HHS Public Access

Author manuscript

J Obstet Gynecol Neonatal Nurs. Author manuscript; available in PMC 2015 April 07.

Published in final edited form as:

J Obstet Gynecol Neonatal Nurs. 2014 ; 43(5): 655–663. doi:10.1111/1552-6909.12494.

Implementation of Evidence-Based HIV Interventions for Young Adult African American Women in Church Settings

Jennifer M. Stewart, PhD, RN [assistant professor]

the Department of Community Public Health, Johns Hopkins University, School of Nursing, Baltimore, MD

Abstract

Objective—To assess the barriers and facilitators to using African American churches as sites for implementation of evidence-based HIV interventions among young African American women.

Design—Mixed methods cross-sectional design.

Setting—African American churches in Philadelphia, PA.

Participants—142 African American pastors, church leaders, and young adult women ages 18 to 25.

Methods—Mixed methods convergent parallel design.

Results—The majority of young adult women reported engaging in high-risk HIV-related behaviors. Although church leaders reported willingness to implement HIV risk-reduction interventions, they were unsure of how to initiate this process. Key facilitators to the implementation of evidence-based interventions included the perception of the leadership and church members that HIV interventions were needed and that the church was a promising venue for them. A primary barrier to implementation in this setting is the perception that discussions of sexuality should be private.

Conclusion—Implementation of evidence-based HIV interventions for young adult African American women in church settings is feasible and needed. Building a level of comfort in discussing matters of sexuality and adapting existing evidence-based interventions to meet the needs of young women in church settings is a viable approach for successful implementation.

Keywords

HIV/AIDS; African American churches; young adult women; African American; implementation; evidence-based interventions

African Americans are the racial/ethnic group most affected by HIV, which continues to have a devastating effect on youth and women in particular. Young African American women are far more affected by HIV than young women of other races. In 2009, young

Correspondence: Jennifer M. Stewart, PhD, RN, Community Public Health, Johns Hopkins University, School of Nursing, 525 N. Wolfe Street, Baltimore, MD 21287. jstewa44@jhu.edu.

The author reports no conflict of interest or relevant financial relationships.

heterosexual African American women represented 65% of women diagnosed with HIV. Currently, the rate of HIV/AIDS diagnoses for Black women is 20 times greater than that for White women. An estimated one in 32 women will contract HIV in their lifetimes (Center for Disease Control and Prevention [CDC], 2012). Evidence-based interventions to prevent acquisition of HIV are key among this population.

Numerous evidence-based interventions (EBIs) for HIV prevention with proven efficacy have been developed for African American women (DiClemente & Wingood, 1995; Jemmott, Jemmott, & O'Leary, 2007; Wingood et al., 2011). These interventions have been tested in a variety of locations including schools, clinics, community centers, and salons with positive outcomes, including increased condom use, reduction in number of sexual partners, and increased knowledge and negotiation skills (Dancy, Wilbur, Talashek, Bonner, & Barnes-Boyd, 2004; DiClemente & Wingood, 1995; Flay, Graumlich, Segawa, Burns, & Holliday, 2004; Jemmott et al., 2007).

Although significant strides have been made in the development of evidence-based HIV interventions, innovative work is needed to implement these interventions into community and clinic settings for effective uptake. Widespread implementation of HIV EBIs is imperative to the sexual health of young African American women. To effectively promote widespread uptake of evidence-based HIV risk-reduction interventions for young women, it is crucial to partner with community institutions that have significance in their daily lives.

> Young adult African American women ages 18 to 25 remain disproportionately affected by HIV and AIDS.

In the United States, 87% of African Americans report a religious affiliation, and 80% of young African American women report formal attendance at a Christian church (Pew Forum on Religion and Public Life, 2008). The African American church community has been instrumental as a conduit for health promotion interventions with proven efficacy focusing on conditions such as heart disease (Sutherland, Hale, & Harris, 1995), diabetes (McNabb, Quinn, Kerver, Cook, & Karrison, 1997), and cancer (Campbell et al., 2007; DeHaven, Hunter, Wilder, Walton, & Berry, 2004; Markens, Fox, Taub, & Gilbert, 2002).

