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Facilitators and Barriers to HIV Activities in Religious Congregations: Perspectives of Clergy and Lay Leaders from a Diverse Urban Sample

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Abstract

This paper examines facilitators and barriers to HIV activities within religious congregations, the relative internal or external sources of these influences, and suggestive differences across congregational types. Results are based on in-depth interviews with clergy and lay leaders (n = 57) from 14 congregations in Los Angeles County, California, purposively selected to reflect diversity in racial-ethnic composition, denomination, size, and HIV activity level. Many common facilitators and barriers were related to norms and attitudes, only a few of which appeared overtly associated with theological orientations. Clergy support was a facilitator particularly prevalent among congregations having higher HIV activity levels, indicating its importance in sustaining and expanding HIV programs. Resource issues were also prominent, with material resource barriers more frequently mentioned by smaller congregations and human resource barriers more among larger congregations. Organizational structure issues were mostly centered on external linkages with various social service, public health, and faith-based entities. Analysis of internal versus external sources highlights the roles of different stakeholders within and outside congregations in promoting HIV activities. Potential differences across congregational types represent fruitful areas for future research.

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Keywords

Religious congregations; HIV activities; Facilitators; Barriers

Introduction

The potential role of religious congregations in promoting health and reducing health disparities has been of ongoing interest to public health professionals and policymakers (Haugk 1976; Koenig 2003; Lasater et al. 1986; Olson et al. 1988). Congregations historically have provided an important web of social support in many communities, as well as access to resources such as food, health care, education, and job opportunities (Chaves and Tsitsos 2001; Cnaan 2002). They remain central institutions within African-American, Latino, and other communities of color (Cnaan et al. 2006; Lincoln and Mamiya 1990; Min 2002) and are often among the last to leave distressed neighborhoods, thereby shouldering much of the burden of meeting community needs (Foley et al. 2001).

Because of these important roles in mobilizing communities to address social, health, and other needs and work for social change, some have proposed that religious congregations could play a similarly powerful role in helping address HIV (Merz 1997), particularly among racial and ethnic minorities who bear a disproportionate burden of HIV infection (Centers for Disease Control and Prevention 2009; Hernández et al. 2007; McNeal and Perkins 2007). However, while data from the 2006–2007 National Congregations Study indicate that 58 % of religious congregations are involved in health-related activities, only about 6 % have programs serving people living with HIV (Chaves and Anderson 2008; Frenk and Trinitapoli 2012; Williams et al. 2013). Identifying the range of barriers and facilitators to HIV activities among religious congregations is critical to understanding how different types of congregations may (or may not) become involved and the potential for engaging a greater proportion of the faith community in the response to the HIV epidemic.

This paper advances studies that have focused on congregations of a single racial or ethnic community (Berkley-Patton et al. 2010, 2012; Brown and Wells 2005; Chin et al. 2005; Francis and Liverpool 2009; Griffith et al. 2010; Hernández et al. 2007; Hicks et al. 2005; Leong 2006; McKoy and Peterson 2006; McNeal and Perkins 2007; Smith et al. 2005; Stewart 2012) or were limited to single respondents within a congregation (Cunningham et al. 2009; Tesoriero et al. 2000) by identifying facilitators and barriers to congregational HIV activities using multiple in-depth interviews and case studies from a diverse sample of urban religious congregations. Moreover, unlike other studies that primarily described the experiences of authors implementing a congregationally based HIV intervention (Agate et al. 2005; Merz 1997), we sought to learn from the experiences that congregations themselves had in contemplating involvement and implementing various HIV-related activities. As part of this approach, our sample of congregations was also purposely selected to reflect a range of HIV activity.

We organize facilitators and barriers based on our wider project's framework of four dimensions of factors that influence congregations' willingness and capacity to adopt, implement, and maintain HIV-related activities (Derose et al. 2010): (1) *norms and*

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attitudes, the extent to which congregations and the wider communities they are embedded in provides social and cultural support for HIV activities; (2) *organizational structure and process*, the "compatibility" (Rogers 2003) of HIV activities with organizational roles and practices within and outside the congregation; (3) *resources*, the financial, material, and human resources that can be mobilized from within congregations or wider environments to support HIV activities; and (4) *demographics*, the ethnic/racial, income, educational, and health composition of congregations and community settings.

