Published in final edited form as:
AIDS Educ Prev. 2014 February ; 26(1): 28–42. doi:10.1521/aeap.2014.26.1.28.

AN INTERVENTION TO REDUCE HIV-RELATED STIGMA IN PARTNERSHIP WITH AFRICAN AMERICAN AND LATINO CHURCHES

Kathryn Pitkin Derose, PhD, MPH[1], **Laura M. Bogart, PhD**[2], **David E. Kanouse, PhD**[1], **Alexandria Felton, MPH**[1], **Deborah Owens Collins, PA-C, MSHCA, MPAS, AAHIVS**[3], **Michael A. Mata, MA, MCP, MDiv**[4], **Clyde W. Oden, OD, MPH, MBA, MDiv**[5], **Blanca X. Domínguez, MPH**[1], **Karen R. Flórez, DrPH, MPH**[1], **Jennifer Hawes-Dawson, BA**[1], and **Malcolm V. Williams, PhD, MPP**[1]

[1]RAND Corporation, Santa Monica, CA

[2]Harvard Medical School and Boston Children's Hospital, Boston, MA

[3]Long Beach Department of Health and Human Services, Long Beach, CA

[4]Fuller Theological Seminary, Pasadena, CA

[5]Bryant Temple African Methodist Episcopal Church, Los Angeles, CA

Abstract

HIV-related stigma negatively affects prevention and care, and community-based interventions are needed. Here we describe the development of a multi-ethnic, faith-based intervention to reduce HIV stigma that included: educational workshops on HIV, testing, and stigma; peer leader workshops using role plays and drawing on principles of motivational interviewing; a pastor-delivered sermon on HIV that incorporated theological reflection and an imagined contact scenario; and congregation-based HIV testing events. Lessons learned include: partnership development is essential and requires substantial investment; tailoring intervention components to single race-ethnic groups may not be preferable in diverse community settings; and adapting testing processes to be able to serve larger numbers of people in shorter time frames is needed for congregational settings. This development process successfully combined the rigorous application of social science theory and community engagement to yield a multifaceted HIV stigma reduction intervention appropriate for Protestant and Catholic churches in African American and Latino communities.

Keywords

HIV stigma; faith-based organizations; community interventions; HIV testing; research partnerships

INTRODUCTION

An estimated 1.2 million adults and adolescents were living with HIV in the US at the end of 2010, with one-fifth unaware of their infection and thus unable to benefit from improved treatment (Centers for Disease Control and Prevention, 2012). African Americans and Latinos are disproportionately affected; together they accounted for 64% of new HIV cases

Corresponding author: Kathryn Pitkin Derose, PhD, MPH, RAND Corporation, 1776 Main Street, PO Box 2138, Santa Monica, CA 90407-2138, Tel: (310) 393-0411, extension 6302, derose@rand.org.

in 2009, while representing only 30% of the US population. In 2007, HIV was the third leading cause of death for African Americans aged 35–44 and the fourth leading cause of death for Latinos in the same age range (Centers for Disease and Control and Prevention, 2012). Finding ways to reach more African Americans and Latinos with HIV testing and linking the newly diagnosed to clinical care and supportive programs are increasingly important for addressing the epidemic.

The national HIV/AIDS Strategy holds that stigma reduction is essential to reducing HIV-related disparities (National Center for HIV/AIDS, 2012). High levels of HIV stigma are associated with a lower likelihood of HIV testing in the general public (Fortenberry et al., 2002). Yet despite acknowledgement of the detrimental effects of HIV-related stigma, it remains a significant barrier to both prevention and treatment efforts (Earnshaw & Chaudoir, 2009). Moreover, few interventions aimed at reducing stigma are reported in the literature (Sengupta, Banks, Jonas, Miles, & Smith, 2011). Multi-faceted, multi-level, community-based interventions are needed to truly reduce the stigma related to HIV (Mahajan et al., 2008).

Faith-based organizations have been suggested as important to community efforts to address HIV, but their potential role in reducing stigma and promoting testing and linkage to care is not well-studied. Recently, congregation-based HIV prevention interventions have appeared in the literature, almost exclusively focused on African American churches (Agate et al., 2005; Baldwin et al., 2008; Berkley-Patton et al., 2010; Berkley-Patton, Moore, Hawes, Thompson, & Bohn, 2012; Griffith, Pichon, Campbell, & Allen, 2010; MacMaster et al., 2007; Marcus et al., 2004; Tyrell et al., 2008; Wingood, Simpson-Robinson, Braxton, & Raiford, 2011). HIV-related stigma has been noted as a barrier to congregation-based efforts (Williams, Palar, & Derose, 2011), but few studies have measured HIV-related attitudes and stigma in a church-affiliated population (Berkley-Patton, Moore, et al., 2012; Bluthenthal et al., 2012; Lindley, Coleman, Gaddist, & White, 2010; Muturi & An, 2010) and none have reported on congregation-based interventions designed primarily to reduce stigma.

Here we describe the development of a multi-faceted intervention that aims to reduce HIV stigma in partnership with African American and Latino churches. This Facilitating Awareness to Increase Testing for HIV (FAITH) intervention was developed collaboratively and in an iterative fashion by researchers, faith leaders, and public health professionals after extensive qualitative research and by drawing on stigma reduction theory that has not yet been tested through community programs. Intervention components were first pretested in two congregations (one African American and one Latino) and then fully implemented and tested in five congregations (one large Latino Catholic church, 2 medium-sized African American Baptist churches, and 2 small Latino Pentecostal churches). The present article focuses on development of the intervention. Other manuscripts will report extensive process and outcome evaluations of the full intervention pilot. By describing the development of this intervention, we provide in-depth information about designing a stigma reduction intervention and lessons learned that may be applied to other settings.

