HHS Public Access

Author manuscript

AIDS Behav. Author manuscript; available in PMC 2020 November 01.

Published in final edited form as:

AIDS Behav. 2019 November ; 23(11): 2936–2945. doi:10.1007/s10461-019-02604-7.

Love with No Exceptions: A statewide faith-based, university-community partnership for faith-based HIV training and assessment of needs in the Deep South

Robin G. Lanzi[1,2], **Alison P. Footman**[1,2], **Edward Jackson**[2], **Brook Y. Araya**[1,2], **Corilyn Ott**[2,3], **Ronald D. Sterling**[2,4], **Tammy R. Davis**[2,4], **Kathryn A. Kaiser**[1]

[1]University of Alabama at Birmingham, School of Public Health, Department of Health Behavior

[2]University of Alabama at Birmingham, Center for AIDS Research

[3]University of Alabama at Birmingham, School of Nursing

[4]Alabama Ninth Episcopal District of the African Methodist Episcopal Church

Abstract

This project established a faith-based, university-community partnership with the African Methodist Episcopal (AME) church in Alabama to develop a statewide training model to address HIV knowledge and stigma, promote discussion and generate action plans to address HIV in the Deep South. A community-engaged research team consisting of church leadership and university researchers developed and implemented the model, *"Love with No Exceptions."* Mixed methods were used to evaluate the model delivered in 3-hr sessions in 5 state regions (N=146 clergy and laity). The majority of participants reported feeling better prepared to serve those living with or affected by HIV and would implement education and awareness activities in their churches. Participants' HIV knowledge increased from pre- to post-training. Stigma-related attitudes showed minor changes from baseline. These results reflect that partnerships between academic institutions and churches can deliver promising steps towards impactful HIV education in the Deep South.

RESUMEN

Este proyecto se basó en una colaboración entre la Universidad de Alabama y la Iglesia Episcopal Metodista Africana (AME) en Alabama para desarrollar un modelo de capacitación en todo el estado para abordar los temas del estigma y del conocimiento sobre el VIH; promover el debate al respecto, y generar planes de acción en el sur de los Estados Unidos . Un equipo de investigación basado en participación comunitaria formado por líderes de la iglesia e investigadores universitarios, desarrolló e implementó el modelo "Amor sin Excepciones". Se utilizaron métodos mixtos para evaluar el modelo que se administró en sesiones de 3 horas en 5 regiones estatales (n = 146 clérigos y laicado). La mayoría de los participantes informaron que se sentían mejor

Correspondence should be sent to Robin Gaines Lanzi, PhD, MPH, University of Alabama at Birmingham, 1720 2nd Avenue South, 227 Ryals School of Public Health Building, Birmingham, AL, 35924, Tel: 205-975-8071, rlanzi@uab.edu, Fax: 205-934-9325.

All authors included on this manuscript declare that he/she has no conflict of interest.

All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

Informed consent was obtained from all individual participants included in the study.

preparados para servir a las personas que viven con o están afectadas por el VIH y que estarían dispuestos a implementar actividades de educación y sensibilización en sus iglesias. El conocimiento sobre el VIH entre los participantes aumentó después de la capacitación. Las actitudes relacionadas con el estigma mostraron cambios menores comparados con actitudes antes de la intervención. Estos resultados demuestran que las asociaciones entre instituciones académicas e iglesias pueden incrementar la educación sobre el VIH. Los resultados son prometedores y pueden impactar el sur de los Estados Unidos.

Keywords

HIV; Training; Faith; Community Engagement; CBPR; Deep South

INTRODUCTION

Within the United States, over 1.1 million people are infected with HIV, and one out of seven individuals are unaware of their infection status [1,2]. The US South and African American populations experience disproportionate rates of HIV when compared with other regions and races within the United States [1,3-5]. When compared with residents of other US regions, Southerners living with HIV are less likely to receive timely medical care or treatment, which leads to fewer individuals experiencing viral suppression [3]. In 2016, African Americans represented only 12% of the US population yet accounted for 45% (17,670) of all new HIV infections [1,6]. In Alabama, African Americans are seven times more likely to become infected with HIV when compared with non–African Americans [7].

Higher HIV rates among African Americans stem from a multitude of complex factors, such as poverty, poor access to health care, lack of adequate sexual health education, and HIV-related stigma [4,8,9]. In the Deep South, HIV-related stigma often results in negative health outcomes and is seen as universal [10]. Research has shown that stigma can contribute to fear of disclosure, leading to underreporting of cases and an increase in transmission of the disease [11-14]. Stigma is also a barrier to seeking and receiving HIV care, which is necessary to successfully manage HIV infections [15,16]. As such, combating stigma is essential for primary as well as secondary prevention of HIV. Improving knowledge and awareness through education remains one of the most important tools to reduce HIV-related stigma [11,12,17,18]. Previous studies have shown that education interventions targeted towards communities saw improved community acceptance and understanding of people living with HIV (PLWH) [5,18-20]. However, few studies have used a community focused approach, such as community-based participatory research (CBPR), in creating interventions to address HIV and improve social support for PLWH [21]. Therefore, when trying to reduce HIV-related stigma, involving communities and support systems of those greatly affected by HIV, in the development of education programs, can help in providing a more supportive environment for PLWH to seek and maintain care.