Following D'Aunno et al. (1999), the framework highlights the effects within the four dimensions of internal versus external sources of support to engage in HIV-related activities, which in turn affect the diffusion, implementation, and outcomes of congregational HIV efforts for individuals and communities.

The specific objectives of this paper are to: (1) identify the range of facilitators and barriers to HIV activities as perceived by multiple clergy and lay leaders within religious congregations, (2) understand internal and external sources of influences on these activities, and (3) explore differences in facilitators and barriers across congregations varying on characteristics, such as level of HIV activity, racial-ethnic composition, denomination, and size.

Methods

Case Study Design

The overall project utilized a comparative case study design (Eisenhardt 1989; Yin 1994) that allows in-depth exploration of congregational dynamics, incorporation of multiple perspectives and sources of data within congregations, and comparison of HIV activities across types of congregations, using a community-based participatory approach described elsewhere (Derose et al. 2010, 2011).

Congregational Sampling and Case Selection

The project focused on the three geographic areas within Los Angeles County that are most highly affected by HIV, according to county health department surveillance data. We compiled a list of 80 congregations that were identified by our community experts and other local sources as having been involved in HIV activities in the three study areas and administered a brief telephone screening questionnaire (with a response rate of 88 %). Using the screening data in consultation with our community advisory board, we recruited a purposive sample of 14 congregations to obtain variation on our main outcomes of interest (extent and type of HIV activities, including those without current activities) as well as other factors known to influence implementation of congregational health programs (including HIV), such as racial/ethnic profile of the congregation, religious denomination, and congregational size and resources (Tesoriero et al. 2000; Thomas et al. 1994). Each congregation received an unrestricted financial contribution for participation in the study.

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Data Collection

We collected data during multiple visits over a roughly 1-year period for each case congregation, mostly during 2007. Our methods included the following: qualitative, in-depth *interviews* with clergy and lay leaders on topics such as congregational background and dynamics, involvement in health and HIV/AIDS activities, and interactions with external entities; a *congregational information form* that asked for basic information about congregational membership, resources, and programs; *observations* of religious services, health and HIV-related activities, and facility context; and a review of *archival information* (e.g., congregational documents, news stories).

The main data source for this paper consists of the interviews, which were conducted in-person with 57 individuals across the 14 congregations (3–6 per congregation), including at least one clergy and one lay leader at each. The interviews used a semi-structured protocol typically lasting 1.5 h (range 1–4 h) and were recorded digitally supplemented with detailed manual notes.

Coding of Barriers and Facilitators

The interview protocols included several questions that specifically asked about the "biggest challenges in starting and keeping" health and HIV efforts going, ways that the congregation or its members have "tried to overcome these challenges," and circumstances that "have made it easier or harder to implement these activities." Other questions on the protocol also elicited responses on perceived barriers and facilitators to implementing and sustaining HIV activities, including how and why the congregation became involved in activities, how their activities have been organized and changed over time, congregational and denominational attitudes and policies toward HIV and related issues (e.g., homosexuality, drug, and alcohol use), and community attitudes and interactions with the congregation around health and HIV issues. For the subset of congregations that had low or no current HIV activities, we asked similar questions about any prior HIV activities conducted by the congregation, as well as the "kinds of things that might steer the congregation toward or away from HIV-related issues" in the future.

For this analysis, the perceived facilitator or barrier codes were defined as any issues that respondents perceived as having encouraged or hindered the successful launching or maintaining of HIV programs and activities within their congregation. We only included quotations in which the response or its context explicitly described the issue as a facilitator or barrier from the perspective of the interview respondent (e.g., "That was a problem…", "The thing that really helped get us started…"). These emergent themes were then classified according to the four principal contextual dimensions in our framework.

In keeping with the framework, each perceived facilitator and barrier quotation was additionally coded according to whether it reflected an influence *internal* to the congregation (e.g., congregant attitudes, clergy priorities), *external* to the congregation (e.g., community conditions, funding sources), or both. Given that our unit of analysis was the congregation, denomination influences, as well as linkages to other outside organizations and entities, were coded as external.