METHODS

Community partnering approaches

The FAITH intervention resulted from several years of relationship-building and collaboration among researchers, faith leaders, and public health professionals and an extensive, exploratory research phase to better understand congregational interest in and capacity for HIV-related activities. Consistent with a community-based participatory research (CBPR) approach (Israel, Schulz, Parker, & Becker, 1998), clergy and public health partners were involved in all stages of the research, including proposal development, an on-

going Community Advisory Board (CAB), data collection, analysis and interpretation (Derose et al., 2010), as well as the actual development of the FAITH intervention. Our exploratory, case study research, conducted with 14 racially and ethnically diverse congregations in three geographic areas of Los Angeles County that have been highly affected by HIV, found that congregations conducted a wide array of prevention and education, care and support, and awareness and advocacy activities serving both congregants and segments of their communities and that most congregational HIV activities were done in partnership with external organizations (Derose et al., 2011). We also found that HIV-related stigma posed barriers to congregational involvement and that HIV activities helped to reduce stigma in congregations (Bluthenthal et al., 2012). Using these results, we developed a multi-component, church-based intervention to reduce HIV-related stigma in collaboration with a local health department and faith leaders.

To develop our multi-component intervention, we first conducted a systematic literature review of HIV-related stigma and its consequences, stigma reduction interventions, and community-based HIV testing. Using these results, we worked closely with our clergy and public health partners to design each component and its associated activities and materials and pre-tested the methods in two congregations (one African American and one Latino). Below we summarize the theoretical basis of our intervention, the various components, and how they were pretested.

Stigma reduction theory

Our intervention is based on a conceptual framework that incorporated social psychological theories of stigma reduction, including the contact hypothesis (Pettigrew & Tropp, 2006). Previous research suggests that effective HIV stigma-reducing interventions should include both an informational component and a contact component (L. Brown, Macintyre, & Trujillo, 2003; Heijnders & Van Der Meij, 2006; Mahajan et al., 2008). Informational components address misconceptions about the disease and educate about modes of transmission and treatment, aiming to reduce fears about infection by increasing knowledge about transmission and ways to reduce risk. However, since HIV-related stigma is not solely driven by lack of knowledge about the disease, interventions that merely present information about HIV are largely not effective in reducing stigma (L. Brown et al., 2003).

Contact components promote direct or indirect interaction with people with HIV, engendering empathy for people with the stigmatized condition by prompting people to focus on a stigmatized person's perspective. Direct contact can include interaction with or testimonials by people with HIV. Indirect contact can include role-plays and discussions about hypothetical contact situations; testimonials heard through media rather than face-to-face; or imagined, "simulated" contact in which individuals are asked to think about a positive interaction with a stigmatized individual. Contact is most effective when it is institutionally supported (Pettigrew & Tropp, 2006) and takes place between individuals of equal status.

Our congregation-based intervention addressed stigma at the individual, congregation, and community levels. We aimed to leverage congregations' broad reach and ability to influence attitudes, first among congregants, and then more broadly in the community through established social networks. The HIV-related attitudes that we aimed to address included: comfort level interacting with HIV positive individuals (Herek, Capitanio, & Widaman, 2002); feelings of shame or rejection for being HIV positive (hypothetically) (Kalichman et al., 2005; Lauby, Bond, Eroglu, & Batson, 2006; Simbayi et al., 2007) or blaming people who have HIV (Herek et al., 2002) and stigmatizing attitudes towards addiction (Ronzani, Higgins-Biddle, & Furtado, 2009), "homosexuality" and "homosexuals" (Larsen, 1980). Our rationale was that reducing these various types of HIV-related stigma in collaboration with

congregations would increase community capacity to engage in HIV prevention activities and make congregations more welcoming environments for people with HIV, allowing them to tap into the community networks and social support provided by many congregations.

Congregation-based testing component

We included congregation-based HIV testing in our stigma-reducing intervention, both because our formative work suggested that testing would be more easily embraced than other prevention strategies among congregations (Derose et al., 2011) and because we believed that HIV testing and stigma reduction would be mutually facilitative in congregational settings. HIV testing reinforces the perception that the HIV epidemic is present in the community served by the congregation, making it harder to see HIV as only affecting "the other," and thus increasing empathy for those living with HIV. Moreover, pastors' and lay leaders' support and promotion of HIV testing establishes a positive norm that encourages acceptance of testing as an adaptive response to a health threat, helping to "normalize" HIV as a health issue rather than a moral issue (Koch & Beckley, 2006; McNeal & Perkins, 2007). For all these reasons, an ongoing program of HIV testing could have de-stigmatizing effects that are sustained over time.

INTERVENTION COMPONENTS

We operationalized the information and contact components through various congregation-based activities that were designed to operate at individual, congregational and community levels (see Table 1). All materials were professionally translated into Spanish and reviewed by bilingual members of the research team; adaptations were made by consensus.

HIV education workshops

These were designed to raise awareness about HIV, increase knowledge about HIV and HIV testing, and engender empathy for those affected by HIV. Each lasted about 90 minutes and was co-facilitated by a research team member and one of the health department partners. Table 2 outlines the specific topics and activities included.

The initial discussion about how HIV was affecting the community utilized a project-generated brochure that incorporated local statistics on the HIV epidemic and which groups were most affected. The discussion about HIV and HIV testing started with an 11-minute publicly-available education video [*What do you know about HIV and HIV testing?* (Brown University, 2012) and led into a counseling and testing presentation by health department staff, which involved a walk-through of the testing and counseling process to help participants understand and visualize exactly what was involved and to dispel concerns about confidentiality or about being judged for their behavior. For the group discussion on community perspectives (FAQs), participants wrote anonymously on index cards descriptors that they had heard in the community about HIV and people with HIV; the facilitators then led a discussion about these community beliefs. We also created a personal testimonial video of publicly available clips of people with and affected by HIV talking about the stigma they have experienced, particularly in the church environment. After workshop participants viewed the video, the facilitators led a discussion about stigma. This discussion focused on workshop participants' reactions, thoughts, and related experiences prompted by the comments made by persons in the video. The facilitator then led the group through a project-generated brochure that highlighted the consequences of stigma (from the literature) and ideas about what the Church can do to address stigma (e.g., support and encourage people with or affected by HIV, promote HIV testing, advocate for laws to protect people with HIV from discrimination).