Despite the role that the African American church community has played in other disease processes, it has been slower to develop and implement HIV interventions. From a historic perspective, this trend is most likely due to discomfort in discussing sexuality (Harris, 2010). Of late however, the African American church community have become increasingly open to care and support of HIV- and AIDS-infected individuals (Stewart & Dancy, 2012), HIV testing (Berkley-Patton et al., 2010), and risk reduction (Wingood et al., 2011). However, limited evidence is available on the barriers and facilitators to implementation of existing HIV EBIs into church settings.

Despite the prominent role the African American church community has in the health of African American women (Campbell et al., 2007), the church remains underutilized as a forum for evidence-based HIV prevention interventions. Partnering with church bodies embedded in African American communities is a logical step in implementing evidence-based, culturally and contextually competent HIV risk-reduction strategies. However, little

is known about the unique needs and HIV-related risks of church-affiliated African American young adult women or the feasibility of implementing EBIs into the membership's cultural and contextual framework. No evidence of these interventions having been implemented for use among young African American women in the church is available. This finding is surprising considering the prominent role the church has in the African American community (Taylor, Mattis, & Chatters, 1999).

Religion is reported to have a compelling influence on the daily lives and behaviors of African Americans (Pew Forum on Religion and Public Life, 2008). Furthermore, the church body has long served as the center of social change in the African American community. As a trusted community institution among African Americans, it is often looked to for social support, a concept with a well-documented effect on protective health behaviors (Sutherland, Hale, & Harris, 1995; Taylor & Chatters, 1999). Despite these facts, young adult African American women in church settings are a virtually invisible population for implementation of targeted interventions.

With the plethora of evidence-based HIV prevention interventions already available, it is important to illuminate the process whereby these interventions can be implemented in churches for widespread use. African American church communities are receptive to HIV risk-reduction interventions that are designed or adapted to be in alignment with their church's culture and their unique religious needs (Stewart & Dancy, 2012; Stewart, Sommers, & Brawner, 2013). This step is vital to effective implementation in this setting. Planned adaptation of interventions has also been presented as a viable approach to implementation of evidence-based interventions (Lee, Altschul, & Mowbray, 2008). Therefore, an adapted evidence-based HIV intervention could provide a culturally acceptable and effective approach to the African American church's involvement in HIV risk reduction.

Process Model

Wingood and DiClemente's (2008) The Assessment, Decision, Administration, Production, Topical Experts, Integration, Training, Testing (ADAPT-ITT) model was used to guide the study. This model provides a prescriptive method for adapting interventions to promote effective implementation and acceptability. The ADAPT-ITT model has been used widely to effectively adapt EBIs and enhance their implementation in a variety of studies (Copenhaver, Lee, Margolin, Bruce, & Altice, 2011; Latham et al., 2010). The framework provides eight phases to adaptation. Because the effort to harness the potential of church-based setting for EBIs is still in the early stages of development, in this study I focused on Phase 1 of the process model: assessment. Assessment involves eliciting information on the target population regarding the risk factors, barriers and facilitators, preferences for content and delivery, capacity and needs via focus groups and individual interviews with the target population and key stakeholders.

Future researchers may fully explore the remaining seven phases of the ADAPT-ITT model, which include selection of an appropriate intervention to adapt, pretesting, and iteratively adapting the intervention and pilot testing. Adaptation of EBIs for use in church settings

may be a viable approach to encouraging the implementation and uptake of these interventions. Church-based partnerships represent an innovative approach that will not only have the potential to reach great numbers of the target population but may also promote sustainability and integration of EBIs into the cultural framework of the African American church community.

Adaptation must be preceded by a careful assessment of the risk factors and feasibility of HIV interventions in church settings to promote successful implementation. Thus, the purpose of this study was to assess the barriers and facilitators to the use of African American churches as sites for implementation of EBIs for HIV among young African American women. I focused on three primary goals to achieve this purpose: (a) assessing the HIV-related risks of African American women ages 18 to 25 in church settings, (b) assessing the feasibility of implementation of an evidence-based HIV risk reduction intervention for young adult women in church settings, and (c) determining the necessary adaptions needed for successful implementation of evidence-based HIV interventions into church settings.

Methods

Design and Participants

A cross-sectional, mixed methods study design was used to elicit the barriers and facilitators to adapting and implementing a HIV risk-reduction intervention in church settings for young adult African American women. A purposive sampling strategy was used to recruit church communities not yet involved in delivery of HIV interventions, programs, or messages of any kind. Church communities were recruited via three strategies: recruitment from a local HIV/AIDS conference attended by the research team, referrals from individuals attending other local African American churches, and pastor referrals.