Of great interest in HIV prevention among African Americans is the role that religion and the church can play in lowering the risk of acquiring and transmitting HIV by reducing existing stigma [22]. Reports have shown that African Americans are the most religiously

committed racial group within the United States [9]. Across the nation, 56% of US adults report that religion plays an important role in their lives, while 80% of African Americans report feeling this way about religion [9]. Historically, churches have been a center point among African American communities providing social cohesion and organization [18,20,23,24]. Most recently, churches have become a center for health promotion and disease prevention, especially as concerns for health equity have become more pronounced [5,20]. While stigma around HIV is still prevalent in churches, more religious institutions are recognizing the role they can serve in educating their communities on HIV prevention and lowering HIV-related stigma [25]. Because HIV education can act as a protective factor against stigma [8,20], HIV education programs within the religious community can help lower stigma both within the church and the surrounding community. The Black Church & HIV initiative was formed to do just that [26]. It has conducted numerous initiatives, training sessions, and town hall meetings, one of which the University of Alabama at Birmingham (UAB) Center for AIDS Research Behavioral and Community Sciences Core Faith and Spirituality Research Network (CBCSC-FSRN) co-sponsored in Birmingham, Alabama. This type of community-engaged research is critical to ensure that research and interventions meet the needs of the faith community. In 2016, the African Methodist Episcopal (AME) Church passed new legislation to help encourage HIV education within the church [27]. The legislation states that:

> *"…clergy, at all levels, and appointed or elected officers shall be required to obtain a basic scientific foundation to understand HIV/AIDS. This can be summarized as 'What effective religious leaders should know about HIV/AIDS.' Mandatory training shall be provided annually throughout each Episcopal District, at ongoing or special planned sessions as directed by the Presiding Bishop and Presiding Elders. Each clergy person or officer is required to be certified and/or updated at least once every four years through this offering."*[27]

This legislation is an important step to begin the dialogue, education, and awareness about HIV. Importantly, there is an established community engaged research partnership between a local AME church and the UAB CBCSC-FSRN. (Note: There are 20 AME districts globally with 13 based in the United States. One of the 13 AME Districts in the United States covers the state of Alabama and is referred to as the 9th District of the AME Church. There are approximately 275 AME churches across Alabama.) In Birmingham, the local AME church is part of the UAB CBCSC-FSRN, which aims to bring together researchers and faith and spiritual communities to conduct collaborative research that addresses behavioral, environmental, economic, and social HIV-risk and -protective factors in the Deep South. As a function of this collaboration, Alabama Ninth Episcopal District of the AME Church sought to partner with the CBCSC-FSRN to develop, implement, and evaluate the statewide HIV faith-based educational training. This project is unique in that the AME church initiated the development of statewide HIV faith-based training with the university and partnered with the university to develop, conduct, and evaluate the statewide HIV faith-based training. Further, these training sessions were held in the church with clergy, faith leaders (deacons and elders), and laity, and offered to all AME churches statewide. Deacons and elders are ministerial orders for preachers (clergy) of the AME Church. Laity are members of the local church who have not been ordained as deacons or elders, but who support the work of the

ministry through various ministries, boards, and auxiliaries. They work along with the pastors in fulfilling the vision and commission of the church [28].

This project was formed in the truest sense of community-engaged research. Our objectives were to establish a university-community partnership with the African Methodist Episcopal (AME) church in Alabama to develop a HIV faith-based training model to address HIV knowledge and promote discussion about what can be done in the faith setting to address HIV in the Deep South. In this paper, we discuss how the partnership was established and how it resulted in developing a faith-based HIV training model, setting the stage for future, larger interventions.

METHODS

Community-Engagement Approach.

Our approach is grounded in community engagement principles, which includes equitable participation at all levels and sharing of resources, local relevance of public health problems, joint preview and dissemination of findings, trust-building, and demonstration of tangible and, ideally, sustainable benefits to the community involved [29,30]. Our community engagement team includes local and statewide community partners, including the AME Bishop of Alabama Ninth Episcopal District of the AME Church, the AME Health Coordinator for the Alabama Ninth Episcopal District of the AME Church, a local AME Church Pastor, and the CBCSC-FSRN. Together, the community engagement team jointly developed the training model using a “Head, Heart, Feet” framework. This framework was originally conceived in a town hall meeting held by the CBCSC-FSRN in partnership with the Black Church & HIV [26] to discuss the impact of HIV in Birmingham and how the faith community can join together to fight the epidemic. As proposed and endorsed, the efforts should center on a Head (education), Heart (faith journey), Feet (resources) framework to be effective.

Training

Building on our collective experiences, along with incorporating the AME mandate, our community engagement team developed a 3-hour faith-based HIV training program, named *Love with No Exceptions*. Aligning well with our Head, Heart, Feet model, the AME legislation requires that:

> “The annual training should provide at least three or more contact hours about HIV/AIDS. Content should provide understanding of: (1) current prevalence and impacts of the HIV/AIDS pandemic in local communities, statewide, and globally, (2) the biology of the virus and its disease, (3) community resources available, and (4) practical ways religious leaders can help to eliminate HIV infection, AIDS and death from AIDS-related causes.”

