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Practicing What Is Preached: Congregational Characteristics Related To HIV Testing Behaviors And HIV Discussions Among Black Women

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Abstract

Through the current analysis, we aimed to better understand the relationship between congregational support and HIV prevention behaviors among a sample of high risk, HIV negative Black women. Participants were 434 Black women who were at high risk for contracting HIV through heterosexual sex. They were recruited from a city in the Mid Atlantic Region. Data were collected through face-to-face interviews and Audio-Computer-Assisted Self-Interviews (ACASI). Results revealed three congregational characteristics were important for Black women's comfort level discussing HIV and their likelihood of returning for their HIV test results: feeling loved by their congregation, having ministries that helped people with their problems and feeling listened to by their congregation. Thus, religious congregational support was a significant correlate of Black women's comfort discussing HIV prevention and treatment as well as their motivation to return to get their HIV test results.

Keywords

HIV; Black women; Church

Introduction

The rates of HIV are staggering among urban Black women in the United States. In 2009, the estimated rate of new HIV infections for black women was more than 15 times as high as the rate for white women, and more than three times as high as that of Latina women (Centers for Disease Control and Prevention (CDC), 2011). The rates in Baltimore, Maryland mirror those at the national level, where one out of every 38 non-Hispanic Black women is reported to be infected with HIV (Maryland Department of Health and Mental Hygiene, 2010). Effectively addressing the burden of HIV among Black women may benefit from merging traditional and non-traditional mechanism of HIV education, prevention and

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treatment efforts. For example, because many people turn to churches for guidance and spiritual support, it is likely that churches could serve as key venues for communicating health promotion messages about HIV.

Churches have and continue to play an important role in the lives of many Americans (Lincoln and Mamiya, 2001; Miller, 2007). This may be especially true for Black women in the United States, given that more than eight-in-ten black women said religion is very important to them, and roughly six-in-ten said they attend religious services at least once a week (Pew Research Forum on Religion & Public Life, 2009). Evidence from the past 20 years of research strongly supports religious participation as a protective factor for physical and psychological well-being among African Americans (Levin, Chatters & Taylor, 2005). Although the positive associations between religion and health outcomes among Black women are clear, the specific nature of the relationship is less clear.

Central to Social Ecological Theoretical Perspectives is the notion of understanding multiple levels of influence including the mediating role of environmental factors on health behaviors and disease outcomes (Bronfenbrenner, 1977; Stokols, 1992). For instance, individual attitudes and beliefs regarding HIV prevention behaviors may be influenced by health promotion messages received from religious leaders. At the interpersonal level, the decision to disclose one's HIV status may be motivated by the level of support they receive from their peers in social settings. As an organization, the church's ideology on sexuality may serve as both a barrier and facilitator to addressing the phenomenon of HIV-related stigma. These three levels of influence are equally important to framing the current paper. Thus, the purpose of the current study is to better understand the relationship between congregational support and HIV prevention behaviors among a sample of high risk, HIV negative Black women. For the purposes of this study, HIV prevention behaviors are defined as returning for HIV test results and discussions of HIV prevention and treatment.

HIV Prevention Efforts in Black Churches

Increasingly, studies have reported the growing HIV prevention and treatment efforts of Black churches in the United States. These efforts range from hosting annual HIV testing days, to building capacity to deliver HIV services, observing of World AIDS Day, and implementing interventions around HIV education (Agate, Cato, Watson Mullins et al., Berkley-Patton, Bowe-Thompson, Martinez et al., 2012; Francis & Liverpool, 2009; Griffith, Campbell, Allen et al., 2010). Despite the evidence of the direct efforts to address HIV prevention and treatment within Black churches, little discussion has been given to the indirect and less explicit ways that churches might aid in the prevention and treatment of HIV.

The CDC estimates that one in five U.S. adults and adolescents are unaware of their HIV-positive status (CDC, 2012). An untreated or undiagnosed condition can lead to a myriad of consequences such as a compromised immune system and infecting sexual partners. It is possible that congregations would embrace HIV testing more readily than other prevention strategies, such as condom promotion and distribution, which may help normalize HIV as a health rather than a moral issue (Koch and Beckley, 2006; McNeal and Perkins, 2007).