Data were collected from the key stakeholders that would be involved in implementing an EBI for young adult women. These individuals included the pastor of the church, who provides the direction for programming, the church leaders, who are closely involved in delivering programs, and the young adult women, who are prospective study participants. I conducted four interviews with pastors, two focus groups with church leaders (n = 18) older than age 18 years, two focus groups with church attending young adult women ages 18 to 25 (n = 20), and surveys of congregants (n = 100) older than than18 years across four churches. The inclusion criteria for the selected church communities were that each community had to have a reported Black or African American population of ≥ 60%, the pastor had to offer support of the church community participating in the study and could not have offered any interventions, programs, or initiatives related to HIV. The exclusion criteria were that the church membership had fewer than 30 young adult African American women, and/or was unwilling to provide verbal support for conducting the study in the church setting (from pastor). The inclusion criteria for the pastor was that he must be older than age 18 years, willing to participate in the study, able to speak and read English, and be the chief pastor for the church. The exclusion criteria for the pastor included being in the role of the chief pastor for less than one year.

Inclusion criteria for the church leaders included older than age 18 years, leadership positions confirmed by the pastor, church membership for more than 6 months, and able to speak and read English. Exclusion criteria included assuming leadership position for fewer than 6 months. Inclusion criteria for the young adult women included membership within the selected church for more than 3 months, self-identified as Black or African American, between ages 18 and 25, able to speak and read English. Data for this phase were collected between November 2012 and May 2013.

Procedure

Following approval by the University's Institutional Review Board, pastors were approached and informed about the study. If interested in participating, pastors were then screened for study participation. If the pastor extended his or her verbal support and the church demographics met the criteria for participation, she or he was asked to provide consent for participation in their interview. Following completion of the interview, the pastor identified and facilitated introductions to church leaders and young adult women who were then screened and asked to participate in the study. Once informed consent was obtained, the church leaders were asked to participate in a focus group that took place in their church at a mutually agreed-upon day and time. Focus groups were followed by the congregational survey, which took place after a church service. Survey participants also provided informed consent prior to participation. Interview and focus group participants received $40 and survey participants $20 as an incentive.

Measures

In-depth, semistructured interviews and focus group guides contained questions about HIV-related risk behaviors, barriers and facilitators to the implementation of HIV EBIs, beliefs and attitudes toward HIV risk-reduction interventions, and needs and preferences for implementation. All interviews and focus groups were audio recorded and transcribed. Any identifying materials were then stripped from the transcribed documents. The survey items mirrored the qualitative data collection guides and included an assessment of HIV-related risk behaviors, a needs assessment, beliefs and attitudes toward HIV risk reduction interventions, and barriers and facilitators to implementation.

Data Management and Analysis

I used a convergent parallel design (Creswell, Klassen, Plano Clark, & Smith, 2011) to investigate the risk behaviors of church attending African American women ages 18 to 25 and barriers and facilitators to implementation of HIV EBIs in church settings from the perspective of the pastors, church leaders, and the targeted population. This approach to analysis is most appropriate when the quantitative and qualitative data are collected at the same time. Once collected, qualitative and quantitative data were analyzed separately as outlined below. Findings were then merged for final interpretation. This technique provided an in-depth view of the phenomena of interest and the ability to see how the results converged or diverged.

Qualitative Approach

The qualitative data were analyzed in accordance with Auerbach and Silverstein's (2003) grounded theory coding method. Transcribed focus groups provided raw text that was narrowed down to relevant text or the text related to the specific research concerns. This relevant text was searched for repeating ideas or the use of the same or similar words and phrases to express the same ideas. From these groups of repeating ideas, themes were gleaned. These themes were groupings of repeating ideas that have something in common.

The themes were further grouped into more abstract ideas termed theoretical constructs. Lastly, a theoretical narrative was constructed that served as the summary or what was learned about the research concerns and provided a bridge between the researcher's questions and the participants' subjective experiences. This process tells the story of the participants' experience by weaving together their own words and the researcher's theoretical framework.

This type of inquiry has the potential to enhance the depth and relevance of findings. Listening to community members' own descriptions of facilitators and barriers to implementing HIV interventions brings to light perspectives on these issues that researchers may not otherwise be aware of. The points of view represented by the voices that appear in the findings sections are essential to hear to shape interventions that resonate with this particular population.