Thus, at each of the sessions, the first hour, “the head,” included an HIV 101 educational session led by a trained and certified HIV educator team member. In the second hour, “the heart,” a clergy leader, who developed this session, shared faith-based messages on loving all as well as practical ways that compassion can be demonstrated from the pulpit;

additionally, a person living and thriving with HIV shared her personal journey along with inspirational messages on living with HIV. The final hour, “the feet,” was moderated by a panel of medical providers and local HIV organizations. On-site HIV testing, counseling, and HIV resources were available at all sessions.

Stigma was directly addressed and discussed by Pastor Sterling, who provided guidance on how church leaders and individuals within the church membership could act to reduce institutional and enacted stigma via modification of community norms. The three women who presented as PLWH discussed both their own experiences as stigmatized persons as well as observations of those around them, and told stories of how they overcame these experiences in various ways.

Evaluation

A mixed methods approach was employed to assess whether we achieved our key objectives to (a) establish a faith-based, university-community partnership with the AME church in Alabama to develop a faith-based training model to address HIV knowledge and (b) to promote discussion about what can be done in the faith setting to address HIV in the Deep South. As such, both quantitative and qualitative assessments were included in the evaluation.

Quantitative measures

Before the training, participants were surveyed for demographic information that included age, gender, education level, household income, whether they lived in urban or rural areas, and the role that they have in the church (clergy or laity). They were also surveyed for perceptions about HIV resources available in the community and the church’s acceptance toward PLWH. Before and after the training, to assess knowledge uptake and potential change in attitudes, participants completed two questionnaires (pre/post-test) on HIV knowledge and one questionnaire on attitudes toward PLWH. For HIV knowledge, a validated 18-item questionnaire was used to assess knowledge of HIV transmission and prevention [HK-18) [31]]. A second, 10-item assessment of knowledge (HK-10) was used from the SISTA program [32]. For attitudes towards PLWH, six HIV stigma questions were adapted from a validated 42-item questionnaire and covered two factors/dimensions including concerns about occasional encounters with PLWH and avoidance of personal contact with PLWH [13]. These six statements for rating agreement included: (1) Being around someone who has HIV does not bother me; (2) I would not be worried for my health if a co-worker had HIV; (3) It would not bother me if there was a boarding house for people with HIV on my street; (4) I could not be friends with someone who has HIV; (5) I would limit my contact with a person whom I know is infected with HIV; and (6) I would not hug someone with HIV. After the training, participants were asked two questions about whether they felt better prepared to serve PLWH because of the training and if they would implement HIV education training in their churches.

Qualitative information

During the training and after the “Head” and “Heart” sessions, participants were given an open-ended survey that included the following probe: “In order to address HIV/AIDS in

your community, the faith community needs to… (Please list all of the ideas that you have).” Participants completed the surveys, submitted their forms, and then discussed their thoughts in an open forum, led by AME church facilitators.

Data Analysis

Quantitative analysis—Descriptive statistics were used to summarize demographic data. Changes in knowledge (HK-18 and HK-10) and attitudes from pre- to post-training were evaluated with paired samples t-tests for descriptive purposes only and should not be interpreted as evidence or quantification of a treatment effect of the training. Any questions left blank on knowledge questionnaires were counted as “incorrect”. Missing data was not imputed to avoid possible conflation of reasons participants may have opted out of responding (e.g. lower knowledge uptake versus discomfort with expressing statements that may involve personal conflict with attitudes or beliefs versus being in a hurry to leave at the end of the session, or some combination of these and other factors).

For the stigma-related attitudes questions, we assigned negative valence scores of −2 or −1 to statements of “strongly agree” or “agree” respectively to statements that reflect a negative attitude, and +2 or +1 valence scores to statements of “strongly agree” or “agree” for statements that reflect a positive attitude. Conversely, the “strongly disagree” and “disagree” were assigned a corresponding negative valence for positive attitude statements (−2 and −1 respectively). Thus, for the three positively and three negatively stated attitudes in the question set, maximum positive or negative attitude scores would be +/−12. Total net scores using these valences were calculated for pre- and post-training and compared with a paired-samples t-test. While knowledge could be expected to increase post-training, there was no *a priori* hypothesis that a significant change in attitudes would occur in either direction. Between groups (laity and clergy) comparisons were performed at baseline and at post-training intervals to assess group differences using Welch’s test due to imbalance in group numbers (laity n = 28, clergy n = 87). Levene’s test for equality of variances was performed.

Qualitative analysis—Two researchers who conducted thematic analysis using NVivo 11 analyzed free response written answers to the question regarding what the faith community needs to do to address HIV. The data analysis process began with all responses being entered into the database and reviewed by the researchers. The first researcher created an initial code framework and codebook. All responses were independently coded using an open coding method, allowing codes to emerge from the data. A second researcher utilized the coding framework to begin coding and added codes as they emerged. Then researchers discussed discrepancies until common codes and themes were agreed upon.

