectiveness program, which mandates how school districts implement their youth drug use and violence prevention curricula.[83] These researchers determined that the strongest relationships with program adoption were shown by relative advantage and compatibility, followed by complexity, and last by observability. Because the attributes showed varying levels of influence on program adoption, this exploration allowed researchers to rank their influence.

Meyer et al. examined how innovation attributes compare across preventive health innovations within the same organizational context by developing a scale that ranks relative perceptions of attributes across three different innovations and also across organizational roles.[84] Their findings, which show that relative advantage and complexity are key to the innovation process, indicate the importance of using specific attributes to test organizational climate and perceptions prior to adopting an innovation.[84] These researchers

were also able to expand the model for use in other contexts by identifying additional influential attributes.

Application of Diffusion of Innovation Models to HIV/AIDS Prevention

One of the earliest and most notable applications of Diffusion of Innovations to HIV/AIDS prevention was the San Francisco's STOP AIDS program in the 1980s. At a time when approximately 48% of the gay and bisexual population of San Francisco was HIV-infected, the men themselves founded this organization that utilized opinion leaders and small group meetings to reach a critical mass of early adopters to spread the idea of HIV prevention and create a self-sustaining diffusion process.[77] Largely due to this organization's outreach, HIV incidence in San Francisco dropped from 8000 in 1983 to 650 in 1985, and the reported rate of unprotected anal intercourse dropped from 71% in 1983 to 27% in 1987.[77] Similar models using opinion leaders to champion the cause of HIV prevention have been replicated by Kelly et al., with gay men in urban bars throughout United States,[33] and Miller et al. with male prostitutes and patrons in New York City bars.[33]

Utility in HIV research has been demonstrated internationally for Diffusion of Innovations approaches. In Tanzania, Jean Burke conducted a qualitative study using in-depth interviews and focus groups to examine the acceptability of preventive strategies to reduce infant HIV infection.[85] In that study, Burke applied innovation characteristics to participants' responses, examined participants' ideas about how to further diffuse the preventive strategies, and

categorized participants' responses according to the model's major components (innovation, social system, communication strategies, and time frame).

More recently, researchers have worked to specify the components of Diffusion of Innovations that are most relevant to HIV/AIDS prevention. Rao and Svenkerud[34] identified six essential components:

- 1) *Communication channels* – the means by which messages are transmitted.
- 2) *The innovation-decision process* – the 5-stage process through which an individual or group reaches implementation of an innovation.
- 3) *Homophily* – the extent to which two or more people perceive that they are similar to one another.
- 4) *Attributes* – perceived characteristics of an innovation.
- 5) *Adopter categories* – based on the time-frame needed to adopt a new idea, technique, or process.
- 6) *Opinion leaders* – group members or others who are respected for their knowledge of and reputation related to a particular topic.

Diffusion is also defined as a message about a new idea that creates a kind of social change or alteration in the structure and function of a social system.[14] This study considers the social system of the Black church and the innovation of HIV prevention activities. Historically, churches in general have not engaged in HIV activities, be they prevention or treatment. Within the larger Black community, the response to the impact of HIV/AIDS has become one that seeks to promote social justice and social change. Based on its historical and societal position within Black communities, the Black church has been called upon to initiate structural and social change that address the needs of those infected and affected by HIV. Although this charge is predicated on the

assumption that adoption of HIV activities by Black churches is a positive act, the desirability of specific innovations have been shown to vary according to the specific situation of various adopters (churches). Everett offers the analogy of mechanical tomato pickers being adopted by large commercial farmers, but proving to be too expensive for smaller growers and eventually putting many of them out of business.[14] An innovation that appears to be beneficial, and may be so under certain circumstances, is not always conditionally appropriate.

By examining the primary elements of Diffusion of Innovations, researchers explore why seemingly good ideas with obvious advantages are often difficult to adopt and may undergo extensive delays in adoption.[14] As indicated above, four primary elements comprise Diffusion of Innovations: 1) the innovation itself; 2) the channels through which it is communicated; 3) the time over which it is communicated; and 4) the social system in which the behavioral change is meant to occur. This study examines the function and perception of HIV/AIDS prevention innovations among Black church leaders and congregants. Although some Black churches have engaged in and become key collaborators in addressing HIV/AIDS, the Black church community as a whole has remained relatively uninvolved.

To better understand why the larger church community has not adopted seemingly necessary innovations that can be so historically, socially, and culturally influential and valuable, this study considers the role and perception of 5 key prevention models. The line of inquiry for these prevention models, which is guided by the innovation characteristics outlined by Rogers's Diffusion of

Innovations framework, also expands the model within this specific context.

Assessing Rogers's characteristics permits innovations' design and modification as well as the enhancement of their social acceptability and efficacy.[76]

Attributes of Innovations

An innovation is an idea, practice, or object perceived as new by an individual or other unit of adoption.[14] Newness of an innovation is not determined by its first use or exposure, but rather by the knowledge needed to adopt it or the persuasion or decision to adopt it.[14] Prevention innovations are ideas that are adopted in order to lower the probability of some unwanted future event. Ideally, Black churches would engage in HIV prevention activities to lower the rate of transmission and negative impact of HIV within a congregation and/or larger community, and would support HIV treatment activities both to ameliorate the negative effects of living with HIV/AIDS and as a form of secondary prevention. It is difficult, however, to estimate the impact of prevention innovations because their potential and delayed effects will occur at some future, unknown time. Moreover, desired effects may occur without the presence of an innovation or may never occur without one. The non-occurrence of future events is more difficult to perceive and objectify than the outcomes or benefits of an innovation that has been designed to produce immediate or short-term benefit.[14]

The decision to adopt an innovation is largely determined by how the unit of adoptions perceives the innovation.[14, 86] As modeled by other theoretical frameworks, perception of an innovation or new behavior more strongly

influences the decision to adopt than any objective definition or conceptualization of the innovation. Perceived attributes have the strongest effect on whether the innovation is appealing to the potential adopter.[82] Not only do perceived attributes of innovations help to determine the rate of adoption, they are specific to the innovation being adopted[14] and can contribute to tailoring the innovation to increase group ownership and participation.[16] These key attributes or characteristics, which explain between 49 and 87 percent of the variance in the rate and likelihood of adoption of innovations, are identified by Rogers's Diffusion of Innovations as *relative advantage*, *compatibility*, *complexity*, *trialability*, and *observability*.

Relative advantage, one of the strongest predictors of adoption, is defined as the degree to which an innovation is perceived as better than the idea it supersedes.[14] The greater the perceived relative advantage of an innovation, the more rapid its rate of adoption. Relative advantage can be perceived in terms of prestige, economics, convenience, and/or satisfaction; its sub-dimensions include economic profitability, low initial cost, decrease in discomfort, maintenance or rise of prestige, conservation of time and effort, and immediacy of reward. Most applications of relative advantage have conceptualized it in terms of economic profitability in the context of business, technology, or agriculture.[14] In this case, Black churches would need to perceive that adopting HIV activities is more advantageous or beneficial than not adopting them, including the perception of one or more demonstrated benefits of engaging in the innovation.[87] As is characteristic of prevention innovations, the delayed benefit

and perception value of a non-event directly affect relative advantage, often lowering it without specific strategies to prevent or counteract this. In accordance with how Meyer et al. conceptualized relative advantage, this study explores relative advantage in terms of innovation effectiveness or the degree to which an innovation is capable of achieving the ideal end-state (the prevention of HIV).[84]

Compatibility is the degree to which an innovation is perceived as consistent with existing values, past experiences, and needs of potential adopters.[14] Greater compatibility between the innovation and the social system seeking intervention means that less ambiguity will be present and that familiarity and rate of adoption will be greater. Compatibility can be conceptualized in relationship to sociocultural values and beliefs, previously introduced ideas, and/or client needs for the innovation. This study allows for the exploration of each of these sub-dimensions as well as the Black church leaders' perceptions of HIV activity specifically.

When innovations are incompatible with a group's or institution's pre-existing cultural values and beliefs, they are less likely to be adopted. For example, church doctrine prohibits sexual activity before and outside of the context of marriage, discourages same-sex sexual partnerships, and in some cases discourages the use of contraception. Therefore, messages regarding condom use or mutually exclusive sexual partnerships outside of marriage may be key to the ABC prevention strategy, but are often viewed as contrary to church doctrinal teachings, values, and beliefs.

Familiarity with new innovations is also a factor: previously introduced ideas set the stage and are more likely to be adopted. Introductions can refer to practices that have already been adopted, as well as to collective memory of or familiarity with past experiences. Innovations that are highly compatible with existing structures can segue into less compatible innovations as the unit of adoption becomes less threatened by previously incompatible ideas and practices. The more an innovation meets a perceived need belonging to a potential unit of adoption, the more compatible it is found to be.

To date, many have charged the church with the need to engage in HIV-related activities, but less of an imperative has been indicated from the church's perspective. Because potential adopters may not recognize a need until an innovation has been developed and made available to them, understanding potential adopters' subjective conceptualizations is essential. Evidence suggests that change or adoption of an innovation that seems inconsistent with organizational values will be resisted; therefore, modifications that make the values of the innovation more congruent with church values can increase the likelihood of adoption.[16]

Technology clusters, another key consideration for compatibility of an innovation, refers to one or more distinguishable technological features that are perceived as being interrelated.[14] Because innovations can be perceived by potential adopters as closely related, even when the innovations are not strictly technological, bundling the new ideas can affect the rate of adoption. For example, at this time it is unclear whether Black churches that are amenable to

establishing a general health ministry are also more likely to perceive HIV initiatives as compatible with such work. Perhaps clustering HIV activities within a holistic health ministry would increase churches' adoption of HIV-related activities.

Complexity is the degree to which an innovation is perceived as difficult to understand and use.[14, 84] The greater the level of complexity, which raises the need to develop new knowledge and skills, the slower the rate of adoption. An innovation perceived to be too long, costly, or burdensome is also less likely to be adopted.[87] If Black church leaders perceive adopting HIV/AIDS activities as easily understandable and they feel equipped for the task, they will be more likely to adopt one or more innovations. Complexity is also a function of the number of components of an innovation. To achieve the desired results, increasing the number of components may require a higher degree of mastery and more facets of implementation.

Trialability is the degree to which an innovation may be experimented with on a limited or trial basis. The greater the option for implementing an innovation on a trial basis, the greater the rate of adoption. This effect is largely due to the lesser uncertainty offered by trialability (if an innovation doesn't work on the smaller scale, it can be reinvented or even abandoned for more widespread use). If Black church leaders are able to test small-scale activities without investing in large-scale activities that could cost them financially or even socially, they will be more likely to adopt such activities. Late adopters of an innovation have an additional benefit, that of trying the innovation indirectly (i.e. by evaluating the

experiences of earlier adopters). An examination of the learned experiences from other churches engaging in HIV activities can lead to understanding how trialable the innovation might be to those who have yet to adopt. Periods of trialability can also incur reinvention of the innovation. Reinvention allows adopters to customize or modify the innovation to more closely fit their framework. Such modifications can be minor or change the innovation altogether.

Finally, *observability* is the degree to which the results or effects of an innovation are visible to others (most importantly, the affected population). The greater the observability, the greater the rate of adoption. The impact of observability is often indicated by the adoption of an innovation in clusters or networks of related adopters. Unfortunately for HIV/AIDS prevention researchers, the concept of safer sex is one with subtle or even unobservable outcomes and includes recommendations that can seem contradictory and confusing, such as the trio of abstinence, monogamy, and condom use. These complications have slowed the adoption of safer sex practices. As a prevention innovation, the benefits or outcomes of avoiding HIV infection are difficult to observe and may negatively affect the adoption of prevention activities for any entity. Observability also includes the effects of an innovation that was previously used by other organizations and has gained popularity or a good reputation because of this use.[86]

According to Landrum, examining the perceived attributes of an innovation provides opportunities to modify it and strengthen the likelihood of its adoption.[82] Although these 5 attributes have been identified as key to the

initiation of the adoption process, they may not always be the most important perceived characteristics for a particular set of respondents.[14] Therefore, this study seeks to discover additional innovation characteristics or key attributes that affect the willingness of Black churches to engage in HIV prevention activities.

Importance of Opinion Leaders

Rogers's Diffusion of Innovations also incorporates the influence of key people, called opinion leaders, who disseminate information about an innovation to other members of a group or system. Opinion leadership is based on the degree to which an individual is able to influence other individuals' attitudes or overt behavior informally, in a desired way, with relative frequency, and is maintained by that individual's technical competence, social accessibility, and conformity to the system's norms.[14] Opinion leaders are usually internal to the context in which they exert influence and have an ongoing involvement with the process of innovation.[88] As demonstrated in previous studies, opinion leaders are able to change others' perceptions of what is normative behavior, increase buy-in from other members of their social system, and affect the critical mass needed to sustain the innovation's diffusion.[33] This success is not based on an opinion leader's own innovativeness necessarily, but rather by his or her ability to evaluate an innovation for its fit with the local context and then to facilitate group buy-in.

These tasks are largely accomplished because of the opinion leader's core characteristics (credibility and the ability to persuade others) and because such people are also perceived as knowledgeable, trustworthy, accessible,

approachable, willing to share their knowledge, and as good advisors about complex situations.[88] Much of the influence of opinion leaders disseminates by word of mouth and face-to-face communications through their extensive peer and social networks. Their level of influence enables them to facilitate and accelerate an innovation's rate of diffusion.[89]

Opinion leaders have demonstrated effectiveness in decreasing the rate of unsafe sexual practices and the rate of cesarean births. One of the most notable applications of the opinion leader model is the Popular Opinion Leader intervention, in which well-liked, well-regarded community members persuade their peers by discussing how they use condoms to protect themselves from HIV.[16]

Opinion leaders are also essential for reaching culturally unique populations, such as commercial sex workers.[33] When opinion leaders who are homophilous (i.e., perceived as similar to the target population) communicate an innovation, it is more readily received by the target population. The same is true for a culturally unique and distinct population such as Black church membership. In the context of HIV/AIDS, a culturally unique group experiences marginalization, discrimination, and challenges to receiving health messages;[90] all of these markers can be applied to African American communities and to the Black church. Opinion leaders in these populations may be even more significant when the disparities between the Black community and the rest of American society are taken into consideration.[90]

Although other leaders in the Black church assist in the creation and maintenance of norms, the pastor is the primary opinion leader and gatekeeper of ideas and innovations. From the top of the hierarchy and the most centrally positioned person within the network, a pastor is able to facilitate and influence the communication structure of his church.[14] As with opinion leaders from other systems, this position allows pastors to model innovative behaviors for their congregants. While pastoral influence is key to the adoption of new activities, pastors are rarely the ones who implement new ideas. For that reason, this study also interviewed other key opinion leaders and decision makers such as deacons, auxiliary leaders, and assistant ministers.

The S Curve and Adopter Characteristics

Whereas innovation attributes are useful in understanding how and why black church pastors and congregation members perceive and socially construct HIV prevention, a more comprehensive examination of innovation adoption would conceptualize the church, as an institution exhibiting varying levels of innovativeness and falling into categories of early or late adopters.

Innovativeness is one of the most studied components of the Diffusion of Innovations Theory and represents the degree to which a unit of adoption, such as a church, is relatively earlier in adopting new ideas than other churches. [14] Innovativeness has been represented by the time-associated S-shaped curve, which demonstrates the normal cumulative rate of adoption of an innovation. Though this is the widely accepted distribution curve in the literature, rate of

adoption is specific to an innovation and a system; therefore, it's necessary to determine if the S-curve applies to HIV prevention adoption among black Baptist churches. [14] This is particularly necessary as the S-curve is based on the successful adoption of an innovation and HIV prevention remains largely unadopted by black Baptist churches.

There are a number of factors that influence the rate of adoption and the cumulative curve including the social acceptability of the innovation, the level of interaction between members of the systems, the level of innovativeness of non-leaders in the system, the ability to identify who the adopter is, and the threshold. [14] Adoption of HIV prevention innovations among black Baptist churches is likely to follow a slower rate than that of the S-curve given that this is a preventive and taboo innovation, and they tend to diffuse more slowly. [14] HIV prevention's potential incompatibility with normative church culture and values may also limit the amount of interaction between churches specific to HIV prevention, as churches are less likely to discuss the concept or strategies for engaging in a seemingly discordant activity. Another key factor that may impede the rate of adoption is the threshold required for an innovation to readily diffuse through interpersonal networks or between churches within the same network. Adoption by a critical mass and their evaluation, and hence approval, of the innovation is necessary for diffusion to occur between entities.

Rate of adoption is also influenced by a balance between the innovation-development and the diffusion-planning processes. As is consistent with this

study, the context in which the innovation is diffused, must inform the development and implementation of the innovation. Glanz and Rimer emphasize the importance of the socioenvironmental and ecological factors as key determinants of adoption. [91] For systems beyond the individual level, several internal organizational factors inform the context of adoption and influence innovativeness; centralization, complexity, formalization, interconnectedness, and organizational slack. [14] Centralization is the degree to which power and control are held by few individuals within the system. Many black churches are highly centralized as the pastor and key leaders hold primary decision-making authority, but through congregational autonomy, individuals within the church are also able to influence decision making. Complexity is the degree to which an organization's members possess a high level of knowledge and expertise, and is usually defined by the members' range of occupations and formal professional training. This would vary across churches, though some churches are primarily comprised of members from similar socio-economic strata. Formalization is the degree to which an organization emphasizes following rules and procedures for member performance. Black Baptist churches are steeped in governing rules, procedures, norms, and beliefs that govern member behavior. Interconnectedness is the degree to which the units in a social system are linked by interpersonal networks. Given that membership in the Black Baptist church is voluntary and based on theological and socio-cultural ties, many of its members are likely to share interpersonal linkages. Finally, organizational slack is the degree to which uncommitted resources are available to an organization. Many

churches operate on limited personnel and fiscal resources and have few unobligated resources.

In addition to being influenced by individual and organizational characteristics, the S-curve is segmented into adopter categories, defined as innovators, early adopters, early majority, late majority, and laggards. [14] Innovators are necessary to begin the trend of adoption and are those units that are usually in control of substantial financial resources to absorb potential losses, have an ability to understand and apply complex technical knowledge, are able to cope with a high degree of uncertainty about an innovation, and may not be respected by others in the system. [14] Becoming an innovator in this context may meet considerable opposition as many black Baptist churches operate on limited fiscal resources, have a limited scope of public health-specific technical expertise, require some certainty of outcomes prior to engaging in new activities, and are strongly guided by social and theological acceptability among their peer churches. The characteristics necessary to become an innovator could be contrary to many aspects of the black Baptist culture and existence.

Given the range of organizational and aggregate characteristics present among black Baptist churches, it must be determined if these characteristics follow the expected trends for engaging in HIV prevention amongst black Baptist churches. While each of these components influences the shape of the curve that represents the rate of adoption, HIV prevention faces the same innovativeness/needs paradox of most innovations. [14] African Americans who comprise black Baptist churches are significantly and disparately impacted by

HIV/AIDS, but despite the level of need of the benefits of HIV prevention, churches may be the last to adopt the innovation. In addition to the perception of the individual prevention innovations, considerations regarding the rate of adoption and characteristics of units within the adopter categories, such as a church, are necessary to inform the rate of adoption and specific pattern of diffusion.

CHAPTER 3

Study Rationale, Purpose, Orientation, Methodology, Analysis, and Features

Overview

A primary aim of this study is to understand how Black church leaders and congregants socially construct HIV and think about how it can be prevented. Its second aim is to compare and contrast key considerations for the possible introduction of various HIV prevention innovations to the Black Baptist church. This part of the inquiry was guided by the 5 innovation attributes defined in Rogers's Diffusion of Innovations model. Its third aim is to explore participant-driven HIV prevention models.

Rationale for Research Design and Sampling Issues

This study is a qualitative inquiry that employs principles of interpretive description and grounded theory (Table 9). Participants were sampled purposively, based upon their ability to offer specific perspectives that broaden conceptualizations or understandings of the phenomenon.[92] For the focus groups, sampling and segmentation were informed by epidemiological evidence about the age groups that show the highest HIV prevalence within Black communities at a particular geographic location (Central and Eastern North Carolina). For individual interviews, sampling was informed by the potential

differentiation of perceptions on the bases of respondents' positions within a church, the size of that church's congregation, and the church's geographic location. Congregants and church leaders were the main groups asked to share their attitudes about HIV/AIDS and its prevention according to Black Baptist perspectives.

The method known as interpretive description was developed by Thorne et al. to address the need to generate grounded knowledge for clinical nursing contexts,[93] but the process is applicable to other substantive areas as well. Basic description is appropriate for phenomena;[94] however, due to its interpretive nature, this study attempts to link and recontextualize data for practical applications as well as future theoretical uses.[93] Consistent with other applications of interpretive description, this study aims to move beyond theoretical roles for and hypothetical partnerships between researchers and the Black church for HIV/AIDS prevention to the development of usable, informed tools for engaging the Black church in key prevention models.

Interpretation not only includes the presentation of ideas and themes, it also offers explanations for how themes, patterns, subthemes, connections, and contradictions join to produce informative core meaning,[74] which according to the philosophy of naturalistic inquiry is defined as the constructed and contextual nature of human experience through shared realities.[93] Naturalistic inquiry provides the following framework for constructing research design and interpreting findings:

- 1) Multiple constructed realities that can be studied only holistically. Reality is recognized as complex, contextual, constructed, and ultimately subjective.

- 2) Interaction and mutual influence between the inquirer and the “object” of inquiry; indeed, the knower and known are considered to be inseparable.
- 3) The acknowledgement that no a priori theory is able to encompass the multiple realities that are likely to be encountered; rather, theory must emerge or be grounded in the data.[93]

Although meanings uncovered in interpretive research are rooted in and true to participants’ views, they are presented in a way that is useful to the broader population.[74] The process of conducting interviews with pastors and their designees familiarized study staff with the perspectives of Black church leaders about HIV and its prevention; focus groups consisting of Black church congregants provided laity perspectives of HIV and the church’s role in its prevention. Gaining an understanding of how Black church leaders and congregants think about HIV, the meanings they assign to concepts associated with it, and several key prevention strategies, offered substantial insight into which innovations can be used to successfully establish partnerships between public health researchers and the Black church to impact the spread of HIV/AIDS in the Black community. Based on what is already known about the roles and influences of the Black Baptist church in Black communities, and the devastating impact of HIV/AIDS upon African Americans, this researcher has been able to develop an analytic framework and root meaning to which the findings of this study are linked.

Both interpretive description and grounded theory allow for inductive sampling of “the positions or experiences that each participant or informant might represent [and that] cannot be known until data collection is well underway.”[95] Due to time and cost limitations, this researcher purposely selected participants

and allowed for inductive development of her line of inquiry so that emergent themes and patterns could be more closely examined.

Use of a qualitative approach was intended to capture socially constructed meanings applied by individuals to interactions with their world and to investigate these individuals' interpretations of reality at a particular time in a particular context.[96] As with interpretive description, selected cases were information-rich as determined by the purpose of the study.[94] The socially constructed reality under examination was that of Black church leaders and congregants and their understandings and social constructions of HIV/AIDS and HIV/AIDS prevention.

Study Purpose and Orientation

In a qualitative research project, the researcher's assumptions, orientations, values, and prior knowledge all influence data interpretation. Therefore, the researcher has the responsibility of examining, and considering reflexively, all of the influences that shape the research process. Reflexivity means a researcher's analysis of decisions, interpretations, and interests, as well as other parts of self, and how and to what extent these factors inform the research.[97] According to the constructivist view, which acknowledges multiple realities and thus the validity of a researcher's lens of interpretation, all biases cannot be eliminated (as the positivist view would have us believe). However, their influence can be acknowledged through the reflexive process.[95]

As a public health researcher whose training emphasized health behavior and health education, I consider myself a health advocate and a promoter of specific health strategies geared toward the prevention and/or amelioration of

negative health conditions and effects. This study stems from my conviction (i.e., a combination of assumption, belief, and experience) that the gap between what research indicates and what people's lives require must be filled. Specifically, the role of the church in HIV prevention and its limited involvement in practice can be, and must be, adjusted to improve the health of church members and the community at large. My assumptions about the basis for this gap stem from my observations of the misunderstandings and misconceptions within the Black church community about the extent of the HIV/AIDS epidemic among and its impact upon Black Americans, as well as limited manner in which it has merged its goals and roles with those of health promotion, both conceptually and pragmatically. Furthermore, as a public health practitioner, I recognize the limitation of intervention construction without the informed perspective of the target population.

In addition to my orientation as a public health researcher, and perhaps more deeply ingrained, are my assumptions, values, and cultural understandings as a member of the black Baptist community. My membership in this community has contributed to my choice of the study in question and will influence the study's implementation, and interpretation of the findings. My affiliation with the study population serves to both grant me credibility with the participants through shared language and experience, and allows participants to freely discuss issues with someone believed to share their emic perspective. Though this connection functions as an inroads to data collection, it can potentially overly influence the development of the social constructions, as the goal of this study is to build the

constructions based upon the researcher's understanding of the participant's perspectives instead of her own.

I identify myself as a social constructivist; that is, one who operates from the belief that individuals seek understanding of the world in which they live and work, and develop subjective meanings around their experiences.[98] Similarly to other qualitative approaches, social constructivism recognizes varied meanings assigned by individuals to their experiences, which requires the researcher to understand the range and complexity of those meanings and understandings from participants' perspectives—as constructed through their interactions with others and as the results of their cultural and historical norms.[98] Due in part to this informative nature, social constructivism aims to inductively build a theory or pattern of meaning from participants' subjective viewpoints, while also acknowledging the influence of the researcher's perspectives upon her interpretation and reconstruction of those experiences and perspectives.[98] Social constructivism influenced my shaping of the questions posed in this project, its open-ended line of inquiry, and my interpretation and recontextualization of the data into findings.

Location of the Study

This study was conducted in Forsyth and Edgecombe counties, respectively located in North Carolina's Piedmont and Eastern regions. According to the 2000 census, Forsyth and Edgecombe counties were 25.61% and 57.46% Black or African American, respectively. Table 3 offers an overview of county-specific epidemiology.

	Forsyth County	Edgecombe County
Population	306,067 – 2000 census	55,606 – 2000 census
N.C. HIV Disease by County Rank Order¹	13 th – 25.2 avg. rate ² (N.C. – 20.1 avg. rate)	2 nd – 420.2 avg. rate
N.C. HIV/AIDS Cases Living as of 12/31/08	1,134	255
N.C. HIV Disease Cumulative Cases through 12/31/08	1,710	387
N.C. AIDS Cumulative Cases through 12/31/08	782	235

(North Carolina 2008 HIV/STD Surveillance Report, Epidemiology & Special Studies Unit, HIV/STD Prevention & Care Branch. N.C. Division of Public Health & N.C. Department of Health and Human Services)

Table 3: Forsyth and Edgecombe Counties' HIV/AIDS Epidemiology

Methodology for Individuals

Inclusion/exclusion criteria. Interview participants were selected according to certain characteristics of the church to which they belong. Included churches were 1) predominantly Black; 2) of the Baptist denomination; 3) did not have a ministry to specifically address HIV/AIDS; 4) had a pastor who had been in service in that church for at least one (1) year; 5) located in either Forsyth (urban) or Edgecombe (rural); and 6) had Sunday attendance of either ≥ 300 or <100 .

Churches' Baptist identity was determined by their affiliation with the General Baptist State Convention. The sample was limited to Baptist churches to

1. HIV disease represents all new diagnoses of HIV, regardless of stage.

2. Rates are expressed as cases per 100,000 population.

control for the influence of hierarchical power structures found in other denominations. Baptist churches operate according to the Congregational governance system, which grants autonomy to individual local churches.[99] Churches' programming decisions, which are made without mandates from a governing body, include whether or not to engage in HIV prevention activities.

The infrastructure, expertise, or capacity to independently create or engage in HIV-related innovations are often lacking in these churches. However, because central tenets of community-based health promotion are partnership and collaboration, it is not the goal of a community-engaged research project such as this one to foster independent HIV/AIDS programs in these settings. Based on this premise, involvement included direct involvement in the innovations and indirect involvement through referrals to or cooperation with off-site services. For consideration in this study, such involvement would have to be within the context of HIV. For example, a church's non-HIV-specific messages about abstinence were considered non-involvement in HIV prevention activities.