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Results

Congregation and Interview Participant Characteristics

Table 1 describes key characteristics of the 14 congregations and 57 interview participants. Six of the congregations were predominantly African-American, 4 were Latino, 2 were white, and 2 were of mixed composition (i.e., no racial-ethnic group >70 %). The congregations were from various denominations (Jewish Reform and various Christian, including Catholic, mainline Protestant and Evangelical/Pentecostal) and ranged in membership size from less than 150 members to more than 8,000. Slightly more men (30) than women (27) were interviewed, and more lay leaders (35) than clergy (22). Level of HIV activity was classified according to definitions from a previous analysis (Derose et al. 2011): 4 of the congregations were categorized as low HIV activity (i.e., activities were infrequent or not targeted specifically to HIV); 4 as medium (i.e., activities were more frequent than once a year and targeted HIV, but were an extension of what congregations already do); and 6 as high (i.e., frequent and targeted HIV activities that included multiple types of activities beyond what congregations traditionally do).

Perceived Facilitators to Congregational HIV Activities

Table 2 shows the number of congregations in which the various facilitators of congregational HIV activities were mentioned, how we classified facilitators (internal and/or external influences), and the dimension of our conceptual framework to which each facilitator corresponds. The most commonly perceived facilitators (i.e., mentioned by more than half of our congregations) were as follows: (1) perceived need or demand for HIV-related outreach or services and (2) external entities and linkages.

Perceived need or demand included comments indicating that HIV programs or services were started or continued because of a need or unmet demand within either the congregation or wider community.

> So I would think that's something that there's a need. If you ask in the population, do you know anybody that has AIDS? Friend, relative, neighbor, co-worker? Everybody raises their hands, so there's a big issue. (*Clergy, African American Catholic congregation*). It started out, I think, by us getting involved with [a substance abuse treatment center], and the ladies and children coming out of that program, and a lot of them were HIV-positive. You know, what are we doing in the community to help that? (*Lay leader, mixed race, non-denominational congregation*).

External entities and linkages encompassed all references to external organizations or individuals as reasons why the congregation became or stayed involved in HIV activities, including the availability of resources or programs offered by external entities as well as the "social capital," i.e., connections and relationships of the congregation and its members to external entities as conduits of initiation and support for HIV efforts.

> For instance, [the head of our HIV ministry] is on the board with [a residential treatment facility]. And [that facility] is working with other ministries in training… And she works with them in facilitating training, drawing in other churches who

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> are interested in starting HIV and AIDS ministries and things like that. (*Lay leader, African American Catholic congregation*).

> One blessed thing about our church is that we have a lot of gifts and talents… and a lot of people in different positions on jobs and stuff. We happen to have one of the directors [of a local] hospital center… And so when we get ready to do health fairs and we need information and people to come in, she's usually our person who does that for us. And then we have a nurse, a head nurse who works at the [county hospital]… She's president of our Usher Board. So between the two of them, they… know the connections, they bring in the band, the medical band… they bring in all the nurses; they just do it. Between the two of them, that's our health department. (*Clergy, African American Protestant congregation*).

Personal experience was a somewhat common perceived facilitator (i.e., mentioned by between a third to a half of the congregations). This category included personally having HIV, knowing a friend, family member, congregant or acquaintance with HIV, or directly caring for someone with HIV.

> ..we do health education classes at our church for HIV… And one of the reasons why: we have a member who is HIV positive. And he came to the church and he talked to the pastor about it and… then they made the announcement in the church that he was a member and he was HIV-positive. And so that kind of helped us form our health awareness classes and program. (*Clergy, African American Protestant congregation*).

Clergy support for HIV activities ranged on a continuum from passive acceptance or tolerance (e.g., not strictly enforcing denominational restrictions on promoting condoms), to providing moral support or political cover, indirect support (e.g., mentioning activities during sermons, appearing at events), or direct support (e.g., personally running a program).

> …[The rabbi] makes sermons about HIV related types of policy and helps educate people, and ensures that that voice is included. …There was a little dip in interest, and [the rabbi] revived that interest to remind people that although there are a lot of people who are getting better, there are a lot who aren't. (*Lay leader, White Jewish Reform congregation*).

