“Wake Up! HIV is at Your Door”: African American Faith Leaders in the Rural South and HIV Perceptions: A Qualitative Analysis

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Abstract In Alabama, 70% of new HIV cases are among African Americans. Because the Black Church plays an important role for many African Americans in the south, we conducted qualitative interviews with 10 African American pastors recruited for an HIV intervention study in rural Alabama. Two main themes emerged: (1) HIV stigma is prevalent and (2) the role of the Black Church in addressing HIV in the African American community. Our data suggest that pastors in rural Alabama are willing to be engaged in HIV prevention solutions; more formalized training is needed to decrease stigma, strengthen HIV prevention and support persons living with HIV/AIDS.

Keywords Black Church · African Americans · HIV · Stigma · Rural south

Introduction

More than one million people in the USA are living with HIV infection, and African Americans are disproportionately affected (Centers for Disease Control and Prevention [CDC] 2014). The rate of new HIV diagnoses per 100,000 among African Americans in 2013 was estimated to be 55.9 compared with 6.6 for whites (CDC 2015). In 2013, the southern region of the USA accounted for half of new HIV diagnoses and had the highest rate of new AIDS diagnoses (CDC 2015). In Alabama, African Americans made up 26% of the population in 2013 (U.S. Census Bureau 2013); however, they had 70% of newly diagnosed infections in 2013 (Division of HIV/AIDS Prevention and Control, Alabama Department of

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Public Health 2014). Some rural areas in Alabama, including the state’s agricultural Black Belt region, have emerged as sites where new HIV infections are geographically concentrated, indicating a need for increased HIV prevention efforts in these areas (Division of HIV/AIDS Prevention and Control, Alabama Department of Public Health 2011).

HIV-related stigma, or negative feelings toward persons, groups and communities with high rates of HIV infection (Goffman 1963; Herek et al. 2002), is especially prevalent in the southern, rural USA and can decrease willingness to undergo HIV testing, to disclose HIV status or to access treatment (Stall et al. 1996; Gielen et al. 1997). For people living with HIV/AIDS (PLWHA), especially in rural areas, stigma is also associated with depression (Emlet 2007; Vyavaharkar et al. 2010). The effects of stigma can be magnified for PLWHA in rural areas if there is a deficit of trained medical professionals and available points of care are geographically dispersed (Heckman et al. 2006). Effectively addressing HIV in rural African American communities requires decreasing stigma by increasing awareness and providing accurate information regarding HIV. Because the church has such a prominent role in the lives of many African Americans, especially in the south, the faith institutions may be vital partners for ongoing HIV prevention efforts that include stigma reduction and increased support for African American PLWHA.

Religion is an important component to the lives of many PLWHA (Lorenz et al. 2005) and can have a positive impact on both physical and psychological well-being (Cotton et al. 2006; Simoni et al. 2002; Siegel and Schrimshaw 2002; Litwinczuk and Groh 2007; Ironson et al. 2006). However, Foster and Gaskins (2009) found that church leadership and members were not identified as sources of support for PLWHA. Barriers to engaging the African American faith communities in HIV education include fear of endorsing extramarital sex by promoting condom use (Nunn et al. 2012), financial constraints (Smith et al. 2005), homosexuality (Eke et al. 2010) and stigma (Wooster et al. 2011). Given both the importance of the African American church and the negative effects of HIV-related stigma, partnerships between public health professionals and the faith community may be vital components for addressing HIV. Understanding how these partnerships should proceed from the faith leaders’ (e.g., pastors’) perspectives for effective HIV prevention strategies has been understudied.

The purpose of this study was to explore African Americans pastors’ attitudes and perceptions about HIV in rural Alabama. Findings from this research can contribute to the development of faith-based HIV education, prevention and stigma reduction interventions in rural, southern settings.

Methods

Pastor Recruitment

A purposive sampling strategy was used to recruit 10 African American pastors in rural parts of Alabama into an HIV-stigma research study in faith-based settings. The research team utilized community contacts to initiate pastor recruitment. Pre-existing relationships with community and university organizations, HIV advocacy groups and nonprofit

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1 Historically, the Black Belt was known for its rich, fertile dark soils and association with the south’s antebellum plantations, cotton and slavery. Today, the Black Belt, which is largely populated by African Americans, is typically characterized by its demographics and economic downfall (Webster and Bowman 2008; Tullos 2004).
organizations were also used. Inclusion criteria for pastors included: being a senior pastor (leader in the church), age 19 years or older, self-identify as African American and presiding over a predominately African American congregation in rural Alabama. Efforts were made to include several denominations. Churches with less than 30 members were excluded from participation. After signing informed consent, pastors completed one-on-one semi-structured qualitative interviews. The complete interview guide is shown in Table 1. Pastors received $25 for their participation. The study protocol was reviewed and approved by the University of Alabama Institutional Review Board.