Churches also met inclusion criteria via maximum variation sampling, which permits consideration of manifestations of a particular phenomenon across a range of cases that are phenomenally and/or demographically varied and also information-rich for study purposes.[94] For this study's sample, information-rich criteria included location (urban vs. rural) and congregational size. Urban vs. rural location was deemed critical because of the cultural differences between urban and rural communities. In the latter, the cultural context for sexual relationships is often heavily influenced by racism, discrimination, limited

employment opportunities, limited recreational outlets, and economic and social inequities that facilitate risky sexual behaviors and patterns.[100]

Because organizational theory indicates that the size of an organization influences its likelihood of engaging in innovations, churches were also stratified by size for this study. Larger churches have been associated with active health promotion programs,[56] which could include HIV prevention activities. Because other church studies have found that the more close-knit environments of smaller churches, particularly in the rural South, facilitate greater perceived impact of health promotion activities,[6] and because perception of innovations is directly related to rate of adoption, smaller churches were chosen for this study.

To construct the sampling frame for interviews, the study coordinator reviewed the roster of the General Baptist State Convention (GBSC) and identified each church in Forsyth and Edgecombe counties (Forsyth n=50; Edgecombe n=44). The study coordinator then contacted each church by phone to determine their average Sunday attendance as <100, 100-300, or >300. If churches did not respond to at least 3 attempted contacts, the study coordinator consulted knowledgeable local ministry leaders to determine appropriate segments. After excluding churches that were closed, not predominantly Black, didn't respond after 3 attempts, or that had an average Sunday attendance of 100–300, the sample was reduced to churches with <100 and >300 Sunday attendees. Each church with <100 and >300 attendees was contacted by phone to verify its average Sunday attendance (church size), determine the length of

post of the pastor, and determine the presence of an HIV/AIDS-related ministry.

The sample construction is outlined in Table 4.

	Forsyth	Edgecombe
# of churches on GBSC roster	50	44
# of churches with <100 attendees per Sunday	11	16
# of churches with >300 attendees per Sunday	8	12
Total churches recruited for interviews	4	4

Table 4: Sample Construction

Sample size. Most interpretive description studies use sample sizes of 5–30 participants, but the primary consideration in determining sample size is the level of occurrence of the desired phenomenon within the targeted population. Because non-participation in HIV prevention activities among Black Baptist churches is the prevailing norm, this inquiry benefitted from a more in-depth exploration of underlying, subjective experiences of fewer points of comparison. Given that the phenomenon (lack of HIV/AIDS prevention) is widespread, it is more likely that the social constructions provided by study participants represent findings that are worthwhile and far-reaching.[92]

2 large, rural (2 interviews)	2 large, urban (4 interviews)
2 small, rural (4 interviews)	2 small, urban (2 interviews)

*Large is defined as ≥ 300 in attendance on a given Sunday.

*Small is defined as < 100 in attendance on a given Sunday.

*Urban is defined as ≥ 750 people per square mile.

*Rural is defined as < 750 people per square mile.

Table 5: Churches for Black Pastor and Leader Recruitment

Eight churches were selected for interview recruitment. Next, key informant interviews were conducted with opinion leaders within each church. To meet inclusion criteria for key informant interviews, pastors and leaders had to have decision-making authority or influence on church programming and teaching. Leaders were defined as decision makers such as ministers, board of director's members, deacons/deaconesses, auxiliary leaders, or any equivalent position defined by the pastor.

Leaders who were asked to participate in semi-structured interviews had the most knowledge of the history and scope of a church's culture, teachings, and programming. Leaders other than pastors were included in the interviews because pastors are influential in the implementation and success of any church program but are rarely the best-informed about details of project implementation.[3] However, studies indicate that the pastor of a Black church is a key gatekeeper and opinion leader whose approval is necessary for both the implementation and success of new processes and activities, particularly when an innovation is a radical one such as HIV prevention. When an innovation is perceived as radical, support from an administrative champion can be essential.[14] Therefore, prior to consideration and adoption of an innovation, it is necessary to understand the perspectives of a variety of key decision makers

and opinion leaders (in this case, pastors and other important figures within a particular church).

Recruitment. After churches that met inclusion criteria were identified, recruitment for interviews began. The study coordinator contacted each church's pastor by phone to describe the study and request participation in an in-depth interview. Five follow-up phone calls were made to the pastors who did not initially respond. During phone calls, the study coordinator scheduled an interview and asked the pastor to compose a list of up to 5 leaders who might participate in a leader interview, including contact information. Participants were selected according to the following criteria: period of service duration of at least one (1) year; and inclusion of at least one (1) female leader. The inclusion of female respondents was essential, as women comprise the majority of Black Baptist church membership and largely sustain church programs with their donations. Moreover, women are traditionally underrepresented in higher church ranks.[56] Each lay leader was contacted by phone up to five (5) times to provide a description of the study and a request for participation.

Data collection was initiated and completed in one (1) church prior to beginning data collection in subsequent churches. This process reinforced the iterative nature of this study and allowed for earlier data collection, which in turn informed the line of inquiry and analyses for later data collection. Within each church, pastors and leaders who agreed to participate in the study completed informed consent and a brief demographic information sheet, and participated in an in-person, audio-taped, semi-structured interview. Interviews lasted

approximately 1 hour and were transcribed by a professional transcriptionist. Later, each transcript was read and verified against the audio file to ensure accuracy.

The interview guide consisted of open-ended, non-judgmental questions that elicited each interviewee's perspectives, definitions, meanings, and experiences. Interviews began with an assessment of the participants' social construction of HIV. To assess initial perceptions of the 5 HIV prevention innovations, the interviewer presented participants with a list of the innovations and a brief description of each—how it is defined, what it can address, and how it can be used. Participants were then given the opportunity to respond to questions based on that standard information. At the conclusion of each interview, the interviewer requested permission from each pastor to recruit and conduct a congregant focus group.

An interview is defined as a directed conversation that, conducted intensively, allows in-depth exploration and interpretation of a particular topic or experience.[97] For this study, interviews were conducted with Black Baptist church pastors and leaders to gain insight about their perspectives on the Black church's stances about HIV/AIDS and prevention. To help elicit responses from interviewees and explore topics that emerged, the researcher employed the use of appropriate probes: detail-oriented, elaboration, and clarification probes, (after Patton, 1990).[101] Detail-oriented probes are designed to elicit more information about the context under investigation. Elaboration probes are designed to elicit examples or to get the interviewee to tell the interviewer more about a situation.

Last, clarification probes are designed to help the interviewer understand something that the interviewee has stated.

The process of interviewing is most effective when differences or impressions that may arise are recognized. Charmaz refers to this process of recognition as “negotiations”; they can include power differentials, influence of status, distrust, loyalties, gender, race, or age.[97] The interviewer was cognizant of any evidence of these differentials during data collection, cited them in field notes or memos, and considered them during data analyses.

Data management. Each interview was professionally transcribed and the raw data were organized, managed, and coded using ATLAS.ti, v.5.2. This program was chosen for this study because its functions are well suited to descriptive inquiry and conceptual modal development. These functions include the ability to create models based on analyses, matrices of data by codes, and development and maintenance of a codebook.[74]

Methodology for Focus Groups

Inclusion/exclusion criteria. Congregants included in the focus groups 1) attended a predominantly Black Baptist church at least twice per month; and 2) were either women between the ages of 25 and 54 years or men between the ages of 35 and 44 years.

Congregants who attend church at least twice each month have steady, regular contact with church culture, practices, and teachings. The age range criteria represent the African American age groups most impacted by HIV/AIDS. While it is essential to understand the perspective of church leaders, only

congregants can supply the perspectives of those who receive and support church programming. Accordingly, one sub-aim of this study is to compare and contrast leaders' and congregants' understandings of HIV and perceptions of prevention innovations. A clear idea of the differences in perspectives between these two groups can be useful for key decision makers in charge of church programming and meeting congregational needs.

Recruitment. Focus group participants were recruited through church announcements, bulletins, and word of mouth. After 5–8 congregants had been identified across churches (to avoid clustering effects of using participants all from the same church), standard procedure was for the study coordinator to contact each one, verify that they met the inclusion criteria, and inform them of focus group logistics (date, time, location, etc.). Each potential participant also received a reminder phone call one day prior to the scheduled focus group. Unfortunately, in spite of these precautions, all of the rural focus groups had several no-shows in each group and thus it was difficult for them to meet the minimum number of participants. Focus group size therefore ranged from 3 to 8 participants.

Data collection. Congregants who agreed to participate in the study completed the informed consent process and filled out a short demographic information sheet. Focus group duration was approximately 80 minutes. Each group was audio-taped; the tapes were transcribed by a professional transcriptionist; and, to ensure accuracy, each transcript was read and verified against its audio file. The groups began with an assessment of members' social

constructions of HIV. Next, each group briefly discussed members' initial perceptions of each of the 5 innovations, after which a brief description of each innovation—how it is defined, what it can address, and how it can be used—was presented for further discussion.

The focus group approach was the appropriate data collection strategy for this part of the study because such groups' discussions help researchers understand how groups of people who have something in common feel or think about an issue or idea[102] and also to understand the beliefs and attitudes that underlie human behavior.[92] The focus group environment promotes discussion and interaction through group dynamics. Several sessions are conducted to elicit the full range of members' ideas and opinions and to allow for comparisons across groups. For this study, focus group participants were primarily chosen based on their shared characteristic of engagement in the Black church environment, but also because of their demographic similarities.

The focus group guide consisted of open-ended, non-judgmental questions that elicited perspective, definitions, meanings, and experiences from participants. The guide began with general, non-intrusive questions and progressed to more specific inquiries about HIV. As with the individual interviews, the moderator used appropriate probes to clarify participants' statements and meanings, and to help them expound on points that arose.

The composition of the focus groups was designed to promote homogeneity and natural discussion. The groups were also segmented based on

key similarities (i.e., gender and age) to avoid power or gender differentials. The segmentation is summarized in Table 6.

4 Females, 25-34 ³	2 Females, 35-54 ⁴	1 Males, 35-44 ⁵
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Table 6: Focus Group Segmentation

The complete sample and overviews of the extent of data generated is presented in Table 7 (composition, number of participants, duration of sessions, and number of transcribed pages generated per group).

Table 7: Data Description

3. In 2005, AIDS was the leading cause of death for black women ages 25–34 (CDC).

4. In 2005, AIDS was the third leading cause of death for black women ages 35–44 (CDC).

5. In 2005, AIDS was the leading cause of death for black men ages 35–44 (CDC).

Respondent Category		Type of participant(s)	Number of participants	Duration (min)	Number of Transcribed pages
Interviews	EL1P	Rural, Large; Pastor	1	70	48
	EL2P	Rural, Large; Pastor	1	95	38
	ES1P	Rural, Small; Pastor	1	61	31
	ES2P	Rural, Small; Pastor	1	35	18
	ES2L1	Rural, Small; Leader	1	44	26
	ES2L2	Rural, Small; Leader	1	38	24
	FL1P	Urban, Large; Pastor	1	46	23
	FL2P	Urban, Large; Pastor	1	54	21
	FL2L1	Urban, Large; Leader	1	54	21
	FL2L2	Urban, Large; Leader	1	28	13
	FS1P	Urban, Small; Pastor	1	45	27
	FS2P	Urban, Small; Pastor	1	57	27
Focus Groups	FF35-54	Urban, Females, ages 35–54	6	95	74
	FF25-34.13	Urban, Females, ages 25–34	5	104	49
	FF25-34.14	Urban, Females, ages 25–34	7	80	58
	FM	Urban, Males, ages 35–44	5	104	57
	EF25-34	Rural, Females, ages 25–34	3	44	24
	EF35-54	Rural, Females, ages 35–54	8	49	29
	EFU	Rural, Females, ages X	3	74	30
Totals			49	1177	638

Data Management. After professional transcription, the text of each focus group's session was managed using ATLAS.Ti to organize and code the raw data. ATLAS.Ti is an appropriate program for this study because its functions are well suited to descriptive inquiry and conceptual model development.

Each data collection event concluded with a debriefing session, conducted by the researcher, that presented an overview of the session. Notes about unusual occurrences and key ideas were made during the session. Questions for the debriefing session included:

- 1) How long did the data collection event last?
- 2) Were there problems with the layout of the room? Briefly describe the setting.
- 3) Were other people (besides participants) present during the data collection event? If so, who were they and what were their roles?
- 4) Was there anything unusual about this interaction?
- 5) Were there any interruptions?
- 6) How was the participant(s)'s mood?
- 7) Did the participant(s) seem to easily understand the questions?
- 8) Did the questions flow logically?
- 9) What interesting points were raised for you (during the discussion or the feedback)?

Data Analysis of Interviews and Focus Groups

Data analysis incorporated continuous reshaping and refining as the data's construction emerged. The researcher functions as the primary tool for extracting and interpreting the data in an interactive process; collection and analysis are performed simultaneously. This multitasking enables the researcher to make adjustments to lines of questioning as themes or concepts emerge.[96] Participants were questioned about their social constructions of HIV/AIDS and prevention as well as their key considerations for HIV prevention within the church context.

Data analysis, informed by interpretive description, focused on constructions of meaning within participants' subjective experiences and the lived

contexts within which their actions evolved and developed meaning.[92] Analysis of the data went beyond comprehensive descriptions of phenomena to classifying and creating linkages that synthesize, theorize, and recontextualize that data.[95] The goal of such analysis was to inductively interpret the meanings given to HIV and prevention by Black church leaders and congregants. The study was designed to gather rich data (i.e., direct quotes of perceptions, opinions, observations, etc., that get beneath the surface of social and subjective life)[97] which could also help attach meanings to the researcher's own descriptions of context, participants, and interpretations.[96] Rich data also help the researcher gain deeper understandings of the interrelationships and connections among core elements of an experience through the use of detail, context, and interpretive description.

Participants were questioned about their perceptions and understandings of HIV/AIDS in the contexts of the Black community and the Black church, and also about their perceptions of the use of 5 key prevention innovations by the Black church, generally, and churches they are familiar with, specifically. Exploration of the texts and meanings shared by study participants was facilitated by immersion in the data and the use of coding. Prior to coding, the researcher conducted several reads of each transcript in order to become immersed in the happenings of the data without segmenting it into less meaningful sections. This routine began the process of synthesizing and recontextualizing the data. Coding procedures for this study were adapted from

the coding structure articulated by Glaser and Strauss for use with grounded theory. The full analytic process is outlined in Table 8.

Analytic Steps	Components
1. Open Coding	<ol style="list-style-type: none"> 1. Break down and define data 2. Examine range of responses 3. Group codes into conceptual categories 3. Start making comparisons between categories 4. Refine codes/categories and meanings 5. Create memos
2. Secondary Analysis	<ol style="list-style-type: none"> 1. Make comparisons between categories 2. Examine interrelationships between categories 3. Define linkages between categories 4. Create memos
3. Case-level Analyses	<ol style="list-style-type: none"> 1. Make comparisons between and within respondent categories 2. Examine literal and theoretical replication 3. Create memos
4. Model Development	<ol style="list-style-type: none"> 1. Develop conceptual model illustrating concepts and interrelationships
5. Validation	<ol style="list-style-type: none"> 1. Member checking 2. Audit trail

Table 8: Analytic Process

Coding

Primary analysis. Coding is the process of assigning descriptive or categorizing labels to segments of data.[97] Data is sorted by codes to define respondents' stories.[103] *Open coding* is the initial process of breaking down the data into distinct parts for comparison.[103] This study focused on data related to understandings, perceptions, and social constructions of HIV, and ways to prevent it. Initial coding closely defined the data and included chunking logical sections of text.

After initial identification, codes were sorted, compared, and grouped into categories based on their similarities. Such categories offer a broad representation of the phenomena being studied and help researchers stay clear about what is happening in the work at any given time, as well as what they are learning about the subject under investigation.[95] Conceptual groupings also help to further define the range of the phenomena. In this study, extended conceptualization of categories and sub-categories formed the basis for a conceptual model and suggested areas to explore in subsequent data collection.

To assess similarities and differences between units of data, this study employed Strauss and Corbin's constant comparative method. Constant comparison allows comparisons between units of data at each level of analysis, to identify emerging categories and the relationships between them.[97, 104] Comparisons were drawn between initial and subsequent interviews. This comparative process was used throughout the analysis and largely informed the emergent line of inquiry.

Secondary analysis. The second level of analysis was a form of *axial coding*, also defined by Strauss and Corbin. Axial coding, which is more selective than open coding, reassembles categories and sub-categories derived from open coding to demonstrate their relationships and conceptual linkages.[97, 103] In this study, the axial coding re-related categories and sub-categories to each other based on analytic fit and appropriateness.[97] This stage of analyses also gave particular consideration to the most pertinent and relevant emergent categories.

Open coding and secondary analysis are not completely distinct events. While clarifying and building the relational structure, secondary analysis offers opportunities for refining definitions of categories and sub-categories, specifically by expanding preliminary conceptual linkages in a way that widens the range of possible interpretations and understandings.[93] In this study, the core elements of HIV/AIDS construction and HIV prevention were determined according to the interrelationships and analytic fit of some of the categories.

The final analytic product of this study contains thematic development, comparisons, and interpretations across units of analysis that are combined to create a contextualized, conceptual model based upon the researcher's interpretations of respondents' socially constructed perceptions and understandings of HIV/AIDS, as well as upon their perceptions of the 5 key prevention innovations and their feedback about implementing such innovations within their churches. These results are the product of the researcher's understanding of the data, synthesis of meanings, theorization of relationships, and recontextualization of said meanings and relationships into findings.[93]

Findings are presented in model form. As products of interpretive description, however, they should be practical and applicable—useful in terms of assessment, planning, and intervention strategies.[93] The conceptual model and themes generated from this work offer grounded insight into the Black Baptist church's understandings of HIV/AIDS and the acceptability and feasibility of implementing the key prevention models articulated in public health intervention research. A more nuanced understanding of pragmatic considerations provides a

firmer basis for translating research into practice, particularly at a key institution within a heavily impacted community.

Data analysis also examined literal and theoretical replication. Literal replication uses pattern-matching across focus groups to determine if focus groups and interviews with similar composition yield similar results.[105] For example, my analysis sought to determine if women ages 25–34 across focus groups offered similar data patterns and if pastors and leaders from large rural churches offered similar data patterns. By contrast, theoretical replication seeks to determine if focus groups and interviews of different compositions produce predictable or theoretically different findings.[105] A sample question might be if urban churches produce different results from rural churches.

Memos

Memo writing began at the start of analysis and involved making analytic notes of direct comparisons or comparable points of information that arose during the iterative process of data collection and analysis.[97] As memos and the codes within them were compared, preliminary conceptual categories were formed that offered insights about areas to explore further, as well as justification for the areas already explored. Memos clarify relationships between categories.[97] These categories and relationships formed the basic conceptual framework of the study and were continually refined as more data collection occurred and more categories were recognized.

Memos were recorded in informal language, and through unfiltered, spontaneous writing. This free-response writing clarified comparisons and

relationships between codes and categories, and allowed the analyst to explore patterns, assumptions, meanings, and actions articulated by interview participants.[97] Memos were also checked against raw data to ensure that patterns of progression matched the emergence of memo material. In addition to serving as a way to track the research process, memos also serve as field notes that record the contexts and occurrences of data collection.

Validating the Theoretical Schema

Lincoln and Guba name *trustworthiness* as the primary criterion for judging qualitative research.[74] The level of trustworthiness determines the worth and rigor of the research. In this study, it was supported through credibility, dependability, confirmability, and the use of an audit trail.

Credibility expresses the level of confidence in the truth of findings, the level of logic between findings and their explanations, the level at which findings are substantiated by the data, and the level of accuracy of the findings as determined by the study population. To ensure credibility, this study includes documentation of the researcher's analytic decisions and conceptual progression in the form of memos. These memos recorded the researcher's path of logic and substantiated her process and analytic directions. To ensure the accuracy of findings from the study population's perspective, and to ensure that the researcher's conceptual linkages made sense to the sample and offers a new perspective on their relationships and understandings, the collective study findings were shared with a select group of the participants.

Of the 12 individual interviewees, 2 were asked to review the final conceptual products as a form of member checking. They were selected based on 1) having indicated a willingness to be contacted for member checking during their data collection event; and 2) their availability at the time of member checking. Of the 37 focus group participants, 7 were asked to review the final conceptual products. They were selected based on 1) having indicated a willingness to be contacted for member checking during their data collection event; 2) their availability at the time of member checking; and 3) their representation of a cross-section of the respondents.

Dependability, which refers to a study's level of consistency and adherence to the rules of qualitative methodology, is assessed by the level of logical connection between the research questions, purpose, and design, and the replicability of the processes used.[74] In this study, dependability is supported by memo documentation and by literature support for the study design.

Confirmability is determined by the level to which findings represent the perspectives of study participants instead of the researcher.[74] The primary means of demonstrating confirmability is the researcher's process of reflexivity. Prior to and throughout the study process, this researcher closely and honestly examined her biases, assumptions, and reactions to the research process.

Finally, the researcher maintained an audit trail to document observations, decisions, and conclusions—i.e., to illustrate the processes used to arrive at the findings.[74] The audit trail consisted of the memos and notes taken throughout the research process.

Study Component	Methodological Approach	
	<i>Grounded Theory</i>	<i>Interpretive Description</i>
Worldview/Orientation	<p>Focus on subjective experience, symbolic interactionism (one's communication and actions express meaning)</p> <p>Area where little or no theory exists, or don't agree with existing theories</p>	<p>Reality is socially constructed, appreciating experience from the perspective of others, while simultaneously accounting for the cultural and social forces that may have shaped that perspective, focus on the lived context within which actions evolve and become meaningful</p> <p>Lack of existing theory to explain phenomena</p>
Key Elements	<p><i>Theoretical sensitive coding</i> - generating theoretical strong concepts from the data to explain the phenomenon researched</p> <p>Need to <i>compare</i> between phenomena and contexts to make the "theory" strong.</p> <p>Core meaning</p>	<p>Offer description of a phenomenon</p> <p>Draw linkages between data and recontextualize it for theoretical use and practical application</p> <p>Focus on experience</p> <p>Core meaning</p>
Sampling Strategy		Maximum variation sampling—purposively broaden conceptualization or understanding, meaningful variations, expected variations, illustrates subgroups
Sample Size		Size determined by the high level of occurrence of phenomenon within the population, Smaller sample needed
Analysis	<p>Inductive</p> <p>Constant comparison</p> <p>Range of dimensions of concept</p> <p>Open Coding – identifying concepts</p> <p>Secondary analysis – connecting the concepts</p>	<p>Inductive</p> <p>Focus analysis on construction of meaning within subjective and intersubjective experiences</p> <p>Testing/challenging initial interpretations</p> <p>Adjusting questioning as themes emerge</p>
Products		<p>Coherent conceptual description, thematic patterns, commonalities that characterize the phenomenon, account for inevitable variations between them</p> <p>Products have application potential</p> <p>Constructed truths</p>
Why this is not the full method	<p>No selective coding with theoretical sampling – "who" was predetermined, re-entry into field</p> <p>No axial coding, theory generation</p>	<p>No clinical context/phenomena</p> <p>No clinical response</p> <p>No comparison of phenomena</p>

Table 9: Applied Components of Grounded Theory and Interpretive Description

CHAPTER 4

Study Results

This chapter reports the results of the project's primary aim (to examine social constructions of HIV and the prevention of it by the Black church). To frame the findings in this particular context, it begins with a brief explanation on the organizational structure and foundation of the Black Baptist Church.

Structure of the Black Baptist Church

The norms and criteria for acceptable behavior of Baptist church affiliates are expressed in terms of four membership qualifications: 1) a regenerate heart, 2) a confession of faith, 3) the reception of baptism, and 4) (living) a Christian life.[106] As interpreted by Baptist theologians, the regenerate heart, confession of faith, and pursuit of Christian life have the most direct implications for HIV prevention guidelines. The regenerate heart, which validates a spiritual transformation of and for Christ, is the quality that distinguishes Baptist church members from other religious groups. According to the New Hiscox Guide for Baptist churches, this qualification must be demonstrated by a transformation that extends beyond moral character as defined by secular society into morality as defined by Christian standards of character and moral worth. The confession of faith compels individuals to consistently adhere to established norms, and assures other members that those who profess have experienced the same

transformation and function under the same theological framework. Finally, a Christian life is the lived expression of the spiritual transformation that results from doing what is commanded by God.

One pastor per Baptist church provides care and authority in spiritual matters, theological interpretations, administration, and supervision for the entire congregation.[106] The pastor may be assisted by associate or assistant ministers in ministerial duties, and by deacons in secular duties (such as finances and church rituals). Both ministerial and secular duties are based on Biblical precedents. Other offices that have evolved in response to the organizational growth of the church can include a board of trustees, a board of Christian education, and a board of missions and outreach. Each of these governs an area of special interest and organizational management. While each office contributes to the overall function of a church, all ultimately operate under the direction of the pastor.

All Baptist churches practice the same core rituals, ordinances, and ceremonies, but may vary the institutionalization or implementation of those practices. In addition to the previously described organizational and authority structures of individual churches, Baptist churches can voluntarily affiliate with particular groupings of churches, called Associations. Associations have no official authority over individual churches' practices, but rather promote adherence to shared visions and standards of conduct, and also support inter-church missions, education, and initiatives.

In sum, both the membership guidelines and the organizational structure of the Black Baptist church influence expectations for members' behavior. For the purposes of this study, these influences provide insight into the experiences and ideas expressed by church leaders and congregants. When concepts were compared by rural versus urban settings, size of church, and respondent characteristics, little variability was found. Therefore, findings are presented in conceptual categories rather than by attribution to the original theoretical groupings.

Social Constructions of HIV/AIDS

These results address the project's primary objectives:

- 1) To examine the Black church's social constructions of HIV and its prevention
 - 1a) To develop a conceptual model that reflects Black church leaders' interpretations of HIV/AIDS and prevention strategies.
 - 1b) To develop a conceptual model that reflects Black church congregants' interpretations of HIV/AIDS and prevention strategies.

HIV/AIDS has remained largely unaddressed by the Black Baptist churches in this study, primarily due to how church leaders and members view its causes, associated behaviors, and characterizations. Based upon respondent conceptualizations, HIV/AIDS symbolizes an individual's unsanctioned behaviors, morally harmful experiences, and unacceptable characterizations. Respondents described seven core components of their understanding of living with HIV/AIDS: 1) behavior, 2) knowledge, 3) morals, 4) spirit, 5) emotional experiences, 6) physical experiences, and 7) social experiences and responses (See Figure 1).

Several components were described by one respondent when asked what it means for someone to be infected:

Well, it means that questions will be automatically projected about that person in terms of their sexuality or amorality...so there are stigmas and stereotypes that automatically accompany anyone who's infected with AIDS...so that's something that they have to wrestle with. [Pastor, Rural Small Church]

All respondents associated HIV/AIDS not only with engagement in sexual activity, but also with the most unacceptable forms of sexual behavior by church standards: homosexuality, bisexuality, and promiscuity or multiple partners. Because the sanctity of marriage is a core tenet of the Black Baptist church, sexual activity is specifically reserved for marriage between a man and a woman. Sanctity of marriage negates the acceptability of multiple partners, partners of the same sex, and pre- or extramarital sex—the sexual behaviors that respondents associate with HIV/AIDS. Avoiding HIV infection by maintaining sexual purity or sanctity of marriage is viewed as a measure of one's spiritual discipline and avoidance of sin. These key tenets of Christianity, as observed by the Black Baptist church, are meant to be lived as proof that one has achieved the state of salvation.

People who become HIV-infected are perceived to be ignorant, lacking knowledge of and good judgment about how to protect themselves from infection. These attributions, which are usually framed as blame, hold people living with HIV/AIDS (PLWHA) personally responsible for their ignorance and disease outcomes, with no consideration of the socio-cultural and ecological contexts of their decision making and behaviors.

Given that the church is imbued with the moral authority to shape and dictate members' behavior, PLWHA who do not comply with that authority (as evidenced by their HIV infection) are viewed as deviant and lacking the moral standards set by the church. Because the church as an institution defines morality and executes moral authority, and strongly prohibits engaging in controversial, ill-perceived sexual behaviors, HIV/AIDS is a highly moralistic issue for the church. Respondents reported that PLWHA and those who associate with them can face harsh judgments from church leaders and members for defying moral standards. Moreover, the same moral standards are not necessarily applied to other health conditions.