Ethics Statement—This study protocol was approved by the University of Alabama at Birmingham Review Board. Because risks associated with this study were minimal, the University of Alabama at Birmingham Institutional Review Board recommended we obtain verbal informed consent. Prior to the training, participants were given an information sheet about the study, informed of the details of the data collection, and provided an opportunity to decline to participate.

RESULTS

Five separate sessions were conducted with a cumulative 146 participants (107 clergy and 39 laity) who participated in the full 3-hour training session across the state, based on the Alabama Ninth Episcopal District of the AME Church's five conference locations, between February and May 2017. At all but one of these sessions, there were both clergy and laity present; the exception was comprised solely of clergy. Among these 146 participants, some did not complete all questions (78% of all participants completed all of the 6 stigma questions (n=114; missing responses ranged from 3–7 on Time 1 and 10–13 on Time 2); 50% of participants left no blank responses on either administration of the HK-18, 19.2% left no more than one blank response on both administrations of the HK18, and 30.8% left 2 or more responses blank). We report complete case analyses for the stigma questions (n=114) and by scoring blanks as incorrect on the HK questionnaires (N=146). We note that for this topic in this setting, a reluctance to provide complete responses on topics that may be uncomfortable is not surprising (discussed later). The degree of missingness observed was not evaluated for patterns, and data were not imputed.

All participants were African American, and the majority were clergy (73%), female (55%), and living in an urban setting (57% - see Table I). Only 39% of all participants reported knowing someone living with HIV. When examining HIV programs, only 23% of clergy and 29% of laity knew of HIV programs, initiatives, or resources available in their communities. About 79% of lay members reported that their congregation would be accepting of HIV education programs, while around 69% of clergy reported similarly. Interestingly, around 67% of laity reported their congregation would be accepting of members living with HIV, while only around 45% of clergy endorsed this belief (Table II).

HIV knowledge, although reasonably high at baseline on both questionnaires (HK-18: M = 12.6, SD = 3.7; HK-10: M = 8.4, SD = 1.6), increased significantly from pre- to post-training among all participants on the HK-18. The mean increase in the HK18 scores was 2.3, SD = 3.4, $t(145) = 8.09$, $p < .001$. The mean increase in the HK10 scores was 0.1, SD = 2.2, $t(145) = .565$, $p = .573$; this may represent a ceiling effect with this set of questions. When examining the stigma-related attitudes toward PLWH before and after the training, a small change towards the positive direction was observed within participants (M = .34, SD = 3.3) but was not statistically significant, $t(113) = 1.11$, $p = .271$. Between groups, laity reported lower mean positive attitudes on stigma-related questions (M=5.7, SD=3.99) compared to clergy (M=7.8, SD=3.52) at both baseline [t(1,39.4) = 5.96, p = .019] and at time 2 [laity M = 6.1, SD = 4.10; clergy M = 8.1, SD = 3.72; t(1,40.2) = 5.38, p = .026], although both groups' summed attitudes were in the positive range at both time points (maximum possible positive attitude score = +12, lowest −12). Levene's test for unequal variances was not significant at either interval (p = .32 and .35 for time 1 and 2, respectively).

After the training, about 97% of all participants reported that they felt better prepared to serve those living with or affected by HIV because of the training. For next steps, 97% of participants said that they would implement HIV education training in their churches, and 98% reported that they would implement HIV awareness activities at their churches.

The major themes extracted from participants' responses to the question on what they thought the faith community should do to address HIV centered on the need to conduct more education/ training opportunities, have a varying communication mechanism, include youth in the work, and show love, empathy, and compassion toward PLWH (See Table III for example quotes by clergy and laity). While the themes were commonly shared by both clergy and laity alike, there were subthemes that were emphasized by one group over the other. Laity more than clergy felt the church needed to distribute information more. Clergy talked more about the need to address current issues within the church. Quotes included, "stop pretending that congregants are not sexually involved outside of marriage," "be realistic about what is going in the community," and "develop a tough skin and address the chronic issue." Only the clergy discussed the need to promote safe sex and provide support groups.

Education/Training

Both clergy and laity expressed the need for more education and training on HIV. One clergy member said, "Have more training sessions like the one we had today!" Another expressed, "Education is the key. The people need to be educated about HIV because so many people have misconceptions about HIV." Lay members added that education and training sessions should be provided regularly in schools, churches, and the community.

Communication

Participants agreed that using a variety of communication channels to convey HIV health messages would be helpful. They suggested using commercials, seminars, movie nights, Christian rap parties, flyers, and mailed booklets.

Outreach Comments

The importance of outreach was expressed by clergy and laity, stressing the need to extend beyond the walls of the church to reach a wider audience. They specifically noted the need to reach out to schools and colleges, in addition to partnering with medical professionals and mental health agencies to develop and to implement HIV programs.

Youth Inclusion

Many of the participants recognized the need to involve youth by including them in the discussions and interventions. They noted that engaging them in group discussions, teen chat sessions, and conversations at home and in school could be helpful. One lay participant suggested that HIV education should begin as early as 12 years of age.

Love and Compassion

Clergy and laity thought that it is important for the faith community to show love, empathy, and compassion to people affected by HIV. In response to what the faith community needs to do, one clergy member said, "Have empathy; show love & compassion," and a lay member said, "Let the people know that they care."