**Analysis**

An applied thematic data analysis was utilized to describe the pastors’ attitudes and perceptions about HIV in rural Alabama. The interviews were audiotaped and transcribed verbatim through an electronic transcription service. NVivo (QSR International Pty Ltd. version 8, 2008) was used to assist in coding, developing categories, themes and retrieving coded data.

Two qualitative data analysts (TMA, AM) read each transcript, reviewed transcripts by structural code (Guest and McLellan 2003) and created an emergent, data-driven code list (Guest et al. 2011). The analysts then compared their code lists, discussed discrepancies and created a preliminary content codebook. To ensure coding consistency, analysts independently coded each transcript and assessed intercoder reliability using Cohen’s kappa measure (Hruschka et al. 2004). The analysts reviewed and discussed codes with a kappa score less than 0.80 until a consensus was reached. Text segments were recoded as necessary, and the codebook was finalized. Salient and co-occurring concepts, as in relevant concepts that consistently emerged throughout the interviews, were identified and organized into thematic categories.

**Table 1** Interview guides for pastor interviews pre-assessment

<table>
<thead>
<tr>
<th>Personal</th>
</tr>
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<tbody>
<tr>
<td>1. How did you learn about HIV/AIDS? (i.e., radio, class, seminar, other)</td>
</tr>
<tr>
<td>2. Tell me about any HIV/AIDS education that you have received?</td>
</tr>
<tr>
<td>3. Please tell me about your personal experiences with HIV testing.</td>
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<tr>
<td>4. How would you define stigma and discrimination of persons affected by H/A?</td>
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<tr>
<td>5. What are your thoughts on the way HIV/AIDS is being addressed currently in the African American community?</td>
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<tr>
<td>6. Explain why you are interested in having your congregation participate in this study? (What changes do you hope to gain from participation? Any benefits? Any risks?)</td>
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<table>
<thead>
<tr>
<th>Congregational/community</th>
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<tr>
<td>7. Describe how HIV/AIDS has affected your church and community?</td>
</tr>
<tr>
<td>8. What groups of people in your church and community are most affected?</td>
</tr>
<tr>
<td>9. Has your congregation interacted with PLWHA? (Explain) If so, have they dealt with stigma or discrimination of PLWHA?</td>
</tr>
<tr>
<td>10. What type of HIV preventions services are conducted by your church? Who coordinates these activities?</td>
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<tr>
<td>11. What role could the Black Church play in addressing HIV/AIDS in the African American community?</td>
</tr>
<tr>
<td>12. What advice would you give the research team in conducting Project FAITH at your church? (Prompts: target groups, times to meet, etc.)</td>
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</tbody>
</table>
Results

Characteristics of the Participants

For the ten pastors interviewed ages ranged from 30 to 70 years; 90 % were male. Four Christian denominations were represented: Baptist, African Methodist Episcopal Zion, Christian Methodist Episcopal and Disciples of Christ. All pastors resided and pastored churches in rural counties of Alabama; six had pastored at their respective church 10 years or less. Participants indicated they were aware of HIV through mostly informal channels (e.g., mass media, family or friend living with HIV), literature, self-research or someone working in the field of HIV prevention. Regarding formal HIV education, with the exception of one participant who was trained during seminary, six received training in the context of their non-pastoral profession (e.g., nursing, mortician, sanitation worker). Most pastors reported having interactions with PLWHA (n = 7); four were in a pastoral capacity (e.g., “ministering to people with AIDS”), and three had a family member living with HIV. Regarding HIV testing, 70 % reported ever being tested for HIV and 50 % offered HIV prevention activities at their churches.

Main Themes

Two main themes emerged: (1) HIV stigma is prevalent and (2) the role of the Black Church in addressing HIV in the African American community. Exemplars from the transcripts are used to illustrate these themes.

HIV Stigma is Prevalent

Pastors’ discussions about stigma and PLWHA centered around three subthemes: (a) stigma toward PLWHA, (b) perceived stigma in the church and community and (c) stigmatizing views about HIV and PLWHA.

