HIV/AIDS and the Black Church: What Are the Barriers to Prevention Services?

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The HIV/AIDS epidemic continues to have a devastating impact on the black community in the United States. Trusted community institutions within the black community—the Black Church among them—have often been reluctant to respond to the epidemic in a manner commensurate with the scope of the problem. The aim of the current study was to understand the barriers to HIV/AIDS prevention services offered by black churches in a northeastern metropolitan area by surveying the ministers who lead the churches.

Methods: The study team constructed a 25-item questionnaire that asked questions about the ministers' and congregational demographics as well as general health and/or HIV/AIDS prevention services offered by the churches. The overall response rate was 82% (N=18).

Results: 83.3% (N=15) of the ministers surveyed reported financial barriers as reason for not providing HIV/AIDS prevention services. A majority of the ministers also perceived HIV/AIDS to be a problem in their communities.

Discussion: The resource-related nature of the barriers and the eagerness of the ministers to get more involved suggest that fostering creative partnerships between AIDS service organizations and churches may encourage more churches to offer HIV/AIDS prevention programming in a culturally acceptable manner.

Key words: HIV/AIDS ■ African Americans ■ prevention ■ churches

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INTRODUCTION

The HIV/AIDS epidemic continues to have a devastating impact on the black community in the United States. Although blacks make up approximately 12% of the U.S. population, they accounted for half of all new HIV infections reported in 2003.[1] In Rhode Island, the HIV epidemic also disproportionately impacts blacks and other people of color. In 2003, blacks accounted for 35.8% of all newly diagnosed HIV cases in Rhode Island[2] despite comprising only 4% of the state's population. The impact that the epidemic has on blacks underscores the need for novel intervention strategies to reduce HIV infections in this community.

One area that has not been fully realized is the role that the Church, one of the most trusted institutions in the black community, could play in HIV/AIDS prevention.[3] There are numerous factors that make the Black Church an attractive setting for HIV/AIDS prevention programs. For example, the Church has long served as a vital institution within the black community, setting defining values and norms for community members.[4] The Church has also been a site of social activism and health education within the black community.[5,6] Leaders of churches are often viewed by community members as reliable sources of information and support, and they often have close contact with members of disenfranchised groups.[7]

Given the role and the importance of the Church in the black community, it has the potential to play a much larger role in health promotion and disease prevention.[8] However, the Black Church as an institution has often been reluctant to respond to the HIV/AIDS epidemic.[9] Because of the influential role of ministers in their congregations and surrounding communities, we decided to examine a sample of Rhode Island ministers' attitudes towards providing HIV/AIDS prevention programs in their churches in an effort to better understand perceived barriers to offering HIV/AIDS prevention programs in the Church.

METHODS

This was a pilot study in which the research team constructed a 25-item questionnaire that asked ques-

tions about the ministers' and their congregation's demographics, as well as questions about general health and/or HIV/AIDS prevention services offered by the churches. The survey instrument consisted of a combination of multiple-choice and short-answer items. The instrument was peer-reviewed prior to dissemination. Selected survey items from the instrument employed in the study developed by Tesoriero and colleagues[7] were adapted for use in our survey. After this proposal was approved by the institutional review board of Lifespan Corp., recruitment of study participants was started (June to August 2002). The ministers selected to participate in the study were members of the only clergy organization representing black/African-American clergy in Rhode Island. The organization included 22 members, representing all of the 22 black churches in the region. A member of the survey team met with the ministers to explain the study aims and to obtain informed consent prior to their completion of the survey. Four follow-up telephone calls were made to the nonrespondents to no avail. As this was an anonymous survey, no demographic information about the nonresponders could be obtained.

Ministers were asked to provide demographic information about themselves and their congregations (Table 1). Ministers were also asked if general health promotion programs and/or specific HIV prevention programs were offered in their respective churches. The reasons for providing or not providing HIV/AIDS services were briefly explored. Participants were given a gift certificate for use at a local coffee shop as an incentive to complete the confidential questionnaire. The data for the survey was analyzed using the SPSS 11.5 statistical package for Microsoft® Windows. Fisher's exact tests of significance and frequencies were generated on the data.

RESULTS

Eighteen ministers responded to the survey for a response rate of 82%. The respondents were predominately middle-aged Baptist ministers, with an average of 20 years' experience in the ministry. Their congregations were majority female, although the size of the congregations differed widely (Table 1). The majority of churches did not provide either general health programs or specific HIV/AIDS prevention programs (Table 2). Most ministers felt that HIV/AIDS services were needed in their churches and communities but felt unqualified or too impoverished to provide these services. There were no statistically significant differences among the different demographic groupings of ministers with respect to either offering or not offering health promotion programs or HIV specific services.

DISCUSSION

Although the majority of the ministers indicated that they felt addressing HIV/AIDS was part of their church's mission, there was a paucity of health-related programs offered. Less than a quarter of the congregations reported offering any type of health-related program, but of those that did offer programming, only half offered HIV/AIDS prevention programs (Table 2). Given the fact that the financial resource-related constraints were cited by a majority of the ministers as a reason for not providing HIV/AIDS related services, it is unlikely that these prevention programs will be initiated without additional support. The churches may not be able to further stretch their limited budgets to include other types of health programs.