Routine HIV testing, which aids in the early diagnosis and treatment of HIV, is consistent with the public health goals of HIV control, prevention, and education. Furthermore, routine HIV testing poses community-wide benefits to both HIV negative and positive individuals. On one hand, it allows HIV positive individuals to receive HIV education, pretest and posttest counseling, and linkages to care. On the other hand, it informs HIV negative individuals of their status and provides opportunities for health professionals to discuss steps to reduce their risk of contracting HIV. However, the focus on increasing HIV testing among Black women still may not be sufficient to reduce the incidences of HIV in this population. Black women must also be open to sharing their knowledge about HIV prevention and return for their HIV test results in order to prevent the spread of HIV.

HIV Stigma within Black Churches

Despite involvement from the religious community in HIV prevention and treatment efforts, some churches may still inadvertently contribute to the stigmatization of persons at risk for HIV/AIDS (Cunningham, Kerrigan, McNeely, & Ellen, 2011). In particular, the concerns about HIV stigma have been inversely associated to the uptake of preventive behaviors, like HIV testing, and knowing one's HIV status (Parker and Aggleton, 2003; Vanable, Carey, Blair & Littlewood, 2006). Earlier researchers have suggested that there are organizational, institutional, and cultural values in churches that hinder more effective and consistent HIV prevention and treatment efforts (Merson, O'Malley, Serwadda, & Apisuk, 2008; Piot, Bartos, Larson, Zewdie, & Mane, 2008).

Attempting to reconcile some religious teachings and doctrines with the behaviors that may increase one's risk for transmission of HIV (e.g., same-sex sexual behavior, pre-marital sex, and injection drug use) may discourage some faith leaders from making HIV prevention and a priority and contribute to HIV stigma among congregants (Tyrell, Klein, Gieryic, Devore, Cooper, et al., 2008; Lemell, 2004; Williams, Palar, & Derose, 2011). Person to person conversations and discussions will likely be a critical component in helping congregations prioritize HIV prevention and reduce HIV stigma. Thus, understanding the congregational characteristics that cultivate comfort discussing HIV topics is an essential first step to HIV prevention strategies within faith communities.

Congregational Support

Mattis and Jagers (2001) argued that the positive link between religion and health might be partially explained by the sense of connection and support shared between congregants. Furthermore, Obst and Tham (2009) reported social support to be a direct predictor of well-being among church members. Research on social support suggests that there are a number of different dimensions of social support (e.g., emotional, tangible, instrumental and informational) and that the source of social support (e.g. parent, friend, church member or pastor) is as important as the type of support provided (Krause, Ellsion, Shaw, Marcum, & Boardman, 2001). Consistent with the conceptualization of social support in secular settings, Taylor and colleagues (2004) describe congregational support as a type of social support that is exchanged among church members as opposed to the more formal outreach efforts and events. The authors noted that congregational support addressed multiple dimensions of social support including emotional support (e.g., advice and encouragement, companionship,

spiritual help) and instrumental support (e.g., transportation, financial assistance, goods, and services; Taylor et al., 2004).

The Current Study

Current research exists documenting the role and importance of spirituality and congregational support in the lives of people living with HIV/AIDS (Szaflarski, Kudel, Cotton, Leonard, Tsevat et al., 2012). However, less is known or documented about the ways in which congregational support facilitates uptake of prevention behaviors of high risk, HIV negative Black women. Congregational support may be especially important to high risk, HIV negative Black women in churches as it fosters a safe space for sharing and connecting on an intimate level. A more in-depth understanding the characteristics of churches that encourage HIV prevention behaviors (i.e. being tested for HIV and obtaining the results) among HIV negative Black women will likely enhance researchers' ability to more effectively tailor prevention strategies to this population and within this context.