Respondents explained that within the Black Baptist church, salvation is characterized by a clean spirit; an upstanding lifestyle is the primary goal and focus. Consequently, to become HIV-positive or even to have HIV in one's family can introduce fundamental conflict because these things are considered to indicate lack of salvation, as well as insufficient fortitude to maintain spiritual discipline. Some respondents associate HIV/AIDS with terms such as "unclean spirit" and "evil," labels that are particularly stigmatizing and polarizing in an environment predicated on the avoidance of such characterizations. Moreover, respondents described the experience of being HIV-positive as having emotional components of devastation and anger, physical components of illness and ultimately death, and a social component that manifests in various forms of ostracism.

Given that each of these groupings are negatively perceived, church members cannot disclose the impact of HIV upon their lives without possibly letting themselves in for the associated stigma and hardship. Such reluctance precludes open forums for addressing the reality of HIV/AIDS within the church community. For church leaders and congregants, HIV/AIDS is an indicator of non-compliance with Christian principles, engagement in taboo behaviors, and an inability to demonstrate the kinds of personal transformations that evidence salvation.

The Role of Fear

What comes to my mind is fear...wondering do I have it... the person that I'm having [sex with], do they have it... [Urban Male Focus Group, Ages 35–44]

As expressed in the above quote, respondents strongly associate fear with the concept of HIV/AIDS. This fear is expressed as two basic types of responses. One concerns immobilization (non-response), both as an organization and by individual members; the other concerns maltreatment of people infected with and affected by the disease (See Figure 1). Immobilization leaves church members living with and affected by HIV/AIDS isolated from a primary, essential source of support. Given the negative experiential components of HIV/AIDS (emotional, physical, and social), as well as its other negative associations, individuals within the church strive to distance themselves from the condition. They may do this by avoiding HIV testing to learn their own status, and by not participating in HIV-related activities—even prevention. The maltreatment of PLWHA and others affected by HIV/AIDS seems to be based in part upon respondents'

representations of a typology that church leaders and members condemn and strive to avoid. According to respondents, such representations are expressed both implicitly and explicitly by individual church members and by the church as an institution.

In accordance with the church's mission to care for the sick and needy, almost all respondents agree that the church has a responsibility to respond positively to PLWHA, which includes providing them with support and physical and emotional sanctuary. Although the ideal of how churches should respond to PLWHA is widely understood to include acts of compassion, love, and acceptance, respondents described the opposite in reality. Pastors and congregants compared modern-day HIV/AIDS to Biblical leprosy—the disease of the untouchable. When asked how PLWHA are treated within their church's environment, both interview and focus group participants described scenarios of avoidance, rejection, isolation, judgment, ostracism, and condemnation.

Each of these reactions is largely predicated on ignorance, fear of transmission, and negative associations and behaviors. Fear and ignorance about modes of transmission mitigate exclusionary behaviors, such as ordering PLWHA to use plastic dinnerware at church functions, denying PLWHA water baptism with other church members, not drinking from water fountains after PLWHA, excluding PLWHA from auxiliaries, and not hugging or otherwise touching PLWHA during church fellowship. According to the following description of the funeral for a church member who died of AIDS-related complications, physical distancing is even practiced after death:

[T]hat was probably the first AIDS-related funeral that we had... And I think it was kind of devastating for some of the members because of the way they were funeralized with the plastic wrap and all, and we never had anybody in our church funeralized like that... when they were laid out, they had the plastic covering over the casket...the casket was open but no one could touch it. It had a great big sign, "Do not touch." [Rural Leader, Small Church]

Respondents' inadequate understandings of HIV transmission contribute to their fear of PLWHA. Although respondents correctly identified most of the behaviors that facilitate HIV transmission, they also cited pervasive myths, misconceptions, and uncertainties about other modes of transmission. Among focus group and interview respondents, false beliefs and skepticism about medically defined routes of transmission fuel ostracism and maltreatment of PLWHA and their loved ones. Largely due to fear of transmission and the negative associations and experiences of those affected by HIV/AIDS, PLWHA are relegated to the outskirts of the church's social and physical community. Such reactions are predicated on concerns about modes of transmission, from contact with perspiration and toilet-seat covers to infected blood spread by insect bites and live viruses clinging to eating utensils. Respondents also expressed the beliefs that medical professionals do not yet know all the ways that HIV can be transmitted and that the medical establishment does not share all that it does know about HIV transmission—beliefs that encourage individuals to protect themselves from infection by avoiding contact with all perceived sources of contagion.

HIV/AIDS carries a stigma that is both more feared and more conceptually defaming than other conditions. Focus groups of women, ages 35–54, described the comparative conceptualization of HIV/AIDS within the church.

R2: I think it's [being HIV positive] looked at as...there is no degree of sin but it's looked at like Oh that's the big sin.

R1: The ultimate—

[Affirmations.]

The same group also said later:

R2: ...people in church as a whole have shunned people away.

R1: Hypocrites.

R2: They're ashamed of the ones who's in their family that have It [HIV/AIDS].

R1: You can have sex with a married man but if I have sex and get HIV... You know?

R2: You can have that baby but don't have HIV.

R4: You can sleep with the pastor but don't have HIV.

As demonstrated by this discussion, respondents acknowledge that unacceptable behaviors occur among church members, but those who become HIV-infected are viewed as more sinful or intolerable than those who engage in other unacceptable behaviors.

Contributors to HIV Risk in Black Communities

While the church's primary reactions were described as non-response to and maltreatment of PLWHA, the context for HIV/AIDS risk was said to be shaped by 7 core elements of contextual risk (Figure 1). Church members and

leaders identified the most common facilitators for the spread of HIV in the Black community as:

- 1) Silence around HIV and sex.
- 2) Responses to PLWHA.
- 3) The culture of sex.
- 4) Community brokenness and inadequate resources.
- 5) Decline in the status of Black males.
- 6) Theological standpoints.
- 7) Conspiracy theory.
- 8) Modern culture.

These findings are outlined in Figure 1 (p. 95). Respondents did not indicate that these factors are necessarily specific to the Black community, rather that they are present in their communities.

[T]he United States is the most sheltered country in the world. Everybody else tries to explain about sexual tension throughout the world but the United States is the only country that tries to hide it and we're the worst people in the world for it. [Urban Male Focus Group, Ages 35–44]

One of the most commonly cited contributing factors to the HIV/AIDS epidemic among Black Americans is the pervasive *silence* around HIV and sexual activity, both within the Black church and the Black community at large. Respondents overwhelmingly stated that the Black community and church do not discuss sex, sexuality, or HIV as a potential outcome of sexual activity. This absence of discussion facilitates lack of awareness and understanding of the

magnitude of the problem, denial of the presence of the condition, and the inability of community members to see HIV/AIDS as a relevant condition.

Most groups and individual respondents indicated that members of the Black community are still largely uneducated, unaware, and ignorant about HIV/AIDS. Respondents expressed concern that African Americans are either incorrect or uninformed about how HIV is transmitted, how many and what types of people are HIV-infected, and how to appropriately respond to the epidemic.

Respondents also stated that many African Americans do not know their own HIV status. This lack of awareness, on both individual and community levels, perpetuates risk by failing to create opportunities for community members to learn about HIV, learn their sero-status, and respond with appropriate intervention strategies.

Respondents described a prevailing silence about HIV/AIDS that intersects with denial and a lack of concern. Some respondents indicated that African Americans still think of HIV/AIDS as an issue for white communities and therefore do not see a need to address it within their own communities or personal lives. Respondents from urban churches noted that many African Americans consider their risk for becoming infected to be low and believe that they have little exposure to individuals who are infected. These respondents feel that their churches' silence about the condition and experience of HIV/AIDS magnifies the risk context, perpetuates further spread, and contributes to the view that it is not a significant issue.

Even among those who acknowledge and understand the magnitude of the problem, silence still stifles the church's ability to effectively respond to HIV/AIDS. As one group opined:

...treat [HIV] like the elephant that's in the room—everybody knows it's there, it stinks, but nobody talks about it... And I think the main problem is the whole aspect of sexual, is sexuality and sensuality because if you can't address those issues, you won't be able to address the HIV/AIDS issue. [Urban Female Focus Group, Ages 25–34 (13)]

In sum, the paucity of discussions about HIV and its effect upon the lives of those within Black churches, and upon the Black community at large, stymies the church from carrying out what it has defined as its role in responding to HIV/AIDS and to people affected by it.

Responses to PLWHA. Respondents discussed some of the ideologies that some Black communities may associate with PLWHA which facilitate the wider spread of HIV. These include the embarrassment and humiliation that PLWHA experience when their status is disclosed, which can breed what one group termed “irresponsibility” (i.e., embarrassment, humiliation, and isolation can all contribute to further risky behavior). Respondents largely view PLWHA as sources of disease who deliberately engage in unprotected sex to infect other people. This negative perception prevents church members from supporting and engaging in HIV prevention for PLWHA, which increases the isolation of PLWHA.

Culture of sex. Women focus group respondents pointed to the dishonesty and secrecy that shrouds sexual activity, particularly individuals' disclosure of HIV status and the number and identity of their sex partners. All church members and some leaders indicated that men who have sex with men, but do not practice

disclosure with their female partners, are a major source of HIV transmission in African American communities. This phenomenon is popularly referred to as “the down-low.” While most respondents see this behavior as a conduit for infection, some acknowledge it as the result of community and church norms that prohibit open recognition and discussion of homosexuality. There was a clear sense that the secrecy and silence associated with same-sex partnerships perpetuates dishonesty and risky behavior.

Dishonesty and secrecy were also identified as issues in strictly heterosexual liaisons, wherein hidden infidelity with multiple partners was cited as a major concern. While these cultural norms are a concern throughout the community, a targeted concern about the implications of secrecy and dishonesty among those living with HIV/AIDS was also mentioned. Respondents expressed concern that many PLWHA don't acknowledge their HIV status to their sexual partners, largely due to shame and fear of rejection. Family members sometimes perpetuate this secrecy.

Another component of sex culture in Black communities is the normative beliefs and practices around condom use. Female respondents indicated that Black men do not like to use condoms, often do not use condoms, and that their female partners are often afraid to ask them to use a condom during sexual encounters. The lack of condom use was also cited as a concern for older people, particularly those whose spouses have died. One of the women's groups described the dynamics of new sexual partnerships for widows and widowers who may not have the awareness or skills to practice safer sex in the age of

HIV/AIDS. One theme specific to the male respondent group interviewees, not mentioned in the female groups, was the impact of Viagra and other erectile dysfunction medications that may assist older men in partnering with younger women, often under risky conditions and outside of their existing marriages.

Although their churches do not promote condom use, respondents noted that individuals sometimes form sexual partnerships with church members as a proxy for safer sex. As one pastor explained:

Well, they think because a person is in the church that a person is automatically saved and everyone in the church is not saved... Everyone is not truthful and so therefore they trust the wrong person instead of going to God and really getting a good understanding of what it really is. That's my belief. I don't know, don't think that I think all ladies are like that. It's the majority...as the Bible says they're led away by silly attitudes and attitudes of, like I say, mistrust, putting their trust in the wrong place. [Urban Pastor, Large Church]

Based on these responses, some sex in Black communities occurs unprotected, with multiple and concurrent partners, in some of the riskiest forms, and without full disclosure, which in combination can significantly magnify the risk of HIV transmission.

Community brokenness and inadequate resources: impact of poverty and family structure. The family unit was consistently identified as a key institution and characteristics of disintegrated family structures and broken communities emerged as an important theme. Broken family structures were expressed as 1) single-parent homes and their intersection with poverty; 2) loss of extended families; 3) loss of family values; 4) dispersal of family members; and 5) decline in the status of Black males.

[Y]ou look at the activity of the family and the family structure, both parents are working and the children are now kind of like isolated from their parents... Because both parents now are needed in the workforce and there are no rearing up [raising children] because we institutionalize the young and the old. At an early age the baby is born, we take them to daycare. You keep him for me and the process go on. The old, nobody got time for them and there used to be a time, you know, you had the elderly home, the kind of overseer thing, you know, but that's a lost art, you know. [Rural Pastor, Small Church]

Respondents discussed the impact of single-parent homes and their association with poverty as key facilitators of HIV risk, not only for youth but also for the parents who care for them. For the respondents, single-parent homes were synonymous with single-mother homes. One risk factor for children in single-parent homes was described as the need for economically challenged parents to maintain extended work hours in order to make enough money to support their families, but not making enough to afford appropriate child supervision during their time away from home. This situation is problematic because children are left unsupervised for extended periods, which gives them more opportunities to engage in sexual risk behaviors. The intersection between poverty and single parenthood was also associated with increased HIV risk because respondents assume that single mothers, especially poor ones, engage in risky sexual liaisons. Respondents explained that single mothers living in poverty may engage in commercial sex, or unhealthy partnerships that offer financial incentives, as viable sources of income to support their families. Often, single parents were also seen as lacking the skills to communicate with their children about sex, sexuality, and HIV prevention. Households that are primarily female and also lacking adult male role models were specifically identified as

encouraging male same-sex partnerships, which are assumed to lead to HIV risk behavior and infection. As explained by a church leader:

You know we've had several young boys in our church for some reason and I know people aren't born gay, but that's the way they went. I guess they grew up in all-women's home[s]... The next thing you know—AIDS. [Rural Leader, Small Church]

The change in extended family structures were also viewed as placing women, their partners, and their children at risk for HIV. In this view, older and extended relatives once provided care and support to younger generations, but now are either no longer present or are not serving in the same capacity. In addition to the decreased presence and reliability of extended relatives, some respondents also indicated that more parents are not raising their own children, which further destabilizes the nuclear family structure.

Respondents further characterized community brokenness by the deterioration of traditional values. Indicators of deterioration were described as high divorce rates within communities, absence of values established within the home environment, and inadequate family time. One rural pastor expressed concern that because children with unmarried parents often do not see their parents modeling abstinence or safer sex practices, such children are more prone to engage in risk-taking sexual behaviors that lead not only to HIV but to teenage pregnancy as well. There was a sense among respondents that along with shifts in family structure, a shift has also occurred in normative morals and values within the home that ideally would protect individuals from risky environments and behaviors. One pastor characterized this loss of the protective values base that families once possessed:

If the home environment is not that kind of place, then young people go off into the world ignorant and without the proper moral values that can help to insure them from getting themselves into the situation, be it sexually or be it with drug use or whatever that could cause them to contract AIDS, so I think that's the biggest culprit...not only in the African American community but across America at large...particularly in our community. [Rural Pastor, Small Church]

Older rural women described family deterioration, which contributes to HIV transmission, as resulting from the fast-paced nature of modern life and the lack of the kind of family time that helps shape beliefs and behaviors. In their view, more individuals live away from where their families were originally rooted, and away from close-knit groups that once promoted fellowship, supervision, and positive norms.

Decline in status of Black males. Another indicator of missing links in Black families and communities was cited as the decline in status and presence of Black men. Male respondents discussed the need for male figures in the lives of younger Black men, both in terms of positive modeling and as a source of guidance for issues specific to men, including sexual norms regarding multiple partners and emotional detachment from sexual engagement. As explained by male focus group respondents, ages 35–44:

I've talked to a lot of young men at church and I don't care how wrong it is, you'll hear them say it's okay cause my daddy did it... A boy needs a man figure in his life because there's certain things he ain't going to tell Mom. I don't care how close him and Momma is. There's some things he ain't going to tell Momma.

The urban male group described how reliance on government support discourages stable partnerships between Black women and men, perpetuates

the absence of Black men from households, and creates vulnerability and risk for children, who are forced to grow up without the presence of an adult male figure:

R5: [W]hen you have a system that come in and say I'm going to pay your light bills, I'm going to pay your rent, I'm going to give you food... And I'm going to give you a place to stay and might help you buy a car...if we catch him in the home you may lose all the good stuff that we're giving you. I saw a man and a wife walk down the aisle one day and three days later now I'm about to lose all my Section 8 [government subsidized housing] and my Welfare as long as I'm married, so we've got to get a divorce... He can come over. We can have fun for a day or two but when I'm tired of you, get out of my house... You can't do anything for me that this system isn't doing for me and therefore we can build jails and that brother out on the street, he upset, he angry, he make a mistake and do something foolish and now he in jail and his kids are being raised by the assistance of [government], you know, but all of that goes back and ties into a father being in the home... It goes right back into AIDS because you wipe the man out, you take the head out of the house then you just have a vulnerable situation and then you've got boys coming up in that and you've got little girls coming up in there and it's just, it's a mess.

Brokenness and its intersection with poverty are not limited to families and households, but seen as affecting the entire community. Community brokenness was characterized by the 1) limited availability of recreational activities for youth; 2) lack of healthcare; and 3) prevalence of illegal drug activity. Like the lack of supervision, lack of recreational activities is associated with increased opportunities for youth to engage in risky sex or other unhealthy behaviors. Drug use is also viewed as a key facilitator for HIV transmission within Black communities, through its associations with both sexual risk-taking and family disintegration.

Theological standpoints. Some respondents discussed theological standpoints that can facilitate HIV risk within Black communities while also

creating a sense of false security. Some respondents, who interpret the magnitude of HIV transmission in Black communities through a theological filter, posited that beliefs about opportunities for Divine forgiveness and the absence of a fear of God help facilitate the spread of HIV. Many African Americans may engage in sexual risk behaviors with little consideration for HIV or other sexually transmitted infections because for them, the forgivable nature of their sins and God's assurance of forgiveness supply a mental safety net. When the primary association with HIV is sin, and forgiveness provides the mechanism for overcoming sin, the lack of consequences that are both unavoidable and permanent may encourage engagement in behavior that is forbidden.

In the church it's like Well, you know God forgive anything but I'm going to ask God to forgive me and I can do this [sex]... God will forgive me. God will forgive you for anything so we could just do this [sex] one time. You know? [Laughter.] [Rural Female Focus Group, Ages 35–54]

It was also posited that the acceptability of multiple partners for men is somehow excused by God's forgiveness; such men think, "God know me, I'm a man."

Another theologically grounded perception that facilitates HIV risk and transmission is a lack of fear of God, conceptualized as a barometer of adherence to Biblical directives and behavioral mandates. The more one fears God, the more closely one follows Biblical principles. In terms of HIV, the more one fears God, the more one avoids sexual activity outside of the sanctity of marriage. The lack of fear within current-day Black communities was raised as a problem for youth in particular. Their lack of fear of God, and the heightened risk-

taking that often results, further facilitate the spread of HIV. Male focus group respondents described this as a phenomenon among youth:

[K]ids today, they're not afraid of anything. They don't have that fear in them like we had growing up and one of the biggest things when we read the Bible, God said the only person we should fear is Him and they don't have that fear yet so as Christians we should drill in that point. The only person you really have to fear is not us. It's God cause He's going to be the one to either save you or take you away.

Conspiracy theory. Respondents expressed a sense of distrust, which they feel is typical of African Americans, of medical establishments and disease processes in general. They indicated that the disproportionate burden of HIV infection upon Black communities is the result of purposeful infection by larger, more powerful entities.

There has been a lot of speculation about the virus and where it comes from... And how a certain race of people are targeted with that dreaded disease and even now to the point that people have been deliberately injected with the virus, but that's just speculative.
[Rural Pastor, Small Church]

Some respondents believe that health information is designed to harm instead of help.

Modern culture. Respondents across focus groups and interviews discussed the evolution of modern culture and its impact on HIV risk within Black communities. Various aspects of the current culture, when compared to previous eras, were noted for how they exacerbate risk and create heightened exposure to HIV infection. Modern culture components were said to include: 1) media, such as television, music, and the Internet; 2) increased exposure and opportunities; and 3) lack of fear.

Respondents from most categories discussed the sexually suggestive natures of television, music, and the Internet. Highly sexualized messages, which some see as targeting Black communities, are prevalent throughout various forms of media and encourage risky sexual behaviors such as concurrent partnerships. Rural and urban respondents noted that current media also miss opportunities to promote preventive behaviors such as condom use. These missed opportunities further normalize risky sexual activity without consideration of negative outcomes or how the media might use its influence to help modify risky behaviors.

Through the images they perpetuate, current media also create a context for how men and women define themselves and relate to one another. Respondents discussed the media's pervasive defamation and sexualization of women and promotion of men as thugs and "bad guys," which in the absence of positive role models become normative within Black communities. Such negative, defamatory images encourage power differentials in sexual partnerships, multiple partners, sexual violence, and sex for pleasure without commitment or marriage. Respondents see media portrayals of sex as irresponsible and a source of selfish pleasure, characterizations that directly conflict with the conditions under which the church approves of sexual activity (within the context of marriage, for procreation, and as behavior associated with responsibility). According to many respondents, sex for selfish pleasure is synonymous with multiple partners, lack of condom use, and lack of control. According to one rural pastor:

It's like, if I've got a Maserati and I can run two hundred miles an hour and I can't be accountable for it and I run over and kill you, my

pleasure just messed your life up... We as a society need to wake up and see that picture. Using sex for pleasure is killing us and I don't think it's going to stop... [Rural Pastor, Large Church]

Another pastor of a large, rural church compared the opportunities for popular media to shape behavior and norms with those of the church. In his view, individuals spend more time exposed to and receiving instruction from television, music, and the Internet than from the church. To counter these prevalent, negative, and risk-associated messages, one group posited that campaigns similar to those that have negatively characterized smoking behaviors could be used to increase awareness of the potentially negative outcomes of sexual activity, particularly in the absence of prevention innovations.

R5: TV is a powerful piece and you remember when we did this war on cigarettes, now when you see people smoking it's like, Why are you smoking? [Laughter.] And I think we need to just raise that awareness too like that and then it will flip the thinking behind it, like You don't wear a condom, I mean No, you can't have it [sex]. [Laughter.] I remember the visual piece too. Showing people what [smoking] does to your lungs. [Affirmations.] You show people what they look like with AIDS. Not this picture that they paint on TV, these commercials like you have herpes...we just walking along in the park and everything is fine. Show them what it looks like when you're going through it. [Urban Female Focus Group, Ages 25–34]

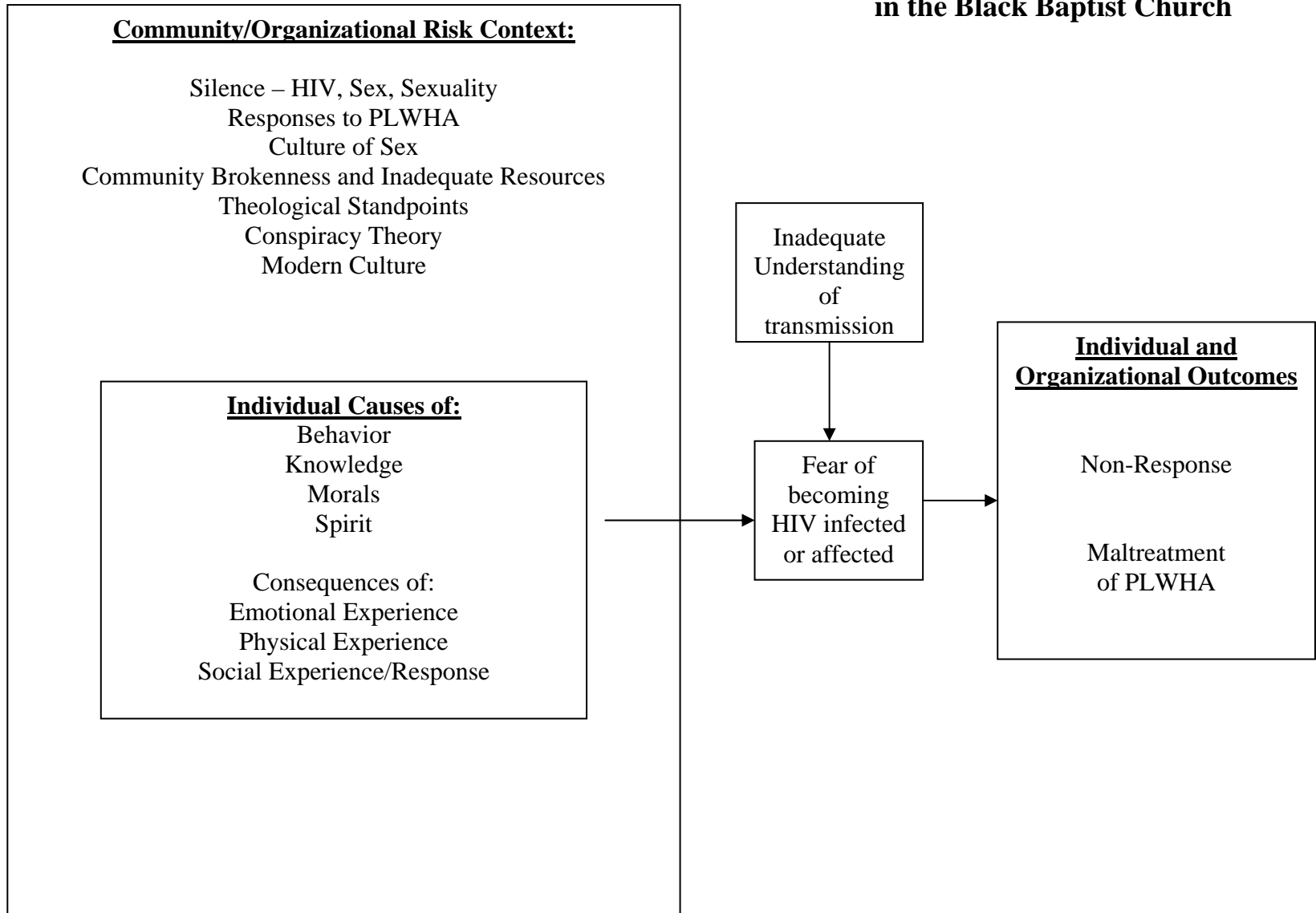
Both rural and urban interview participants characterized modern youth as more independent and able to make decisions at young ages that put them at risk for sexual engagement and its potential consequences. More youth have cell phones that increase their accessibility to partners. They make more decisions for themselves regarding how they spend their time. They are more likely to be able to transport themselves to other locations, and they often live in homes

where parents are working and supervision is lacking. One urban leader described the cultural shift for youth over time:

When I was growing up my mother was still in charge until I left the house. I mean she was the one who was in charge of whether I was going to church that day or not. Now children make their own decisions about that type of stuff...[in the old days] everything was pretty much dictated... [Urban Leader, Large Church]

The third component of modern culture that respondents said fuels HIV risk and infection in Black communities was characterized as a lack of fear, i.e., the force that guides individuals to make decisions that are sanctioned by the church or other guiding figures. Fear can be felt toward God, parents, death, or even sex itself. Modern youth were seen by respondents as lacking fear of any of these things, which in turn facilitates their ability to engage in sexual activity at higher rates than youth in earlier times.

**Figure 1: Socio-Cultural Construction of HIV/AIDS
in the Black Baptist Church**



How Churches Should Respond to PLWHA

The way that church leaders and members conceptualize the facilitators and components of HIV/AIDS shapes their responses to PLWHA. Participants described two components of this issue: how churches should treat PLWHA and how churches actually treat PLWHA. Both focus group and interview respondents overwhelmingly agree that the church has a responsibility to positively support PLWHA and their families, both directly (e.g., services for those infected and affected by HIV/AIDS) and indirectly (e.g., support that targets the congregations attended by PLWHAs and their families). Direct support also includes showing compassion, creating welcoming atmospheres, assistance with medication and transportation, organizing support groups, offering prayer, and demonstrating God's love. The forms of support that benefit PLWHA by targeting congregations include teaching congregants not to fear PLWHA, teaching the importance of maintaining confidentiality, and avoiding judgment, all of which create welcoming and comfortable sanctuary for PLWHA.

In addition to framing the church's ideal response to PLWHA as one of support and compassion, some respondents also see the church's role as helping PLWHA to come to terms with and seek forgiveness for behavior that might have facilitated their HIV infection. Interestingly, these respondents assume an association among HIV infection, the absence of salvation, and the presence of sin. They didn't discuss just facilitating behavior change, but emphasized the sinful nature of those behaviors and the necessity for PLWHA to

acknowledge the consequences of their sin (positive sero-status), seek salvation, repent, and work within the church to avoid engaging in those behaviors again.