Stigma Toward PLWHA The pastors described stigma toward PLWHA in several ways. Some pastors defined stigma more formally such as, “…someone is shunned, dismissed, marginalized, and isolated, as a result of someone believing or knowing that they were either homosexual or a person who had contracted the virus.” A few pastors described how ignorance about HIV contributed to stigma. One pastor stated, “…we actually find people that say, ‘You can look at someone and tell that they actually have it.’ Or you’ll hear them say, ‘It’s a homosexual disease.’” Others provided examples of how they have observed stigma toward PLWHA manifested:

Individuals don’t wanna sit by ‘em on the pew, don’t want to eat anything they bring to the church. They frown when they are in their presence. They embrace them lightly instead of with a good—full embrace or hug. That’s a stigma to us.

Perceived Stigma in the Church and Community Several pastors perceived that HIV is affecting their church and community; however, because of stigma, “It’s a secret thing. People don’t talk about it.” Others felt that PLWHA are less forthcoming with disclosing their status because of the anticipated stigma. One pastor explained:
No one has actually truly come up and say, “I have it.” I’m pretty involved in the community, but I’ll guess a lot of people are, at that point, they’re scared to say it ‘cuz they don’t want people to shy away from them, thinking at that same point that a lot of people are ignorant to the disease and won’t shake their hands or anything like that.

Some participants mentioned they were aware of people in their community having HIV, but only after they had died. A pastor stated, ““…there are so many people that still have AIDS that are hidden…. ‘Cuz I know a person that just died a couple months ago that’s in the community and I didn’t even know they was infected with HIV.” This notion of dying in silence was also articulated by another pastor, “By the time you know it, they almost dead.”

**Stigmatizing Attitudes About HIV and PLWHA**  Participants expressed varying degrees of stigmatizing attitudes or remarks throughout their interview. Some pastors made remarks about PLWHA that overtly implied attitudes toward homosexuality such as, “He was always a little different, I guess, in saying that he was openly gay.” and “I buried one who was transgendered. He was—he was way out there.” One pastor described a culture of stigma toward homosexuals in the Black Church:

…in the “black church,” historically we’ve had this thing about homosexuality. On the one hand it’s been commonly practiced, but on the other hand it’s been commonly denounced. It’s just one of those things where we’ve had this hypocrisy about that issue.

A few made statements that implied the perception of personal responsibility for their disease as in, “It could be something that happened because of carelessness, the way they live.” Others made remarks that described needing to be on guard around PLWHA:

I’d shake his hand, hug him just like I do everybody else, but there’s the awareness there. I mean, it’s just like sometimes you know a person has a loaded gun. If they pull it out, you would be feared, but you just know the person has a loaded gun.

**The Role of the Black Church in Addressing HIV in the African American Community**

Pastors’ perceptions about HIV in the African American community and attitudes regarding the role of the Black Church revealed five subthemes: (a) making progress but more to do in the African American community; (b) African Americans need education across the life span; (c) Black Churches can foster holistic ministry; (d) Black Churches can maximize reach and influence; and (e) Black Churches can provide prevention and promote compassion.

**Making Progress but More to Do in the African American Community**  Six of the participants felt strongly that this issue is not being addressed enough in the African American community. One pastor felt that African Americans, “… don’t want to be bothered… they get tired of hearing it.” This sense of apathy was also expressed by another pastor:

It’s not being’ talked about. It’s just like everything else in the black community. Things that we don’t understand or want to understand, we just don’t talk about it. We just sweep it under the rug until it affects your family directly.
African Americans Need Education Across the Life span  Pastors expressed a sense of urgency to educate and intervene with youth, primarily because of the perceived risk behaviors of youth:

Our young children are growing up. They don’t know enough to take [care of] themselves or to hinder themselves from getting it…it need to be taught more in the church. They need to teach it more in the community.

Also, several pastors identified young adults and elderly to be among the groups most affected by HIV, particularly those who “practice and engage in behavior where it’s unprotected…” For some pastors, their perceptions about the need for more education across the life span were based on their knowledge of current statistics or trends they observed in their community. One pastor conveyed, “I’ve heard of statistics from going to meetings…it is important that we educate our children, our young adults, and our elderly.” Another pastor summed it up this way:

I think we have a lot of education to do. I don’t know that we are giving it the attention that it deserves… in our schools, in our churches, in our homes. Because in the Black Belt we have some serious issues with that problem… When I think of [Name] County, which is a rural county in the Black Belt of Alabama, and it has the highest incidences of AIDS of any county in the state. That says something’ to me, that that’s a problem.