Peer leader (PL) workshop

The workshop was designed to be an optional follow-up session to the HIV education workshops (i.e., people had to participate in the HIV education workshop first but they did not have to participate in the PL workshop, too, before participating in the HIV education workshop). The PL workshop provided participants with an opportunity to apply some of the HIV education workshop's concepts (HIV awareness and empathy for people affected) in a personal and interactive way through role plays. In addition, the PL workshops aimed to give participants experience and tools that would enable them to talk with others in the congregation and community about what they learned. These 90-minute workshops were co-facilitated by members of the project team.

To promote attitude and behavior change, facilitators discussed HIV stigma and HIV testing using a motivational interviewing (MI) style (Miller & Rollnick, 2002), which included open-ended questions, reflective listening, and exploration of ambivalence about HIV testing and reasons for HIV stigma. Congregational participants were also instructed on basic conversation tools that would enable them to talk with others about HIV and HIV testing in a non-threatening and non-judgmental manner. These tools drew on components of MI and included using *open questions* (questions that encourage conversation), *affirmations* (vs. judgmental or discouraging statements), and *reflecting* (saying back what the person heard to show he or she is listening). PL workshop participants were given opportunities during the workshop to role-play using these MI-inspired communication tools to discuss HIV and HIV testing and were asked to talk after the workshop with at least 3–5 other congregational and community members. Our overall approach was based on prior research that showed that the addition of MI to HIV field outreach is effective in encouraging HIV counseling and testing among high-risk groups (Outlaw et al., 2010) and that social network approaches in which minimally trained individuals reach out to others in their network can be more successful than models relying only on more highly trained individuals (e.g., health promoters) (Kelly et al., 1992; Ramos, Ferreira-Pinto, Rusch, & Ramos, 2010). Table 2 outlines specific workshop topics and activities.

Workshop pretests

The HIV education and PL workshops were pretested first in English at an African American Baptist church (14 participants) and revised based on systematic feedback from workshop facilitators, observers, and participants. The workshops were then pretested in Spanish at a Latino Roman Catholic church (16 participants) and again revised based on feedback. At all pretests, trained observers documented content and process-oriented aspects of the workshop (e.g., timing of various activities, key messages covered, participant interest levels, facilitators ability to elicit participation, group dynamics, participant enthusiasm and comfort levels with various activities, etc.). Participants completed evaluation forms about the workshops (e.g., how useful different aspects were, how comfortable they felt, whether materials were appropriate for the church environment, how interested they were in participating in other activities like HIV testing, what they liked and did not like about the workshops, etc.). We summarized the feedback from these completed forms and reviewed with our clergy and public health partners to determine how to modify intervention components, activities, and materials for the full pilot intervention.

Imagined or hypothetical contact scenario and HIV sermon

These were designed to raise awareness about HIV and HIV testing and increase empathy towards people affected by HIV. By having the pastor conduct this activity during a regular worship service, we aimed to tap into the clergy's ability to influence congregants and reach as many people as possible in the congregation. The contact component was based on research that suggests that simulated contact or interaction with someone with a stigmatized

characteristic can help to reduce prejudice (Blair, Ma, & Lenton, 2001; Crisp & Turner, 2009) and thus provides "a viable alternative for reducing prejudice where actual contact between groups is impractical" (Turner, Crisp, & Lambert, 2007). We chose a simulated contact rather than a face-to-face interaction with someone living with HIV based not only this research but also on the advice of clergy members of our CAB, who thought that some pastors would be reluctant to turn over the pulpit to someone whom they may not know. A description of the HIV sermon activity is available from the first author.

The sermon or homily in which this visualization exercise occurs focuses on challenging stigma, encouraging positive and compassionate attitudes toward people with HIV, and promoting HIV testing. During a worship service or large group meeting, the pastor or priest presents the visualization exercise in which congregants imagine meeting a person living with HIV and having a pleasant interaction. The imagined interaction occurs in a place where congregants or parishioners would have time for an extended conversation, such as a barber shop or beauty salon, traffic school, or a bus ride. The pastor or priest guides congregants in a way that leads them to envision a positive interaction.

Our clergy co-chairs of the CAB (co-authors CWO and MM) wove this scenario into a sample sermon on HIV, using the Biblical passage of the Good Samaritan (Luke 10:25–37). This passage relates a story in which Jesus teaches what is necessary to obtain eternal life. Specifically, Jesus indicated that one must "love your neighbor as yourself" and is asked "Who is my neighbor?" Jesus then tells a story of a man being beaten by robbers and left for dead on the roadside and how several religious leaders pass by him without helping; ultimately, the man is helped by a Samaritan (a people despised at the time and therefore this positive portrayal would have surprised Jesus' audience). The sermon then reflects on this passage and on the question of "Who acted as neighbor?" by taking listeners through a visualization exercise of imagining that question in modern times and applying it to meeting someone with HIV.

Clergy were asked to implement this sermon and visualization exercise at their principal worship services on one of the weekends leading up to or including an HIV testing event. We encouraged clergy to adapt the sermon to their own preaching style and tradition. The primary points to emphasize included: recent church activities related to the FAITH project and why the church was participating in their project; how HIV is affecting the African American or Latino community; a story about someone the clergy person knew who had HIV; HIV-related stigma and how it affects people with HIV; the importance of loving others and being non-judgmental; and the importance of HIV testing. One of our clergy collaborators pre-tested the hypothetical contact scenario/HIV sermon at a CAB meeting; overall, CAB members were very enthusiastic about the activity, and they provided specific feedback on how to modify it before the full intervention pilot.