The majority of respondents agree that churches should offer support services to PLWHA, but also acknowledge that such efforts are not the primary function of the church; some wonder if providing those services could make PLWHA feel singled out in a context where they would not receive other HIV-related services. Although most respondents identify building support systems and environments for PLWHA as a key responsibility of the church, one leader from a small, rural church expressed concern about HIV support within a church context. This respondent feels strongly that PLWHA should receive support services from community agencies such as social services and medical clinics, not within the church, and also supports church instruction to PLWHA to refrain from hugging others until uninfected congregants are comfortable enough to touch them. Clearly, respondents recognize a role for churches in engaging with PLWHA; however, the above sentiments exemplify how churches actually respond to PLWHA—with distance, isolation, fear, and judgment.

The role of the Black church in responding to PLWHA was primarily discussed within two frameworks: providing support by changing churches' socio-cultural environments, and correcting the risk behaviors of PLWHA through confession and forgiveness. Table 10 outlines each orientation to church treatment of PLWHA.

	Support-based Target: Church	Correction-based Target: PLWHA
EL1P	Teach no fear	
EL2P	Teach church how to care for PLWHA, compassion, support	
ES1P	Love, compassion, make comfortable, support	Address consequences of their actions
ES2P	Support groups to experience love of God, treatment	If unmarried, keep dress down/pants up
ES2L1	May feel singled out in church, should be done through community agencies	Teach PLWHA to let others hug them first
ES2L2	Embrace them, see what they need	
FL1P	Ministry of touch, support, confidentiality	
FL2P	Care for PLWHA, advocacy, help reach wholeness, create confidential opportunities to share, give hope	
FL2L1	Love, pray, support	
FL2L2	Welcome, disease gets body, church after soul	Ask forgiveness for how got it
FS1P	Don't judge, love, pray, still part of Gods creation	Repent, get God in their lives, seek salvation
FS2P	Offer classes, find someone for them to confide in	Keep from infecting others, refrain from what got them +, testimony for fear factor for others
FF35-54	Should embrace	
FF25.13	God loves them, accept them, teach how to respond to PLWHA	Correct the risk behavior in a loving way
FF25.14	Support groups, teach how to maintain HIV	Forgiveness for whatever they did to get HIV
FM	Support group, sanctuary, employment assistance	
EF25-34	Counseling and support	
EF35-54	Take care of, make comfortable	
EFUnk	Support, don't look down, show care	

Table 10: Orientations to Treatment of PLWHA

Most respondents acknowledge that the church is not currently an accepting and comforting place for PLWHA, but also expressed the hope that with education, positive modeling by church leadership, and exposure to PLWHA, congregations will learn to “treat [PLWHA] like human beings...in a loving way and not look down on them” (FS1P). Currently, none feel confident that their congregations are capable of doing these things.

The Secular vs. the Sacred

As respondents discussed their conceptualizations of HIV/AIDS in terms of determinants, characterizations, and experiences, they described both secular and sacred components. Secular descriptions include socio-behavioral factors defined in non-theological terms, such as pragmatic knowledge, behaviors, and social experiences. Sacred idealizations, which are connected to and driven by theology and church practices, include issues of morality and the spirit. The complete understanding of what HIV/AIDS represents within the context of the Black Baptist church, as a sacred institution within a society that is not theologically based, is the result of two parallel worldviews and even an intersection of the sacred and the secular. Current public health research primarily addresses HIV/AIDS as a solely socio-behavioral condition, but by introducing a non-secular component to their conceptions of and experiences with HIV/AIDS, respondents identified it as a complex and multifaceted issue within Black Baptist church culture.

The development of appropriate HIV prevention initiatives for the Black Baptist church context requires in-depth understanding of the root causes, contributing factors, characterizations, and role functions of the population. Respondents described individual characterizations and personal experiences that they associate with HIV/AIDS, as well as the pursuant fear of transmission and discomfort at even being connected to the phenomenon of HIV/AIDS. They believe that fear is largely what immobilizes churches from mounting organized,

appropriate responses and also creates contexts for maltreatment of those infected and affected by HIV/AIDS.

The individual associations shared by respondents operate within the broader socio-cultural risk context of Black communities, as well as the organizational context of the Black Baptist church, both of which have socio-behavioral and theological aspects. The multiple and bi-directional interactions among these aspects, along with cross-cutting yet parallel perspectives, all indicate the complexity of consideration for developing intervention strategies. The following chapter explores the applicability of 5 prevention innovations according to Rogers's Diffusion of Innovations, and discusses some of the inevitable contradictory elements of faith-based HIV prevention.

CHAPTER 5

Black Baptist Church Perspectives of HIV Prevention Innovations

Black Baptist pastors, leaders, and congregants discussed their understandings and perceived utility of 5 primary HIV prevention innovations (*abstinence, monogamy, condom use, voluntary counseling and testing, and prevention with positives*). Respondents offered insights into the implications and fit of these innovations within the Black Baptist church, both theologically and socio-behaviorally, and considered possible adaptations that would facilitate congruency between the 5 prevention innovations and Black Baptist doctrine and principles. These analyses are related to the second and third aims of this project:

- Aim 2: Identify and compare/contrast key considerations for possible introduction of various HIV prevention innovations (abstinence, monogamy, condoms, voluntary counseling and testing, and prevention with positives) to the Black church.
 - 2a: Examine the perception of 5 key HIV prevention innovation models of Black faith leaders.
 - 2b: Examine the perception of 5 key HIV prevention innovation models of Black church congregants.
 - 2c: Examine the applicability of Rogers's Diffusion of Innovations characteristics for each of the 5 HIV prevention innovations in the Black church.
- Aim 3: Explore participant-driven HIV prevention models.

First innovation: Abstinence. Most Christian churches teach that refraining from sexual contact with other people is the only acceptable behavior outside of the context of marriage, and all of this study's interviewees and focus groups agree that this should be the primary message for HIV/AIDS prevention within the church context—particularly for the unmarried. Respondents understand abstinence as the most reliable and effective method for preventing disease transmission and also as the approach most congruent with theologically based attitudes about sexual abstinence outside of marriage. In this theological context, abstinence represents more than prevention of infection; it is a measure of Christian principles such as spiritual purity and control, the absence of sin, the presence of morality, and a life connected to God.

As Christians, unmarried Black Baptists are expected to demonstrate these principles by their ability to avoid the sin of sexual engagement and to obey the morality and codes of conduct of the church. In accordance with this view's conceptualization of abstinence as a spiritual marker and a measure of God's presence in one's life, it becomes evident that when individuals understand God and love Him enough to demonstrate their commitment to Him, they are more likely to make a decision to adhere to abstinence teachings. Thus, the church's role is to strengthen individuals' relationships with God as a strategy for increasing abstinence. As one pastor described:

God is able to keep you but you have to make the decision. You have to be willing and committed in order to do that. [Rural Pastor, Small Church]

Because of their agreement with the theologically sanctioned placement of sex within marriage only, respondents framed the innovation of abstinence as appropriate for all unmarried people: divorced and widowed men and women, and particularly single youth. They believe that this principle becomes more easily adhered to when it is taught within a larger framework of discipline across multiple facets of life, as a representation of the value of both life and spirit.

Extended discipline framework. For the purposes of this study, abstinence is defined as the practice of refraining from sexual activity, including vaginal, oral, and anal sex. However, several leaders framed abstinence as part of a larger practice of discipline. Models of abstinence that focus solely on sexual activity seem limited to these respondents, who believe that effective models emphasize holistic discipline in the form of lifestyles that include refraining from sex outside of marriage, drug and alcohol use, unhealthy eating, lack of spiritual discipline, and any other behaviors that can bring negative health and spiritual outcomes.

Abstinence as life and spiritual value. Respondents also conceptualize abstinence as an indication of one's appreciation of the value of life and spirit. As a Christian institution, the Baptist church promotes the value of life and spirit and teaches congregants how to maintain and preserve such value by making healthy choices and avoiding defilement of their bodies. Abstinence messages that emphasize self and spiritual worth more than sexual behavior promote abstinence as a way to help individuals value both their own and others' existence. Respondents explained that abstaining from sexual contact outside of marriage promotes respect for the value of life through the physical benefits of

avoiding HIV/AIDS, other sexually transmitted infections, and unplanned pregnancy, as well as respect for the value of the body and spirit through the avoidance of sin. They also believe that abstinence outside of marriage promotes psychological and social benefits by avoiding the negative emotional and social outcomes associated with it, such as guilt, judgment, and stigmatization. As one rural pastor said:

[I]t's not just teaching abstinence but it's teaching discipline... You got not only to be disciplined of your genitals, you've got to eat right. You've got to build the whole person... I've got to say I'm going to teach you how to have a healthy, holistic lifestyle...and teach you how to live life...you've got to value your soul, the substance of who you are as a human being and you've got to value the substance of other people... [I]f the only thing I see in my relationship with you is two genitals coming together, then hell I missed a whole lot in life and I told you that the rest of you ain't worth a crap. [Chuckle.] [I]t's about life and do I value life and do I value the life of another person?... If I value pleasure more than I do your life, then my pleasure becomes more important to me than your life. [Rural Pastor, Large Church]

Abstinence without fear. Black churches have traditionally offered few, limited messages about sex, and the messages that have been perpetuated have been heavily laden with fear. Respondents discussed a desire to separate abstinence messages from fear tactics that have historically emphasized “fire and brimstone” as punishment for behaviors of which the church disapproves. Several leaders indicated that although this strategy is traditional, it has not produced the desired results. Not only do congregants still engage in premarital and extramarital sex, they do so under conditions that pose risk for HIV infection. Respondents understand that by discussing abstinence within larger frameworks

and a commitment to Christian principles, the church can move the concept away from punishment and thus enhance its effectiveness.

Abstinence from youth. Both leaders and congregants heavily emphasized initiating abstinence teachings when children are young. Respondents concluded that when such instruction begins before puberty, it equips young people with sufficient coping strategies to respond to peer pressure and the emotional development of adolescence; moreover, abstinence becomes a standard of living. They agree that teaching abstinence to people who are already sexually active is less effective than beginning with people who have not yet engaged in sex.

Challenges to achieving abstinence. In addition to applying a theological perspective to the development of effective abstinence models, several of the women's focus groups discussed significant, challenging socio-behavioral causes of sexual activity outside of marriage. They declared that the primary way to successfully increase abstinence behaviors among youth is to address their risk issues: development of self-esteem, absence of love and positive attention in the home, and effects of peer pressure. Respondents indicated that youth who do not feel loved, valued, and supported in their homes—particularly girls—search for that validation through other relationships, which often include sexual activity. Therefore, they feel that church-based HIV prevention models must include parental training and encouragement for women and children to open lines of communication within the home, to build self-esteem and perceived self-worth. By addressing these primary causes of deviations from marriage-based

sex, the church can promote the abstinence message and generate increased adherence to it.

Despite their significant insights into how to frame abstinence within the church for successful implementation by congregants, particularly youth, respondents also recognize the limited scope and resources of the church and of the need to partner with outside health services organizations, as a way to extend the church's educational and service offerings. Such organizations would include local health departments and social service agencies.

Abstinence as an achievable goal. Although abstinence was identified as the gold standard and the necessary primary message for church-based HIV prevention, 9 out of 12 leaders and all focus groups indicated that sexual purity is not an easily adhered to or realistic goal for most people. Although 3 leaders indicated that abstinence is achievable, they also endorsed teaching condom use as a back-up method. Most think that sexual abstinence is too high a standard to achieve in reality due to the innate sexual nature of human beings, the sexualization of American society and media, the prevalent lack of discipline and commitment to Christian principles in American society, and an over-reliance by Christians on God's forgiveness for sinful behavior. Abstinence also becomes less likely when individuals undergo extended periods during which they are expected to be without sexual contact or companionship.

Despite their widespread skepticism about the attainability of sexual abstinence, all respondents agree that abstinence should remain the church's

primary recommendation for HIV prevention. An urban pastor described the conflicting nature of the standard and the actual conditions of people's lives:

That's a hard one. You always shoot for the standard but I also know the depravity of man and woman. I mean the standard if one is not married, then the goal is abstinence, to abstain, but the reality is... I guess I'm a idealist in a realistic work...the standard doesn't change because of the inability of man to live up to it, but there are very few who are able. [Urban Pastor, Large Church]

Respondents' assertions that sexual purity until marriage is a fundamental part of Christian (and therefore) church theology is the primary motivation for their support of abstinence as the key prevention innovation and not one from which they are willing to deviate. They also implied that churches are accountable for giving the abstinence message, regardless of how individuals respond to it or whether they are able to achieve it. Individuals are accountable for their actions, but the church as an institution sees itself as responsible for delivering the message. One respondent described the need for the church to promote abstinence as the standard:

We must advocate that regardless of it [abstinence] looks like it's not working you still have to do it because we're going to be held accountable whether parenting or pastoring to let the people know...many is not saved. They don't know. You know? And they think it's just what you do. You know? It's normal to have a relationship [sex]. There's no such thing as being a virgin at marriage. You know? [I]t's very distracting. And very disturbing. [Rural Pastor, Small Church]

Although respondents agree that sexual abstinence is the church's behavioral goal for the unmarried, as the best way to prevent HIV among other things, most acknowledge that emphasis on abstinence is only the beginning of a range of HIV prevention messages. This recognition hinged on respondents'

agreement that “the depravity of Man” concept must be considered an organizing principle around which churches integrate other forms of HIV prevention into church culture and activities. Respondents expressed some variation in their perceptions of activities other than promotion of abstinence (e.g., types of innovation, appropriate audience for innovations), but generally support the church’s provision of additional messages and strategies for those who do not abstain.

Abstinence-only vs. abstinence-plus. Although respondents overwhelmingly agreed that abstinence should be the church’s primary message about HIV prevention, most acknowledged that an abstinence-only approach has not been very effective at changing behaviors or health outcomes. Two models, commonly referred to in the public health field as abstinence-only and abstinence-plus, were discussed by respondents. Two rural pastors, who believe that the church’s message about sexual engagement should end with abstinence, are resolved that the church must adhere to this standard. In their view, it is the responsibility of individuals to deal with the consequences of their deviation from church standards, whether such consequences are emotional, social, or physical; such as HIV infection.

This model of absolutes does not account for any behavioral diversions or provide a safety net when individuals fail to meet church standards. During later discussions, however, the same two pastors did recognize this limitation and support condom teachings within the church.

Abstinence-plus advocates support the teaching of prevention strategies beyond abstinence, particularly those that create contexts for safer sex such as limiting sexual partners and condom use. For the purposes of this study, abstinence-plus also includes VCT and PwP, because both of these can help reduce the spread of HIV. Those who advocate for an abstinence-plus model recognize abstinence as the goal, but also see the church as needing to provide interim back-up plans. The prevailing sentiment among this group is the wish to keep people physically alive until they've received enough teaching and support to become spiritually alive, as evidenced by their ability to maintain abstinence.

So the reality of it is, is it [abstinence] achievable? Yes. Is it likely for duration? I think not. So what is the next best plan? Tell them to protect themselves and give them all the tools...[so] they will be able to live and keep others from dying because of their...lack of control or whatever. [Urban Pastor, Large Church]

Second innovation: Monogamy. For the purposes of this study, monogamy is defined as the practice of restricting sexual behavior to a single partner. Respondents across categories affirmed that many individuals do not practice monogamy due to various socio-cultural influences. To increase monogamous practices, some of the urban respondents offered an expanded context for teaching and helping congregants to achieve them. These include framing and presenting monogamy as the result of well-maintained relationships and as a basic component of understanding and appreciating the concept of marriage. Monogamy teachings address a broader range of behaviors than sexual encounters between two committed people; they also include relationship training that facilitates commitment to monogamous partnership throughout all phases of

a relationship. Respondents who favor abstinence-plus education described monogamy as:

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

Within the Black church, marriage is conceived as a faith-based institution over which churches have spiritual, moral, and behavioral authority. Therefore, churches can help construct symbolism and guiding mandates related to marriage, including its sexual dimension. One urban pastor discussed the church's role in helping individuals understand the meaning and value of marriage as a means to achieving monogamy:

I do think that the church should be able to really help the person to understand that he or she need to refrain until he or she is married...married ladies is having the problem [infidelity] too and married men, but the thing of it is, if you ever get married and you're really, really married...I'm not talking about just getting your name changed and so forth and so on but when you get married you have that trust. And you love that person that you're with so much that you don't need somebody else and so I think that...if we could really teach our young people and our elderly ones too to just refrain until marriage, and on the sexual habits, and so forth and so on...everything would be a whole lot better. [Urban Pastor, Small Church]

The audience for monogamy teachings. All respondent groups support monogamy as a church-appropriate HIV prevention innovation, but reported differing opinions about determining the message's audience. Because the church only condones sexual activity within the context of heterosexual marriage,

all respondents advocated teaching married couples about refraining from extra-marital sexual encounters as a way to adhere to church standards of maintaining their marital vows and also to prevent them from contracting HIV/AIDS and other sexually transmitted infections. In direct contradiction to the parameters of church-sanctioned sex, all but one focus group that discussed audience appropriateness also supported extending the monogamy message to unmarried couples engaged in a committed relationship, and even to singles. As mentioned above, respondents are willing to address the sexual behaviors of unmarried congregants in the context of recognizing such behaviors as proof of human imperfection, also called “depravity.”

Although respondents feel the need to address the reality of sexual activity outside of marriage, many expressed considerable conflict about promoting monogamy as an HIV prevention strategy for the unmarried because such promotion could be perceived as condoning their sexual interactions. The latter is viewed as the lesser of two evils, however, when compared to the potential for HIV infection or other negative health outcomes associated with multiple and concurrent partnerships. Church leaders proved to be more stringent about who should receive monogamy messages, with 7 of the 11 who discussed audience appropriateness supporting it for married couples only. Those who disapprove of monogamy teachings beyond marriage largely believe that the principle of monogamy is implicit in the church’s concept of marriage as a union between two heterosexual people who only have sex with one another, and that explicit teachings on patterns of partnership could be interpreted as promoting sex

outside of the marriage context and thus be contrary to the teachings of the church. There was also a sense that promoting monogamy for the unmarried ignores the consequences of sex, both physically and spiritually, and fails to address that sex outside of marriage is, as one respondent described, a “deviation from Christian morality.”

Due to conflicts around the issue of addressing sexual partnership patterns for the unmarried, respondents indicated that monogamy should be taught discreetly to this group, not overly emphasized, and only as a back-up to be used when individuals within this group cannot attain abstinence. Leaders who support monogamy innovations for those in committed relationships and other unmarried people think that the church should endeavor to promote marriage in addition to encouraging unmarried people to limit their number of sexual partners.

Monogamy is an easily congruent innovation for the Black Baptist church, particularly for the married, but it has seldom been used as an HIV prevention innovation. None of the respondents reported having seen or heard of other churches promoting monogamy as a form of HIV prevention.

Third innovation: Condom use. Within the Black church, condoms have traditionally been the most controversial and least acceptable innovation for HIV/AIDS prevention because they have no theological construction. However, only 1 of the 12 pastors and leaders in this study see no utility for condoms as a prevention innovation, and all of the focus groups support church-driven education about condom use. The primary points of divergence had to do with

levels of implementation; suggestions ranged from openly teaching about and promoting condom use, through referring people to other organizations for condom acquisition, to distributing condoms discreetly (on an individual basis or through specific church auxiliaries). The latter were usually characterized by demographics that respondents associate with HIV risk and condom use (e.g., youth and men's groups).

The majority of respondent groups discussed condoms as an appropriate innovation for youth, based on the assumption that youth are at high risk for HIV infection and that some young people cannot talk to their parents about their sexual needs. Others see condom messages as appropriate for PLWHA, particularly married sero-discordant couples, to help them not to infect others. Across groups, there was the belief that condoms and condom-use education can become part of the Black Baptist church context for the unmarried—after churches have recognized and accepted the low probability of all members remaining abstinent outside of marriage—and for PLWHA as a way to prevent further transmission.

In spite of the support expressed by most respondents for some form of condom promotion, a number of perceptions that make implementation difficult were also discussed. These included 1) the perception of condoms condoning and promoting sex; 2) association of condoms with promiscuity and unfaithfulness; 3) condoms' lack of effectiveness; 4) the need to address root causes of sexual activity outside of marriage; 5) participants' lack of

accountability for their unsanctioned sexual encounters; 8) parental discomfort with youth receiving condoms, and 9) threat of losing church membership.

The conflict of condoms. Discussions about condoms created concerns about inserting ambiguity into otherwise unequivocal church doctrine. For all respondents, condom promotion and education is potentially synonymous with promoting and condoning premarital and extramarital sex. Some respondents also associate condom use with promiscuity and unfaithfulness, which are contradictory to Christian principles about sexual activity. One rural pastor described the problems with church endorsement of condoms:

MOD: HOW DO YOU THINK CONDOMS CONTRIBUTE TO HIV PREVENTION?

A: I think they can. But condoms is something that, how can I say it, for the church it's taboo. [Laughter.] Uh, because to some it would be like condoning sexual activity. So if you're not going to condone it [sex] then you don't have to talk about condoms in a sense...to talk about [condoms], people would ask you well pastor are you condoning [sex]? [Chuckle.] But it's like a taboo area for churches... [Rural Pastor, Large Church]

The contradictory nature of this innovation is a consideration for most respondents; for the one leader who disapproves of condom education within a church context, it is the sole rationale for not supporting condoms as a form of HIV, STD, and pregnancy prevention. This leader compared condom use to a "deviation from Christian morality," completely incompatible with the church's mission and theological teachings. Even the leaders who do support some form of condom innovation overwhelmingly agree that condoms should be promoted as message secondary to abstinence, or mainly to PLWHA. In this view, condoms are the "lesser between two evils" (having protected sex, possibly

outside of marriage, and having unprotected sex and becoming HIV-positive). This framing acknowledges the church's primary stance of sexual activity reserved for marriage but also acknowledges that many people actually have sex outside of marriage. Promoting condom use as a back-up, to be used when abstinence cannot be achieved, was endorsed not only as a way to support church doctrine but also as a way to acknowledge the limitations of condom use. Although condoms are highly effective barriers to HIV transmission when used consistently and correctly, some leaders expressed concerns that condoms are not 100% effective, due to their design, and with people's inability to use them properly.

Another concern about condom promotion is that it, like monogamy promotion, doesn't address some of the underlying reasons for sexual activity outside of the marriage context but only puts a band-aid on the problem. These are the same issues identified as challenges to achieving abstinence (lack of spiritual guidance and morality, low self-esteem, lack of love and support, not valuing one's body, etc.). Although they agree that condoms can reduce the physical consequences of forbidden sex, by increasing avoidance of infection, two rural pastors discussed how they provide a way to circumvent the spiritual consequences of sex outside of marriage. For these respondents, condoms perpetuate a lack of accountability—for living up to God's standards, and for participation in sinful behaviors—which ultimately encourages sex outside of marriage.

[Y]ou can't go passing out condoms...because that will give leeway or an "okay," you know...but it's [sex] still wrong. It doesn't justify

the means because there's consequence... I think that when you do it wrong and God has condemned it and said that the only bed that is not defiled is the marriage and if you go ahead and do it anyway there is some consequence. You know? And that's one thing that's got to be vocalized very high... Not just say Well, I know you're going to do it so here's some condoms, you protect yourself...it's a death sentence. You know? And that's not a fear but it's more or less the reality of sinning. [Rural Pastor, Small Church]

Additionally, some respondents indicated that although the church is a trusted source of information for many people, some parents are not comfortable with others discussing sex and prevention measures with their children. Fears that participating in such a controversial innovation could threaten a church's membership in church associations were also expressed.

Fourth innovation: Prevention with positives (PwP). By definition, PwP includes any support that encourages PLWHA to live and cope well with their condition and specifically emphasizes helping them to avoid both transmitting HIV to others and reinfecting themselves. Because the church is intended to provide support, comfort, and care to all people in need, all but one respondent agreed that the Black church should promote PwP models. The one who disagreed only did so because he doesn't believe that his church is open-minded enough to effectively support the needs of PLWHA, not because he finds fault with the concept.

Respondents feel that PwP formats should provide education, emotional and financial support, and (most commonly suggested) opportunities for testimonials. Rural and urban leaders as well as congregants discussed the church's role in supporting PLWHA's sharing of their experiences with the

congregation. Such forums for testimonials would serve to 1) create further empathy and understanding for PLWHA; 2) encourage other individuals living with illness to feel comfortable sharing their experiences; and 3) function as a source of prevention education for the congregation by demonstrating the consequences of risky behaviors. One urban pastor described the effect testimonials could have on creating further opportunities for discussing and understanding the experience of HIV/AIDS, and for mobilizing churches to appropriately respond and support affected individuals:

I wish those who have been touched by AIDS, whether it's themselves or family members, would share. And I use my two uncles who died of AIDS as a way of bringing fertile ground out for something that's very tragic with our family. So I'm very open about sharing, hoping that other people will be open about sharing so those who are carrying the stigma or those whose family members are carrying the stigma of my brother or my son or my daughter or my sister, they'll be able to have the freedom to say I too was touched...and so we'll come to the conclusion that people who die of AIDS are just people just like us who need love and support as well as family members who need love and support and understanding...[I'm] just being somewhat transparent enough to be able to make people feel like hey, I'm not out here by myself.
[Urban Pastor, Large Church]

As an exemplar of the Black church's conceptual connection between HIV/AIDS and sin, and the need for testimonials to overcome sin and the lack of Divine forgiveness, some respondents discussed the need for PLWHA to publicly confess their status and risk behaviors. They described such confessions as a way to obtain forgiveness for the behaviors that facilitated their infection, solicit support for learning to live their lives by church standards (which would include not engaging in sinful behavior again), and ultimately to gain acceptance from other church members. Testimonials create a forum for confession to be offered

and for forgiveness and acceptance to be received. Respondents expressed that churches are more likely to provide support to PLWHA when they have confessed, addressed their sins, and begun to live their lives in a manner that demonstrates their avoidance of sin and threat of infection to others. One focus group described the need for the church to chastise risk behavior in addition to providing support to PLWHA.

R5: What was the right way? What was the wrong way? You know? We do that with kids, in the classroom: what's right behavior, what's wrong behavior... I just think that when people see what they do like that, it kind of helps them to check and take an inventory of themselves and say okay I don't need to do it like that... And the love of God is not always so chummy-chummy... God rebukes as well. I'm not saying we've got to be beating up on the people... What I am saying is this: the love of God also corrects and that's what I mean by rebuking. It corrects and so we need to be correcting about this behavior, especially if it was a person who got this disease by being careless...but I'm just saying I just don't think that when we're dealing with this person we don't need to just overlook that [behavior]...

RU: Yeah. Correct the behavior.

R5: Yeah. You've got to say okay, we need to talk about what has happened here and...you know...the other lives you have impacted and that type of thing. I just don't believe it should all be on the lines of this gushy-gushy love. You know? No. It needs to be on the lines of correction as well...based on the different situations. [Urban Female Focus Group, Ages 25–34]

Limiting Contagion. While churches can certainly take on a role in PwP, by supporting PLWHA, much of the impetus for engaging in this innovation stems from a desire to encourage PLWHA to come to terms with their infection and refrain from spreading the disease to others, instead of solely supporting them so that they can live well with their condition. Respondents across categories expressed concern that PLWHA are angry about their infection that, lacking the

proper support, may purposely infect other people. There was an assumption that although PLWHA tend to be dishonest about their status, the church could help them to cope with their infection, learn to live with it, and ultimately refrain from infecting others.

Barriers to PwP. Prevention with positives can target congregations to alter the contexts within which PLWHA live and worship as well as focus on direct services for PLWHA. Congregationally focused PwP initiatives can be implemented in any church without the knowledge of the PLWHA within the congregation, but direct provision of services to PLWHA requires knowledge of who is in need of the services. One barrier to providing direct services is the lack of visibility of PLWHA within congregations. Very few respondents said they know of PLWHA within their churches and cited this lack of awareness as a barrier to their church's involvement in PwP activities. Although none of the pastors and leaders attend churches with HIV/AIDS ministries and few of the focus group participants do, respondents did acknowledge that some churches may have ministries that help PLWHA in the context of other things (feeding all who need it/are sick, providing housing assistance). Such help, they specified, just may not be specific to those living with HIV/AIDS.

Fifth innovation: Voluntary counseling and testing (VCT). Voluntary counseling and testing was framed as a prevention strategy that helps individuals become aware of their HIV status and learn how to reduce their risk for HIV/AIDS. Of this study's 19 total interviews and focus groups, 15 support VCT within the church setting, 3 favor modified versions of VCT, and 1 opposes use of

the innovation within the church. Although most respondents support VCT in some form within the church, few are actually familiar with it. Respondents in only 4 of the 19 total interviews and groups had ever heard of a church offering VCT. Some respondents specifically identified the kinds of people they think would need to take advantage of VCT (young people, people who party, and people outside of the church).