The themes in the *attitudes, values, and philosophy* category comprise a rather heterogeneous grouping associated with attitudes, beliefs, and religious philosophies toward HIV and related issues (such as homosexuality, substance use, and other health conditions and behaviors), as well as other values related to the work and social life of congregations. Facilitators in this grouping included feelings of personal satisfaction from the nature of HIV work, other individually held values or beliefs (e.g., "my parents raised me to give back to the community"), and collectively held values, culture or climate of congregations and communities (e.g., a social justice ethic, "civic awareness," a welcoming or inclusive atmosphere).

The *human capital* facilitator included the number of congregants, volunteers or paid staff, the presence of key individuals or core groups of activity leaders, and specialized skills or qualities (e.g., reliable worker, health-related background, organizational skills). Material

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asset facilitators included financial resources (e.g., grants, fundraising), spatial resources (e.g., buildings, meeting space), and materials and equipment (e.g., in-kind donations, computer and office equipment, cars and transportation).

Sources of Influence for Facilitators

For the most common facilitators, perceived need or demand for congregational HIV activities was mentioned fairly equally as coming from within congregations and the wider community. External entities and linkages were by definition coded as external influences, but as the quotations above illustrate, linkages represent the connections of congregational members with the wider community and may be more properly considered to bridge the two. In contrast, all five of the perceived facilitators that fell in the "somewhat common" category (middle of Table 2) were considered internal influences.

Perceived Barriers to Congregational HIV Activities

Table 3 provides an overview of the perceived barriers to congregational HIV activities identified in our interviews with clergy and lay leaders. Four types of barriers were mentioned by more than half of our congregations: (1) attitudes, values, and philosophy; (2) lack of human capital; (3) lack of congregation support, and (4) lack of material resources.

Attitudes, values, and philosophy included HIV-related stigma; indifference about HIV; and characteristics of congregational or community culture and climate, such as a mentality of "us-versus-them" or a focus on monetary versus volunteer participation.

> … we have dedicated ourselves to simpler things like prostate cancer, breast cancer… they have already been worked on… people are more used to them. As opposed to, say, "Let's go to an HIV/AIDS campaign." People, "AIDS, woa!" they're afraid of it. AIDS is a pandemic, which has caused fear in people. (*Clergy, Latino evangelical congregation*).

Human capital barriers included lack of a core group of activity leaders (or their departure due to death from AIDS or leaving the congregation), lack of people with key organizational or service provision skills (e.g., grant-writing, bilingual proficiency), lack of volunteers, and small size (i.e., congregation "not big enough" in membership to support certain services).

Lack of congregational support included lack of involvement, inconsistent participation in HIV activities, and outright resistance to addressing the topic, whether by the congregation as a whole, particular segments, or people outside the congregation. Lack of support was frequently rooted in attitudes of stigma described above but sometimes in other issues, such as linguistic differences or apathy.

> … in terms of sex,… sexually transmitted diseases… we as an African-American community, for some reason, do not jump into that area too quickly, if at all… So when you mention sexual problems or things happening in society, like HIV and AIDS, our people… put blinders on. They hear you and they understand, but sometimes that's how far they want to go… they don't want to be really proactive in forming committees, to say, okay, let's do something about this. …. it's not that [the pastor] doesn't care or that he's neglecting. I think he just feels that he's not

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> going to get the support from the congregation. (*Clergy, African American evangelical congregation*).

> So, the people's response, the [AIDS] walk; I see there's English and Spanish support. But for like a workshop, there has been much less participation. Maybe because they don't want to talk about it or they're scared to talk about it in public. … "If I go they'll see me,"… and, "What am I going to say," that "I have… someone at home" or that "I only want to educate myself." That's a complication. For that reason there's been less participation in workshops and all that. (*Clergy, Latino Catholic congregation*).

Material resources, also among the leading barriers cited across congregations, centered on lack of funding and space.

The somewhat commonly perceived barriers included two—*lack of perceived need* and *lack of clergy support*—that were corollaries of prominent facilitators. Other somewhat commonly perceived barriers among the congregations were related to the *nature of programs* (e.g., program growing very large, convenience of program day/time, or variability in types of participants) and to *competing priorities*:

> So, you need manpower, woman power. And you need money to run some of these outreaches. So, one of the challenges I perceive as being a pastor in the church is so many things that have to be addressed. (*Clergy, African American Baptist congregation*).