Congregation-based HIV testing events

These were designed to increase access to HIV testing and raise HIV awareness by providing on-site rapid oral fluid testing. Health department counselors conducted rapid oral fluid testing and counseling through a mobile clinic. The congregation helped promote the events and the project team provided logistical support.

The test events were held around the times of worship services to maximize access to testing and increase visibility of testing (to help "normalize" testing). Specific testing dates were determined by the churches' and health department's calendars. Pastors and lay leaders were encouraged to undergo testing as role models. Educational materials were made available to those being tested and others who attended the testing events.

The health department modified its usual protocol for community-based testing to adapt to congregation-based settings. Since counseling and testing are usually done in one of two private spaces on the mobile clinic truck, staff typically could only test and counsel about 6 people per hour, with each person spending about 20 minutes on the truck for the entire testing and counseling process. For the congregation events, the health department brought additional clinic personnel to help with the intake process and moved the intake process and waiting period off the truck and into church spaces. People were swabbed and received their results and post-test counseling on the truck. By using the church space for intake process and waiting period, the health department could test 20 people per hour rather than the usual 6 people per hour on the mobile clinic exclusively. Because the mobile clinic was accustomed to conducting HIV testing in community settings, we did not pretest these procedures. However, for the full intervention pilot, we implemented an extensive process evaluation to be able to assess how well these procedures worked in congregational settings.

For intervention pilot, we had a very large Latino Catholic church (2000 members), two small Latino Pentecostal churches (100 members each), and two medium sized African American Baptist churches (150–250 members each). We knew that it was unlikely that everyone in these congregations would want to participate in a workshop and test event. The actual proportion of the congregation that would be targeted to participate in these intervention activities and their timing and frequency varied according to church size and interest. But we wanted to reach a significant number of people at each church with activities that required active engagement (workshops, testing) and nearly everyone with some of the activities that required less intensive interaction (sermon/hypothetical contact). Accordingly, the intervention was implemented over a period of several months, with more workshops and test events in larger churches.

LESSONS LEARNED

Community involvement and a CBPR approach were invaluable in designing the intervention and required investment of time and resources. The clergy partners played key roles throughout the study, especially in incorporating the visualization exercise into the HIV sermon. Likewise, the public health partners helped develop the workshop curriculum and the overall approach to congregation-based testing and played the primary role in conducting the testing. However, developing an effective partnership required substantial investment in relationship building, reflecting the need for adequate and flexible funds to support community-researcher partnerships (Minkler, Blackwell, Thompson, & Tamir, 2003). Further, the deep involvement of the public health department would not have been possible without sufficient funding.

The involvement of the local health department as partner connected area churches to an important community resource with which they typically do not have close contact. The value of this resource was apparent in participants' reactions to health department facilitators at the workshops. They asked many questions in the workshops and approached health department personnel to ask questions one-on-one regarding their personal situations. It was apparent that congregants had previously had few opportunities to interact closely with health department personnel or other public health experts of whom to ask factual questions about HIV. This is consistent with prior research, which has found that most of the partnering organizations involved in congregational health activities are non-profit prevention and social service providers and not local health departments or other government public health agencies (Werber, Derose, Domínguez, & Mata, 2012; Zahner & Corrado, 2004).

Pre-testing the intervention components in English and Spanish provided important feedback from congregational members and our clergy and public health partners. Pre-testing the HIV education and PL workshops provided the researchers and health department personnel additional opportunities, beyond the training setting, to practice co-facilitating the workshops. Through the workshop pretests, we also learned more about prevalent community beliefs about HIV. For example, in the Spanish (Latino) group, many identified sexual relations "without protection," blood transfusion, and sharing needles as primary HIV transmission modes, but some also asked about casual contact (shaking hands, kissing) and mosquito bites. Participants also indicated that people with HIV are judged harshly in their community and face rejection. In evaluation forms, participants were very positive about the workshops and in particular liked the role-playing, the videos, and being able to have their questions answered. For example, one respondent at the African American pretest said, "All of my questions were answered in a non-judgmental way. I feel prepared to discuss HIV/AIDS with my friends."

We also found that tailoring intervention components was necessary but challenging in diverse community settings. Our intervention materials reflected the multi-cultural communities in which we were working, e.g., our brochures included photographs of African Americans, Latinos, and whites, and the text emphasized the growing concentration of HIV cases among African Americans and Latinos. For the Spanish language brochures, we opted to use the same multi-cultural set of photos and text. For the video testimonials, there were many fewer video testimonials of Latinos and in Spanish than there were of African Americans. For this reason and after pilot-testing two versions of the videos (one with African Americans only, in English, another with Latinos only, in Spanish), we created a bilingual video appropriate for both African American and Spanish-speaking audiences.

In general, the evidence is mixed regarding minority group preferences for culturally-specific or multi-cultural materials. Herek and colleagues (1998) found a consistent preference among African Americans for AIDS videos with a black spokesperson and a culturally-specific message, while Brawner et al. (2012) found that African American adolescents reported that seeing only one racial or ethnic group in human papillomavirus (HPV) study materials gave the impression that non-minorities "don't get [HPV]", which could contribute to stigmatization of minorities. In our study, African American participants in the workshop pretest expressed a preference for a multicultural format (in the group discussion about the video and the evaluation forms, participants said they would prefer to see "other races" in the video as well), which demonstrates the importance of pretesting before fielding interventions.

Finally, we found it necessary to adapt the health department community testing protocol for the church setting. To make congregation-based testing as convenient as possible for church members, it needed to occur around the time of regular worship services and other church activities; however, testing large numbers of people in a short period while still maintaining confidentiality was a significant challenge. We worked closely with health department personnel and church leaders to develop a strategy for each congregation so that some of the testing protocol components could be conducted outside of the mobile clinic. This necessitated developing a clear plan for the flow of the testing protocol and making adjustments as necessary. We also had to ensure that a sufficient number of health department personnel were available for weekend test events.