The purpose of the current study is to better understand the relationship between congregational support and HIV prevention behaviors among a sample of high risk, HIV negative Black women. Three HIV prevention behaviors highlighted in the current paper: being tested for HIV, obtaining HIV test results, and feeling comfortable discussing HIV topics with congregants. The main outcome of interest is congregational support. The independent variables are HIV testing behaviors and comfort with HIV discussions. By focusing on HIV negative women and specific HIV prevention behaviors within a faith-based context, the current paper adds a unique perspective to the existing literature on HIV prevention strategies.

Method

The current study is a part of a larger randomized clinical control trial of an HIV prevention intervention for women and their social network members. It was conducted in Baltimore, MD, and is commonly referred to as the CHAT Program. The acronym CHAT was used to describe the 4 communication skills that participants were taught in the intervention: 1) **C**hoose the right time and place; 2) **H**ear what the person is saying; 3) **A**sk Questions; and 4) **T**alk with respect. The CHAT Project was designed to train women to be peer mentors. As a peer mentor, women were encouraged to talk to their social network members about HIV and STD risk reduction. Such discussions were proposed to persuade participants to change their own behaviors and yield safer behaviors among network members. Findings from the intervention have been discussed elsewhere (Davey-Rothwell, Tobin, Yang, Sun, & Latkin, 2011). The current study focuses on data collected during the 18 month follow-up assessment.

Sampling and Recruitment

The sample consisted of women and their social network members. Because the emphasis was on recruiting women at high risk for sexual transmission of HIV, eligibility criteria included: (1) female, (2) age 18–55 years old, (3) did not inject drugs in the past 6 months, (4) self-reported sex with at least one male partner in the past 6 months, and (5) had at least

one sexual risk factor including any of the following: (a) more than two sex partners in the past 6 months, (b) STI diagnosis in the past 6 months, and (c) had a high risk sex partner in the past 90 days (i.e., injected heroin or cocaine, smoked crack, HIV seropositive, or man who has sex with men).

Women were recruited through street outreach, word-of-mouth, advertisements, and referrals from health clinics, and other local community agencies. Recruiters approached women and asked them if they were interested in learning about HIV and STIs and giving something back to their community. Interested persons were given a card with a toll-free number to call for a screening assessment, which lasted about 10 minutes. Eligible participants were scheduled for a baseline visit which consisted of the informed consent process, survey administration and biological testing.

Data Collection

Data were collected at a community-based research center, which is a research space that is affiliated with an academic institution, but located in the community rather than on the campus of the university. No churches were directly involved in the study as recruitment sites or research partners; thus the information regarding churches is based on self-report data. After providing written consent, participants took STI tests and completed the baseline assessment. The baseline assessment included questions covered basic demographic information, sexual history, neighborhood characteristics, involvement in crime and violence, attitudes towards the police, health related communications, and drug use history. Part of the interview was administered by a trained interviewer and part was administered through Audio-Computer-Assisted Self-Interview. The study visits lasted approximately 2.5 hours.

During the visit, participants also completed a personal social network inventory, which included questions about the people they interacted with and follow-up questions about the attributes of each person. Some examples included individuals who provided emotional support, provided financial support, had sex with, socialized with, etc. Based on this network inventory, eligible social network members were identified. Eligibility criteria for social network members were: 18 years or older, and one of the following: someone who injected drugs, sex partner of index, or social network members whom the index participants felt comfortable talking to about HIV or STIs. Index participants were allowed to refer up to five network members to the study. Index participants received a remuneration of $10 for each network member who completed a baseline visit.

Baseline data were collected from September 2005 through July 2007. Data for this present study were collected during the 18 month follow-up assessment. Participants received $45 for completion of the visit, which ended in February 2010.

Participants

A total of 567 women completed the baseline visit. The 18-month follow-up assessment was the only assessment in which participants were asked about congregational support in addition to their HIV prevention behaviors. Accordingly, the sample for the current study was limited to CHAT study participants who completed an 18-month follow-up assessment

(N=506). The sample was further reduced because of the intentional focus on high risk, HIV negative Black women. Focusing on high risk, HIV negative Black women allowed us to highlight the role that religious congregations might play in prevention among a high-risk, yet uninfected group of women. Therefore, to be included in the current analysis, respondents had to meet the following criteria: (a) self-reported African American and (b) self-reported HIV negative status. Among the 506 female participants with 18-month assessment data, 434 women met these two criteria.