Lastly, the category for *attitudes of particular demographic or cultural groups* contains many of the same quotations coded in the attitudes, values, and philosophy category, but includes those that were specifically associated by respondents with particular racial, ethnic, language, class, or other demographic attributes.

Sources of Influence for Barriers

The most common barriers were more often internal than external to the congregation—except for material resources, which was mentioned as both. Similarly, the other commonly perceived barriers were generally internal—except for perceived need or demand and attitudes of demographic or cultural groups, which were both internal and external.

Perceived Facilitators and Barriers by Congregational Characteristics

Lastly, we explore variations in perceived facilitators and barriers by key congregational characteristics that we used in selecting our purposive sample, including level of HIV activity, racial/ethnic composition, denominational group, and size. Although these results are especially tentative given the relatively small number of congregations per type and the study's purposive sampling design, they provide suggestive comparative insights currently lacking in research. We highlight those issues mentioned by at least half the congregations of a particular characteristic (e.g., high activity) compared to other congregations (e.g., medium or low activity).

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First, high activity congregations tended to mention slightly more facilitators *and* barriers than lower activity congregations (an average of two more issues per congregation). High activity congregations also mentioned the facilitators of clergy support, external entities and linkages, and material resources more prominently, while low activity congregations especially focused on the barrier of lack of perceived need or demand for HIV activities.

In terms of racial/ethnic composition, the barriers related to lack of perceived need or demand and to culturally related attitudes and stigma were most prevalent across the Latino congregations. Lack of general congregational support was mentioned frequently by both African-American and Latino congregations.

With respect to religious denomination, the clergy support facilitator appeared especially prevalent among the Catholic and Jewish congregations in the study. Facilitators related to attitudes/values/philosophy were particularly noted among Catholic and mainline Protestant congregations, while those related to personal experience with HIV were more prevalently mentioned among mainline Protestant congregations. The perceived need facilitator was particularly noted among mainline Protestant, Catholic, and evangelical/Pentecostal congregations. Results for two barriers also suggested differences by type of congregation. The competing priorities barrier was especially prevalent among evangelical/Pentecostal congregations and the denomination policy barrier more prominent among Catholic congregations (typically related to prohibitions against condom use).

Finally, larger congregations mentioned human capital as a facilitator and barrier more than small-sized congregations. Smaller congregations tended to emphasize barriers related to material resources and to the nature or appeal of programs themselves.

Discussion

This study provides new information on the facilitators and barriers to congregational HIV activities as perceived by clergy and lay leaders, the relative internal or external sources of those facilitators and barriers, and suggestive differences across types of congregations.

The facilitators and barriers most commonly discussed by the congregational leaders were related to *norms and attitudes*. As previous studies have found, attitudinal barriers often involved stigma related to HIV and/or homosexuality (Berkley-Patton et al. 2010; Hernández et al. 2007; Hicks et al. 2005; Tesoriero et al. 2000) or discomfort with sexuality in general (Brown and Wells 2005; Hernández et al. 2007; McKoy and Peterson 2006; McNeal and Perkins 2007; Merz 1997; Smith et al. 2005); attitudinal facilitators included more welcoming, inclusionary, or compassionate climates and theological orientations within congregations (Chin et al. 2005; Hernández et al. 2007; Hicks et al. 2005). In our study, attitudinal barriers were more frequently described as rooted in particular cultural orientations in the Latino congregations, although attitudinal barriers were also mentioned for other cultural and demographic groups, including African-Americans, the elderly, and middle class individuals. Attitudinal barriers linked to theology were often described as deeply entrenched but tended to be expressed as general religious teachings and beliefs as

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opposed to more formal denominational doctrine or policy, except as noted previously for Catholic prohibitions on condom use.