DISCUSSION

Congregation-based HIV programs have been less common than programs on other health topics (e.g., cardiovascular disease and cancer screening). Barriers to congregational HIV

programs include stigma (Chin, Mantell, Weiss, Bhagavan, & Luo, 2005; Hernández, Burwell, & Smith, 2007; McNeal & Perkins, 2007), lack of pastor experience and knowledge of HIV programming (Hernández et al., 2007; Hicks, Allen, & Wright, 2005), low awareness about the level of need within the congregation and broader community (Chin et al., 2005; Hernández et al., 2007; Hicks et al., 2005), resource constraints (Smith, Simmons, & Mayer, 2005; Tesoriero et al., 2000), and lack of strategic planning around HIV (Hicks et al., 2005). Our intervention aimed to address some of these barriers, especially HIV-related stigma, low awareness, and resource constraints, through a theoretically and empirically-derived, multi-component intervention implemented in collaboration with congregations and a local health department.

Our intervention differs from most previous congregation-based HIV efforts in several ways. First, we focus on stigma reduction *integrated* with HIV testing rather than more general education about HIV prevention, reducing HIV risk behavior (Griffith et al., 2010; Wingood et al., 2011) or primarily the promotion of HIV testing (Berkley-Patton et al., 2010; Lightfoot et al., 2001). Recent work by Berkley-Patton et al. (Berkley-Patton, Thompson, et al., 2012) has incorporated a focus on HIV-related stigma into an HIV awareness and screening intervention and has begun to explore stigma as an outcome of the intervention (Berkley-Patton et al., 2013) as opposed to only a predictor of screening (Berkley-Patton, Moore, et al., 2012). Congregation-based HIV education and testing will likely contribute to reducing HIV stigma, we chose to focus on stigma more explicitly, as an earlier literature review suggested was necessary (Williams et al., 2011).

Second, our congregational HIV workshops incorporated communication tools using an MI style, both in the way facilitators approached participants and in the way peer leaders were trained to talk with others about HIV stigma and testing. Following MI principles, we encouraged participants to adopt a non-judgmental approach in talking with others; we presented this as a skill for participants to learn, not as an attitude they need to change. Church-based interventions trying to influence dietary behaviors have used MI, but usually these are one-to-one counseling sessions delivered by professionals (e.g., dieticians) (D. L. Brown et al., 2012; Resnicow et al., 2001).

Third, we incorporated a hypothetical contact scenario into the HIV sermon, since research suggests such visualization exercises can help reduce negative attitudes and prejudice towards stigmatized groups (Blair et al., 2001; Crisp & Turner, 2009). However, such research has only been conducted in social psychological lab-based studies, not in community settings.

Fourth, we developed an intervention to be implemented in collaboration with a public health partner given research that suggests the importance of partnership for congregation-based health programming in general (Steinman & Bambakidis, 2008; Trinitapoli, Ellison, & Boardman, 2009) and for HIV in particular (Agate et al., 2005; MacMaster et al., 2007; Marcus et al., 2004; Tyrell et al., 2008). Developing collaboration between local health departments and congregations can contribute to sustainability of congregation-based HIV efforts.

Finally, we developed an intervention for two specific racial/ethnic groups – African Americans and Latinos – whereas the overwhelming majority of congregation-based HIV interventions have been developed for African American churches alone (Berkley-Patton et al., 2010; Berkley-Patton, Moore, et al., 2012; Griffith et al., 2010; Wingood et al., 2011). As noted earlier, this diversity presented challenges in tailoring intervention materials, but provided us with a broader experience of how this kind of an intervention could be implemented.

Our development process successfully combined the rigorous application of social science theory and CBPR methods to yield a multifaceted HIV stigma reduction intervention that could be implemented in partnership with a local health department, in both evangelical Protestant and Catholic churches in African American and Latino communities. Of key interest is the extent to which the intervention ultimately reduces stigma and the ways in which it does so; other publications will report on the full intervention pilot, which conducted baseline and follow-up surveys of congregants across the five churches and extensive process evaluation to assess how specific components of the intervention were implemented, variations across different types of congregations, and preliminary effectiveness. However, in-depth description of the intervention itself and the theories behind it can inform other efforts to reduce HIV disparities, given the dearth of stigma-reducing interventions in the literature in general and among congregations in particular.

Acknowledgments

This study was supported by Grant Number 1 R01 HD050150 from the *Eunice Kennedy Shriver* National Institute for Child Health and Human Development (NICHD). Its contents are solely the responsibility of the authors and do not represent the official views of NICHD. The authors are grateful to other members of the study's Community Advisory Board, who provided excellent counsel and guidance in developing this intervention, especially Delis Alejandro, Father Chris Ponnet, and Richard Zaldivar. We also thank Kerry Brown, Carlos Campa, and Patricia Montes of the Long Beach Department of Health and Human Services for their contributions to the HIV education workshop and testing components, and Lizeth Bejarano of RAND for assistance in preparing intervention materials and this manuscript. Blanca Domínguez is now with the Integrated Substance Abuse Program at the UCLA David Geffen School of Medicine.

References

Agate LL, Cato-Watson D, Mullins JM, Scott GS, Rolle V, Markland D, Roach DL. Churches united to stop HIV (CUSH): A faith-based HIV prevention initiative. Journal of the National Medical Association. 2005; 97(7 Suppl):60S–63S. [PubMed: 16080459]

Baldwin JA, Daley E, Brown EJ, August EM, Webb C, Stern R, Devieux JG. Knowledge and perception of STI/HIV risk among rural African-American youth: Lessons learned in a faith-based pilot program. Journal of HIV/AIDS Prevention in Children & Youth. 2008; 9(1):97–114.

Berkley-Patton J, Bowe-Thompson C, Bradley-Ewing A, Hawes S, Moore E, Williams E, Goggin K. Taking it to the pews: A CBPR-guided HIV awareness and screening project with black churches. AIDS Education and Prevention. 2010; 22(3):218–237.10.1521/aeap.2010.22.3.218 [PubMed: 20528130]

Berkley-Patton J, Moore EMB, Simon SD, Thompson CB, Schleicher T, Hawes SM. Assessment of HIV-related stigma in a US faith-based HIV education and testing intervention. Journal of the International AIDS Society. 2013 in press.