Table 1 describes the demographic characteristics of the final sample. The majority of the sample was over 35 years of age (*M* = 43 years). Nearly 50% of the women reported having graduated from high school; however, 9% of women who did not receive a high school diploma reported that they had earned a GED. Most of the women were either single (43%) or married/in a committed relationship (43%). Nearly 40% reported that they had used heroin or cocaine in the past six months. The women in the sample were fairly religious, with over 70% reporting that they pray daily and over 50% reporting that they attend church services at least once a month. Although the women in the sample represented 10 different denominations (e.g., Catholic, Methodist, Nondenominational and Pentecostal), most reported their religious affiliation as Baptist (64.1%). HIV testing was a common practice among the women in the sample, with more than 80% reporting that they had been tested for HIV in the past year. In general, participants indicated high levels of congregational support (*M* = 3.45) and relatively high levels of comfort discussing HIV prevention and treatment in their congregations (*M* = 3.69).

Measures

The development of all measures was guided by a thorough review of the existing constructs related to religiosity and HIV prevention. In order to contain the length of the assessment all questions were reviewed and included in the 18-month assessment after a consensus of the research team was reached. The current study has one dependent variable (congregational support) and two independent variables (HIV testing behaviors and comfort with HIV discussions) of interest. All three study variables are described below in detail.

Congregational Support—. Four items assessed congregational support. Items asked whether participants felt loved and listened to by members of their congregation and if they had ministries to help people with their problems and when they were sick. A sample item reads, “Is there anyone in your congregation who makes you feel loved and cared for?” This dichotomous measure asked participants to respond with “yes” or “no” to the questions. “Yes” responses were given a value of one and “no” responses were given a value of zero. Items were summed to create a scale with a maximum value of four (*M* = 3.45, *SD* = 1.04). Cronbach's alpha for this scale was .77. Congregational support served as the primary dependent variable in the data analysis.

HIV Testing Behaviors—All participants were asked if they had been tested for HIV. For participants who stated being tested, they were asked if they returned for the results of their last HIV test. The item read, “When you last got tested, did you get the result”. Participants responded “yes” or “no” to this item. The decision to obtain HIV test results served as an

independent variable for the analyses of the current study. Eight-six percent of the sample had an HIV test in the past year; 13% did not return for their testing results.

Comfort with HIV Discussions in Church—Two items assessed participants comfort discussing HIV prevention and treatment in their congregations. The items asked, “How comfortable would you feel talking with people in your congregation about HIV prevention” and “How comfortable would you feel talking with people in your congregation about HIV prevention”. Participants responded using a Likert-type scale that ranged from one to five, where one was “very comfortable” and five was “very uncomfortable”. Thus, *lower* values indicated *more* comfort. The items were summed to create a scale with a maximum value of 10 ($M = 3.69$, $SD = 2.18$). Cronbach's alpha for this scale was .90. Comfort discussing HIV prevention and treatment was an independent variable for the analyses of the current study.

Data Analysis

The analyses were conducted with SPSS 20.0. Multiple tests were used to analyze the data. Four demographic characteristics (i.e., age, relationship status, highest grade in school and drug use) were included as covariates in analyses. An ANOVA was conducted to evaluate the effects of congregational support on whether participants obtained their last HIV test results. A hierarchical multiple regression analysis was conducted to predict the overall comfort discussing HIV prevention and treatment in congregations from congregational support, controlling for the same four demographic characteristics.

Logistic regression analyses were also performed with the individual items that comprised the congregational support measure was also conducted. Conducting these analyses offered additional details about the ways in which the individual congregational support items and HIV testing variables were related. Because over 40% of the sample reported that they were very comfortable talking with people in their congregation about HIV prevention and treatment, the responses on the comfort measure were dichotomized into two categories for the logistic regression analyses: very comfortable and all other comfort levels. Chi-squared analyses were performed to better understand the ways in which the individual congregational support items and comfort variables were related. Similarly, the responses on the comfort measure were dichotomized into two categories for these analyses: very comfortable and all other comfort levels.