Implementation of VCT. Respondents suggested a range of formats in which VCT could be delivered in the Black Baptist church setting. Ideas ranged from highly visible, pastor-led initiatives in which the pastor would set the example by being tested, to private VCT, off-site, accompanied by the pastor. Campaigns for public testing, particularly with featured pastoral involvement, would enhance the normalization of testing and the influence of a champion to encourage individuals to participate. Private, off-site VCT opportunities would help to counter the stigmas associated with HIV testing and with the negative perceptions associated with public admissions of risk. Not surprisingly, concerns about confidentiality were identified as a major barrier to offering VCT in the church. Suggestions about strategies to counter this concern included partnerships with outside organizations, who would administer the tests, and offering HIV testing in conjunction with other health screenings. Aside from the logistics of offering VCT, one urban pastor framed the willingness to be tested as an expression of love between two partners and recommended that testing be added to the premarital counseling offered by the church.

[B]efore you get in a committed relationship, part of premarital counseling, maybe the pastor can share [VCT], for the most loving

thing is for both individuals to make sure that they are clean and clear. [Urban Pastor, Large Church]

Components of VCT. Although public health practitioners package counseling and testing within a single innovation, some respondents view them as conceptually separate programs. Those who support the latter version of VCT not only conceptualize counseling as a separate process from HIV testing, but also deem only the counseling component as a natural extension of the church's role and therefore appropriate within the church setting. There was some concern that churches, without partnership with medical organizations, would not have sufficient expertise to administer HIV testing. There was also a sense that testing procedures should take place within a medical establishment, in case of emergency. Even without absolute agreement on how VCT should be administered in church environments, respondents agreed that something should be done to make people aware of their HIV status. One group of rural women mentioned the prevalence of unmarried teenage mothers in their community as evidence that unprotected sex is happening, which to them indicates the need to follow up with HIV testing.

HIV Prevention as a Set of Socio-behavioral and Theological Constructions

In addition to conceptualizing HIV/AIDS as both a socio-behaviorally and theologically informed condition, respondents construct HIV prevention through both perspectives. They discussed each prevention model in socio-behavioral and organizational terms, and offered interpretations and models for 4 of the 5 prevention innovations that were clearly influenced by Baptist doctrine and

theological principles (See Table 11). Condoms were not linked with a theological construction. Other components and models, ones that were not necessarily included in the research prevention innovations described above, were also constructed according to both socio-behavioral and theological viewpoints.

Ultimately, HIV prevention within the Black Baptist church will be contingent on finding or creating compatibility between theological and socio-behavioral perspectives applied to the 5 prevention innovations and other models that are suggested/advocated by church staff and members. Constructions that promote abstinence present no incompatibility, which would seemingly allow optimal integration. Compatibility with monogamy is also present (limiting sexual activity to one partner, building and maintaining committed relationships, and addressing root causes of non-monogamous partnerships).

Significant incompatibility was found, however, in discussions about the audiences to whom monogamy messages would be targeted, definitions of monogamy, and the need for personal accountability and acceptance of the consequences of non-marital sex. Theologically, church doctrine holds that monogamy is only appropriate for married heterosexuals, as sexual relations are only appropriate for this group. Promoting monogamy outside of the heterosexual marriage context would contradict the concept of sex as condoned only within marriage and the promotion of homosexuality as sin. Given the church's strong moral identification associated with both of these contexts, presenting them in any altered way poses significant challenges to the extension of messages about

prevention (beyond abstinence for the unmarried) and monogamy (for anyone other than married heterosexuals).

Progressive prevention messages would require the church and church members to acknowledge the “depravity of Man” as an acceptable framework for constructing prevention responses. Considering sinful human frailty as a normal, if undesirable, condition would mean accepting the probability of humans failing to meet the church-mandated standard of sex only within marriage, and also accepting that it is permissible for the church to promote contingency plans for sex that is premarital, extramarital, or homosexual. Although no respondents said so explicitly, it is clear that churches must validate the depravity of Man as both a condition and a framework, as part of the a reality of HIV risk, and as non-contradictory to church-driven, theologically based promotions of condom use, prevention with positives, voluntary counseling and testing, and monogamy among the unmarried. Without “depravity of man”, condom use – particularly among non-PLWHA – and the ability to ignore the consequences of sexual sin in favor of avoiding disease transmission through monogamy and condom use remain insurmountable barriers to prevention implementation.

Church recognition of human imperfection is also necessary if the church is to validate VCT as a prevention innovation. (Implementation of PwP is less problematic, however, because this innovation already contains an inherent recognition of depravity and thus a basis for compatibility as well: the concept of confession and forgiveness.) Although many Black Baptist churches offer human service support to PLWHA and other individuals in need, confession and

forgiveness must be undertaken before these individuals can receive acceptance and support as church members. Such a requirement is theologically based, not part of the socio-behavioral perspective, which does not associate HIV/AIDS with the concept of sin. VCT is basically compatible with both perspectives; its challenges are related to technical assistance and confidentiality.

Because individuals who are part of Black Baptist church culture are also part of larger socio-cultural community contexts, they subscribe to both worldviews—the theological and the socio-behavioral. Therefore, such individuals may perceive the two worldviews as parallel and as intersecting; they may also perceive bases of compatibility between them. And, in fact, although each worldview contains distinct rationales about how and why to promote prevention strategies, both favor abstinence, monogamy, VCT, and PwP as prevention strategies. Church members' parallel interpretations of condom use could result in conflicting promotion strategies, but such conflicts could be ameliorated by agreement about the necessity of integrating and achieving theological goals within socio-behavioral contexts. In other words, the two worldviews could interact harmoniously in order to provide individuals with safer sex options until they achieve enough theological and spiritual markers to avoid sexual HIV risk.

Table 11: Definitions of HIV Prevention within the Black Baptist Church

Prevention Innovations	Theological Perspectives	Social & Behavioral Sciences Perspectives	Points of Compatibility	Points of Incompatibility
Abstinence	<ul style="list-style-type: none"> Salvation Life connected to God Spiritual purity Avoidance of sin Spiritual discipline Value of life Value of spirit Morality 	<ul style="list-style-type: none"> Holistic behavioral discipline Self esteem Positive attention Rebuilding families Responses to peer pressure 	<ul style="list-style-type: none"> Join the two perspectives 	<ul style="list-style-type: none"> None
Monogamy	<ul style="list-style-type: none"> Theological sanctity of heterosexual marriage Morality 	<ul style="list-style-type: none"> Reduce concurrency and multiple partners for (un)married Relationship maintenance 	<ul style="list-style-type: none"> No extramarital partners Root causes Relationship maintenance <p><i>*Requires "Depravity of man"</i></p>	<ul style="list-style-type: none"> Audience – beyond married, non-heterosexual Reduce # of partners vs. no or one partner Accountability, consequences of sin among unmarried
Condoms	<ul style="list-style-type: none"> None 	<ul style="list-style-type: none"> Protected sex/condom use (PLWHA and non-PLWHA) 	<ul style="list-style-type: none"> None <p><i>*Requires "Depravity of man"</i></p>	<ul style="list-style-type: none"> Condom use among non-PLWHA Accountability, consequences of sin among unmarried
Prevention with Positives	<ul style="list-style-type: none"> Confession and forgiveness Correction-based Physical, emotional support 	<ul style="list-style-type: none"> Physical, emotional support Condom use 	<ul style="list-style-type: none"> Physical, emotional support <p><i>*Recognizes "depravity of man"</i></p>	<ul style="list-style-type: none"> Need for public disclosure Forgiveness
Voluntary Counseling & Testing	<ul style="list-style-type: none"> Counseling Only 	<ul style="list-style-type: none"> Counseling Testing 	<ul style="list-style-type: none"> Counseling Referral/ Partner for testing <p><i>*Recognizes "depravity of man"</i></p>	<ul style="list-style-type: none"> None
Non-Innovation Specific	<ul style="list-style-type: none"> Fear of God Mind, body, spirit 	<ul style="list-style-type: none"> Awareness (transmission, general) HIV, sex, sexuality (Open discussions) Abstinence plus Media reform Access (healthcare, recreation) Youth focus 	<p>This table outlines:</p> <ol style="list-style-type: none"> How does the black Baptist church define HIV prevention? How are the theological and socio-behavioral perspectives compatible? How are the theological and socio-behavioral perspectives NOT compatible? 	

Applicability of Rogers's 5 Innovation Attributes

Assessing specific attributes of the innovations that are recommended in Rogers's Diffusion of Innovations model (abstinence, monogamy, condom use, VCT, PwP) can help researchers predict their acceptability and the likelihood of their adoption. This section considers these attributes in terms of their applicability to Black Baptist churches' participation in HIV prevention, to specific innovations, and to their ability to indicate likelihood of engagement. Applicability is assessed in terms of five attributes: *relative advantage (RA)*, *compatibility*, *complexity*, *trialability*, and *observability*.

Relative advantage (RA) is the degree to which an innovation is perceived as better than the situation or innovation it supersedes. Relative advantage (RA) is a strong predictor of adoption in other studies; however, for almost all churches, there is no preceding HIV prevention innovation to compare advantage. RA subdimensions include economic profitability, low initial cost, increased comfort, social prestige, savings of time and effort, and immediacy of reward. The black Baptist church's primary mission is to teach others its theology and bring them into belief. While these advantages would be effective for adopting innovations that help the church to achieve that mission, engaging in HIV prevention does not necessarily generate any of these advantages for the church, and in fact, may generate the opposite. In addition, church-driven implementation of HIV prevention innovations could sap fiscal and personnel resources from already strained budgets and staffs, generate considerable social discomfort among the congregation, and facilitate social isolation instead of

prestige; moreover, the rewards for engaging in preventive activities are often difficult to observe.

An important component of RA is the perceived level of the new innovation's effectiveness (i.e., its ability to promote the desired end state). Respondents in this study expressed skepticism of the 5 innovations' ability to prevent HIV, particularly as they are currently framed both socio-behaviorally and in terms of public health. As reported above, some respondents expressed concern over condoms' effectiveness in preventing HIV transmission as well as individuals' ability to use them consistently and correctly. Respondents also expressed an overwhelming disbelief in the ability of individuals to practice abstinence, whether their reasons for trying originate in a socio-behavioral or theological perspective. Women in particular tend to believe that men do not adhere to monogamy. When discussing PwP, respondents expressed concerns about PLWHA hiding their status and infecting others. Considering the strength and prevalence of respondents' doubts about the likelihood of achieving the desired behavioral outcomes targeted by the 5 innovations, the relative advantage of implementing them in the Black Baptist church may be low indeed.

Compatibility. Relative advantage, usually one of the strongest predictors of adoption; however, the lack of compatibility between almost all current HIV prevention models and traditional Black Baptist doctrines poses a significant barrier. Compatibility considers an innovation's consistency with potential adopters' existing values, past experiences, and needs. To some degree, most respondents recognize the need for the church to engage in HIV prevention

activities; however, their assessments of the compatibility of the 5 specific innovations vary. Most agree that, as they are currently framed, the 5 prevention innovations show significant incompatibilities with Baptist doctrine. For example, current definitions of abstinence fit church theology and culture, but in order to be adopted they would have to be extended to include the theological conceptualization of abstinence as a form of spiritual discipline and as a practice that enhances emotional connectedness in human relationships. Similarly, monogamy could be conceived as an incompatible message because the church only condones sex within the context of marriage. Condom use would be incompatible because of its associations with condoning sexual activity and the perceived lack of its necessity within the context of marriage, unless couples are sero-discordant.

Three of the five innovations (condom use, VCT, and PwP) are quite recent additions to the Black church context, and even the two that are traditionally endorsed (abstinence and monogamy), are not routinely discussed in the contexts of HIV and disease prevention. Therefore, because of the multiple incompatibilities between church doctrine, constructions of HIV/AIDS and prevention, and models of HIV prevention, as these things are presently understood and practiced, it would be difficult for Black Baptist churches to consider adopting the 5 innovations. Moreover, compatibility is directly connected to perceived relevance and appropriateness; without compatible constructions of the problem of HIV/AIDS and ways to overcome it, church pastors, leaders, and members may never even evaluate the attributes of other innovations. The use of

technology clusters (packaging related programs for adoption) could be advantageous, as most respondents feel it would be desirable for the complete set of 5 innovations to be implemented together within the church or in combination with other efforts (i.e., by general health ministries). However, any proposed innovations would have to be constructed so that they would pose the least possible amount of conflict with established church doctrine.

Complexity refers to the perceived level of difficulty of using and understanding an innovation, and also to the degree to which new skills and understandings would have to be developed in order to use it. Respondents clearly understand how the 5 innovations propose to reduce the spread of, or even prevent HIV/AIDS. However, they also feel that these innovations' complexity would include a wide array of social, cultural, and doctrinal challenges, all of which would have to be overcome prior to implementation, not to mention the actual challenges posed by implementation. Partnership with outside organizations to facilitate implementation could possibly mitigate these challenges, particularly given the limited skill sets and scope of knowledge about HIV prevention that are typically present within churches.

Trialability refers to the extent to which an innovation can be implemented on a limited or trial basis and also to the possibility of adoptors' learning from the experiences of others who have used that innovation. If the beliefs of respondents can be applied to the majority of Black Baptist churches, most are willing to try some form of HIV prevention on a trial basis, but the initial investment can be substantial—particularly for churches with limited fiscal

resources. Churches must also consider the socio-cultural costs of engaging in HIV prevention. Although an innovation may be reversible, the effects of its implementation may not be. Given the taboo status accorded to open discussions of HIV and its prevention, even temporary implementation could have devastating implications for a church's cultural and organizational culture. Trialability offers the opportunity to customize and modify innovations to fit pre-existing frameworks, or even to reinvent them if necessary. Given the understandings and constructions of HIV/AIDS and prevention by Black Baptist church leaders and congregants, public health intervention models would have to be reframed in the contexts of Baptist doctrine and theological interpretation before they could be tested.

Observability refers to the extent that the results and effects of an innovation are visible to the larger community. As previously mentioned, the effectiveness of prevention innovations are difficult to observe, as HIV prevention would be also. Observability also considers the possibility of networks of related adopters who engage in an innovation, but few respondents in this study think that their churches or the Black church as an institution is ready to demonstrate engagement, either culturally or organizationally. In fact, few had observed or even heard of other Black Baptist churches conducting HIV prevention activities.

Circles of Contradiction

The Black Baptist church has neither historically nor traditionally openly addressed what is considered to be unsanctioned sex or sexuality.. This refusal has marginalized the realities of church members' sexual development and

practices; worse, it leaves HIV/AIDS, an infection transmitted mostly through sexual contact, almost completely unacknowledged. Numerous contextual factors of the structure and culture of Black Baptist churches inhibit their ability to fully respond to HIV/AIDS. Even when leaders and congregations want to be responsive to the epidemic, the church's multiple layers of tradition, doctrine, culture, and understanding create conflicting contexts that hamper their progress. In their discussions, respondents identified four key conflicting viewpoints that directly impact the viability of the 5 HIV prevention innovations examined in this study.

First contradiction: *Churches would get involved in HIV prevention activities if someone in their congregations or someone they knew was HIV positive, but both the church's strict theological doctrines and socio-behavioral constructions of HIV/AIDS discourage disclosure.*

Most respondents recognize, very strongly, that the church's mission of caring for the sick and needy should include support services for PLWHA and their families, and that such services would ideally be implemented as a form of PwP. Nevertheless, few churches actually have established such services. Several respondents specifically stated that if PLWHA were known or had self-identified in their congregations, support services would have been provided by their churches to these people and their families. The respondents' modes of expression, however, indicated that the lack of church-based support services for PLWHA is the fault of PLWHA, who do not disclose their status to their pastor

and congregations; in fact, non-disclosure was cited as the primary reason that congregations are not currently providing support services for PLWHA.

Lack of awareness of PLWHA within one's own congregation does not negate the responsibility of the congregation, as a community of faith, to help PLWHA who are not members. However, in any case, the socio-cultural environment of most Black Baptist churches is not conducive to living with HIV/AIDS openly. All respondents described the church's hypothetical and actual responses to people known to be living with HIV/AIDS as exclusionary, stigmatizing, and isolating. Thus, although the church embraces its theological mandate to reach out to and help those in need, church atmosphere is not inviting to those with HIV/AIDS and little has been done to change that.

From the perspective of church leaders, knowledge of PLWHA within a congregation would facilitate engagement in PwP, but leaders also know that the overall church environment must become more welcoming and inclusive before PLWHA can disclose and seek services. However, even if churches do not know of specific PLWHA to whom they can provide assistance, all churches can address their socio-cultural environment so that it promotes acceptance, non-judgment, and sanctuary.

Second contradiction: *Churches want to meet the actual needs of people but are compelled to adhere to church doctrine.*

Most respondents acknowledge that because the Black Baptist church is a key information source and guide for behavioral norms in Black communities, the church should address the sexual risks taken by both church members and non-

members. Not surprisingly, however, the church is caught in a paradox: on the one hand, it is appropriate for the church to adhere to its theologically based practice of teaching that sex is appropriate only within the context of marriage; on the other hand, it is also appropriate for the church to help people who are engaged in sexual activity outside of marriage to avoid HIV, sexually transmitted infections, and other negative outcomes. This problem is particularly poignant in reference to youth, the unsaved, and those who are engaged in church but are not fully committed to church teachings—these are characterized as most vulnerable to extramarital and premarital sexual interactions and, not coincidentally, as least able to adhere to strict guidelines for sexual activity. Nonetheless, some respondents who have encountered prevention messages beyond abstinence outside of marriage strongly promote prevention methods other than abstinence (primarily condom use) in their own homes and to their own children and loved ones. Conflict about providing condoms is evident for this respondent:

I wouldn't say the church needs to give out condoms...not openly give them out in church... I don't know with condoms...I mean if I had a young teenager right now I would just push you better have condoms. I would tell them you don't need to have sex but again they're hardheaded so I would push the condoms on them. [Rural Leader, Small Church]

This conflict exists for the mandate of abstinence messages although they are perceived as ineffective for the masses, for monogamy messages for the unmarried, although the church only condones sex within marriage, and for condom messages although condoms are perceived to promote sexual activity outside of marriage.

The need for preventive strategies and methods beyond abstinence is evident for this population. The potential of the Black church to act as an effective educator, first of all by providing an accepting environment for PLWHA, is also evident. However, the ability of the church to modify its ideals for sexual attitudes and behaviors, and to respond to people's real situations with comprehensive education and resources, remains a challenge.

Third contradiction: *Forgiveness of sin offers a safety net that can encourage people safely engage in sexual behaviors, but forgiveness doesn't prevent HIV infection.*

While no church leaders or congregants in this study condone sexual activity outside of marriage, all acknowledge that extramarital sex does occur among people in the church. Although it is not possible to assess church members' exposure to prevention messages from other sources, it is clear that the churches represented in this sample have limited their promotion of prevention innovations beyond abstinence, and that even abstinence messages are usually not given within the context of HIV prevention. In other words, congregants are engaging in behaviors that can facilitate HIV transmission without full knowledge of the associated risks or how to prevent transmission among those who are sexually active.

Particularly in the absence of comprehensive prevention education, risky sexual activity can easily magnify HIV risk. Currently, however, church discussions about extramarital sex place it solely within the context of sin. Although the goal of these discussions is to convince participants to avoid sin,

respondents indicated that church members sometimes engage in extramarital sex and then rely on the forgivable nature of this sin. This framing of unsanctioned sex as forgivable sin, that can be forgiven, associates risk behaviors with a phenomenon that can be overcome—sin—instead of an incurable disease: HIV/AIDS. When those who engage in illicit sex identify sin as a forgivable condition, they may be fostering a false sense of security about their risk behaviors and thereby decreasing their motivation to reduce, stop, or alter these behaviors.

According to respondents, church members are failing to receive full prevention messages, properly prevent disease transmission, associating extramarital sex only with sin, and being falsely secure in the belief that unsanctioned behavior can be forgiven. Therefore, it is reasonable to conclude that non-abstinent, non-monogamous congregants of churches that do not conduct discussions of sexual risk for HIV/AIDS or offer full HIV prevention education are heightening their risk for infection.

Fourth contradiction: *Churches should love and support PLWHA, but the ideology of fault and blame (based in part on assumptions about how a PLWHA contracted the disease), limits the ability to love.*

Church theology challenges members to love everyone without reservation or judgment. However, respondents described the church's frequent difficulty with loving and thereby supporting people infected with HIV/AIDS. In addition to the negative symbolism of HIV/AIDS within the Black Baptist constructions of assumed behaviors, knowledge, morals, spirit, and experiences,

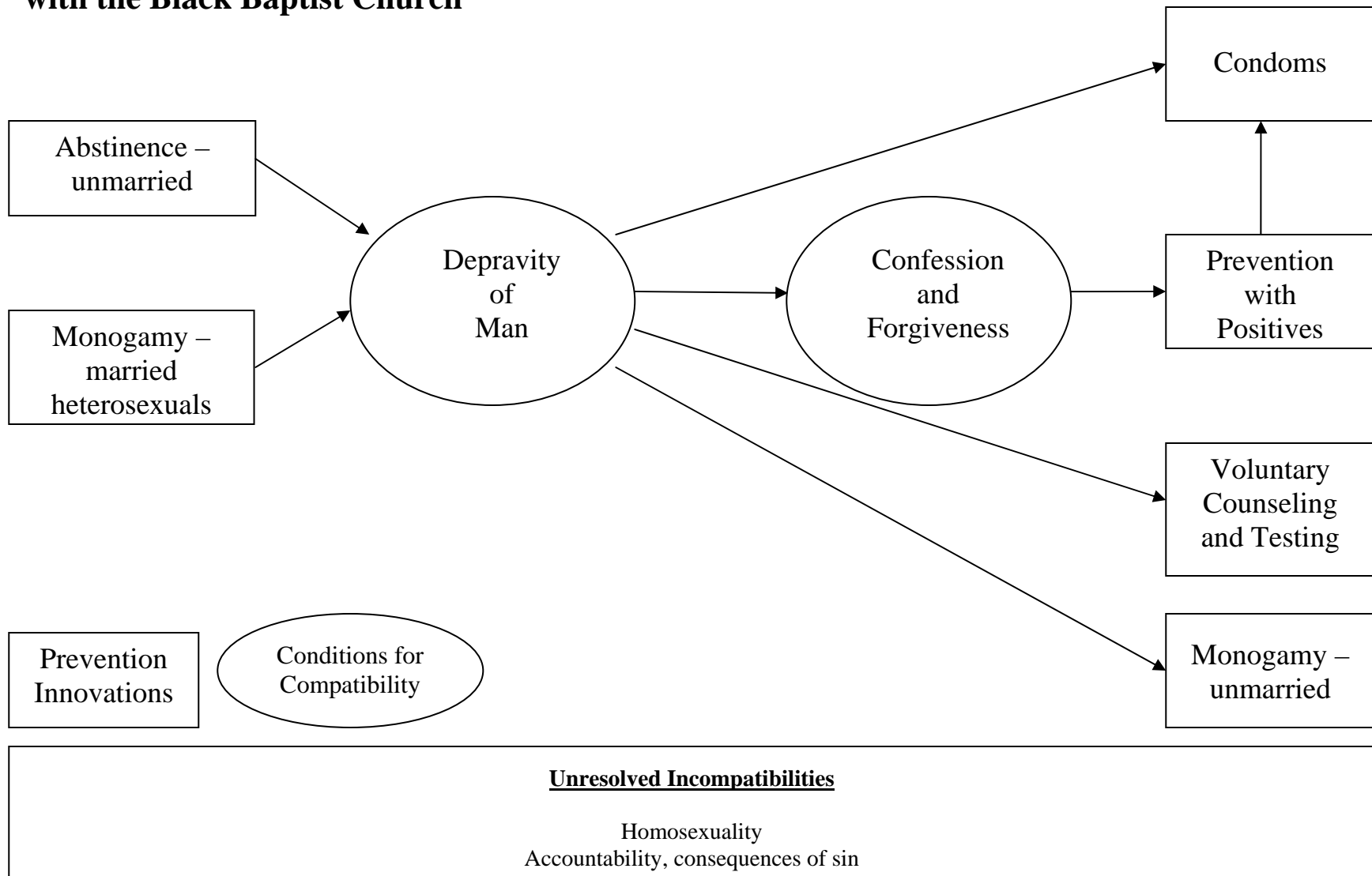
judgment is also imposed upon PLWHA, their families, and their friends. This judgment stems from the images that HIV/AIDS project for this population as well as the judgments associated with how the disease is assumed to have been contracted. When HIV is contracted through situations assumed to be blameless, such as birth, rape, or nonsexual contact with contaminated blood (e.g., transfusion), church members are more able to extend the necessary love and support. However, when HIV is contracted through behavioral choices such as non-marital sex or intravenous drug use, blame overrides the theological command to love; individuals and churches typically respond with criticism and ostracism. Given that churches frame behavior and conditions largely in absolute terms, application of these absolute standards to the church's commanded behavior to love—especially through action—results in a disconnect when the church is unable to extend love to people whose behavior has transgressed absolute boundaries. More churches should recognize and enact the mandate to receive and care for anyone who is suffering, regardless of the cause.

It is possible to apply each of the 5 prevention innovations within the Black Baptist church (See Figure 2). In order to successfully adopt these or other innovations, however, church-based HIV prevention would have to meet the challenges of reconciling theological and socio-behavioral constructions of prevention, as well as of merging the strategies suggested by both perspectives. The gap between the two is greater for some innovations than for others—particularly condom use, with which a theological interpretation is not currently associated. Bridging the gap can be accomplished by merging non-competing

concepts within church contexts, or through linkages such as referrals and collaborations. The resolutions found for some of the most significant points of incompatibility, which lie in defining and balancing desired outcomes from the perspectives of both public health and theology, would inform the adopted strategies.

From a public health perspective, prevention outcomes emphasize the avoidance of disease transmission, whereas the Black Baptist theological perspective emphasizes the avoidance of sin. At this time, public health intervention models do not capture either the nature and concept of sin or the associated concepts of moral accountability, consequences, and conditions for forgiveness. From their perspectives as church leaders and congregants (i.e, theologically driven beings who live in a secular society), this study's participants are sensitive to the dilemma of how to reconcile church doctrines and Biblical principles with a scientific evidence base in order to help congregants and others avoid HIV/AIDS. The next chapter presents data about participants' ideas on how to maximize the transferability of HIV prevention innovations to Black Baptist churches, while minimizing conflicts in compatibility.

Figure 2: Integration of HIV Prevention Innovations with the Black Baptist Church



CHAPTER 6

Defining HIV Prevention Within the Black Baptist Church

This chapter reports findings related to this study's third aim:

Aim 3: Explore participant-driven HIV prevention models and strategies.

Results were derived from study participants' discussion of potential points of compatibility and movement that would help the field of public health and Black Baptist churches to co-construct new HIV prevention models. These points are:

- 1) the church's evolving, self-defined role within African American communities;
- 2) organizational and leadership patterns within the church; and 3) programmatic considerations.

The Church's Role in Addressing HIV/AIDS

A: But the Black church is still the most important thing for we people of color...because it takes us back to our roots... Unless you know where you came from, you can't go anywhere. [Urban Pastor, Small Church]

Although study participants agree that the Black Baptist church has historically been an essential, incomparably influential institution within the Black community, they also note shifts in its emphasis and relevance that impact its present ability to respond to HIV/AIDS. Participants specifically described a conflict between the role that congregants want their churches to play in leading

a community response to HIV/AIDS and how they see their churches actually functioning.

Issues of Relevance. Participants view their churches' lack of response to HIV/AIDS as symbolic of a larger concern about the church's inability to remain relevant to their communities and to the lives of congregants. They acknowledge the church as historically central to their community, but also they identify several factors that have diminished its relevance to the multi-faceted lives people lead today, one facet of which is the possibility or reality of HIV/AIDS. One group of young, urban females described this shift:

I think we're getting out of the era where the church is the primary source for the African American community. We're dealing with generations of people who could care less about the church. The church is not relevant to them anymore...There are a lot of churches that are still trying to do 1970's and '80's ministries when in 2008 you can't do it. [Urban Female Focus Group, Ages 25–34]

The following were cited as contributors to the church's diminishing relevance: 1) lack of response to a spectrum of community issues that extends beyond the spiritual; 2) geographic dispersion and limited connectedness among pastors and congregations; 3) declining involvement of young people; and 4) an organizational structure for decision making that has become more complex.