Berkley-Patton J, Moore EW, Hawes SM, Thompson CB, Bohn A. Factors related to HIV testing among an African American church-affiliated population. AIDS Education and Prevention. 2012; 24(2):148–162. [PubMed: 22468975]

Berkley-Patton J, Thompson CB, Martinez DA, Hawes SM, Moore E, Williams E, Wainright C. Examining church capacity to develop and disseminate a religiously appropriate HIV tool kit with African American churches. Journal of Urban Health. 2012; 90(3):482–499.10.1007/s11524-012-9740-4 [PubMed: 22815053]

Blair IV, Ma JE, Lenton AP. Imagining stereotypes away: The moderation of implicit stereotypes through mental imagery. Journal of Personality and Social Psychology. 2001; 81(5):828–841.10.1037//0022-3514.81.5.828 [PubMed: 11708560]

Bluthenthal RN, Palar K, Mendel P, Kanouse DE, Corbin DE, Derose KP. Attitudes and beliefs related to HIV/AIDS in urban religious congregations: Barriers and opportunities for HIV-related interventions. Social Science and Medicine. 2012; 74(10):1520–1527.10.1016/j.socscimed.2012.01.020 [PubMed: 22445157]

Brawner BM, Baker JL, Voytek CD, Leader A, Cashman RR, Silverman R, Frank I. The development of a culturally relevant, theoretically driven HPV prevention intervention for urban adolescent females and their parents/guardians. Health Promot Pract. 201210.1177/1524839912462389

Brown DL, Conley KM, Resnicow K, Murphy J, Sanchez BN, Cowdery JE, Morgenstern LB. Stroke health and risk education (SHARE): Design, methods, and theoretical basis. Contemporary Clinical Trials. 2012; 33(4):721–729.10.1016/j.cct.2012.02.020 [PubMed: 22421317]

Brown L, Macintyre K, Trujillo L. Interventions to reduce HIV/AIDS stigma: What have we learned? AIDS Education and Prevention. 2003; 15:49–69. [PubMed: 12627743]

Brown University. Informational videos about HIV and HIV testing. 2012. Retrieved October 20, 2012, from http://www.brown.edu/Departments/BRUNAP/aids_video.html

Centers for Disease and Control and Prevention. Wisqars leading causes of death report, 1999–2007. 2012. Retrieved November 27, 2012, from http://webappa.cdc.gov/sasweb/ncipc/leadcaus10.html

Centers for Disease Control and Prevention. HIV in the United States: The stages of care. Atlanta, GA: CDC; 2012.

Chin JJ, Mantell J, Weiss L, Bhagavan M, Luo X. Chinese and South Asian religious institutions and HIV prevention in New York City. AIDS Education and Prevention. 2005; 17(5):484–502. [PubMed: 16255643]

Crisp RJ, Turner RN. Can imagined interactions produce positive perceptions? Reducing prejudice through simulated social contact. American Psychologist. 2009; 64:231–240. [PubMed: 19449982]

Derose KP, Mendel PM, Palar K, Kanouse DE, Bluthenthal RN, Castaneda LW, Corbin DE, Domínguez BX, Hawes-Dawson J, Mata M, Oden CW. Religious congregations' involvement in HIV: A case study approach. AIDS & Behavior. 2011; 5(6):1220–1232. [PubMed: 20953903]

Derose KP, Mendel P, Kanouse D, Bluthenthal R, Castaneda LW, Hawes-Dawson J, Mata M, Oden CW. Learning about urban congregations & HIV/AIDS: Community-based foundations for developing congregational health interventions. Journal of Urban Health. 2010; 87(4):617–630. [PubMed: 20361357]

Earnshaw VA, Chaudoir SR. From conceptualizing to measuring HIV stigma: A review of HIV stigma mechanism measures. AIDS and Behavior. 200910.1007/s10461-009-9593-3

Fortenberry JD, McFarlane M, Bleakley A, Bull S, Fishbein M, Grimley DM, Stoner BP. Relationships of stigma and shame to gonorrhea and HIV screening. American Journal of Public Health. 2002; 92(3):378–381. [PubMed: 11867314]

Griffith DM, Pichon LC, Campbell B, Allen JO. Your blessed health: A faith-based CBPR approach to addressing HIV/AIDS among African Americans. AIDS Education and Prevention. 2010; 22(3): 203–217. [PubMed: 20528129]

Heijnders M, Van Der Meij S. The fight against stigma: An overview of stigma-reduction strategies and intervention. Psychology, Health & Medicine. 2006; 11:353–363.

Herek GM, Capitanio JP, Widaman KF. HIV-related stigma and knowledge in the United States: Prevalence and trends, 1991–1999. American Journal of Public Health. 2002; 92(3):371–377. [PubMed: 11867313]

Herek GM, Gillis JR, Glunt EK, Lewis J, Welton D, Capitanio JP. Culturally sensitive AIDS educational videos for African American audiences: Effects of source, message, receiver, and context. American Journal of Community Psychology. 1998; 26(5):705–743.10.1023/A:1022157914906 [PubMed: 9861691]

Hernández, EI.; Burwell, R.; Smith, J. Answering the call: How Latino churches can respond to the HIV/AIDS epidemic. Philadelphia: Esperanza; 2007.