Despite the limited number of existing services, the data showed that over three-quarters of the ministers recognized that HIV prevention programs are needed within their neighborhood. An almost equal number of ministers reported a need for HIV prevention services in their individual congregations (Table 2). This is interesting because the ministers as a whole did not report serving a high-risk congregation (high-risk was not defined for the ministers), nor did they know acknowledge significant numbers of intravenous drug users (IDU) or men who have sex with men (MSM) among their members. Only three ministers reported having any MSM among their members, and only two reported having any IDU in their congregations. However, given the stigma associated with the categories MSM and IDU, ministers may have given socially desirable answers by underreporting the

Table 1. Denominational affiliation of congregations and congregational descriptives

Denominational Affiliation of Congregations	
Denomination	**Percentage**
Baptist	66.7% (n=12)
African Methodist Episcopal	16.7% (n=3)
Methodist	11.1% (n=2)
Other	5.6% (n=1)

Congregational Descriptives	
Minister's experience	Mean 20.1 years (range 3–55 years)
Minister's age	Mean 48 years (range 34–62 years)
Average length of stay at current church	9.9 years (range 1–20 years)
Gender balance of congregation	94.4% >50% female (n=17)
Congregation size	50% <100 (n=9) 50% 100–499 (n=9)

number of members of either group. In addition, IDU and MSM church members may not disclose their behavior to church leadership. For these reasons and also because the information is based on the minister's perception, it is possible that the number of MSM, IDU and HIV-infected persons within our study congregations is higher than reported.

The large female population of the congregations studied also suggests that the Church may be an ideal place for HIV/AIDS prevention and awareness programming tailored to the needs of black women. This is especially critical because black women constitute a growing share of HIV/AIDS cases, representing 69% of the cases among women in 2003.[10] Only two of the ministers reported that their churches provided any type of HIV/AIDS-related prevention programs. The types of programs offered were AIDS ministries and/or HIV/AIDS literature distribution. This exposes an area of opportunity for more creative partnerships between the churches and other community organizations, which might be able to provide assistance to those churches where such programming is desired.

The responses here suggest that the reasons for not offering services are linked to issues of scarce financial resources rather than issues of morality. While some churches cited opposition to homosexuality and promiscuity as reasons for not offering HIV/AIDS prevention programming, these did not emerge as the dominant reasons for not offering HIV/AIDS services in our survey (Table 2). Our findings regarding the resource-related nature of not offering HIV/AIDS services corroborate with the findings of Tesoriero and colleagues.[7] National organizations such as the National Medical Association (NMA), National Association for the Advancement of Colored People (NAACP) and other sectors of the black community leadership could work with churches to identify the resources needed by ministers in order to optimize their ability to deliver HIV prevention and support services in a culturally acceptable manner. Church leadership concerned about HIV/AIDS prevention in the black community may also be able to apply for

Table 2. Selected Survey Questions and Results

Does your church currently provide health education/prevention services to community members?
Yes 22.2% (n=4) No 77.8% (n=14)

Do you feel that there is a need for HIV-related prevention services in the neighborhood in which your church is located?
Yes 77.8% (n=14) No 22.2% (n=4)

Do you feel that there is a need for HIV-related prevention services in your congregation?
Yes 83.3% (n=15) No 16.7% (n=3)

Does your church currently provide or facilitate the provision of HIV/AIDS-related services to community members?
Yes (11.1%) (n=2) No (88.9%) (n=16)

Types of HIV/AIDS programs offered

AIDS ministry	11.1% (n=2)	Referrals for HIV testing	0
Distribution of HIV/AIDS literature	5.6% (n=1)	Condom distribution	0
On-site HIV/AIDS education	0	Needle exchange information	0
HIV/AIDS support groups	0	Substance abuse counseling	0

If your church does not currently provide HIV/AIDS prevention services, which of the following describes why?

HIV/AIDS not part of church's mission	5.6 % (N=1)
I don't feel qualified to discuss HIV/AIDS in church	22.2% (N=4)
The church does not have staff who are qualified to discuss HIV/AIDS in church	50%= (N=7)
The church does not have financial resources to address HIV/AIDS	83.3% (N=15)
My church is opposed to promiscuity	16.7% (N=3)
My church is opposed to homosexuality	11.1 % (N=2)
HIV/AIDS is not a serious issue in the community	5.6% (N=1)
I'm concerned that having HIV/AIDS programming with attract more HIV-positive people to my congregation	0%
I believe AIDS is God's punishment for sinner	0%
I believe drug use is a sin	0%

N: number of minister respondents

and secure funding through a federal program such as the Faith-Based Initiative. Another resource that churches can explore is the Balm in Gilead, a national religious organization that works to build the capacity of black churches to provide culturally appropriate HIV/AIDS prevention programs.

The small sample size of this study makes generalization problematic, particularly to black churches in other metropolitan areas, which may have vastly different leadership styles and systems of value. Future studies may wish to further examine regional differences in how black churches are responding to the HIV/AIDS epidemic in their local communities. The use of a larger sample in future research is likely to have greater generalizability as well as a greater ability to detect statistically significant differences. Future studies may also seek to garner a better understanding of how churches contextualize and prioritize HIV/AIDS programming in light of other health challenges facing the black community.

Our findings suggest that the reticence of some black churches to aggressively confront the HIV/AIDS epidemic lies in a lack of resources to offer HIV/AIDS-related programming. One implication here is that perhaps by encouraging creative partnerships between local agencies and churches, more programs could be created. This is also another area of missed opportunity, as only two of the congregations reported partnering with local AIDS service organizations (data not shown). These partnerships could also allow for venues to increase routine HIV testing within black communities. The provision of education to the ministers about national-level efforts to get more black churches involved in HIV/AIDS education and prevention work is another area of opportunity. Ministers have clearly identified a desire for more information about HIV/AIDS. As the HIV/AIDS epidemic continues to devastate the black community, it is increasingly imperative that the public health and medical establishments work collaboratively with trusted community institutions such as the Black Church to devise creative strategies to reduce rates of infection and promote healthy behaviors.

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