Black Churches Can Foster Holistic Ministry  There were some pastors who expressed the need for the Black Church to acknowledge that HIV is present and therefore should be addressed: “Wake up! [HIV] It’s at your door.” Pastors believed that it is important for the church to minister to the whole person to include the spiritual, physical and social needs. One pastor expressed:

I’m interested in the health and welfare of our people. To preach to them on Sunday morning’ about spiritual matters and not address the community factors would be a sin. AIDS, HIV is a part of our life now and we have to address that issue. In the way we address sin, we should address health factors.

Black Churches Can Maximize Reach and Influence  Pastors described ways in which the church could use its influence to have a broader reach in the community. Several pastors suggested that the Black Church has a great deal of influence that can be channeled to educate the church and community about HIV to raise awareness and decrease stigma. Two pastors described the church influence:

If you look back in the past, the church was the mouthpiece for the community…that is actually where it will begin- the empowerment, the education. The more the church is informed, the more the church has an opportunity to go out and inform others in the community.

The church could play a great role, because we have a lot of congregations assemble on Sunday. We’ll start talking’ about it. At least, they’ll be aware of it. Then, some stigma that other people have, they’ll be able to downgrade that.

Additionally, policy was mentioned as an area where the church could maximize its influence to benefit the community. A pastor stated:
[HIV] is a scourge on our community. It’s killing too many of our young people who otherwise might be able to make a positive contribution to this society…We oughta be out there at least trying to shape some public policy which impacts the life of our community and helps our community.

Black Churches Can Provide Prevention and Promote Compassion  The pastors felt it was important for the church to provide HIV prevention. Participants shared various HIV prevention activities they were already engaged in, including disseminating educational materials such as “HIV pamphlets,” participating in national events like “Worlds AIDS Day,” discussing HIV in the “disciple women’s group,” and collaborating with other organizations and external guests to provide services. One pastor described how he encourages his congregants to get tested for HIV by being an example:

What I have done in the churches that I have pastored is that I have tried to make it—not make—but request as many of my members as possible to be tested. That’s something’ that I just done as a matter of course. Every time we do it at the church—I do it first, because I don’t want them to say I’m pushing’ something’ that I’m not doing—I do it in front of the congregation.

Along with prevention, some pastors discussed the need for the church to be informed and equipped to care for people affected by HIV and promote compassion. As one pastor stated, “…it’s important that we are all educated on how to treat our parishioners as well as how to take care of ourselves.” This view was also shared by another participant:

I think that it is important, as Christians, that again we treat people like we wanna be treated…we don’t know when we’re gonna have to deal with a family member or someone in the congregation that might have the disease. We got to know how to care for ‘em.

Discussion

This study explored African American pastors’ perceptions and attitudes about HIV in rural Alabama. Our findings can be used to inform HIV prevention strategies with faith leaders and Black Churches in the rural south. While previous research has indicated African American pastors tend to minimize the seriousness of HIV in their communities (Agate et al. 2005), we find that at least in rural Alabama pastors were keenly aware and concerned about HIV, which suggests signs of promise and progress.

As reported in other studies, our findings suggest that the lack of education is often manifested as HIV-related stigma, particularly in the form of unwarranted fears about casual transmission and ostracism toward people at-risk or living with HIV (Herek et al. 2002). Pastors were aware that the perception of being stigmatized (i.e., felt stigma) may result in non-disclosure of diagnosis and persons affected by or living with HIV feeling isolated (Bogart et al. 2008; Poindexter and Linsk 1999). Although the pastors were able to articulate how HIV-related stigma is often projected on people affected by or living with HIV and understood the implications of perceived stigma, our findings suggest that the pastors were unaware of their own stigmatizing remarks. While most of the comments were subtle, the hints of judgment could be construed as negative attitudes toward homosexuals (Jeffries IV et al. 2015) or blaming PLWHA for contracting the disease. Despite the presence of stigma, it is encouraging that the pastors were receptive to
providing HIV prevention activities within their faith settings and surrounding communities. In the same way, Bluthenthal et al. (2012) found that the presence of stigma did not hinder congregational HIV-related activities.

Similar to recent studies conducted with African American faith leaders, this study revealed a strong consensus that the Black Church and its faith leaders can play a vital role in addressing HIV and reducing HIV-related stigma (Moore et al. 2012; Wooster et al. 2011). The pastors described a number of roles they could play that are consistent with the literature. For example, fostering a holistic ministry is a hallmark of the Black Church. Members and community alike seek out the Black Church, not only for spiritual guidance but also to meet their social, emotional, educational and physical needs (Blank et al. 2002; Lincoln and Mamiya 1990). This suggests that pastors in this study perceived HIV in the African American community as an urgent matter that merits their attention and should be integrated into their existing ministries and messages.