Hicks KE, Allen JA, Wright EM. Building holistic HIV/AIDS responses in African American urban faith communities: A qualitative, multiple case study analysis. Family and Community Health. 2005; 28(2):184–205. [PubMed: 15778632]

Israel BA, Schulz AJ, Parker EA, Becker AB. Review of community-based research: Assessing partnership approaches to improve public health. Annual Review of Public Health. 1998; 19:173–202.10.1146/annurev.publhealth.19.1.173

Kalichman SC, Simbayi LC, Jooste S, Toefy Y, Cain D, Cherry C, Kagee A. Development of a brief scale to measure AIDS-related stigma in south africa. AIDS and Behavior. 2005; 9(2):135–143.10.1007/s10461-005-3895-x [PubMed: 15933833]

Kelly JA, St Lawrence JS, Stevenson LY, Hauth AC, Kalichman SC, Diaz YE, Morgan MG. Community AIDS/HIV risk reduction: The effects of endorsements by popular people in three cities. American Journal of Public Health. 1992; 82(11):1483–1489. [PubMed: 1443297]

Koch JR, Beckley RE. Under the radar: AIDS ministry in the Bible Belt. Religious Research Association. 2006; 47(4):393–408.

Larsen KS, RM, Hoffman S. Attitudes of heterosexuals toward homosexuality: A likert-type scale and construct validity. The Journal of Sex Research. 1980; 16(3):12.

Lauby JL, Bond L, Eroglu D, Batson H. Decisional balance, perceived risk and HIV testing practices. AIDS and Behavior. 2006; 10(1):83–92.10.1007/s10461-005-9029-7 [PubMed: 16323035]

Lightfoot M, Rotheram-Borus MJ, Towns B, Cline TR, Webber D, Murphy DA, Tsai LF. Religious groups as diffusers of HIV antibody testing and prevention messages. Journal of Community Psychology. 2001; 29(4):459–472.10.1002/jcop.1029

Lindley LL, Coleman JD, Gaddist BW, White J. Informing faith-based HIV/AIDS interventions: HIV-related knowledge and stigmatizing attitudes at project F.A.I.T.H. Churches in south carolina. Public Health Reports. 2010; 125(Suppl 1):12–20. [PubMed: 20408383]

MacMaster SA, Jones JL, Rasch RER, Crawford SL, Thompson S, Sanders EC. Evaluation of a faith-based culturally relevant program for African American substance users at risk for HIV in the southern United States. Research on Social Work Practice. 2007; 17(2):229–238.10.1177/1049731506296826

Mahajan AP, Sayles JN, Patel VA, Remien RH, Sawires SR, Ortiz DJ, Coates TJ. Stigma in the HIV/AIDS epidemic: A review of the literature and recommendations for the way forward. AIDS. 2008; 22:S67–S79. [PubMed: 18641472]

Marcus MT, Walker T, Swint JM, Smith BP, Brown C, Busen N, von Sternberg K. Community-based participatory research to prevent substance abuse and HIV/AIDS in African-American adolescents. J Interprof Care. 2004; 18(4):347–359. [PubMed: 15801550]

McNeal CS, Perkins I. Potential roles of black churches in HIV/AIDS prevention. Journal of Human Behavior in the Social Environment. 2007; 2(3):219–232.10.1300/J137v15n02_13

Miller, WR.; Rollnick, S. Motivational interviewing: Preparing people for change. 2. New York: Guilford Press; 2002.

Minkler M, Blackwell AG, Thompson M, Tamir H. Community-based participatory research: Implications for public health funding. American Journal of Public Health. 2003; 93(8):1210–1213.10.2105/Ajph.93.8.1210 [PubMed: 12893597]

Muturi N, An S. HIV/AIDS stigma and religiosity among African American women. Journal of Health Communication. 2010; 15(4):388–401.10.1080/10810731003753125 [PubMed: 20574877]

National Center for HIV/AIDS, Viral Hepatatis, STD, and TB Prevention. HIV in the United States: An overview. Atlanta, GA: CDC; 2012.

Outlaw AY, Naar-King S, Parsons JT, Green-Jones M, Janisse H, Secord E. Using motivational interviewing in HIV field outreach with young African American men who have sex with men: A randomized clinical trial. American Journal of Public Health. 2010; 100:S146–S151.10.2105/Ajph.2009.166991 [PubMed: 20147689]

Pettigrew TF, Tropp LR. A meta-analytic test of intergroup contact theory. Journal of Personality and Social Psychology. 2006; 90(5):751–783. doi: 2006-07099-004. [PubMed: 16737372]

Ramos RL, Ferreira-Pinto JB, Rusch ML, Ramos ME. Pasa la voz (spread the word): Using women's social networks for HIV education and testing. Public Health Reports. 2010; 125(4):528–533. [PubMed: 20597452]

Resnicow K, Jackson A, Wang T, De AK, McCarty F, Dudley WN, Baranowski T. A motivational interviewing intervention to increase fruit and vegetable intake through black churches: Results of the eat for life trial. American Journal of Public Health. 2001; 91(10):1686–1693.10.2105/Ajph.91.10.1686 [PubMed: 11574336]

Ronzani TM, Higgins-Biddle J, Furtado EF. Stigmatization of alcohol and other drug users by primary care providers in southeast brazil. Social Science and Medicine. 2009; 69(7):1080–1084.10.1016/j.socscimed.2009.07.026 [PubMed: 19692163]

Sengupta S, Banks B, Jonas D, Miles MS, Smith GC. HIV interventions to reduce HIV/AIDS stigma: A systematic review. AIDS and Behavior. 2011; 15(6):1075–1087.10.1007/s10461-010-9847-0 [PubMed: 21088989]

Simbayi LC, Kalichman S, Strebel A, Cloete A, Henda N, Mqeketo A. Internalized stigma, discrimination, and depression among men and women living with HIV/AIDS in cape town, south africa. Social Science and Medicine. 2007; 64(9):1823–1831.10.1016/j.socscimed.2007.01.006 [PubMed: 17337318]

Smith J, Simmons E, Mayer KH. HIV/AIDS and the black church: What are the barriers to prevention services? Journal of the National Medical Association. 2005; 97(12):1682–1685. [PubMed: 16396060]

Steinman KJ, Bambakidis A. Faith-health collaboration in the United States: Results from a nationally representative study. American Journal of Health Promotion. 2008; 22(4):256–263. [PubMed: 18421890]