Several steps were taken to ensure the trustworthiness of the qualitative data. Credibility was ensured by making visits to each church and church services to develop a familiarity and understanding of the culture of each church. Triangulation was used to collect data via use of interview, focus group, and survey methodology. I provided detailed descriptions of the phenomenon under study in the words of the participants. Upon completion of interviews and focus groups, I performed member checks via provision of a summary of what was discussed during the session and asking if it accurately reflected what was said. Lastly, during debriefings, the principal investigator and the research team discussed beliefs, assumptions, and biases and how these views might affect data analysis as results were iteratively and collectively found and confirmed as a group (Guba, 1981).

Quantitative Approach

Quantitative data were analyzed using descriptive statistics (i.e., frequencies, percents, means, and standard deviations). Questionnaires assessed the HIV-related behaviors, risks, beliefs, religiosity, and needs of the congregants older than age 18 years. Participants were asked about the importance of religion in their lives and influence on behaviors, current and past sexual risk-taking behaviors, and beliefs about implementation and acceptability of a HIV EBI in a church setting.

Validated scales for measurement included (a) the Behavioral Risk Assessment Tool (BRAT) developed by the Wisconsin HIV Prevention Evaluation Work Group and Centers for Disease Control and Prevention (CDC) and (b) the Intrinsic/Extrinsic Religion Scale (IERS) used to evaluate religiosity and spirituality. The IERS has been tested in Black populations with good results. This 14-item scale uses a 5-point response format from

strongly disagree to *strongly agree* and has a Cronbach's alpha of .83. It measures religious practices as well as intrinsic spirituality (Gorsuch & McPherson, 1989).

I used the specific questions relating to implementation and acceptability of the evidenced based intervention from the 100 congregants that completed the survey and also analyzed a subset of 30 surveys from the African American women's population ages 18 to 25 for prevalence of HIV-related risk behaviors among that sample.

Results

The Reality Is We're Having Sex

In this study, the majority of young women between ages 18 and 25 years were sexually active. Of this sample 56% (n = 17) had partners they were sexually active with. The majority also reported one to three partners in the previous 6 months (53%, n = 16). However only 37% (n = 11) used condoms regularly with their sexual partners. Focus group participants spoke on the ideal practice of abstinence as encouraged by the church community and the reality that many young adult congregants were engaged in sexual activity. One young adult participant stated, “The reality is that people in the church–they havin' sex. So I think safer sex talk is important.” Another young adult woman stated, “I feel as though you can push abstinence and you can push safer sex. But safer sex is going to actually get across cause 9 times out of 10 they're having sex.” As evidenced from the quantitative findings, the young adult women had difficulty remaining abstinent in their relationships causing conflict with their religious beliefs. One participant stated, “I think staying abstinent is really hard for a Christian woman. Especially if your partner doesn't want to be. Everyday you going in that house and he say he accepts it. But they really don't.”

> Church communities were aware of some of the HIV-related risks engaged by their congregants. A pastor stated,
>
> There are things that our young people are doing. Even 6th graders. There are a lot of things going on. We're not blind. There's some teaching that needs to go on. We need programs to come in and add HIV teaching to the scriptures. I could see them learning that way.

To address this issue, church leaders occasionally delivered messages about sex to their young adult/youth populations. Out of the four churches sampled, three had active youth ministries. One church leader stated, “We talk about sex. We've had different sessions with the youth leader on that. We've talked about it not a lot, but it's something that comes up in many of the youth sessions.” Another church leader stated,

> We had a youth session and asked how long after you dating someone should you have sex. And the person said, “like after the 3rd date” (laughs). We asked an honest question and it throwed them off guard, so they answered the question. So, like I say, we're not naïve about what's going on. We're smart enough to know that.

We Need to Integrate Our Spiritual Principles

The participants' lives are heavily influenced by their religious beliefs. The majority (83%, *n* = 83) reported that God was very important in their lives and that religious beliefs had a large (52%, *n* = 52) to fair (25%, *n* = 25) influence on their behaviors. Participants consistently reported the importance of integrating these spiritual beliefs into the content of the intervention. One leader stated, “We already provide the spiritual side of things. Now for HIV–we need that information—more practical information. We give them info about spirituality but I'd like them to know physically that it can happen to them.” Integration of spiritual principles into the content of the intervention is crucial for success.