Limited spectrum of issues. Although they recognize that the primary missions of the Black Baptist church are to convey God's teachings, facilitate salvation through acceptance of Jesus Christ, influence people to join the church, and to demonstrate love and compassion, many respondents nonetheless recognize the church's failings in responding (as an institution within a larger community) to members (as entities within congregations) who have diverse,

legitimate needs that include but are not limited to the spiritual. These needs include issues with social and political implications. Participants look to the church for guidance and information on holistic issues, but find a dearth of resources about issues that are outside of the theological or moral boundaries set by the church. For many, HIV/AIDS is only one of several issues that affect their community but that their churches do not effectively address. According to one group of women:

[I]t's past time that the church go back to being a stronger pillar of the community and...when we talk about church, we don't want to talk about HIV. We don't want to talk about politics, but all of these things make up our community: the political, the social, the financial. [Urban Female Focus Group, Ages 35–54]

Respondents noted that churches have been able to address health issues such as heart disease and obesity, but have largely avoided topics directly related to HIV/AIDS risk that are traditionally taboo, such as sexuality, teen pregnancy, sexual orientation, and domestic violence.

At the same time, participants are aware that the one issue increasingly emphasized by pastors is money. They become concerned when their pastors focus on issues related to prosperity, which many congregants view as a distant reality. Overall, participants are well aware of the Black Baptist church's history of engagement with community issues such as education and civil rights. What alarms them is the shift in focus of the church and its leadership to practices and issues that they perceive as irrelevant to their everyday lives.

Geographic dispersion of congregations and reduced connectedness among pastors and congregations. Participants noted that, in the past, pastors

would live in the communities/neighborhoods where their churches were located. This geographic and personal immersion both connected pastors to, and informed them about, the daily life issues of both the general community and their particular congregants. In current times, however, participants are aware of the growing trend of pastors living outside the communities or neighborhoods that they serve. The consequences for pastors who commute to their churches only for Sunday services and specific evening activities during the week include social distance and disconnection from the daily lives of their parishioners. As interpreted by some respondents, the motive is preference:

Preachers don't want to live among their parishioners. They want to live on the outside. They don't know what's going on in the community. They have to read it in the paper. They don't walk their community anymore. [Female Focus Group, Ages 35–54]

Other respondents attribute the diminishing relevance of the church to the geographic dispersion of congregants. They described the disappearance of neighborhood churches, whose members were immersed in one another's lives and experiences. Members of today's churches, by contrast, reside in a variety of communities or neighborhoods. Although commuting and communing regularly for specific church services and activities, study participants noted a diminished sense of connectedness, required to encourage congregants to meet one another's pressing needs. As one pastor described:

[P]eople just don't honor fellowship and enjoy one another like they did and we are spread out more now than we ever was, especially we people of color. It was once we were so closely knitted until the one at the far end of the street hurt, the one on the other far end of the street was hurting just as bad, but now we so spread out and we just don't have that close fellowship...basically the only time we really fellowship with each other is that few hours we be together on

Sunday. And sometimes they'll come back for Bible study...it's good now yet it's bad because it spreads us out so much. But the thing of it is we just don't have that closeness that we used to have. [Urban Pastor, Small Church]

Lack of youth involvement. Participants are particularly concerned by the diminishing relevance of their church to younger generations, who they consider to be the most vulnerable to HIV/AIDS. However, their churches offer few programs to engage youth or opportunities for youth involvement in planning church activities. One group described the probable impact of this situation:

They won't let the younger folks do but so much in the church, they say the young folk are the people of tomorrow but if you don't give them nothing to do today, they ain't going to be there tomorrow... A lot of churches won't let the young folks use their gift and talent and they're going to go somewhere where they can use it and that's why a lot of churches are not growing... [Urban Male Focus Group, Ages 35–44]

Participants indicated that churches not only lack youth involvement in church activities, they also lack focus on programs that are relevant and engaging to younger generations, which would include issues of HIV risk and prevention. Hence, young people could choose not to remain involved in church activities and ultimately to miss opportunities for HIV prevention messages offered through the church. According to one woman:

[I]t's sad because they [churches] sit up there and focus on old peoples' ministry... You know I have a daughter that's getting ready to turn 21 and she's like Well, Momma, what about our ministry? What about us? [Affirmations.] And then you know I mention that to my pastor. He says Well, it's coming. She said Well, by the time it comes, I'm going to be gone... She said, There's nothing for me to come back to... [Urban Female Focus Group, Ages 35–54]

If church activities and leadership involvement could be reoriented toward youth, respondents believe that the programmatic focus of the church would naturally expand to include HIV/AIDS and other issues relevant to these populations.

More complex organizational structure for decision making. Some participants discussed the impact of the increasing complexity of church organizational structures on the ability of churches to respond to social issues, including PLWHA. To introduce new or potentially controversial programs to their churches, study participants described having to navigate progressive stages of approval that often discourage program proponents from introducing their ideas. Respondents who compared this situation to a negative feature of secular institutions described their church as “operating like the world.”

Churches’ multi-layered organizational structure also affects pastors’ accessibility to parishioners, and by extension their ability to communicate with their congregations about issues of importance and concern. Because pastors often have limited time and competing priorities, they were described as more likely to accept a new idea or ministry when there is sufficient congregational support or a champion to make it operational. Difficulties with relaying an idea or program to the pastor so that he can voice his support were cited as contributors to the diminishing relevance of the church. According to one pastor:

[W]e live in an age now where pastors want to not be accessible to people. And they want you to go through a lot of red tape to get to them. And I’m thinking it’s because they want to feel important.
[Rural Pastor, Large Church]

Barriers to engagement. According to their conceptualizations both of HIV and of the church’s role in addressing the condition, respondents defined

numerous types of barriers that inhibit the Black Baptist church's engagement in HIV prevention activities. These include: 1) *time limitations and competing priorities*, 2) *congregational and organizational characteristics*, 3) *pastoral/leadership characteristics*, 4) *risk acceptance and admission*, 5) *the veiling of HIV and associated risk behaviors*, 6) *conflicting theology*, 7) *frameworks of disparity*, and 8) *forced accountability*.

Time/Competing Priorities. Respondents portrayed their churches as epicenters of demands by Black communities for social, educational, political, financial, and, of course, spiritual support. Pastors and leaders across churches discussed the strong negative impact of time limitations, due to multiple, competing priorities, on adding HIV prevention to their responsibilities. Even for churches that have identified HIV-related activities as a need, the necessary time and resources are often already allocated to other issues that are traditionally defined as more salient and immediate. In addition, pastors and church leaders are cognizant of time limitations as a barrier for congregants to participate in HIV-related activities. One pastor described the busy lives of his congregants, who daily balance the daily responsibilities of work, caring for family members, and social obligations:

I don't know how it is in yours [the interviewer's church]; when the person says Amen, it's like if you have family you're probably rushing home to get to dinner and all that. And so there's no time really to share and I think that our lives generally are on a roller-coaster where we're just like running to do the next thing... [Urban Pastor, Large Church]

Most respondents agree that their church has a role in preventing HIV transmission but also agree that this is not the church's central role or function.

Therefore, when time and resources are constrained, HIV prevention is less likely to surface among the priorities to be addressed.

Congregational/organizational characteristics. Organizational characteristics of a church, as well as the individual characteristics of a pastor, affect the level of that church's responsiveness to HIV. Organizational characteristics include: 1) *median age of the congregation*, 2) *mission of the church*, and 3) *ability to work in gray* (e.g., undefined) *areas*.

Age of the congregation. Respondents routinely referred to the median age of a congregation and the association of advanced age with models of traditionalism as predictors of church involvement in HIV prevention activities. Churches whose membership is older on average were described as less likely to engage in cutting-edge or controversial issues, including sex and HIV. Not only are these churches perceived as avoiding sensitive or controversial topics, they are also unlikely to address any area that cannot be directly linked to God or the Bible.

The old mindset. [Affirmations.] The old way of thinking that you shouldn't be teaching people about condoms and all of that. They should be focused on the Lord and all of that. [Rural Female Focus Group, Ages 25–34]

Mission of the church. As is common when any group of people are organized around a specific issue, belief, or activity, church initiatives are guided by both formally established mission statements and less-formal organizational cultures. Respondents discussed how some churches focus on strictly interpreted theological mandates while others expand their interpretations of church mission to include topics such as health, social causes, and politics. The

latter tendency is usually guided by the ability to connect new initiatives to messages in the Bible. As one urban leader stated:

No, it [HIV prevention] hasn't been preached from the pulpit and I don't think it will because I have trouble finding it in the Scriptures.
[Urban Leader, Large Church]

According to one pastor, churches whose missions already include social activism or community engagement will be more likely to participate in HIV prevention activities, as well as other causes that cannot be strictly defined as theological. This expanded view of Black churches' roles in society at large, but particularly in African American communities, better captures functions related to HIV and other issues that affect the fabric of all communities. Most respondents deemed churches that are unable to connect their messages and activities to the daily lives and current issues of congregants, particularly younger populations, as irrelevant—both in function and purpose. However, these respondents initially conceptualized HIV risk as an issue for young people, whereas many Baptist churches are mostly comprised of older people. Given the widespread association by pastors, leaders, and congregants of HIV risk with youth, the failure of church agendas to routinely include HIV/AIDS-related activities can be attributed to the disease's perceived lack of relevance.

Inability to find middle ground/operate in the gray areas. Another key organizational barrier noted across respondents is the assumption that a wide range of HIV prevention innovations cannot be co-implemented. These respondents indicated that most people conceptualize HIV prevention along a continuum, with abstinence-only models at one end and comprehensive

prevention education at the other. The majority who favor promoting HIV prevention identify abstinence-only as the gold standard of prevention innovations, but also recognize the value of other models. Based on the Black Baptist church's theological limitation of sexual activity to the context of marriage, members will inevitably conceptualize some points on the continuum as mutually exclusive. When inferred as an organizational characteristic of churches, this inability to operate within "both/and" frameworks in favor of only and strictly "either/or" scenarios creates both a context of inflexibility and an inability to respond effectively to complex issues. Respondents who see Black Baptist churches as particularly unable to find middle ground or points of compromise on issues related sexual activity and HIV prevention conclude that the gold standard would be diluted if churches were to try to expand their philosophy, and, consequently, that the church's ability to reach people would be reduced.

A lot of times what happens with Christians and what happens in the church is we have a very black-and-white view of everything [Affirmations.] and there's no gray area for anybody. So what happens is...either they're right or wrong. We find no way to compromise and not that we should be compromising in our beliefs, but the only way we're going to win people over is to learn to accept people where they are. [Affirmations.] You can't clean fish until you catch them and you've got to catch them first before you clean them. [Urban Female Focus Group, Ages 25–34]

Pastoral/leadership characteristics. Pragmatically, organizations are not only a function of the collective culture that produces them but also of the individuals who comprise them. Along with identifying organizational barriers to HIV prevention engagement, respondents also listed pastoral and leadership characteristics that affect innovation adoption. These include: 1) *the scope of*

practices engaged in by church leaders; 2) the length of time the pastor has been in his post at the church; and 3) the pastor's perception of the need for him to conform with congregational preferences.

Scope of practices of church leaders. Developing and collaborating on prevention initiatives requires content knowledge and a base of applicable skills to be effective. Some rural respondents feel that their churches' leaders are inadequate, both in quality and quantity, to address HIV prevention. Similarly, church leaders perceive that the information sufficient to recognize HIV as a salient issue and the skills to know how to properly address it are lacking in their churches.

Pastor's length of time at the church. Participants reported that the length of time a pastor has been leading a church significantly influences his ability to initiate HIV prevention activities. Because sex and HIV are controversial topics within the church, pastors must have an established relationship of trust and respect with their congregations before they can introduce new or cutting-edge ideas. Similarly, a congregation needs to be confident in its trust of their pastor's leadership, wisdom, and theological solidity before following his lead on new programs. These necessary qualities usually increase over a pastor's tenure in and shared experience with a congregation. One pastor described how this process of conformity with and support for a pastor's ideals develops:

[O]ver a period of time...the church becomes like its pastor. It takes on the identity of its pastor... And his attitude and his mindset is continually being placed into the people so when I say I don't have any problem with that [introducing an HIV prevention innovation], I've taught my people long enough and they know that if

I don't have any problem with it, they're not going to have any problem with it. [Rural Pastor, Large Church]

Pastor's conformity with congregational preferences. Because Baptist churches operate with congregational autonomy, each church has the authority to initiate and terminate its pastor's employment. In acknowledgment of these conditions, many pastors do their best to oblige the wishes of their flock (deviations can and do result in dismissal). This was particularly a concern of some rural respondents. However, some respondent groups gave less credence to the possibility of a pastor being ousted, believing instead that pastors and leaders would be more concerned about the possibility of church members becoming upset enough about HIV prevention messages to leave the church, which in turn would have a negative effect both programmatically and financially.

Risk Recognition and Admission

Part of the decision to engage in HIV prevention activities within a church entails the recognition of risk within that congregation, or at least recognition of the potential for risk. Both the recognition and admission of risk are formidable challenges for churches that do not condone sexual activity outside the context of marriage. In fact, recognizing or acknowledging risk are considered the same as admitting that a church's current teachings and strategies are not completely effective. Although Black churches admonish the unmarried to avoid sexual activity, all respondents acknowledge that this group does engage in it. This acknowledgment does not mean that such activity is associated with increased HIV risk, however. One leader opined that church members find it easier to

pretend that they are without risk than to acknowledge the reality of risk and receive the education to reduce or prevent it:

[T]he people, if they have a need or if they're out there allowing themselves to be in situations where they could be taking risks, they're not going to tell you that they're taking risks...it just seems so much more palatable to pretend that that's for everybody else, not for me. I think it's a culture that we, you know, where everybody wants to look like they're doing everything right. [Urban Leader, Large Church]

The disconnect between church members' recognition of risk and the realities of their sexual behaviors allows them to dissociate from the reality of HIV/AIDS as well. Despite their own risk behaviors, those who are not HIV-positive view the virus as irrelevant to their life's context and as "somebody else's problem." To complete the cycle, these members' dissociation from HIV risk helps them to avoid risk admission and also to allay the fears associated with the possibility of being HIV positive. By separating nearly all discussions and activities related to HIV risk from the contexts of church and church membership, churches have created a prevailing silence around HIV.

Fear of risk admission clearly augments church members' fear of risk recognition. Some respondents are reluctant to participate in church-based HIV prevention activities for fear that participation would be an outward admission of personal HIV risk behavior, positive HIV status, or HIV-positive family members or loved ones. And if the combination of stigmas associated with HIV/AIDS and fears about admitting behaviors deemed unacceptable by the Black Baptist church would keep congregants from participating in any church activities associated with HIV, church leaders would be less inclined to offer programs.

In any organization, leaders are instrumental in modeling behaviors and creating impetuses for new ideas. As the organizational head of a Black church, a pastor has the ability to educate through sermons, Bible study sessions, and personal testimonials. Although pastors said they often share personal stories about their experiences with other health conditions, it is difficult for them to convey their sexual experiences and how they have overcome the risks associated with HIV and other STDs. However, such examples are seen by congregants as an essential part of moving churches into HIV prevention. Without leadership testimonials, it is more difficult for congregations to normalize messages about risk, HIV/AIDS, and prevention.

Black Church pastors are also unlikely to speak to their congregations about sexual risk behaviors they have personally engaged in because such stories may negatively impact their reputations as religious leaders. Some respondents did cite the importance of pastors' personal experiences to normalizing risk recognition and admission within congregations; however, they also feel that sensational media coverage of some pastors' marital infidelities and non-marital partnerships has diminished all pastors' status and credibility, both of which are necessary if pastors are to effectively teach their congregations about avoiding risky behaviors. Therefore, to reduce the potential of being viewed as hypocrites, pastors refrain from sharing their stories.

Veiling of HIV and Associated Behaviors

It's [HIV] like the elephant that's in the room. Everybody knows it's there. Everybody knows it stinks. Everybody knows it's big and it's sitting over in the corner but nobody talks about it. [Urban Female Focus Group, Ages 25–34]

Congregants named the silent, veiled nature of sex within the Black Baptist church as one of the largest barriers to addressing HIV and prevention there. Sex and sexuality have long been taboo topics; moreover, based on their association with HIV/AIDS, both are currently relegated to the quiet corners of this institution. For many church members, HIV is associated with a specific realm of sexuality: same-sex partnerships. Homosexuality was often categorized by respondents as *the* unforgivable sin for the Black church; many conceptualize it as the root cause of HIV. Due to beliefs that same-sex partnership is a sin so grave as to be unaddressable, and that the very existence of HIV is a result of that sin, the silence that shrouds sexuality within the Black church has been extended to HIV.

Some women respondents raised another taboo topic that is denied an open forum in church environments and is, ironically, also associated with HIV risk: domestic violence. Respondents clearly stated that church leaders and members often pretend to be unaware of domestic abuse situations and that if they are aware, they still don't talk about such situations openly.

In sum, the silence that surrounds HIV/AIDS in Black churches is mingled with the shame and taboos associated with sexual behaviors in general, as well as with homosexuality and domestic violence specifically. This shame and silence are perpetuated when loved ones living with HIV/AIDS are shunned by

their families and/or hidden from public discussion—even after death, when families conceal the cause of death from friends, relatives, and fellow congregants. In respondents' communities, drug use—particularly the kinds that are associated with poor, unglamorous lifestyles—is an additional cause of embarrassment and unsympathetic judgment. The Urban Female Focus Group, Ages 25–34, contributed these remarks:

R2: And it's very rarely people that are in church will openly confess [Affirmations.] that, that they have HIV/AIDS...because they are not in an environment where it's comfortable... People are comfortable coming up and saying I was diagnosed with cancer. Please pray for me. I was diagnosed with diabetes. Please pray for me... Probably [in] most congregations at least one person is suffering with [HIV] but it's not an atmosphere to come up and just say that because you don't know how you'll be treated.

R3: I think people are probably more comfortable coming and saying I smoke crack than to say, [Laughter.] you know, than to say that I have HIV because it's just like Oh well if you smoke crack you can get over that but if you have AIDS...we can't touch you or, you know, that kind of thing.

The taboo nature of HIV/AIDS discussions conceal other assumed, unsanctioned sexual liaisons as well. Respondents believe that confronting HIV and sex would force churches to confront heterosexual behaviors among congregants that are also risk factors for HIV infection but have been less stigmatized and openly criticized in the church context. According to some urban respondents, if churches were to criticize homosexuality in the context of HIV risk, they would also need to admit and have open discussions about various other types of premarital and extramarital sex that are perceived to be common in churches (e.g., single or married women who enter into sexual partnerships with married men, pregnancies that occur outside of marriage, and unmarried

people who have sex). If equivalent sexual risks among heterosexuals were to be exposed, some congregants believed that the sexual activities of homosexuals would become less demonized and that HIV would be discussed as an issue that concerns all people, regardless of sexual orientation. Many church-based stereotypes about same-sex partnerships, including that homosexuality is the cause for HIV, would lose merit when those same behaviors are revealed in heterosexual partnerships.

Church teachings. The teachings that permeate Black church culture can also stifle engagement in HIV prevention. Respondents indicated that many pastors emphasize financial wealth and prosperity, probably as a way to empower and uplift African Americans in a society that is permeated with institutionalized racism and wherein communities of color face continual hardship. However, this emphasis is also seen as avoidance of other relevant issues, some that are even more dismal than poverty. Avoidance of HIV/AIDS is not considered to be as attractive a topic as prosperity; moreover, open discussion about it would require difficult acknowledgements and spawn uncomfortable debates about topics on which the church has been silent.

One teaching within Black Baptist churches is that of “claiming” or “not claiming” a situation or illness as a key determinant of an event taking place. Some respondents recognize that not claiming sero-positive status places PLWHA at risk for transmitting their infection, and also supplies a rationale for church leaders to avoid addressing HIV prevention. In short, respondents feel

that by not claiming the presence of HIV in African American communities, individuals and churches are allowed to maintain the present climate of silence.

And denial will mess you up in any situation for illness of any kind, blood pressure, diabetes. If you in denial then it will control you but if you go ahead and accept the fact that you can control it, but you got so many church folk, not Christian but church folk that [say] uh, I ain't claiming this and that. You just have to get real. If you got it, you got it. If you don't, you don't. Now you can walk in your Divine healing if you have it because God, He can cure all diseases. But see you got so many people that's in denial, I ain't claiming this and I'm not claiming that in the church. [Urban Male Focus Group, Ages 35–44]

HIV/AIDS Prevention Education from Black Baptist Church Perspectives

Despite study participants' overwhelming agreement that changes and barriers within the Black Baptist church have reduced its ability to holistically address and remain relevant to the complete lives of Black people, they still harbor a strong, underlying desire for the church to become more engaged in social and community issues. In other words, although not all Black Baptist churches are ready to address HIV/AIDS prevention, all can address related socio-cultural issues: there are non-HIV-specific innovations that the Black church could implement to help prevent HIV/AIDS. Based on the ideological purposes and functions of the church, respondents feel that, with the proper resources and public health assistance, it could become a complementary source of HIV/AIDS prevention activities, including education and support.

Most respondents understand HIV/AIDS as symbolic of other societal problems that the Black Baptist church could take the lead in addressing. To strategically meet the holistic needs of congregants and the community at large,

and also reduce the spread of HIV/AIDS, respondents suggested that Black Baptist churches: 1) develop explicit missions and ministries that incorporate social, political, and educational welfare; 2) seek collaboration with non-traditional partners, such as mental health organizations and financial counseling services; and 3) create consistent, ground-level, community presences in African American communities. As some particularly thoughtful comments noted:

Black churches need to get away from their sheltered life and go out into the community, find out what disease, what poverty level, what housing problem, anything that's hurting that community around the church they should be involved in... If we see people passing away and that's not how God wanted us to do because He stepped out there. He helped everybody that asked for his help. [Affirmations.] And we ask for His help in being Christian so we have to pass that message on. [Male Focus Group, Ages 35–44]

Respondents consistently discussed aspects of current-day Black family structure and dynamics that they perceive as fueling the spread of HIV/AIDS in African American communities. At the same time, they recognize that strengthening the Black family is core function of the church. As explained by one pastor, due to the routine participation of family units in churches, the success of one increases the success of the other:

[T]he church is made up of homes, families. And so goes the family, so goes the church; it's a kind of reciprocal relationship and if you have weak families you're going to have weak churches and vice-versa... And consequently the solidness of the home and the church will create concentric circles of strength in terms of the larger communities of the world. [Rural Pastor, Small Church]

Respondents' specific suggestions about how the church can build and support Black families include: 1) parent communication training; 2) help and guidance specifically for Black males; 3) help with couples' relationships; 4)

promotion of dialogue about sex, spousal abuse, sexuality including same-sex relationships; 5) opportunities for family engagement; and 6) help and guidance specifically for non-traditional/non-familial support networks.

Because most respondents consider HIV/AIDS risk to be of particular concern for youth (as previously noted), creating prevention programming for this group would be compatible with church doctrine. Such youth-focused strategies could include: 1) building self-esteem and confidence; 2) creating long-term extracurricular activities; 3) monitoring their exposure to sexually charged media; and 4) involving them in key decision making. The implementation of more youth-focused programs would also improve that group's perception of church relevance and thereby increase the number of young congregational members.

Much participant discussion centered on the urgency of filling the moral vacuum left in Black communities by the deterioration of Black families. Currently, respondents rely on the church as the institution that they trust for moral guidance. They expect the church to establish and promote standards regarding sex and sexuality, particularly when morals are not being taught within the home environment. As one pastor explained:

[T]he church I believe very strongly must somewhat compensate and fill that moral vacuum that is left in the home... We haven't been as active and aggressive as we ought to be in spreading our message, which is a message of morality, which entails to some degree abstinence. [Rural Pastor, Small Church]

As previously discussed, many respondents conceptualize HIV as a moral issue that results from immoral choices and behaviors. The church could take advantage of this conception to promote HIV prevention behaviors and choices

that fit with its moral doctrines. Moreover, the moral authority of the church could be used to address emotional outcomes of engaging in HIV risk behavior, such as guilt and shame, and social outcomes such as ostracism by fellow church members. Health and human service agencies would be poorly equipped to address the latter.

There are also HIV-explicit ways that the Black Baptist church could help prevent HIV/AIDS. In churches that are ready to directly address the issue, creating a sense of ownership of the problem would be a first step. This would require reframing the condition as a growing threat to Black communities and church members; presenting it as an inseparable combination of spiritual, physical, and mental components; and naming the church as an essential partner in fully addressing it. Churches would also have to take the lead in declaring that HIV/AIDS is an illness to which all people are susceptible, regardless of their spiritual, moral, or mental state. These approaches would usefully set socio-behavioral perspectives within the church's salient, essential theological mandates.

Respondents are aware that the Black Baptist church already has many strengths and assets that can be used in the service of HIV/AIDS prevention, particularly from a theological perspective. At the same time, they recognize the disadvantages of expecting a church to address HIV prevention by itself. To increase the range of HIV prevention options and their medical credibility, respondents suggested that churches consider partnering with organizations that provide HIV/AIDS-specific services, and that services be offered within churches

as well as referred by churches to partner agencies. These partners could include private medical practices, health departments, and case management organizations.

Respondents unanimously support the use of comprehensive HIV prevention innovations within the Black church. Because they fully recognize the magnitude of HIV/AIDS and the centrality of the church in the life of African American communities, respondents strongly approve of HIV prevention messages that promote abstinence as the primary innovation, followed by the other four prevention innovations. Abstinence messages could explicitly refer to HIV/AIDS, but also to spiritual discipline and purity. Monogamy messages would be best communicated by churches, when designed for married couples. By contrast, messages about condom use could emphasize referral to local distribution sites. However, to reach populations that the church views as particularly vulnerable to temptation, condom messages could also be communicated through male and youth auxiliaries. Messages relative to PwP could focus first on shifting congregational perceptions of HIV, increasing the general knowledge base about HIV/AIDS, and improving perceptions of PLWHA (the latter could be augmented by outreach ministries to PLWHA that would provide specific services). Messages promoting VCT could be accompanied by referrals to partner agencies or on-site administration, according to individual churches' preferences. Even when on-site VCT would not be provided, respondents expressed willingness to provide the necessary information and referrals to congregants and community members.

HIV Prevention Model Programmatic and Logistical Recommendations

Teach from the top down and lead by example. Within Black Baptist churches' decision making structures, pastors and leaders are central determinants of congregational programs. Moreover, as previously mentioned, congregations with long-time pastors tend to take on the personality of their pastor. It will therefore be essential to at least gain pastors' approval, although active collaboration would ideally underly pastoral modeling of voluntary engagement in HIV prevention. The advantages of gaining pastoral approval and influence for encouraging congregants to become involved in HIV prevention cannot be overstated:

I think it's going to take a lot of pastors. People look to their pastors and how most of the time how their pastors react to an issue is the way they respond to an issue. [Affirmations.] Period. If their pastor is against something and very closed-minded about it, more than likely they will be. So if we can get pastors to become more educated, more open to talk about it and let people know it's not a gay disease, it's not a drug addict disease. It is a disease. [Affirmations.] At this point, uh, it's a highly preventable disease. [Urban Female Focus Group, Ages 25–34]

Clearly, it is essential for the pastor of a given church to endorse and even participate in church-based HIV prevention innovations. In addition, the stage of the pastor-congregational relationship also affects the likelihood of HIV prevention innovations becoming part of church programming. Even pastors who are fairly new may have established enough trust to introduce or endorse nontraditional or historically controversial issues, particularly in more traditional churches.

Utilize auxiliary services as a segue to sermons. Because worship

services are sacred, particularly those held on Sunday mornings, not all Black Baptist churches would be comfortable if HIV/AIDS was addressed during a service or used as the subject of a sermon from the pulpit. Therefore, respondents suggest that the subject be first approached in Bible study sessions and auxiliary meetings and programs, and through co-sponsoring HIV prevention programs at other locations. These forms of participation could segue into Sunday morning worship, where the church's largest captive audience for receiving HIV prevention messages is found.