Results

Bivariate analyses indicated that congregational support was not significantly associated with the demographic characteristics. Congregational support was significantly related to comfort discussing HIV in congregations ($r = -.221$, $p < .001$), indicating that women with higher levels of support were more comfortable discussing HIV in their congregations than those with lower levels of congregational support. Congregational support was also related to the decision to return for HIV test results ($\chi^2 = 12.04$, $p = .017$), indicating that women with higher levels of congregational support were more likely to return for their HIV test results than women with lower levels of congregational support.

Main Analyses

Congregational support was a significant predictor of women's decision to return to get their last HIV test results, $F(4,343) = 3.12$, $p=.015$. The demographic variables included did not significantly add to the variance explained in obtaining the results from their last HIV test. Results from the hierarchical multiple regression, show that the demographic characteristics accounted for a significant amount of variance in comfort discussing HIV prevention and treatment among women, $R^2= .175$, adjusted $R^2= .031$ $F(5,348) = 2.76$, $p < .028$. Still, congregational support accounted for a significant portion of the variance after controlling for the demographic characteristics, R^2 change = .051, $F(5,348) = 19.401$, $p < .001$. Based on these results, congregational support appears to offer additional predictive power beyond that contributed by demographic variables.

Individual Item Analyses

Three of the scale items included in the congregational support measure were related to Black women's comfort level discussing HIV: attending churches where they felt loved by their congregation, that had a ministry that helped people with their problems, and where they felt listened to by their congregation (see Table 2). Black women reporting feeling loved by their congregation had a 2.2 increased odds of returning to obtain their results compared to Black women who did not feel loved by members of their congregation (95% C.I. = 1.01, 4.73, p = .047). Black women reporting having a ministry at their church that helps people with their problems were three times more likely to obtain their HIV test results than Black women who did not report having a ministry in their church that helps people with their problems (95% C.I. = 1.26, 8.45, p = .015). Finally, Black women reporting having someone in their congregation who listens to them were more likely to obtain their HIV test results than Black women who did not feel like anyone listened to them in their congregation (UOR = 2.2, 95% C.I. = 1.2, 4.5, p = .012). The presence of a ministry in the church that helps people when they are sick did not affect the likelihood that high risk, Black women would obtain their HIV test results.

Comfort with HIV Discussions in Church

Three of the scale items included in the congregational support measure were also associated with an increased likelihood of Black women returning for their HIV test results (see Table 3): attending churches where they felt loved by their congregation, that had a ministry that helped people with their problems, and where they felt listened to by their congregation. Black women were more likely to be very comfortable discussing HIV prevention in churches where they felt loved by their congregation ($\chi^2 = 4.01$, $p = .045$). Black women were more likely to be very comfortable discussing HIV treatment when their churches had a ministry that helps people with their problems ($\chi^2 = 4.29$, $p = .038$). Being in congregations where they felt listened to by members of their church was the only time that Black women reported being more likely to be very comfortable discussing both HIV prevention and treatment ($\chi^2 = 5.49$, $p = .019$; $\chi^2 = 5.76$, $p = .016$, respectively). Again, the presence of a ministry in the church that helps people when they are sick did not affect the likelihood of Black women being comfortable discussing HIV treatment or prevention in their congregations.

Discussion

The purpose of the current study was to better understand the relationship between congregational support and HIV prevention behaviors among a sample of high risk, HIV negative Black women. Study findings suggest that congregational support is a significant predictor of women's decision to return to get their last HIV test results. Furthermore, congregational support appears to be a strong predictor of comfort discussing HIV prevention and treatment with fellow congregants among women. In particular, attending churches where they feel loved by their congregation, that had a ministry that helped people with their problems, and where they felt listened to by their congregation, seem to have the greatest influence on the prevention behaviors of these women. These findings underscore the mechanisms by which faith communities might play a role in HIV prevention for high risk, HIV negative Black women.