Tesoriero JM, Parisi DM, Sampson S, Foster J, Klein S, Ellemberg C. Faith communities and HIV/AIDS prevention in new york state: Results of a statewide survey. Public Health Reports. 2000; 115(6):544–556. [PubMed: 11354338]

Trinitapoli J, Ellison CG, Boardman JD. US religious congregations and the sponsorship of health-related programs. Social Science and Medicine. 2009; 68(12):2231–2239. [PubMed: 19394739]

Turner RN, Crisp RJ, Lambert E. Imagining intergroup contact can improve intergroup attitudes. Group Processes & Intergroup Relations. 2007; 10(4):427–441.10.1177/1368430207081533

Tyrell CO, Klein SJ, Gieryic SM, Devore BS, Cooper JG, Tesoriero JM. Early results of a statewide initiative to involve faith communities in HIV prevention. Journal of Public Health Management and Practice. 2008; 14(5):429–436. [PubMed: 18708885]

Werber L, Derose KP, Domínguez BX, Mata MA. Religious congregations' collaborations: With whom do they work and what resources do they share in addressing HIV and other health issues? Health Education and Behavior. 2012; 39(6):777–788.10.1177/1090198111434595 [PubMed: 22491006]

Williams MV, Palar K, Derose KP. Congregation-based programs to address HIV/AIDS: Elements of successful implementation. Journal of Urban Health. 2011; 88(3):517–532. [PubMed: 21331749]

Wingood GM, Simpson-Robinson L, Braxton ND, Raiford JL. Design of a faith-based HIV intervention: Successful collaboration between a university and a church. Health Promotion Practice. 2011; 12(6):823–831.10.1177/1524839910372039 [PubMed: 21511996]

Zahner SJ, Corrado SM. Local health department partnerships with faith-based organizations. Journal of Public Health Management and Practice. 2004; 10(3):258–265. [PubMed: 15253522]

Table 1

FAITH intervention activities, component type, and level

Intervention Activity	Information Component	Contact Component	Level of Intervention
HIV education workshops	• Brochure/discussion on how HIV affects local community • *Video/brochure on HIV and HIV testing*[1] • Counseling and testing presentation • *Brochure/discussion of HIV transmission facts*[2] • Discussion about community beliefs about HIV and people with HIV • Brochure/discussion about HIV-related stigma, its consequences, and what the church can do	• Stigma testimonials[3] (video)	Individual
Peer leader workshops	• Presentation and role plays drawing on motivational interviewing techniques • Handout with tips for peer leaders to use in conversations about HIV with church members or others in their social networks	• *Video on isolation and pain experienced by people with HI*[4] • Role play on HIV disclosure • Role play on how to talk to someone about HIV testing	Individual, with outreach to congregation
HIV sermon/imagined contact scenario	• How HIV affects community, why should church care • The importance of routine HIV testing • Theological support for empathy for people with HIV	• Imagined contact with person who has HIV	Congregation
Congregation HIV testing events	• Individual, risk-based counseling • Educational brochures and promotional materials		Congregation

Italicized items were publicly available or used with permission. All others were developed specifically for the FAITH project.

[1] http://www.brown.edu/Departments/BRUNAP/aids_video.html

[2] *HIV Facts* brochure available from http://pub.etr.org/

[3] Video clips used with permission from The Positive Project, International Planned Parenthood Foundation, and the Soy Campaign (Kaiser Family Foundation).

[4] *La cruz que pesa* video used with permission from Kizzy Lugo, Graphic Designer + Animator, Caracas, Venezuela

Table 2

Content of FAITH Workshops (HIV Education and Peer Leader)

Title	Content	Minutes	Main Messages/Purpose
HIV Education workshop			
Welcome – Why We Are Here	Present overview of session; discuss rules for safe learning environment; conduct icebreaker; distribute and discuss brochure outlining how HIV is affecting local community	20	Provide motivation for why people should get involved in HIV; increase participants' comfort level with topic and in group
Basic Facts about HIV and HIV Testing	Show video about HIV and HIV testing and discuss accompanying brochure; demonstrate process for rapid oral HIV test at church	20	Emphasize the importance of routine HIV testing to prevent transmission and facilitate treatment; familiarize participants with what to expect when the mobile testing clinic comes to the church
Frequently Asked Questions about HIV and HIV Testing	Discuss participants' anonymous answers to questions about what people in the community think about people with HIV and how HIV is spread	15	Address misconceptions and generate discussion about common community views about HIV and people with HIV (start discussing stigma)
Understanding HIV and Stigma through Video Testimonials	Show and discuss video with clips of people with HIV or affected by HIV talking about experiences of stigma and discrimination; distribute and discuss brochure about how stigma affects people with HIV and the community at large	25	Educate participants about the negative impact of stigma; identify ways that the church can support those with HIV and promote testing
Next Steps	Discuss lessons learned in session; provide information about peer leader training and HIV testing events	5	Encourage continued learning and participation in other project activities
Peer Leader workshop			
Welcome	Present overview of session; describe duties and requirements of peer leaders	10	Motivate participants about the important role they can play in sharing information about HIV and HIV testing with others
Putting Yourself in the Shoes of Someone with HIV	Show and discuss short film "La Cruz que + Pesa;" role play an HIV disclosure scenario; debrief role play experiences	25	Encourage empathy among participants for people living with HIV
How to Talk with People about HIV Testing	Provide an overview of communication tools for talking with others about testing (open questions, affirmations, reflecting); role play talking about testing with another congregant; brainstorm on whom peer leaders will talk with about the HIV testing events	35	Make participants more comfortable talking about HIV with other congregants; encourage non-judgmental interactions
Next Steps	Discuss lesson learned in session; review peer leader roles and responsibilities; provide event flyers, brochures, and bookmarks for peer leaders to distribute	15	Help participants develop a concrete plan for putting their training into action