Capitalize on the strength of churches' volunteer base. As noted by respondents, the Black Baptist church has one of the largest continuous volunteer bases within African American communities, but individual churches often operate with very constrained budgets. Although a church may not be able to allocate fiscal resources to introducing a particular innovation, it can readily mobilize enough person-power for implementation. Such a volunteer base could not only perform the work of the innovation, it could also organize a network of volunteers from several Black Baptist churches for similar endeavors, and to promote acceptance and dialogue more generally. Networks of volunteers across churches could effectively magnify the reach as well as the content of HIV prevention innovations. As a focus group of urban males observed, "You can go a couple of blocks and there's a church on every corner."

Make specific provisions. To alleviate the burden of competing priorities for volunteers and funds, churches could allocate a variety of resources directly to HIV prevention activities (e.g., fiscal and personnel support, identifying a

champion within the congregation or making a specific ministry responsible for implementing HIV prevention activities, and then engaging other auxiliaries and members in these efforts).

Find the best fit. Some respondents indicated that an HIV prevention innovation could best fit within the church as part of a larger program instead of as a stand-alone ministry. They suggested identifying specific auxiliaries perceived to be HIV-relevant. For example, churches that have health ministries or other types of mission groups would be good places to establish HIV prevention. If a church views HIV as a youth issue, youth ministries could be the best places to start.

CHAPTER 7

Discussion and Conclusions

Myriad, significant evidence substantiates the impact of HIV/AIDS upon the Black community and the Black church, and affirms that ongoing, committed efforts to promote the kinds of behavior changes that can effectively address the condition are required from both communities and churches. Current evidence-based intervention models provide strategies for preventing HIV/AIDS, but lack the necessary theological salience for adoption within the Black church environment. These factors, and the findings of this research, not only emphasize the centrality of the church's theological perspectives, they also indicate specific adaptations that can extend the applicability of HIV prevention models within the institution most trusted by Black communities: the Black Baptist church.

Summary of Findings

In this study, respondents conceptualized HIV/AIDS as more than a physical health condition: they interpreted it as a state of human failing that has multiple causal pathways and is grounded in both socio-behavioral and theological worldviews. Within both the Black Baptist church and the Black

community at large, each of these components operates within the context of specific social, cultural, and theological factors.

Respondents framed the Black Baptist church's reluctance to directly address the existence of HIV/AIDS in congregations and communities as the result of the church's general institutional silence around matters of sex, sexuality, and STIs, as well as the church's traditional patterns of response to people who deviate from the church's established norms of sexual behavior. They also viewed the larger community culture, modern media, and normative shifts in Black family characteristics as reducing fear-based adherence to approved behavioral standards, encouraging risky behavior through increased accessibility to risk opportunities, presenting a constant stream of sexually explicit portrayals of Black women and men, and contributing to the deterioration of familial norms,.

Respondents frequently referenced the concept of broken communities, and stated that characteristics such as single-mother homes, absent or negatively modeling males, and lack of access to health care and support resources further exacerbate risk in disenfranchised communities of color. In addition to these community and societal factors that contribute to increased HIV/AIDS risk, respondents described more intimate aspects of sexual partnerships that facilitate risk. These included dishonesty, the lack of safer sex practices, multiple concurrent partners, and non-disclosure of HIV-positive status.

The conceptualizations of HIV/AIDS and risk within Black communities mirror the contradictions in the Black Baptist church debates about the strategies

it should use to respond to those affected by HIV/AIDS. Among congregants, the theological concept of God as One who forgives was declared to create a false sense of security and a disinclination to self-protect from infection, and also to obviate the necessity to adhere to church teachings about risk avoidance through abstinence and marriage-based sex. Both their concept of HIV and AIDS as conditions to be denied at all costs, and their culture of stigmatizing people who suffer from them, underly rampant fears of becoming infected or affected. These community-wide fears, which are exacerbated by inadequate understandings of transmission, have long immobilized positive church responses and fostered negative ones.

However, the social constructions of HIV/AIDS promulgated within church and community can be improved and even reversed by corollary constructions of HIV prevention that are presented in terms of church-supported theology and combine avoidance of sin with socio-behaviorally-based avoidance of disease. As evidenced by the discussions and suggestions of study respondents, construction informs the compatibility of current, evidence-based innovations with church traditions. Each of the 5 innovations has the potential to be applied within Black Baptist church contexts; however, adoption of these or any other prevention innovations must first seek to incorporate, and thereby reconcile, the two dominant worldviews of congregations (the theological and the socio-behavioral).

Public health interventionists overwhelmingly emphasize the socio-behavioral conceptions of HIV/AIDS, and prevention strategies that utilize these

conceptions. Although some of these ideas and plans already fit well within church contexts, participants in this study repeatedly delineated additional theologically based strategies. Of the 5 prevention innovations, they clearly, consistently connected 4 with theological interpretations that can be presented compatibly with their socio-behavioral conceptualizations. Condom use was the only exception. A short summary of respondents' reactions to each of the 5 innovations appears below.

Abstinence was endorsed both socio-behaviorally and theologically as the most effective prevention model. Respondents recognized that the socio-behavioral framework for abstinence includes the avoidance of disease transmission, various individual character attributes, and support systems (interpersonal and institutional). Theologically, abstinence was described by respondents as the manifestation of spiritual purity and a life connected to God and His teachings. According to all respondents, abstinence is both the theological and socio-behavioral standard for the unmarried; however, few respondents believed that this standard can be achieved by many people or sustained over extended periods of time.

Although respondents unanimously validated *monogamy* as both a socio-behavioral and theological prevention strategy, they were also very aware of the limitations that church-based audiences would place on it and that it can be used as an excuse for circumventing responsibility for sexual activity. Theologically, the Black Baptist church considers monogamy to be a compatible innovation primarily for heterosexual married couples, particularly within the framework of

cultivating and maintaining such relationships so that partners refrain from extramarital sexual activity. From the socio-behavioral perspective, this framework is also appropriate for same-sex and unmarried couples but is highly incompatible with the theological concept of sex outside of marriage as sinful in all cases, as well as with the theological construction of homosexuality as sinful in all cases. These conflicting interpretations set up one of the biggest contradictions reported by respondents: they recognized the preventive power of monogamous partnerships, but also recognized that the intended church-based audience for this message would largely be composed of people whose sexual activity is deemed sinful by the church. Almost all respondents recognized that the problems with implementation created by this contradiction would be some of the largest, if not the largest, caused by any HIV/AIDS prevention innovations that Black Baptist churches might adopt.

Because it is not currently linked to a theological conceptualization by the Black Baptist church, *condom use* initially appears to be antithetical to church-based contexts and has been discussed as such in other literature.[58] However, through their recognition of the depravity of Man, and their desire to respond compassionately to the innately imperfect nature of humanity, some respondents stated that they have reconciled the absence of a theological basis for condom use with the socio-behavioral urgency of preventing disease transmission—particularly among PLWHA. Respondents also recognized that some churches may find it impossible to resolve the incompatibility between theological perspectives and socio-behavioral realities. Nonetheless, most respondents

supported condom promotion as a prevention innovation within the Black Baptist church, even if only due to their conviction that many congregants possess limited ability to maintain abstinence. In an attempt to minimize the inherent conflicts of supporting theologically sanctioned sex and responding to socio-behavioral sexual risk, respondents suggested a range of implementation strategies that included church-based instruction about and distribution of condoms as well as church-made referrals to outside or partner agencies for condom instruction and distribution. Some respondents could not envision addressing condom use at all.

Respondents largely viewed *prevention with positives* (PwP) as a theological mandate for churches. As such, they stated that PwP should include both financial and emotional support as well as forums for in-church testimonials and confessions, which would in turn bring about forgiveness and church acceptance for PWLHA. Socio-behaviorally, PwP was also advocated as a strategy for controlling contagion within Black communities and particularly for reducing the risk of infection among the uninfected (largely through *condom use* by PLWHA). In general, resolving the two worldviews was seen by respondents as resting in the significant theological need for PLWHA to confess and seek forgiveness.

Finally, respondents' conceptualization of *voluntary counseling and testing* (VCT) was divided into separate entities, of which testing was viewed as the least plausible fit within the church environment but easily achieved through outside agency collaborations and referrals.

Given the black Baptist church's social construction of HIV/AIDS and HIV prevention, it becomes evident that both the condition and its amelioration are connected to medical concepts as well as organizational and community level factors. Nor was it surprising that respondents described numerous HIV-explicit and non-HIV-explicit strategies for preventing HIV transmission. For churches that are already organizationally and culturally prepared to directly address issues of HIV, study participants recommended that prevention begin with open forums for discussions about sex and sexuality, specific allocation and mobilization of personnel and fiscal resources, and the creation of partnerships with outside organizations to supplement in-church skills bases. Most significantly, as normative, necessary parts of both the church's spiritual mission and the collective church body's holistic daily routine, many respondents strongly supported not only the church's redefinition of HIV/AIDS as a condition but also the expansion of the church's mandate to accept and help those in need to include PWLHA.

Because they acknowledge that not every Black Baptist church will openly and directly speak to HIV/AIDS, respondents also identified non-HIV-explicit strategies that can create contexts for HIV prevention at Black Baptist churches. These strategies included creating auxiliaries and opportunities for individuals to respond to situations occurring within the multi-faceted lives of congregants, re-establishing the physical presence and credibility of Black Baptist churches in Black communities, responding to the specific needs of Black youth, and being

willing to address and promote moral standards that are perceived as protective against HIV risk.

Additional Understandings of the Promotion of HIV Prevention Initiatives by the Black Baptist Church

The results of this study validate reports from prior research about the importance of religion and spirituality in people's lives, and the relationship between religious and spiritual activities and health.[107] Because more than 90% of Americans believe in God or a higher power and 60% consider religion to be very important in their lives, and because 75% of patients surveyed want their physician to incorporate religion with their healthcare, consideration of ways to build synergies between religious activity and health care is essential.[108]

At this time, the structure of health-care promotion models adopted by the Black Baptist church both parallel and intersect the conceptualizations of HIV/AIDS and prevention held by the general population. However, formidable challenges to instituting regular, comprehensive prevention innovations remain; these have been identified in the literature and also discussed in this study. A major barrier is enacted by the strong association between HIV/AIDS and homosexuality in Black communities, as well as the Black church's unwillingness to address issues of homosexual life or to even modify its condemnation.[58]

Several leaders and groups in this study also discussed the matter of congregational buy-in, which is essential if churches are to engage in such historically controversial and taboo subjects. Because Baptist churches operate with congregational autonomy, and are supported by members' tithes and

offerings, congregants can cut off financial support when they don't condone programmatic decisions; this in turn can and does hinder church operations. Although this barrier would be salient in some congregations, most respondents clearly stated that more congregants are supportive of HIV prevention activities in church contexts than is widely known within Black Baptist communities. In any case, all respondent categories acknowledged the need for their churches to engage in some form of HIV prevention.

This expressed desire for engagement is consistent with recent studies in which church leaders indicated interest in, support of, and acceptance of the responsibility for conducting HIV prevention activities within the church.[57, 109] Some leaders in this study were concerned about backlash from their congregants in response to the controversiality and perceived incompatible nature of HIV prevention innovations within their churches. However, the majority of leaders and congregants stated their support for HIV prevention and even for comprehensive prevention strategies delivered through the church. All of the focus groups in this study (a total of 79 people) and 10 out of its 12 interviewees supported prevention models beyond abstinence-only. One urban pastor likened abstinence-only models to telling only part of the truth about sex and HIV prevention.

You have to be real with folk. If you're going to come in and give the half truth than that's not truth at all...it's just a dressed up lie
[Urban Pastor, Large Church]

Although the sense of responsibility for engaging in HIV/AIDS prevention is growing among Black church leaders, few studies prior to this have outlined

specific strategies for Black Baptist churches' engagement in socio-behavioral models within the church's pre-existing theological framework. The gap between the church acknowledging that it should respond to HIV/AIDS, and determining how that should take place, still exists and is still wide. At this time, data about how specific prevention models could be integrated into the theology and doctrines of the Black Baptist church are limited, particularly models that take specific social constructions into account. Interventionists have constructed prevention innovations based on public health conceptualizations of HIV/AIDS and medically defined prevention strategies; however, this approach has neither considered the theological framework within which Black Baptist churches and congregants operate nor treated this framework as an integral part of the broader socio-cultural contexts conceptualized by Black church members.

The findings of this study, by contrast, do inform the necessary modification of current prevention models and also suggest other strategies for HIV/AIDS education and prevention among Black Baptist church members. Similar to prior research, this study examines the necessity of overcoming the multiple time and fiscal restraints faced by churches in order to implement HIV prevention programs,[54, 58] and considers the possibility of adding HIV prevention to other, established health promotion programs.

Studies of the relationship between religion and HIV prevention in other cultures have called for integrating theological perspectives and principles with socio-behavioral constructs. For example, studies have examined Buddhist precepts and health belief models to increase the saliency of prevention

messages,[110] the moral role of Chinese and South Asian religious institutions within the context of prevention needs,[111] and Islamic texts that support safer sex methods, including condom use.[112] One intervention study combined spirituality and preventive health behaviors by utilizing theological concepts that were also found to be instrumental in the Black Baptist exploration.[113]

Margolin et al. developed a spiritual self-schema for reducing impulsivity among HIV-positive drug users using principles of Buddhism, such as doing no harm to self and others (analogous to the Black Baptist emphasis on valuing life and spirit), morality, avoiding sexual misconduct, and the spiritual practice of forgiveness.[113] Each of these concepts is also key to HIV prevention among Baptists. Participants in this study were allowed to freely interpret numerous theologically based moral principles based on their own theological and moral stances, a freedom that emphasizes the importance of emic, culture-specific interpretations and applications of spiritual and theological principles to questions of behavior change.

Previous studies that have considered issues of HIV and AIDS within the Black church have largely focused on the attitudes and opinions of pastors and church leaders while overlooking the influence of congregants' perspectives upon shaping church contexts for HIV prevention programming. This study is among the first to document the overwhelming support that congregants harbor for comprehensive church-based HIV/AIDS prevention and models.

Implications for Future Research

Respondents discussed ways to make the 5 innovations more compatible with the socio-cultural contexts and theological perspectives of the Black Baptist church. Many of these modifications included strategies to address root causes of HIV risk, as well as non-HIV explicit strategies, but whether congregants were aware of linkage between participation in such programs and actually changing sexual behaviors remains unclear. Future studies are needed to test these non-HIV explicit strategies and messages, as well as their effect on decreasing sexual risk behaviors. Future research will also be essential in order to determine which factors can be best modified for inclusion in intervention programs that promote both HIV risk avoidance and the avoidance of sin. Findings from this study suggest that the theological concept of forgiveness may be a salient reason for congregants to go against their theology and engage in risk behaviors. Further study is needed to verify this relationship and to determine whether, as well as how, it can be modified.

Applications for Diffusion of Innovations

One of the biggest challenges to establishing HIV prevention innovations in Black Baptist churches is the adaptation of specific, evidence-based strategies to increase their compatibility with the theological perspectives of these churches. The innovation attributes defined by Rogers's Diffusion of Innovations will be useful for informing the *adoptability* of evidence-based HIV prevention innovations, but more research is needed about how to enhance their

compatibility. Respondents to this study perceived current HIV prevention models as lacking advantage, compatibility, trialability, and observability; moreover, they were seen as prohibitively complex. Rogers's theory defines some innovation attributes; other attributes may predict the likelihood of adoption more precisely. Two attributes that may prove instructive are impact on social relations (i.e., the amount of disruption a potential innovation may cause in the adoptor's immediate social environment) and time required (it is reasonable to surmise an inversely proportional relationship; i.e., less time would mean a greater likelihood of adoption).[114] Future studies will also be needed to clarify other aspects of diffusion. These will include the appropriateness of innovation-development and innovation-decision processes, development of useful communications channels, useful analysis of the nature of the social system, estimation of the extent of change agents, and other factors having to do with organizational readiness.[14]

One specific strategy to increase compatibility would be the development of shared language and meanings among church leaders, members, and public health professionals. Subsequent studies are needed to clarify and define the dimensions of HIV-related language commonly used within Black Baptist church culture (e.g., morality and sin). Given the significant impact of the church's current silence around sex and HIV/AIDS, the identification and development of shared language and meaning will be essential to promote open dialogue and develop prevention interventions.

According to previous studies of other at-risk populations,[59, 115] after basic innovations have been successfully adapted to church culture it will still be

necessary to define and implement facilitators that will prepare churches to engage specifically in HIV prevention. This process will include the development of technical skills and decisions about specific information to offer and distribute, but it will also include helping churches to recognize that church members do incur sexual risk and that such situations require intervention. Respondents in this study recognized that any type of person can potentially be at risk for HIV transmission; however, they also demonstrated a disconnect between their conceptualizations of HIV risk and church membership.

Unfortunately, even if all of the above conditions are met, churches may remain unlikely to engage in HIV/AIDS prevention activities because church culture and life seem to lack relevance to today's congregations, particularly younger members. Creating salience, in and of itself, may prove to be an effective strategy for creating readiness. Utilization of other theoretical frameworks, such as Stages of Change and other organizational theories, may also contribute to developing church readiness.

Study Limitations

Although respondents expressed a wide range of views about meanings and experiences of HIV/AIDS, underlying causes of HIV transmission, and how churches should respond, their contexts for understanding the condition were primarily hypothetical—particularly among church leadership. Of the 12 pastors and leaders interviewed, only 4 (33%) claimed to know of someone living with HIV/AIDS (1 unknown). Among FG participants, 22 of 36 (61%) admitted knowing a PLWHA (3 unknown). Given these very low percentages, conceptions

of HIV/AIDS and the utility of prevention innovations may be differently constructed in the actual presence of HIV/AIDS and PLWHA, as well as from PLWHA's perspectives. Considering respondents' limited experience with HIV/AIDS and PLWHA, their perspectives about disclosure may be rooted in contexts promoted by the church and not necessarily reflective of the actual presence of PLWHA within the church.

Originally, this study's recruitment plan included 16–24 interviews with pastors and leaders across 8 churches and 48–64 focus group participants across churches. Five of the 8 pastors declined consent for recruitment of leaders within their churches. Those who directly declined indicated that their responses were representative of church leaders' sentiments. Additionally, since the pastor is the final authority on church initiatives, their participation obviated the need for additional interviews. Those who indirectly declined did so through non-participation in the referral of church leaders or by not returning phone calls. It is therefore necessary to conclude that important church leaders and congregants may not have been interviewed.

Due to pastors' refusals, and also due to constraints of time, resources, and access, it was not possible to organize nominations from each participating church's entire congregation of persons considered to be key informants. Recruitment for rural focus groups also presented challenges. For example, several local community leaders anecdotally reported that rural Baptist churches are suffering a decline in membership caused by the popularization of non-denominational churches. Also, because memberships of Black Baptist churches

are usually predominantly female, recruitment for the rural male focus group proved to be impossible. Although this elimination of an entire focus group category deviated from the original recruitment plan, so little variation was found among the remaining respondent categories that it is expected that rural males would exhibit minimal differences in response from other respondents.

Throughout the study period, the researcher remained sensitive to the requirements of interpretive description, which positions the researcher as the primary tool for data collection and interpretation, and to the attendant risk of bias in her interpretations. However, this potential methodological problem was countered through the researcher's process of reflexivity, in which she used memos to examine and document her decisions, interpretations, assumptions, and interests, as well as other parts of self that could have informed the research.

Study Strengths

As part of the comparative analysis, responses between groups were compared and differences between the responses were evaluated. Overall, little variation was found between constructions of HIV and prevention reported by urban and rural respondents, members of large and small churches, and even between interview and focus group respondents. Although the segmentation of data collection was theoretically informed, the striking similarities found across groups clearly indicate similar applicability of findings across Black Baptist churches in North Carolina, and thus less need for theoretical sampling in subsequent studies. One of the most significant findings of this study is that the

same factors that inform how Black Baptist churches understand and want to address HIV/AIDS are present in most church contexts.

Previous studies that have focused on the assumptions and opinions of Black church pastors and leaders ignore the significance of congregants' perspective in shaping church contexts. Because this study offers the perspectives of each role that is instrumental in program implementation, the applicability of its findings are strong and reliable.

Public Health Implications

Practice. Because target population perceptions are integral to the development of successful, culturally appropriate intervention content and delivery strategies, the findings of this study have significant implications for public health practice and Black Baptist church programming. Similarly to the way that information gained from focus groups in the San Francisco STOP AIDS project was used to learn how much gay men knew about HIV/AIDS to design effective interventions,[33] the information gathered in this study from interviews with leaders and congregant focus groups can be used to inform modifications to current prevention interventions within the Black church and to develop future, participant-driven practice models.

Another key implication of these findings is the support they provide for community-engaged research models. Based on the multiple interpretations of HIV/AIDS and prevention offered by respondents, it is clear that effective development of interventions, and their translation into practice, will require

multidisciplinary research teams and cooperation among community, congregation, and academy.

Theoretical. Innovation attributes can vary by context and innovation. Nonetheless, these findings support the applicability of Rogers's innovation attributes to the context of HIV prevention within the Black Baptist church. Variations can also be observed in the amount of influence that each attribute exerts on innovation adoption rates. Because the worldviews of HIV/AIDS prevention innovation participants so strongly influence their understandings of HIV and prevention, this study's findings affirm that compatibility is the strongest predictor of HIV prevention adoption by Black Baptist churches.

Value of Study Findings

These study findings reveal a significant desire by Black Baptist leaders and congregants for their churches to engage in a range of HIV/AIDS prevention activities. However, they also demonstrate the complexities of determining message content, audiences for delivery, and conceptualizations (e.g. of sin, disease, forgiveness, morality, sexuality, vulnerability, and more) about which all parties can agree or at least willingly compromise. Therefore, these findings should be used to begin the process of adapting current prevention models and developing other, non-HIV-explicit models to address the root causes of HIV risk within Black communities. Integration of these findings into intervention development may help to significantly curb the effects of HIV/AIDS in Black communities by bridging the gap between evidence-based models and church practices.

This study's findings also expand both the utility and applicability of Rogers's theory of Diffusion of Innovation. In accordance with the CDC's Goals for the 21st Century, this work lays a foundation that can expand the field of public health and also enable healthy people in every stage of life—especially those at greater risk of health disparities—to live optimal, high-quality lives.

APPENDIX I: Pastor Screener Telephone Script

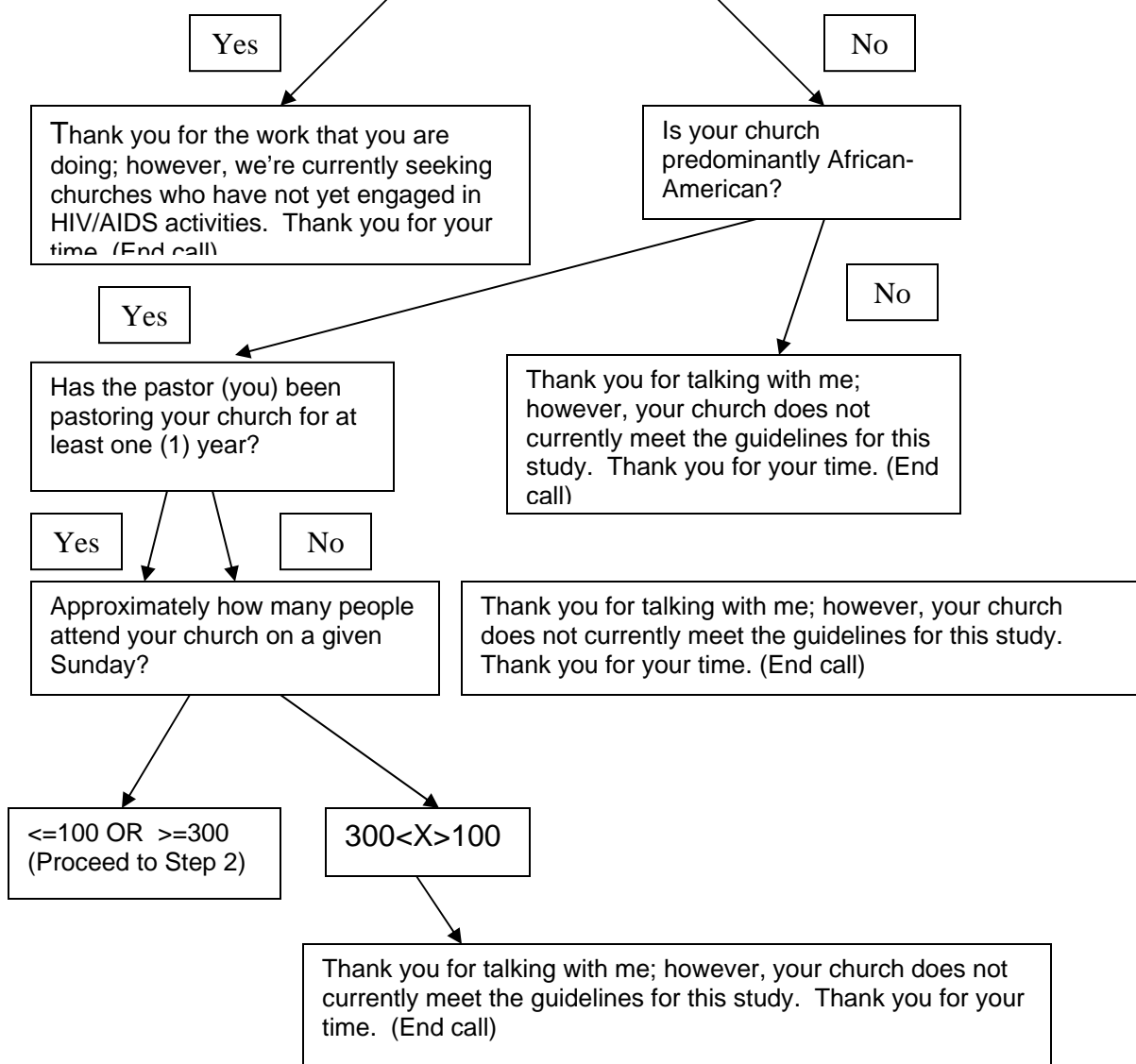
Caller: Hello, may I speak with pastor [insert name]?

If able to speak with pastor or church representative: [Insert name], my name is [insert name], and I am a graduate student at UNC-Chapel Hill. I'm conducting a research study to better understand how black church leaders and members think about HIV prevention. May I ask you a few questions?

If yes: proceed with Step 1

If no: proceed with Step 3

Step 1: Does your church currently have a ministry that specifically addresses HIV/AIDS?



Step 2: Place church on “small” or “large” list according to Sunday attendance.

Your church meets the criteria for this study and we’re interested in learning more about how you and your church think about HIV/AIDS and prevention.

Would you be willing to schedule some time to talk with me in person?

If yes: We will need approximately 1 ½ hours to talk. When is a good time for you?

If no: This interview will only take about 1½ hours of your time and would greatly help this research. Can I provide you with more information so that you might reconsider?

Step 3: Contingency.

If unable to speak with pastor: My name is [insert name]. I’m a graduate student from UNC-Chapel Hill interested in talking with him/her about a study on HIV prevention. When is a better time for me to reach him/her? (Leave contact information if able.)

APPENDIX II: Focus Group Screener Telephone Script

Caller: Thank you for your interest in the HIV Prevention in the Black Church Study. How did you hear about this opportunity? (Wait for reply) We are looking for individuals to share their thoughts about HIV and prevention in a small group discussion. I'd like to ask you a few questions to determine if you qualify for participation.

Step 1:

Do you attend a predominantly African-American Baptist church?

Do you attend at least twice per month?

(If no to either question, proceed to Step 2)

Are you:

- Male or female?

If Male: Are you between the ages of 35 and 44?

If yes: Great. You fit our criteria for participation in this study. We will hold a focus group in your area in the near future. As you probably saw on a flyer, your participation is confidential—we will not share your information with anyone. Also, food and drinks will be served at the focus group. May I have your contact information so I may contact you once that group is scheduled?

(Record on Potential Participants sheet)

I look forward to seeing you there. Thank you again for agreeing to participate.

If no: What other information I can share with you to help you to participate?

If Female: Are you between the ages of 25 and 34?
Are you between the ages of 35 and 54?

If yes: Great. You fit our criteria for participation in this study. We will hold a focus group in your area in the near future. As you probably saw on a flyer, your participation is confidential—we will not share your information with anyone. Also, food and drinks will be served at the focus group. May I

have your contact information so I may contact you once that group is scheduled?

(Record on Potential Participants sheet)

I look forward to seeing you there. Thank you again for agreeing to participate.