For many Black women, churches serve as sources of love, guidance, and support through positive and negative life experiences (Stone, Cross, Purvis, & Young, 2003). In other cases, churches also perpetuate HIV stigma and may discourage Black women from disclosing the HIV status (Cunningham et al., 2011). Nonetheless, churches remain an underutilized space for health promotion around HIV. The findings of the current study suggest that certain congregational characteristics might make churches more conducive spaces for HIV prevention and treatment efforts for Black women.

Religious involvement has been strongly associated with greater social support, which could influence the positive relationship between religion and health (Koenig, 2011). Evidence from Krause (2006) suggests that support from fellow church members may be more efficacious than assistance that is given by secular social network members. Findings from Stone and colleagues (2003) also suggested that the support provided by the religious community was seen as extremely helpful in times of crisis. Furthermore, Brodsky (2000) reported that Black women discussed support from other church members as one of the most positive effects of being affiliated with a religious institution. Our findings reveal that some, but not all, forms of congregational support promote HIV prevention behaviors such as returning for HIV tests and feeling comfortable discussing HIV with other congregants. In particular, results from the current study suggest that specific congregational characteristics, such having a ministry that helps people when they have problems, indeed, provide support and foster Black women's comfort in discussing health issues and returning for the results of their HIV tests.

Newman and colleagues (2008) also noted that spiritual practices and beliefs act as a buffer when individuals are faced with negative life events, such as illness. Nonetheless, neither testing behaviors nor comfort levels discussing HIV with fellow congregants were influenced by the congregational characteristic of having a ministry for the sick. This lack of finding can be interpreted in a number of ways. On one hand, ministries for the sick may not necessarily encompass HIV. When churches have ministries dedicated to health, often chronic diseases (e.g., diabetes, hypertension, and heart disease), cancer prevention, substance abuse, and physical fitness have been prioritized over sexual health (Aaron, Levine, & Burstin, 2003; Brown, Scott, Lacey, Blount, Roman et al., 2006; Dodani and

Fields, 2010; Drake, Shelton, Gilligan, & Allen, 2010). Therefore, as Akers and colleagues (2010) noted, high risk individuals may feel alienated by churches and not view such ministries as receptive for discussing HIV prevention and treatment. On the other hand, some ministries for the sick may not be involved in activities that address sexual health. For example, congregations with ministries for the sick may not be equipped to connect HIV infected and affected individuals with relevant services or support systems. In these cases, supportive interactions offered by this ministry may not match the support seeker's goal (Peterson, 2010).

Bluthenthal and colleagues (2012) argue that strategies that are congruent with congregations' current levels of comfort and openness around HIV might facilitate a process of attitudinal and normative change around HIV prevention strategies in churches. Previous research suggests that building on existing strengths and structures of congregants might also be an efficient strategy for increasing comfort and efficiency to delivering HIV prevention messages (Berkley-Patton et al., 2012; Pichon, Griffith, Allen, Campbell, Williams, et al., 2012). Thus, collaborations among churches, HIV service agencies, and public health professional might offer an opportunity for churches to obtain additional training, couch HIV prevention in social justice and public health language instead of sexual risk behavior terms, gain confidence in addressing sexual health topics and support congregation-wide health promotion efforts (Nunn, et al., 2012; Williams, Griffith, Pichon, Campbell, Allen, et al., 2011; Williams, Palar, & Derose, 2011). Furthermore, partnering with other agencies might also enhance the capacity of churches to assist in addressing structural factors such as, employment options, community and family violence, educational opportunities, and quality drug treatment that also contribute to the HIV risk among Black women.

Strengths and Limitations

This study is not without limitations. In this study, only a cross-section of the full longitudinal dataset was used in the secondary analysis, which limited our ability to make causal links between the variables of interest. Additionally, the data were based on self-reports, which may suffer from social desirability bias. Moreover, the generalizability is limited by the demographic characteristics of the sample. Data were collected from women who were at high risk for contracting the HIV virus, which is not representative of the general Black female population. Furthermore, all participants were HIV negative. Perhaps the findings would be different for HIV positive Black women, who were excluded because of the low prevalence in the full sample. In addition, many participants reported feeling very comfortable discussing HIV prevention and treatment in their churches. However, we are unable to report the nature, quality or recipient of such discussions. Thus, further research is necessary to explore the content of HIV discussions among congregants.