The other major themes that emerged from the discussions included the need for financially and emotionally supporting PLWH, free testing services, and stigma prevention (Table III).

DISCUSSION

Since faith-based organizations play a central role in the lives of African Americans, existing literature emphasizes the importance of engaging faith leaders in combating HIV [29,33,34]. This engagement, however, is hindered by HIV-related stigma, a contributor to the HIV epidemic within the African American community [9]. Community engagement methods have been found to positively influence the engagement of members of faith-based organizations in destigmatizing HIV. This study describes how faith-based and academic communities can partner together using community-engaged research to provide short, effective, and efficient HIV training to facilitate conversations about HIV and acceptance for PLWH.

Through the partnership between UAB CBCSC-FSRN and the AME Church, university researchers and community members worked hand in hand to develop the community informed 3-hour training titled *Love with No Exceptions* designed to address clergy's knowledge about HIV and potentially improve attitudes towards PLWH among AME's faith leaders. This collaboration is a highly promising community/university partnership that can set the stage for a new level of collaboration statewide in the faith community, which could have a profound impact on the HIV epidemic in the African American community not only in Alabama but also across the country. According to our community partners, this is the first time that HIV training was held statewide and offered to all AME church pastors. Having the critical academic and community partners in place, all of whom have a proven track record of success within the African American community, ensured the successful development and implementation of *Love with No Exceptions* faith-based HIV training and will ultimately pave the way for future collaborations and initiatives to address the HIV epidemic in faith-based settings. For instance, the AME Church has membership in 20 Episcopal Districts in 39 countries on five continents, with the work administered by 21 active Bishops and 9 General Officers [35]. Building on these could potentially help denominations understand the importance of HIV awareness training. Further, some denominations are not structured like the AME Church, which means the authority resides in the local church; they are only accountable to themselves. A delegation of AME churches could be a vanguard to encourage other denominations to review and understand the importance of HIV awareness training and testing. Legislation similar to the AME mandate can help to encourage churches to provide HIV education that can be disseminated into the community and improve relationships between the church and PLWH. These actions combined can foster a more inclusive and welcoming environment, dismantling existing stigma.

Pre- and post-training assessments showed that *Love with No Exceptions* was successful with all participants in addressing HIV knowledge and awareness of modes of transmission of HIV. Although there was only a minor change in HIV-related stigma attitude among participants, further large-scale longitudinal studies could demonstrate the effectiveness of *Love with No Exceptions*–type training in reducing HIV-related stigma among members of faith-based organizations.

Of great interest to this project and moving forward were the differences in knowledge and attitudes between clergy and laity. Clergy often had higher knowledge scores pre- and post-

training. This could partially be explained by clergy having more education since 74% of them were college graduates or attended graduate school compared with 38% of laity. More clergy also reported knowing someone living with HIV. Knowing individuals living with HIV has been shown to help lower stigma and public attitudes toward HIV [36]. Therefore, with more clergy knowing someone living with HIV, there is a chance of HIV stigma being lower within the church setting.

Responses regarding attitudes toward PLWH were mainly positive both pre- and post-training for both clergy and laity. Further, at all of the sessions, overwhelmingly the attendees responded positively to the woman living with HIV who shared her journey along with inspirational messages on living with HIV. Often, her message ended with a standing ovation. During the panel discussions at the final hour, there were lively discussions centered on the importance of training like this and opportunities for future training and outreach in local churches. Additionally, at each of the sessions, on-site HIV testing was conducted, and counseling services and educational materials were provided. All of these highlight the church as a place of acceptance and an important place for sharing information about HIV.

Limitations of this study included having a small sample size, making it difficult to generalize findings. However, this exploratory study can inform larger, more rigorous studies to provide generalizable findings. Particular attention should be paid to ensuring complete data collection in a way that participants are comfortable with, and content refinement at the level of the audience's medical knowledge is key. We observed a large amount of missing responses, which further limits interpretation of the analysis. Further, the HIV Knowledge questions about whether there is a vaccine to prevent HIV also tended to create confusion when combined with discussions on PrEP (Pre-Exposure Prophylaxis). PrEP refers to an orally ingested medication that is given to HIV-negative individuals who are at risk of contracting HIV to prevent them from becoming HIV positive [37]. As part of the training, we discussed PrEP but did not highlight the difference between that and a vaccine. This highlights an area for improvement for future training approaches. Regarding the reported attitudes about PLWH, some of the participants may have felt uncomfortable in having their prior views challenged in a setting such as was presented here and confirmation bias may have influenced the level of information uptake. Understanding of the mechanisms of confirmation bias reveals that the 'congeniality' of the new information (how much information supports existing beliefs) can affect the receptivity of participants to challenging messages, but this bias is reduced when the information is of higher quality [38]. Thus, information presented should be presented by knowledgeable persons who incorporate the best available scientific facts.