It was noted by all participants that the church community could serve as an asset to HIV intervention efforts. It was a natural venue for getting health-related knowledge. One young adult participant stated, “Because a church is like a hospital; it's like a place where people can come and get well and get knowledge so they're not ignorant. That's what we're supposed to be.” This statement points out the pivotal role churches have in caring for the health and well-being of people. It provides the opportunity to gain the tools necessary to care both for the body and the spirit. This points to the potential of the church to create sustainable change that resonates deeply with an individual.

> Young adult African American women are in need of evidence-based HIV prevention interventions in church settings.

The young adult women were overwhelmingly in support of HIV risk-reduction interventions into the church. They felt the need for these interventions and for individuals in the church that could give them the information and support needed to promote their sexual health:

> In the church, the reality is that it's needed because there are people in the church that are sexually active. And that's not to say that everybody agrees with it, but we need that person who is approachable to head a group or something like that. So that we can get that help from someone that's going to back whatever choice you make.

On the other hand one salient barrier was observed that concerned how to address the very private concept of sexuality in a public setting. A young adult participant stated,

> People want to be ignorant to the fact, about sex and HIV. That's a barrier. People are not comfortable talking about it, with truths coming out but the pro is the help that could be offered and the knowledge that could come out of it.

The difficulty of addressing the reality of sexuality in African American church communities is well known (Lincoln & Mamiya, 1990). Due to the historically conservative approach many church communities have adapted concerning sex and HIV, this tenet will undoubtedly represent a barrier to implementation of HIV interventions.

Despite the qualitative findings that indicated a significant barrier to participation in a HIV EBI, quantitative findings showed something different. It was found that of the general congregation 70% (*n* = 70) would not feel embarrassed to participate in a HIV intervention in their churches and 73% (*n* = 73) felt they would receive support for their participation in

the intervention from other church members. This fact coupled with young adult women's strong desire and need to get past barriers to integrate HIV prevention interventions into church settings could turn the aforementioned barrier into a facilitator if church leaders and young women engaged in dialogue about their needs.

Based on the discussion of the qualitative findings, some pastors frankly admitted their awareness of the sexual activities of some members of their congregations: “We're not blind.” That admission from the church leadership combined with the quantitative findings that indicated the congregation members' openness and desire for integration of discussion of sexual behaviors and HIV prevention suggests that open communication is a significant barrier. From this perspective perhaps secrecy also plays a role in hindering efforts:

> Everything about sex and HIV is kept a secret. It's a barrier ‘cause older people don't know how to talk about it. So, like even with my parents, they gave me the basics but I had to learn a lot of things on my own …. We don't know stuff so we need someone to help us out so we don't just jump in there and do it.

We Need to be Involved

The pastors, church leaders, and young women all gave feedback on the implementation of a HIV EBI into a church setting. Participants wanted information on HIV and AIDS signs and symptoms, how to prevent it, how it is transmitted, and HIV testing: “We need to know what it is and how to prevent HIV from happening. We need to know about the medications you need if you are HIV positive and steps you take to, you know, to keep healthy.”

Church leaders felt it would also be beneficial to hear from individuals that are living with HIV/AIDS. One of the participants in leadership stated, “They need to see someone with AIDS. Someone that has suffered through some things physically.” In regards to HIV, participants also felt they needed information on HIV testing and disclosure included in the intervention:

> Well, with the HIV testing you also need to know how to have relationships, how to tell about being positive, and ask who they've been with … If you're going to have sex, then it should be safe sex and you should communicate with your partner.

A greater percentage of participants felt that the addition of abstinence-based messages was necessary (72%, $n = 72$) however 62% ($n = 62$) also reported wanting safer sex messages to be integrated into abstinence approaches. Despite this desire church congregations felt that abstinence would be better accepted (70%, $n = 70$) whereas 40% ($n = 40$) felt safer sex would also be accepted in the church setting. Participants gave in depth suggestions on the messages that should be given and not given in a HIV risk-reduction intervention. A definite emphasis was voiced on incorporating abstinence, especially from the lead-ership's perspective. One leader stated, “Support abstinence. It doesn't have to always end up in bed. They see that in the music in the industry. But you don't have to do what's in front of you. They need to see another perspective.”

Pastors and church leaders would often draw the line at distribution of condoms. One church leader stated, “Most of the barriers would be the scriptures but for the most part teaching

condoms. It would go against teachings in the word that we're preaching. I couldn't tell you from a pulpit …. It would have to be privately." When asked, most participants stated they were willing to provide education, information, skill building activities and sessions, and HIV testing if supported by an outside organization or clinic to manage positive results.