Despite these limitations, the current study makes several important contributions to the literature. First, this study adds to the knowledge base by providing evidence for the positive relationship between congregational support and (1) HIV testing behaviors and (2) comfort discussing HIV within a faith-based context. These associations are important to consider in designing behavioral interventions in faith contexts. This study also contributes to previous

research by highlighting the differential influence that specific congregational characteristics have on the HIV prevention and treatment behaviors of high risk, HIV negative Black women. Churches range on the continuum of congregational support, and knowing where the church lies may have a direct influence on HIV prevention behaviors of marginalized subgroups within and across congregations. For example, congregational support might also be a pathway to promote treatment and medical care for HIV positive women, in addition to increased testing among HIV negative women. Although direct HIV service and programming would be ideal, study results show that basic congregational characteristics can encourage some types of prevention efforts among Black women who are at risk for HIV infection. Such an environment might, as suggested by our findings, encourage women to know their status and more openly discuss HIV topics with their church network.

Conclusion

Black women bear a disproportionate burden of HIV/AIDS in the United States. Churches should and can be involved in the extended HIV prevention and treatment response. Given the high rates of religious participation among Black women, the rationale for greater involvement in HIV prevention and treatment among Black churches and the beneficial impact on their involvement on women is clear (Hatcher, 2008). Although direct HIV service and programming would be ideal, study results show that basic congregational characteristics can encourage some types of prevention efforts among Black women who are at risk for HIV infection.

Future researchers working with churches on HIV prevention efforts might consider encouraging faith leaders to continually provide a safe space for high risk individuals and support them with resources as they move forward in addressing HIV in their communities. Future researchers might also consider examining church leaders' training and education around sexual health topics and how these experiences affect the tone of the messages and activities of the ministries within their churches. Understanding the factors that foster supportive and helpful congregations will aid in our efforts to blend traditional and non-traditional mechanisms of HIV education, prevention, and treatment efforts to reduce the burden of HIV among Black women.

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Table 1

Characteristics of Study Participants (N=434)

Variable	N	%
Age (*M* = 43, *SD* = 8.23)		
19-23	11	2.5
24-35	52	12
36-49	278	64.1
50+	93	21.4
Education		
Grade 1-11	215	49.5
12th/Diploma	156	35.9
>High School	61	14.0
Relationship Status		
Single	188	43.3
Married/Committed	185	42.6
Other	49	11.2
Used heroin or cocaine in past 6 months		
No	267	61.5
Yes	167	38.5
HIV testing behaviors		
Had an HIV test in the past year	371	85.5
Returned for test result	361	83.2
Did not return for test result	57	13.1
Religious Activity		
Pray Daily	309	71.2
Attend church at least monthly	233	53.7

Table 2

Unadjusted OR predicting return for HIV test results

Variable	OR	95% C.I.	p-value
Yes, loved by congregation (N = 351)	2.19	1.01, 4.73	0.047
Yes, ministry that helps sick (N = 348)	2.08	0.88, 4.95	0.10
Yes, listened to by congregation (N = 352)	2.33	1.21, 4.50	0.012
Yes, ministry that helps with problems (N = 350)	3.26	1.26, 8.45	0.015

Table 3

Percentage of participants who were very comfortable discussing HIV prevention and treatment in their congregations

Variable	Discussing HIV Prevention % (χ^2)	Discussing HIV Treatment % (χ^2)
% Very comfortable when loved by congregation (N =353)	45.6 (4.01*)	47.3 (3.09)
% Very comfortable when have a ministry helps with problems (N = 352)	48.5 (1.92)	51.4 (4.29*)
% Very comfortable when listened to by congregation (N = 354)	41.2 (5.49*)	43.2 (5.76*)
% Very comfortable when have a ministry that helps sick (N = 350)	47.4 (3.06)	49.7 (3.02)

* $p \leq .05$