An additional consideration in this framework that cannot be separated is the discussion of topics about sexual behavior, across the spectrum of LGBTQ+, at a level of detail that is generally outside the scope of faith-based groups and settings. As people who may participate in training sessions may also struggle with their feelings of stigma about sexual practices they may not understand or support, learning about HIV facts may be difficult to process in a short period of time. Additional training topics on these areas should be developed and evaluated to determine if integrating them into a course on HIV can help participants overcome conflicting feelings. The conversation will need to evolve with the

church and public health perspectives to bring people together toward the common goal and stay engaged in the conversation. Future studies may benefit from evaluating whether the level of general education, age or knowing someone living with HIV personally may be related to knowledge or stigma-related beliefs.

In conclusion, the university/AME church partnership using a community-engaged research approach successfully developed, implemented and evaluated a faith-based HIV training that can serve as a guide for other states seeking to meet the new AME mandate to conduct faith-based HIV training. As such, it has the potential to serve as the foundational model program for the AME church and other faith communities throughout the country in developing and implementing HIV training in the faith community and in creating an innovative faith-based HIV intervention with African American pastors, church leaders, and youth ministries.

ACKNOWLEDGEMENTS

We are thankful to the Black Church and HIV for their co-sponsorship of the Town Hall. We also thank Dr. Dustin Long, Department of Biostatistics, Center for AIDS Research, University of Alabama at Birmingham, and Amal Alyusuf for their helpful comments on the analysis. We are grateful to the Alabama Ninth Episcopal District of the AME Church, Bishop Harry L. Seawright, and all of the clergy, laity, church members from the AME local churches, as well as our panel participants including medical providers and local HIV organizations and agencies who provided on-site HIV testing, counseling, and HIV resources that were available at all sessions. Further, we wish to express our unwavering love and admiration for the people living and thriving with HIV who spoke at each of the sessions. We acknowledge support from the University of Alabama at Birmingham (UAB) Center For AIDS Research CFAR, an NIH funded program (P30 AI027767) that was made possible by the following institutes: NIAID, NCI, NICHD, NHLBI, NIDA, NIMH, NIA, NIDDK, NIGMS, NIMHD, FIC, NIDCR and OAR and the Health Promotion and Disease Prevention Research Center supported by Cooperative Agreement Number 5U48DP005037 from the Centers for Disease Control and Prevention. The opinions expressed are those of the authors and not necessarily of UAB or any other organization.

This research was supported by the University of Alabama at Birmingham (UAB) Center For AIDS Research CFAR, an NIH funded program (P30 AI027767) that was made possible by the following institutes: NIAID, NCI, NICHD, NHLBI, NIDA, NIMH, NIA, NIDDK, NIGMS, NIMHD, FIC, NIDCR and OAR and the Health Promotion and Disease Prevention Research Center supported by Cooperative Agreement Number 5U48DP005037 from the Centers for Disease Control and Prevention.

References

1. Health and Human Services. U.S. Statistics. Available at: https://www.hiv.gov/hiv-basics/overview/data-and-trends/statistics. Accessed: 04/26/2019.
2. Centers for Disease Control and Prevention. Alabama State Health Profile. Available at: https://www.cdc.gov/nchhstp/stateprofiles/pdf/alabama_profile.pdf. Accessed: 04/26/2019.
3. Southern AIDS Coalition. HIV/AIDS in Alabama. Available at: https://southernaids.files.wordpress.com/2017/03/alabama-hiv-diagnoses-2015-fact-sheet.pdf. Accessed: 04/26/2019.
4. Centers for Disease Control and Prevention. HIV in the Southern United States. Available at: https://www.cdc.gov/hiv/pdf/policies/cdc-hiv-in-the-south-issue-brief.pdf. Accessed: 04/26/2019.
5. Abara W, Coleman JD, Fairchild A, Gaddist B, White J. A faith-based community partnership to address HIV/AIDS in the Southern United States: Implementation, challenges, and lessons learned. Journal of Religion and Health. 2015;54(1):122–133. [PubMed: 24173601]
6. Centers for Disease Control and Prevention. HIV Surveillance Report: Diagnoses of HIV Infection in the United States and Dependent Areas, 2016 Available at: http://www.cdc.gov/hiv/library/reports/hiv-surveillance.html. Accessed: 04/26/2019.
7. Alabama Department of Public Health. Brief Facts on African-Americans and HIV in Alabama, 2017.