If no: What other information I can share with you to help you to participate?

Step 2:

Thank you for your interest, but we do not currently have a group meeting your criteria.

APPENDIX III: Leader Screener Telephone Script

Caller: Hello, may I speak with [insert leader's name]?

If able to speak with leader: My name is [insert name] and I received your contact information from your pastor [insert name]. I'm conducting a study to better understand how black church leaders and members think about HIV prevention.

Have you been in church leadership for at least one (1) year?

If yes: As a lay leader in your church, would you be willing to schedule some time to talk with me in person?

If yes: We will need approximately 1 ½ hours to talk. When is a good time for you?

If no: This interview will only take about 1 ½ hours of your time and would greatly help this research. Can I provide you with more information so that you might reconsider?

If no: Thank you for talking with me; however, you do not currently meet the guidelines for this study. Thank you for your time.

If unable to speak with leader: My name is [insert name]. I'm a graduate student from UNC-Chapel Hill. Pastor [insert name] suggested I speak with him/her. When is a better time for me to reach him/her? (leave contact information if able).

APPENDIX IV: Data Collection Guide (Focus Groups and Individual Interviews)

Introduction for individual interviews: Thank you for agreeing to participate in this interview. I'm interested in talking with you, as a leader in the Black church, about how you think about HIV/AIDS and ways that it can be prevented.

Introduction for Focus groups: Thank you all for agreeing to participate in this focus group. I'm interested in talking with you, as members of Black Baptist churches, about how you think about HIV/AIDS and ways that it can be prevented.

Social Construction Questions:

1. What comes to mind when you hear the term HIV/AIDS?
(Probe for why these terms are associated for them)
2. What are some of the ways that you know of that HIV can be transmitted?
3. Who do you imagine when you think of someone infected with or at risk for HIV/AIDS?
4. What does it mean to be infected with HIV?
 - a) What does it mean within society at large?
 - b) What does it mean within the church?
5. Do you know of PLWHA in your congregation?
 - a) If yes, what do you know of their experience living with HIV/AIDS in this congregation?
 - b) If no, how do you think your church would respond to a member if they were known to be HIV-infected?
6. How are PLWHA treated?
 - a) In society at large?
 - b) Within the Black church?
7. To what do you attribute the spread of HIV/AIDS within the African-American community?
 - a) Probes: socially, historically, behaviorally

8. What differences do you think exist in the causes of the spread for different age groups?
9. What can be done to prevent HIV/AIDS?
 - a) By anyone
 - b) By Black churches
10. What is the Black church's role in addressing HIV? How would you define it?
11. What changes, if any, have you seen in the status or role of the church in the Black community over the past 25 years?
12. How appropriate is it to address issues of HIV/AIDS during a Sunday morning service?
13. What kinds of messages or programs should the Black church offer regarding HIV/AIDS?
14. What kinds of messages or programs should the Black church offer regarding HIV prevention?
15. What kinds of messages or programs should the Black church offer regarding or for those already living with HIV/AIDS?

If they indicate that they have sponsored an HIV/AIDS education program:

You indicated on your demographic sheet that your church has sponsored an HIV/AIDS education program. Please tell me more about the type of program your church participated in.
 Who did your church collaborate with to conduct this program?
 How was the collaboration arranged?

Diffusion of Innovations:

The prevention ideas I'd like to discuss are 1) abstinence, 2) monogamy, 3) condoms, 4) voluntary counseling and testing (VCT), and 5) prevention with positives.

*Don't give the innovation descriptions until they've told how they think they contribute to HIV/AIDS prevention.

1. Tell me about how you think these innovations or ideas could help to prevent HIV/AIDS.

- a. What about (fill in innovation name for which they don't offer an explanation)?

(Give respondent a sheet with brief descriptions of all of the innovations. Respondents can respond regarding any innovation for each question.)

2. Has your church ever used any of these innovations for HIV prevention?
3. Have you been involved in any HIV-related activities in other ministries you've been involved in? Tell me about those.
4. Do you think there is a need for or benefit to participating in any of these innovations within the church? (Relative advantage/observability)
 - a. What about (fill in innovation name for those for which they don't offer an explanation)?
 - b. Where or for whom might there be room for condom messages within the church?
 - c. Where might there be room for voluntary counseling and testing within the church?
 - d. Is abstinence an achievable goal?
5. Tell me about other churches that you have seen or heard of doing any of these kinds of innovations locally or non-locally. (Observability)
6. Do you think any of these innovations could be done in your church? Why or why not? (Compatibility)
 - a. For those that could be done within their church: How might this innovation fit within your current church environment? (Compatibility)
 - i. Probes: values, past experiences, needs
7. What would affect your church's decision to use any of these innovations?
 - a. What would be your role as pastor in your church's decision to use these innovations?
8. How would your church members respond to these innovations or how would they feel about them taking place in this church? (Be sure to get responses for each innovation.)
9. For (the innovations they said they would do), what kinds of changes do you think your church would have to make in order to do these?
 - a. Probes: organizational, cultural

10. Do you think it would ever be possible for (the innovations they said they would not do) to be offered through your church?
 - a. If so, what kinds of changes do you think your church would have to make in order to do these? (Complexity)
 - i. Probes: organizational, cultural
11. If you could try these innovations temporarily to see how they work before you invest in them, would you? Why or why not? (Trialability)
12. What else would it take for your church to engage in these innovations?
13. What are some other ways you think that the Black church can help to prevent HIV/AIDS?

APPENDIX V: Focus Group Reminder Telephone Script

Caller: Hello, may I speak with [insert name]?

If not available: When is a better time to reach him/her?

If available: This is Malika Roman Isler with the HIV prevention in the Black church study. I'm calling to remind you about the focus group on (session date that matches appropriate gender and age) at (time) at (location) in (name of city). Will you still be able to come to that session?

If yes: I look forward to seeing you there. Thank you again for your interest in this research study.

If no: What further information can I provide you that might help you to participate in the focus group?

Thank you.

APPENDIX VI: Individual Interview Reminder Telephone Script

Caller: Hello, may I speak with [insert name]?

If not available: When is a better time to reach him/her?

If available: This is Malika Roman Isler with the HIV prevention in the Black church study. I'm calling to remind you about your interview on (give date) at (time) at (location). Will you still be able to come to that interview?

If yes: I look forward to seeing you there. Thank you again for your interest in this research study.

If no: What further information can I provide you that might help you to participate in this interview?

Thank you.

APPENDIX VII: Focus Group Demographic Survey

Group ID _____

Please complete the following short survey.
All information is confidential and will only be used in group summaries.
Thank you!

1) What is your gender?

- 1) Male
- 2) Female

2) How old are you? _____

3) What is the highest grade you completed in school? Please circle only one.

- | | |
|-----------------------------------|-------------------------|
| 1) Less than high school | 5) Some college |
| 2) Some high school | 6) Completed college |
| 3) Graduated from high school/GED | 7) Some graduate school |
| 4) Technical school or training | 8) Graduate Degree |

4) Are you: (Please circle only one)

- | | |
|-------------------------------------|------------------|
| 1) Married or living with a partner | 4) Widowed, or |
| 2) Separated | 5) Never Married |
| 3) Divorced | |

5) Are you: (Please circle all that apply)

- | | |
|----------------------------------|---|
| 1) Working part-time | 5) Retired |
| 2) Working full-time | 6) Unable to work due to illness or condition |
| 3) Taking care of home or family | 7) Other (Specify) |
| 4) In school | _____ |

6) How would you rate your knowledge of HIV/AIDS? Please circle only one.

1	2	3	4	5
Very little knowledge		Some knowledge		Very knowledgeable

7) Have you ever been tested for HIV/AIDS?

- 1) Yes
- 2) No
- 3) Unsure

8) Do you personally know anyone living with HIV/AIDS?

- 1) Yes
- 2) No
- 3) Unsure

9) Should the church offer HIV/AIDS education?

- 1) Yes
- 2) No
- 3) Unsure

10) Would you support teaching on the following in your church? Circle as many as apply.

- 1) Abstinence (not participating in sexual activity)
- 2) Condom use
- 3) Monogamy (having one sex partner at a time)
- 4) Prevention and support for people living with HIV/AIDS
- 5) HIV/AIDS counseling and testing

11) Would you support HIV/AIDS education for the following groups through your church?

Circle as many as apply.

- 1) Married people
- 2) Unmarried adults (ages 18 and older)
- 3) Youth (under age 18)
- 4) Church leaders
- 5) General congregation

12) Before taxes, was your household's total income last year: (Please circle only one)

- 1) Less than \$5,000
- 2) \$5,000 to less than \$20,000
- 3) \$20,000 to less than \$40,000
- 4) \$40,000 to less than \$60,000
- 5) \$60,000 to less than \$80,000
- 6) \$80,000 or more

If you would like to give us any feedback about this focus group, please do so here:

APPENDIX VIII: Individual Interview Demographic Survey

Interview ID _____

Please complete the following short survey.

All information is confidential and will only be used in group summaries. Thank you!

1) Which position do you hold in church? (Please circle all that apply)

- 1) Pastor
- 2) Ministerial staff
- 3) Church staff
- 4) Lay leader (please specify auxiliary or group)

5) Other (please specify)

2) How long have you been with this church? _____

3) What is your gender?

- 1) Male
- 2) Female

4) How old are you? _____

5) What is the highest grade you completed in school? Please circle only one.

- | | |
|-----------------------------------|-------------------------|
| 1) Less than high school | 5) Some college |
| 2) Some high school | 6) Completed college |
| 3) Graduated from high school/GED | 7) Some graduate school |
| 4) Technical school or training | 8) Graduate Degree |

6) Are you: (Please circle only one)

- | | |
|-------------------------------------|------------------|
| 1) Married or living with a partner | 4) Widowed, or |
| 2) Separated | 5) Never Married |
| 3) Divorced | |

7) Are you: (Please circle all that apply)

1) Working part-time

2) Working full-time

3) Taking care of home or family

4) In school

5) Retired

6) Unable to work due to illness or condition

7) Other (Specify)

8) How would you rate your knowledge of HIV/AIDS? Please circle only one.

1	2	3	4	5
Very little knowledge		Some knowledge		Very knowledgeable

9) Have you ever been tested for HIV/AIDS?

1) Yes

2) No

3) Unsure

10) Do you personally know anyone living with HIV/AIDS?

1) Yes

2) No

3) Unsure

11) Should the church offer HIV/AIDS education?

1) Yes

2) No

3) Unsure

12) Would you support teaching on the following in your church? Circle as many as apply.

1) Abstinence (not participating in sexual activity)

2) Condom use

3) Monogamy (having one sex partner at a time)

4) Prevention and support for people living with HIV/AIDS

5) HIV/AIDS counseling and testing

13) Would you support HIV/AIDS education for the following groups through your church? Circle as many as apply.

- 1) Married people
- 2) Unmarried adults (ages 18 and older)
- 5) Youth (under age 18)
- 6) Church Leaders
- 7) General congregation

14) Has your church ever sponsored or participated in an HIV/AIDS related program?

- 1) Yes
- 2) No

15) Before taxes, was your household's total income last year: (Please circle only one)

- 1) Less than \$5,000
- 2) \$5,000 to less than \$20,000
- 3) \$20,000 to less than \$40,000
- 4) \$40,000 to less than \$60,000
- 5) \$60,000 to less than \$80,000
- 6) \$80,000 or more

16) For pastors only: Do you work anywhere outside of the church?

- 1) Yes
- 2) No

If you would like to give us any feedback about this interview, please do so here:

Thank You!

APPENDIX IX: Member Checking Form

HIV Prevention in the Black Church Member Checking Form

Thank you for participating in this study. When this study is complete, we will ask some of the participants to review the findings for their appropriateness and provide some feedback. Participation in this part of the study is completely voluntary and confidential.

If you agree to review the results and provide feedback, you will be:

1. Contacted by phone to determine if you are still interested in participating
2. Sent written results to review, and
3. Participate in a 30-minute phone or face-to-face meeting to discuss your response to the results.

Completion of this form does not guarantee that you will participate in this part of the study or that you cannot change your mind about participating if you are contacted.

Interview Participants:

Name:	
Phone #:	Alternate Phone:
Church Name:	

Focus Group Participants:

Name:	
Phone #:	Alternate Phone:
Church Name:	

For Project Use Only:

County:

Interview Participant:

Female ____

Pastor ____

Lay leader ____

Focus Group Participant:

Female, 25-34 ____

Female, 35-54 ____

Male 35-44 ____

Appendix X: HPBC Study Codebook

Codes:

{CHURCHCULTURE} – Any mention of the culture or way things are done within or around the Black church setting. Can include pastor behaviors, church norms, or practices.

{TRANSMISSION} – Any mention of patterns of transmission, how HIV is transmitted, contagious. Ex: Unknowing person sleeps with someone of unknown status, use of needles.

{OTHERBEHAVIOR} – Any mention of non-sexual behaviors associated with HIV/AIDS

Ex: Dishonesty, not talking about HIV/AIDS.

{MARRIAGE} – Any mention of the dynamics of HIV/AIDS within or related to marriage.

{HIDDEN} – Any mention of infection being hidden, people not knowing that they have it, or others not knowing who has it, not wanting to know who has it.

{CHURCHROLE} Any mention of the church's role in the community.

Ex: Helped to bring us to where we are, meeting place.

{BIBLE} Biblical explanations for HIV/AIDS or prevention or references to Biblical principles, references to God's Word or God's way. Ex: Leprosy.

{OTHERPREV} – Any mention of other ideas/concepts that contribute to prevention.

Ex: 2-parent homes, parental teachings.

{PERSEXP} – Any mention of the respondent's personal experience with HIV/AIDS.

Ex: Knowing someone, praying for someone, etc.

Social Construction:

1. What comes to mind when you hear the term HIV/AIDS? (Probe for why these terms are associated for them)
 - a. {SEXUALBEHAVIOR} – Any mention or association with sexual behavior, any mention of sexual behaviors contributing to the spread of HIV, sex as a drug, homosexuality, bisexuality.
 - b. {SPIRIT} – Any references to spirit or spiritual, or lack thereof.
 - c. {DISEASE} – Any mention of the disease itself, or characteristics of the disease, origin of the disease. Ex: Incurable disease, death sentence.
 - d. {EXPERIENCE} – Anything related to PLWHA and conditions surrounding them – isolation, death, being ill, sickness, costs of meds, cures, stigma, etc.

- e. {DENIAL} – Any mention of people not wanting to know their status or the status of others.
 - f. {MORALS} – Any mention of morals, morality.
 - g. {TRANSMISSION} – Any mention of patterns of transmission, how HIV is transmitted, contagious. Ex: Unknowing person sleeps with someone of unknown status, use of needles.
 - h. {LACKEDUC} – Any mention of people not adhering to education being used, lack of behavior change.
 - i. {SPREAD} – Any mention of how the disease is spreading, numbers going up.
 - j. {HIDDEN} – Any mention of infection being hidden, people not knowing that they have it, or others not knowing who has it, not wanting to know who has it.
 - k. {COMMREACT} – Any mention of community reactions to PLWHA, include family responses. Ex: Social rejection, isolation from activities, treated badly, living death sentence.
 - l. {CHURCHREACT} – Any discussion about how the church would respond to PLWHA, or what living with HIV/AIDS means in a church context.
 - m. {BIBLE} – Biblical explanations for HIV/AIDS or prevention or references to Biblical principles, references to God's Word or God's way. Ex: Leprosy.
 - n. {YOUTH} – Any mention of youth, their risk or behaviors, etc.
 - o. {SENIORS} – Any mention of senior citizens, older adults, their risk or behaviors, etc. Ex: Erectile dysfunction, Viagra.
2. What are some ways that you know of that HIV can be transmitted?
- a. {TRANSMISSION} – Any mention of patterns of transmission, how HIV is transmitted, contagious. Ex: Unknowing person sleeps with someone of unknown status, use of needles.
3. Who do you imagine when you think of someone infected with HIV (or at risk for HIV)?
- a. {UNKNOWN} – Any mention of not knowing who has it or being able to determine who has it. Any mention of there being no association of a particular person with HIV/AIDS.
 - b. {PERSEXP} – Any mention of the respondent's personal experience with HIV/AIDS. Ex: Knowing someone, praying for someone, etc.

- c. {SEXUALBEHAVIOR} – Any mention or association with sexual behavior. Any mention of sexual behaviors contributing to the spread of HIV, sex as a drug, homosexuality, bisexuality.
 - d. {WHORISK} Any mention of the level of risk of people in church OR community, who is at risk.
 - e. {BLACK} – Any mention of the Black experience, meaning for being infected with HIV/AIDS, being Black being associated with HIV/AIDS or risk.
4. What does it mean to be infected with HIV (black community)? Probes: Within society at large, within the church.
- a. {BIO} – Any biological explanations for HIV, correct or incorrect.
 - b. {COMMREACT} – Any mention of community reactions to PLWHA, include family responses. Ex: Social rejection, isolation from activities, treated badly, living death sentence.
 - c. {BLACK} – Any mention of the Black experience, meaning for being infected with HIV/AIDS, being Black being associated with HIV/AIDS or risk.
 - d. {EXPERIENCE} – Anything related to PLWHA and conditions surrounding them. Ex: Isolation, death, being ill, sickness, costs of meds, cures, stigma, etc.
 - e. {CHURCHREACT} – Any discussion about how the church would respond to PLWHA, or what living with HIV/AIDS means in a church context.
 - f. {ACCESS} – Any mention of differential access to treatment, differential experience living with HIV/AIDS, may include mention of celebrities or rich people like Magic Johnson.
 - g. {PROGRESS} – Any mention of people living longer and better than they used to.
 - h. {EXPERIENCE} – Anything related to PLWHA and conditions surrounding them. Ex: Isolation, death, being ill, sickness, costs of meds, cures, stigma, etc.
 - i. {BIBLE} – Biblical explanations for HIV/AIDS or prevention or references to Biblical principles, references to God's Word or God's way. Ex: leprosy.
 - j. {PEREXP} – Any mention of the respondent's personal experience with HIV/AIDS. Ex: Knowing someone, praying for someone, etc.
5. Do you know of PLWHA in your congregation?
- a. {KNOWNO} – Doesn't know of PLWHA in their church.
 - b. {KNOWYES} – Does know of PLWHA in their church.

6. How are PLWHA treated? Probes: In society at large, within the Black church.
 - a. {COMMREACT} – Any mention of community reactions to PLWHA, include family responses. Ex: Social rejection, isolation from activities, treated badly, living death sentence.
 - b. {CHURCHREACT} – Any discussion about how the church would respond to PLWHA, or what living with HIV/AIDS means in a church context.
7. To what do you attribute the spread of HIV/AIDS in the African American community? What differences do you think exist in the causes of the spread for different age groups? Probes: socially, historically, behaviorally.
 - a. {MODERNCULTURE} – Any reference to lifestyles or cultures that facilitate the spread of HIV. Ex: Music, places we hang out, change in norms, change in family structure/teachings.
 - b. {SPIRIT} – Any references to spirit or spiritual, or lack thereof.
 - c. {YOUTH} – Any mention of youth, their risk or behaviors, etc.
 - d. {GANG} – Any mention of gang activity, influence of gang culture.
 - e. {SEXUALBEHAVIOR} – Any mention or association with sexual behavior. Any mention of sexual behaviors contributing to the spread of HIV, sex as a drug, homosexuality, bisexuality.
 - f. {LACKEDUC} – Any mention of people not adhering to education, instruction, lack of behavior change.
 - g. {BLACK} – Any mention of the Black experience or meaning for being infected with HIV/AIDS, being Black being associated with HIV/AIDS or risk.
 - h. {CHURCHROLE} – Any mention of the church's role in the community. Ex: Helped to bring us to where we are, meeting place.
 - i. {MORALS} – Any mention of morals, morality.
 - j. {OTHERPREV} – Any mention of other ideas/concepts that contribute to prevention. Ex: 2-parent homes, parental teachings.
 - k. {DRUGS} – Any mention of drugs, or influence of drugs on HIV/AIDS.
 - l. {MALE} – Any mention of social construction/condition of the Black male.
 - m. {SENIORS} – Any mention of senior citizens, older adults, their risk or behaviors, etc. Ex: Erectile dysfunction, Viagra.
 - n. {NOTALK} – Any mention of not discussing sex, sexuality, or erectile dysfunction.
 - o. {OTHERBEHAVIOR} – Same as above.

8. What can be done to prevent HIV/AIDS? Probes: By anyone, by black churches. (Remember to look at the CONTRIBUTE codes here.)
- a. {EDUCATION} – Any mention of the church providing or being a source of information about HIV/AIDS. Any mention of education, the need for it, lack of it, can be inside or outside of the church. Any mention of HIV education, about the disease itself, epidemiology, including awareness.
 - b. {OUTREACH} – Any mention of the church doing outreach in the community.
 - c. {OVERFEAR} – Any mention of not being fearful of discussions or PLWHA.
 - d. {BARRIERS} – Any mention of barriers to Black churches participating in HIV prevention activities. Ex: Age of congregation, “traditional,” newer pastor.
 - e. {FUNDS} Any mention of the church raising or contributing money to HIV activities.
 - f. {PROGRAMS} – Any mention of STI, HIV-related programs that have taken place in the church or how programs should take place. Any mention of any experiences collaborating with HIV programs, or ways that collaboration can take place. Ex: Not on Sunday morning, What they should include (teachings on family).
 - g. {SELFCHANGE} – Any mention of changes in life perspective. Things the individual can do. Ex: Stop feeling sorry for oneself, accountability.
 - h. {TESTIMONIAL} – Any mention of using stories of PLWHA as a form of prevention.
 - i. {PARTNERS} – Any mention of partnering with pastors, churches, or other entities to address HIV/AIDS.
 - j. {SALVATION} – Any mention of having/needing God in your life, salvation, getting saved.
9. What is the Black church’s role in addressing HIV? How would you define it?
- a. Prevention.
 - i. {CHURCHPREV} – Any mention of what churches should say about prevention, circumstances or ideologies around church prevention. Can include specific innovations. (Remember to run with innovation specific codes.)
 - b. Addressing/dealing with those who already have HIV.
 - i. {CHURCHPOS} – Any mention of what churches should say about PLWHA or do for PLWHA, respond to PLWHA

10. What kinds of messages or programs should the Black church offer regarding HIV/AIDS? Check contribute codes.
 - a. {COMPASSION} Any mention of concern, compassion, minister to.
 - b. {EDUCATION} Any mention of providing or being a source of information about HIV/AIDS. Any mention of education, the need for it, lack of it, can be inside or outside of the church. Any mention of HIV education, about the disease itself, epidemiology, including awareness.
 - c. {EVENTS} Any mention of events that the church should have. Ex: Singings, food services, block party.
 - d. {SIN} Any discussion of sin, wrong, punishment related to HIV/AIDS or sexual behavior.
11. What kinds of messages or programs should the Black church offer regarding HIV prevention?
 - a. {CHURCHPREV} – Any mention of what churches should say about prevention, circumstances or ideologies around church prevention. Can include specific innovations. (Remember to run with innovation specific codes.)
12. What kinds of messages or programs should the Black church offer for those already living with HIV/AIDS?
 - a. {CHURCHPOS} – Any mention of what churches should say about PLWHA or do for PLWHA, respond to PLWHA.
 - b. {SALVATION} – Any mention of having/needing God in your life, salvation, getting saved.
 - c.

Diffusion of Innovations:

The prevention idea I'd like to discuss is (fill in innovation name).

1. What do you know about how these innovations contribute to HIV/AIDS prevention? Tell me how you think these innovations or ideas could help to prevent HIV/AIDS. (Complexity - how they understand the model.) Flaws they see with it, effectiveness, how they relate it to prevention.
 - a. {CONTRIBUTE1} – Abstinence.
 - i. Is abstinence achievable?
 1. {ACHIEVEYES} – Any mention of abstinence being an achievable goal.
 2. {ACHIEVENO} – Any mention of abstinence not being an achievable goal.
 - b. {CONTRIBUTE2} – Monogamy.
 - c. {CONTRIBUTE3} – Condoms.

- d. {CONTRIBUTE4} – PwP.
- e. {CONTRIBUTE5} – VCT.

Researcher will provide participant(s) with a description of the first innovation and proceed through these questions.

2. Has your church ever used any of these for HIV prevention?
 - a. {EVERUSED1} – Abstinence.
 - b. {EVERUSED2} – Monogamy.
 - c. {EVERUSED3} – Condoms.
 - d. {EVERUSED4} – PwP.
 - e. {EVERUSED5} – VCT.
 - f. {EVERUSED6} - Any mention of never having used any innovation for HIV prevention, any HIV activities.
3. Do you think there is a need for or benefit to participating in any of these innovations within the church? (Relative advantage/observability.)
 - a. {NEED1} – Abstinence.
 - b. {NEED2} – Monogamy.
 - c. {NEED3} – Condoms.
 - d. {NEED4} – PwP.
 - e. {NEED5} – VCT.
 - f. {NEED6} – General need response.
4. Tell me about other churches that you have seen or heard of doing any of these kinds of innovations.
 - a. {OTHER1} – Abstinence.
 - b. {OTHER2} – Monogamy.
 - c. {OTHER3} – Condoms.
 - d. {OTHER4} – PwP.
 - e. {OTHER5} – VCT.
 - f. {OTHER6} – Any mention of not knowing of other churches or not being sure of other churches using any of these innovations.
 - g. {OTHER7} – General yes responses and supporting text.
5. Do you think any of these innovations could be done in your church? Why or why not?
 - a. {DONE1} – Abstinence.
 - b. {DONE2} – Monogamy.

- c. {DONE3} – Condoms.
 - d. {DONE4} – PwP.
 - e. {DONE5} – VCT.
 - f. {DONE6} – None could be done.
 - g. For those that could be done within their church: How might this innovation fit within your current church environment? (Compatibility.) Probes: Values, past experiences, needs, how these might be introduced into the church. Ex: Through specific ministries/auxiliaries.
 - i. {FIT1} – Abstinence.
 - ii. {FIT2} – Monogamy.
 - iii. {FIT3} – Condoms.
 - iv. {FIT4} – PwP.
 - v. {FIT5} – VCT.
 - vi. {FIT6} – General discussion of fit.
6. What would affect your church's decision to use these innovations? What would be your role as pastor in your church's decision to use these innovations?
- a. {PASTORDECIDE} – Any mention of the pastor being the source of decision making, or his role in decision making.
 - b. {RESOURCES} – Any mention of having the appropriate resources or people to teach this innovation.
 - c. {CHURCHDECIDE} – Any mention of the church/congregation being the source of decision making.
 - d. {COMMSTATE} – Any mention of the responding to the state of the community, or individuals in the church.
 - e. {CHURCHCULTURE} – Any mention of the culture or way things are done within or around the Black church setting. Can include pastor behaviors, church norms, or practices.
7. How would your church members respond to these innovations or how would they feel about them taking place in this church?
- a. {RESPONSE1} – Abstinence.
 - b. {RESPONSE2} – Monogamy.
 - c. {RESPONSE3} – Condoms.
 - d. {RESPONSE4} – PwP.
 - e. {RESPONSE5} – VCT.

- f. {RESPONSE6} – General responses, not specific to 1 innovation.
- 8. For [the innovations they said they would do] what kinds of changes do you think your church would have to make in order to do these? (Complexity.) Probes: Organizationally, culturally.
 - a. {CHANGES} – Any changes needed.
 - b. {CHANGES6} – No changes needed.
- 9. Do you think it would ever be possible for (the innovations they said they would not do) to be offered through your church? If so, what kinds of changes do you think your church would have to make in order to do these? (Complexity.) Probes: organizationally, culturally.
- 10. If you could try these innovations temporarily to see how they work before you invest in them, would you? Why or why not? (Trialability.)
 - a. {TEMPYES} – Any mention of being willing to try an abstinence innovation on a temporary basis along with any conditions for trying it. Ex: Time to conduct it.
 - b. {TEMPNO} – Any mention of not being willing to try an innovation temporarily.
- 11. What else would it take for your church to engage in these innovations?
 - a. {OTHERENGAGE} – Any mention of nothing else being needed to conduct this innovation.
- 12. What are some other ways you think that the Black church can help to prevent HIV/AIDS?
 - a. {EDUCATION} – Any mention of the church providing or being a source of information about HIV/AIDS. Any mention of education, the need for it, lack of it, can be inside or outside of the church. Any mention of HIV education, about the disease itself, epidemiology, including awareness.

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