We found other attitudinal influences that have been identified by others, such as perceived need or demand for HIV activities (Chin et al. 2005; Cunningham et al. 2009; Hicks et al. 2005; Smith et al. 2005; Tesoriero et al. 2000), personal experience with HIV (Hernández et al. 2007), clergy support (Agate et al. 2005; Cunningham et al. 2009; Hicks et al. 2005), general congregational support (Agate et al. 2005; Hicks et al. 2005; Merz 1997; Tesoriero et al. 2000), and competing priorities (Agate et al. 2005; Cunningham et al. 2009; Hernández et al. 2007; Merz 1997; Smith et al. 2005; Tesoriero et al. 2000). In our study, clergy support was frequently reported as a facilitator among congregations with higher levels of HIV activity, indicating its importance in maintaining and expanding HIV programs and services.

Factors related to *resources* were also prominently mentioned across our study congregations, most commonly as barriers, but also as facilitators. As one might expect, lack of material resources—funding (Hernández et al. 2007; Smith et al. 2005; Tesoriero et al. 2000) but also space and supplies—was a barrier frequently reported among smaller congregations. In contrast, lack of human capital was a more frequently mentioned issue among the larger congregations, indicating that other challenges to HIV work may be more pressing to congregations of a smaller size.

In addition to issues discussed in other studies, such as lack of knowledge and qualifications to talk about HIV prevention (Brown and Wells 2005; Francis and Liverpool 2009; Smith et al. 2005; Tesoriero et al. 2000) and education levels of clergy and congregants (Hernández et al. 2007), our study suggested the salience of other aspects of congregational human resources for HIV activities, including having access to a pool of willing volunteers, and people with relevant expertise—whether organizational skills, health background, or knowledge and familiarity with the community and wider resources.

The most common issue related to *organizational structure and process* cited across our study congregations concerned external entities and linkages. In contrast to a previous study that focused on issues such as difficulty collaborating with AIDS service organizations and managing the complexity of the grant funding process primarily as barriers (Hicks et al. 2005), in our study, congregations' external entities and linkages were more commonly perceived as facilitators and potential opportunities for HIV activities. This was particularly true for congregations with higher levels of HIV activity. The lack of such linkages does not appear to prevent programs from starting, but their presence as "social capital" seems to facilitate and sustain activity.

Our analysis of *internal and external* sources of facilitators and barriers identified some that were by definition more likely to be internal (e.g., personal experience with HIV, clergy, or congregational support), some that had both internal and external elements (e.g., perceived need or demand, stigma related to HIV disease or sexuality), and others that were more likely by definition to be external or bridging of the two (i.e., external entities and linkages).

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Limitations

Our study is well-suited to describing the variety of facilitators and barriers experienced across diverse congregations; however, the results may not be representative of the population of religious congregations more generally due to the purposive sampling strategy and location in one metropolitan area. In addition, despite conducting interviews with multiple clergy and lay leaders in each congregation, our study did not directly incorporate perspectives from the wider body of congregants or participants in congregational programs and activities, who often include individuals from the community at large. Leaders' perceptions help shape and explain their actions, yet their positions within congregations may result in privileging or excluding certain explanations or to differentially attributing reasons for their versus others' behavior (Malle et al. 2007).

Conclusion

A variety of barriers and facilitators affect congregational HIV activities; while norms and attitudes were prominent, these often were not described in terms of theology or religious philosophy. For example, although denominational policy and doctrine were discussed at length in many of the interviews, policies or doctrines were only identified overtly as barriers to HIV activities in three of our congregations, mostly related to restrictions on condom use. Understanding how theology and religious philosophies are related to the variety of attitudes and norms that may be more proximately related to support for congregational HIV activities (such as inclusive attitudes or competing priorities) is a fruitful area for future research.

The distinction between internal and external sources of facilitators and barriers highlights roles different stakeholders within and outside congregations can play in promoting congregational HIV activities. Internal influences are more directly leveraged or addressed by clergy and congregants, while outside stakeholders could focus on external influences within their purview. For example, the public health community could facilitate external outreach and linkages, denominations could create theological reflections and materials, and funders could create mechanisms to address material resources, especially for smaller congregations, which comprise the bulk of the faith community. In this regard, additional research that directly assesses the perspectives of congregational members who are not leaders as well as other community members who participate in congregational programs—and how these perspectives interact with those of congregational leaders—would further advance understanding of the dynamics involved in introducing and sustaining HIV activities within religious congregations.