8. Aral SO, Adimora AA, Fenton KA. Understanding and responding to disparities in HIV and other sexually transmitted infections in African Americans. The Lancet. 2008;372(9635):337–340.
9. Nunn A, Cornwall A, Chute N, et al. Keeping the faith: African American faith leaders' perspectives and recommendations for reducing racial disparities in HIV/AIDS infection. PLoS One. 2012;7(5):e36172. [PubMed: 22615756]
10. Reif S, Safley D, McAllaster C, Wilson E, Whetten K. State of HIV in the US Deep South. Journal of Community Health. 2017;42(5):844–853. [PubMed: 28247067]
11. Malcolm A, Aggleton P, Bronfman M, Galvao J, Mane P, Verrall J. HIV-related stigmatization and discrimination: Its forms and contexts. Critical Public Health. 1998;8(4):347–370.
12. Klein SJ, Karchner WD, O'connell DA. Interventions to prevent HIV-related stigma and discrimination: Findings and recommendations for public health practice. Journal of Public Health Management and Practice. 2002;8(6):44–53.
13. Beaulieu M, Adrien A, Potvin L, Dassa C. Stigmatizing attitudes towards people living with HIV/AIDS: Validation of a measurement scale. BMC Public Health. 2014;14(1):1246. [PubMed: 25476441]
14. Clark HJ, Lindner G, Armistead L, Austin B- J. Stigma, disclosure, and psychological functioning among HIV-infected and non-infected African-American women. Women & Health. 2004;38(4):57–71.
15. Yehia BR, Stewart L, Momplaisir F, et al. Barriers and facilitators to patient retention in HIV care. BMC Infectious Diseases. 2015;15(1):246. [PubMed: 26123158]
16. Vyavaharkar M, Moneyham L, Corwin S, Saunders R, Annang L, Tavakoli A. Relationships between stigma, social support, and depression in HIV-infected African American women living in the rural Southeastern United States. Journal of the Association of Nurses in AIDS Care. 2010;21(2):144–152. [PubMed: 19879778]
17. 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]
18. Coleman JD, Tate AD, Gaddist B, White J. Social determinants of HIV-related stigma in faith-based organizations. American Journal of Public Health. 2016;106(3):492–496. [PubMed: 26794158]
19. Brown L, Macintyre K, Trujillo L. Interventions to reduce HIV/AIDS stigma: what have we learned? AIDS Education and Prevention. 2003;15(1):49–69. [PubMed: 12627743]
20. Lindley LL, Coleman JD, Gaddist BW, White J. Informing faith-based HIV/AIDS interventions: HIV-related knowledge and stigmatizing attitudes at Project FAITH churches in South Carolina. Public Health Reports. 2010;125(1_suppl):12–20. [PubMed: 20408383]
21. Coughlin SS. Community-Based Participatory Research Studies on HIV/AIDS Prevention, 2005–2014. Jacobs Journal of Community Medicine. 4 2016;2(1):019. [PubMed: 28066841]
22. Foster PP, Bradley EL, Aduloju-Ajijola N, et al. Testing our FAITHH: HIV stigma and knowledge after a faith-based HIV stigma reduction intervention in the Rural South. AIDS Care. 2018;30(2):232–239. [PubMed: 29119799]
23. 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. [PubMed: 16396060]
24. Foster PP, Cooper K, Parton JM, Meeks JO. Assessment of HIV/AIDS prevention of rural African American Baptist leaders: implications for effective partnerships for capacity building in American communities. Journal of the National Medical Association. 2011;103(4):323–331. [PubMed: 21805811]
25. Griffith DM, Campbell B, Allen JO, Robinson KJ, Stewart SK. YOUR Blessed Health: an HIV-prevention program bridging faith and public health communities. Public Health Reports. 2010;125(1_suppl):4–11.
26. National Association for the Advancement of Colored People. About The Black Church & HIV: The Social Justice Imperative. Available at: https://theblackchurchandhiv.org/. Accessed: 04/26/2019.
27. African Methodist Episcopal (AME) Church. HALT-2: Leader Training on HIV/AIDS 2016.

28. Compilation Committee. The Doctrine and Discipline of the African Methodist Episcopal Church. 50th - Bicentenntial ed. Nashville, TN: The AME Sunday School Union; 2016.
29. Berkley-Patton J, Bowe-Thompson C, Bradley-Ewing A, et al. Taking it to the pews: A CBPR-guided HIV awareness and screening project with black churches. AIDS Education & Prevention. 2010;22(3):218–237. [PubMed: 20528130]
30. Marcus M, Walker T, Swint JM, et al. Community-based participatory research to prevent substance abuse and HIV/AIDS in African-American adolescents. Journal of Interprofessional Care. 2004;18(4):347–359. [PubMed: 15801550]
31. Carey MP, Schroder KE. Development and psychometric evaluation of the brief HIV Knowledge Questionnaire. AIDS Education and Prevention. 2002;14(2):172–182. [PubMed: 12000234]
32. Wingood G Diffusion of Effective Behavioral Interventions (DEBI) Field Guides: Archived Evaluation Field Guide & Instruments - SISTA Pre-test post-test surveys. Available at: https://effectiveinterventions.cdc.gov/en/2018-design/home/interventions-previously-supported-by-cdc/sista/EvaluationFieldGuideInstruments.aspx. Accessed: 10/10/2018.
33. Brown EJ, Williams SE. Southern rural African American faith communities' role in STI/HIV prevention within two counties: an exploration. Journal of HIV/AIDS & Social Services. 2006;4(3):47–62.
34. Stewart JM. Pastor and lay leader perceptions of barriers and supports to HIV ministry maintenance in an African American church. Journal of Religion and Health. 2014;53(2):317–325. [PubMed: 22870846]
35. Church AME. African Methodist Episcopal Church: The Official Website. Available at: https://www.ame-church.com/. Accessed: 4/26/2019.
36. Gerbert B, Sumser J, Maguire BT. The impact of who you know and where you live on opinions about AIDS and health care. Social Science & Medicine. 1991;32(6):677–681. [PubMed: 2035043]
37. Centers for Disease Control and Prevention. HIV/AIDS PrEP. Available at: https://www.cdc.gov/hiv/basics/prep.html. Accessed: 04/26/2019.
38. Hart W, Albarracin D, Eagly AH, Brechan I, Lindberg MJ, Merrill L. Feeling validated versus being correct: a meta-analysis of selective exposure to information. Psychol Bull. 7 2009;135(4):555–588. [PubMed: 19586162]

Table I.