For structure, young adult women preferred a small group setting for the delivery of the intervention. They also preferred to have two facilitators, one that was close in age to them and one slightly older: "I think it should be a mixture of persons in your age range and someone slightly older who has been there. And it's gotta be in small groups." The young women felt that the HIV intervention could be a once-a-month event that incorporated incentives and activities:

> It should be every month and you always got to offer food (laughs). Make it fun. Incentives and giveaways to pull people in. They might be coming for that, but at the same time they're getting health information and spiritual information.

In addition to the standard HIV content, young adult participants discussed other issues to integrate into an intervention including STIs, single parenting, financial issues, skill building within the context of intimate relationships, and substance use:

> We facing single parenting. A lot of young ladies our age with kids. Bills, money, financial issues. The stress of becoming an adult. Sometimes it gets overwhelming. Small things rack up you need things, resources. It's hard to become an adult. Juggling school and work, more responsibilities, men and relationships. We just facing all of those issues.
>
> Adaptation of existing evidence-based interventions may be a viable approach to implementing these interventions into church settings.

Another young adult participant spoke on the influence of substance use on HIV risk: "You know its drinking, smoking, peer pressure. Getting with the wrong group of people and wrong setting. We need to talk about that and HIV too."

Discussion

Young adult women in the African American church setting need and have a desire to engage in EBIs that can keep them safe sexually. Although the literature often indicates that religion is a protective factor in regards to sexual activity (Amey, Albrecht, & Miller, 1996), evidence exists to show that it exerts less of a protective effect on African American populations (Rote & Starks, 2010). This study supports these findings, as the majority of these women are sexually active and do not use condoms regularly.

The church community is aware that their young adult congregants are often sexually active, however, a large degree of secrecy is associated with these behaviors and perhaps a lack of knowledge exists about how to broach the subject. This study supports the existing evidence regarding church leaders' ambivalence about addressing sexuality and HIV in church settings (Eke, Wilkes, & Gaiter, 2010). Church communities would like to be able to give information on HIV risk reduction but need assistance from nurses and other health care providers to feel comfortable and competent to provide accurate, up-to-date information.

As a whole, the congregations were in support of implementing interventions into the church setting and felt that such interventions and their participation in them would be accepted. In alignment with other studies (Francis & Liverpool, 2009; McNeal & Perkins, 2007), church leaders would like the interventions to integrate spiritual principles, including abstinence. In most cases, they are not willing to distribute condoms to their congregants (Brown & Williams, 2005; Khosrovani, Poudeh, & Parks-Yancy, 2008). Distribution of condoms was associated with encouraging sexual activity. If church leaders were made aware of the incidence of sexual activity and that comprehensive education does not necessarily promote sexual activity, it could increase their openness to distribution of condoms.

Young adult women wanted the reality of their daily lives to be integrated into the HIV intervention and suggested that it is necessary to address other issues such as STIs, single parenting, intimate relationships, and financial problems within the context of HIV. An intervention that addresses HIV within the context of other sociocultural issues has yet to be developed for young adult women in church settings. This approach would create an intervention that resonates with their daily lives and struggles and is a viable new direction for prevention research.

This study was limited by its small sample size. The church communities, though matched on denomination and size, likely had other organizational differences that would cause variation. Data collection took place in the church and was self-reported, which may have caused bias in the results.

Nurses have often been involved in the development and implementation of HIV risk-reduction programs in African American church communities. With their knowledge base and training in prevention they are ideal candidates for implementation of such programs. In addition partnerships with community clinics can be a viable avenue for bringing in the resources for HIV testing and prevention. Church communities have a desire to have access to these programs when adapted to meet their unique needs but must have exposure to them, which can be led by nurses. The process of assessment outlined in this study can be critical to understanding the context for implementation of evidence-based interventions or guidelines into clinical settings. Patients may need to have interventions adapted to meet their contextualized needs and maintain fidelity of the intervention at the same time. Nurses can lead this endeavor, evaluate the outcomes, and reinforce the applicability and uptake of EBIs.

Acknowledgments

Funded by the National Institute of Drug Abuse, Center for Prevention and Implementation Methodology, Grant P30-DA027828. The author acknowledges Drs. Loretta Sweet Jemmott and Gina Wingood.

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