The suggestive results on variation among different types of congregations also imply that approaches to promoting HIV activities need to take into account differences in relevant congregational characteristics, such as racial/ethnic composition and size. Further examining these findings through studies using wider samples of congregations and analyses that do not rely strictly on self-reported identification of facilitators and barriers would improve the ability to tailor HIV and other health promotion activities within religious congregations. The findings presented here, based on in-depth study of a diverse set of urban religious congregations, provide more comprehensive insights for future research and initiatives on

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the involvement of different congregations in addressing such critical public health priorities as HIV.

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Table 1

Congregation and interview participant characteristics

Congregations (n = 14)	**Frequency**
Predominant race or ethnicity[a]	
African-American	6
Latino	4
White	2
Mixed[b]	2
Congregation size[c]	
Large (501 members)	6
Medium (151–500 members)	5
Small (150 members)	3
Denomination	
Catholic	3
Evangelical, Pentecostal, or non-denominational	4
Mainline Protestant	4
Baptist	1
Jewish (Reform)	2
Level of HIV activity	
High	6
Medium	4
Low	4

Interview participants (n = 57)	**Frequency**
Race/ethnicity	
African-American	22
Latino	15
White	18
Asian	1
Other	1
Gender	
Female	27
Male	30
Role	
Clergy	22
Lay	35

[a]The predominant race/ethnicity comprises 70 % of regular participants (except for "mixed")

[b]No individual race/ethnicity comprises >70 % of regular participants

[c]Measured in terms of the number of reported congregational participants that attend services monthly

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Table 2

Facilitators to congregational HIV activities as reported by clergy and lay leaders

	# of congregations citing issue						
Perceived facilitators	**Total**	**Internal[a]**	**External[a]**	**Norms and attitudes**	**Organization structure and process**	**Resources**	**Demographics**
Perceived needs or demand	8	6	4	✓			
External entities/linkages	8	0	8		✓		
Personal experience	7	7	1	✓			
Supportive clergy	7	7	0	✓			
Human capital	7	7	0			✓	
Attitudes, values, philosophy	5	5	1	✓			
Material resources	4	3	2			✓	
Nature or appeal of program	3	2	2		✓		
Institutionalization of program	3	3	0		✓		
Prevalence/risk among demographic groups	2	2	1				✓

[a]The number of congregations describing a facilitator as internal to the congregation and the number describing it as external are not mutually exclusive, since some congregations may report the issue as being both (e.g., perceiving needs or demand for HIV services both within the congregation as well as in the community at large). Thus, the sum of the internal and external columns for a facilitator may be greater than the total number of congregations citing that issue

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Table 3

Barriers to congregational HIV activities as reported by clergy and lay leaders

	# of congregations citing issue						
Perceived barriers	**Total**	**Internal[a]**	**External[a]**	**Norms and attitudes**	**Organization structure and process**	**Resources**	**Demographics**
Attitudes, values, philosophy	11	10	7	✓			
Human capital (lack)	10	10	2			✓	
Congregation support (lack)	9	9	0	✓			
Material resources (lack)	8	6	6			✓	
Perceived needs or demand (lack)	6	4	5	✓			
Nature of program	6	5	2		✓		
Competing priorities	6	5	1	✓			
Clergy support (lack)	5	5	0	✓			
Attitudes of demographic/ cultural groups	4	4	4				✓
Program lifecycle	3	1	3		✓		
Changing acuity/ mortality of HIV pop	3	0	3				✓
Denomination policy/doctrine	3	0	3	✓			
Clients with diverse/difficult needs	2	0	2				✓
External services/ resources	2	0	2			✓	
External entities/ linkages (lack)	2	0	2		✓		
Coordination or organization (lack)	2	2	1		✓		
Other demographic-related challenges	1	1	0				✓

[a]The number of congregations describing a barrier as internal to the congregation and the number describing it as external are not mutually exclusive, since some congregations may report the issue as being both (e.g., noting attitudes of stigma toward HIV both within the congregation as well as in the community at large). Thus, the sum of the internal and external columns for a barrier may be greater than the total number of congregations citing that issue