Demographic characteristics of included participants (Total N = 146, Clergy = 107, Laity = 39) across the five Alabama training locations conducted in 2017

	Total % (N)	Clergy % (N)	Laity % (N)
Mean Age (years)	55.6	55.1	57.3
Gender			
Female	54.8 (80)	47.7 (51)	74.4 (29)
Male	45.2 (66)	52.3 (56)	25.6 (10)
Education Level			
Did not graduate from high school	2.1 (3)	0.9 (1)	5.1 (2)
High school graduate	5.5 (8)	1.9 (2)	15.4 (6)
Some college	21.9 (32)	17.8 (19)	33.3 (13)
College Graduate	33.6	35.5 (38)	28.2 (11)
Attended graduate school	30.8 (45)	38.3 (41)	28.2 (11)
Other	6.2 (9)	5.6 (6)	7.7 (3)
Household Income			
< $20,000	14.5 (20)	7.6 (8)	36.4 (12)
$20,000 - $29,999	13.8 (19)	12.4 (13)	18.2 (6)
$30,000 - $49,999	28.3 (39)	29.5 (31)	24.2 (8)
$50,000 +	43.5 (60)	50.5 (53)	21.2 (7)
Geography			
Urban	56.9 (83)	57.0 (61)	56.4 (22)
Rural	43.2 (63)	43.0 (46)	43.6 (17)
Knows someone living with HIV			
Yes	38.7 (55)	42.3 (44)	29.0 (11)

Table II.

Perceptions about HIV resources available in the community and church acceptance towards people living with HIV, (Total N = 146, Clergy = 107, Laity = 39)*

	Total % (N)	Clergy % (N)	Laity % (N)
Do you currently have any HIV programs, initiatives, or resources available in your community?			
Yes	24.1 (35)	22.6 (24)	28.2 (11)
No	43.5 (63)	47.2 (50)	33.3 (13)
Don't Know	32.4 (47)	30.2 (32)	38.5 (15)
How accepting do you think your congregation would be to HIV education and/or initiatives?			
Accepting	71.9 (105)	69.2 (74)	79.5 (31)
Somewhat accepting	27.4 (40)	29.9 (32)	20.51 (8)
Not very accepting	0.7 (1)	0.9 (1)	0.0 (0)
How accepting do you think your congregation would be to a member living with HIV?			
Accepting	51.1 (73)	45.8 (49)	66.7 (24)
Somewhat accepting	46.2 (66)	51.4 (55)	30.6 (11)
Not very accepting	2.8 (4)	2.8 (3)	2.8 (1)

*Totals may not add up due to missing data

Table III.

Themes that emerged when trainees were asked to complete the sentence, “What the faith community needs to do to address HIV…”.

	Example Quotes	
Themes	**Clergy**	**Laity**
Education/Training	Have more training sessions like the one we had today! Informative workshops about HIV prevention or treatment Education is the key. The people need to be educated about HIV because so many people have misconceptions about HIV	Start HIV/AIDS training in youth as early as 12 years old Provide training for (All) young &/ old in churches Provide HIV/AIDS training as part of pre-high school education Have HIV/AIDS programs on a regular basis in schools, churches and communities We have to educate ourselves to educate the community
Communication	I think for a period of time we have allowed the conversation on HIV/AIDS to lie dormant. It is time to reactivate the conversation and begin the talk again through commercials. Seminars; movie nights; Christian Rap parties	Provide flyers in church bulletins on HIV/AIDS information Mailed booklets
Stigma prevention	We must educate our people. I think it’s best to hold seminars or classes to give intervention regarding HIV. This will better prevent stigma.	Remove the stigma from it; Not be judgmental
Love and compassion	Practice love vs. judgment Have empathy; show love & compassion Love those who have HIV/AIDS	Let the people know that they care Show compassion
Outreach/ community-wide approaches	Speak to high school students and other teenagers through after school programs as well as during school programs, hold events at school to inform teenagers, make an effort to present to college students Partner with medical professionals, mental health agencies, etc. to collaborate and implement, initiate programs	Walk in the community and have group discussions Quarterly workshops in the community to cover to facts, mailed booklets, mandatory classes/ sessions in the schools Dec 1st World AIDS Day - participate or sponsor HIV community or activity
Health fairs/Testing	Free testing for community Instead of occasional needs to be more frequent educational events and HIV testing Have/ conduct testing	Keep making sure that people get tested for the disease More health fairs
Support	Have support groups Embrace people with HIV/AIDS Teach others to not exclude contact with people who have HIV/ AIDS	Have support groups; open door policies
Finances	Seek funding opportunities for additional trainers	Financial support to HIV community organizations
Youth	Conversation and education at home, school, teen chat sessions Open dialogues with teens at home, church and school; breakout sessions; workshops; free testing	Start HIV/AIDS training in youth as early as 12 years old Include teenagers in the discussion