In addition, the pastors acknowledged their influence and ability to shape norms and attitudes among their members and in the community (Berkley-Patton et al. 2010; Moore et al. 2012; Sutton and Parks 2013). According to the National Association for the Advancement of Colored People (NAACP), on a typical Sunday, there are approximately 20 million parishioners who attend Black Churches across the nation (NAACP 2014). With reach and influence of this magnitude, pastors are urged to use the pulpit as a platform to raise awareness about HIV (Moore et al. 2012), to preach messages that frame HIV as a social justice issue rather than a moral one (NAACP 2014; Nunn et al. 2012) and to promote care and compassion toward people affected by or living with HIV. Furthermore, pastors are encouraged to maximize their political influence by participating in local and national decision-making forums and coalitions (Hicks et al. 2005).

Limitations and Strengths

There are a number of limitations in our study. First, we used a purposive sampling approach and had a small sample; therefore, our findings may not be representative of rural Alabama more broadly or generalizable to other pastors. Second, although there was some diversity in denominations included, there are many other denominations within the Black Church that may differ in terms of doctrine, attitudes, beliefs and HIV prevention practices. Third, the pastors participated in an HIV-related risk-reduction study, which could suggest a selection bias, because they were aware of HIV in their communities and agreed to be in an HIV study.

Despite the limitations, there are several strengths. Our sample included pastors from the rural south, an area disproportionately affected by HIV, especially among African Americans. The pastors represented four denominations and ranged in age from 30 to 70 years, allowing us to hear a range of perspectives. Also, none of the pastors expressed concern that the inclusion of HIV prevention activities would compromise their church doctrine.

Recommendations and Implications for Future Research

Our findings warrant consideration of several recommendations and implications for future research. To better equip faith leaders to address HIV and combat stigma, it is recommended that faith leaders receive ongoing HIV training and technical assistance (Coleman
et al. 2012). Faith leaders are revered as credible sources of information by their congregations and in the community (Stroman 2005), and faith leaders could benefit from specialized training and technical assistance to provide HIV education to others (Coleman et al. 2012), sensitivity training regarding homosexuals (Lemelle 2004) and training on how to reduce HIV-related stigma. These actions may enable faith leaders to assess their personal HIV-stigma beliefs (Berkley-Patton et al. 2013) and correct misperceptions about HIV in the Black Church and community. Furthermore, to support community-level HIV prevention efforts, trainings could address the prevention benefits conferred by advancements in HIV treatment (Cohen et al. 2011) and by pre-exposure prophylaxis for high-risk HIV-uninfected persons (Golub et al. 2010). Incorporating this type of HIV prevention education in seminaries would be optimal; however, it has been previously cited that very few black clergy, in both rural and urban settings (i.e., 10–20 %), complete their professional training in seminary (Lincoln and Mamiya 1990). Other potential avenues might include local Bible schools or denominational training programs.

Regarding HIV testing, research suggests that pastors could be particularly instrumental in normalizing HIV testing, which may help reduce stigma associated with HIV testing (Nunn et al. 2013). Faith leaders may wish to consider making HIV testing a regular part of church-related HIV prevention activities.

It is important to consider other faith institutions attended by persons at-risk for HIV since the “Black Church” does not engage all at-risk African American communities (Aholou et al. 2011). With a larger sample of faith leaders, public health professionals could explore and compare attitudes about HIV prevention and stigma, to inform culturally appropriate, faith-based HIV prevention and stigma reduction efforts. In addition, negative perceptions by some congregants about HIV prevention in faith settings may cause some faith leaders to be reluctant to address HIV (Foster et al. 2011; Nunn et al. 2012); to reduce this barrier, future studies might assess congregants’ knowledge about HIV, stigma and receptiveness to HIV prevention in faith settings.

Conclusion

Our findings add to the emerging body of literature regarding HIV prevention with faith leaders in the south (Foster et al. 2011; Lindley et al. 2010; Moore et al. 2012). Despite evidence of HIV stigma, even among pastors, the faith leaders were willing to be engaged in HIV prevention solutions and to support PLWHA in their churches and surrounding communities. This work supports the goals of the National HIV/AIDS Strategy, which underscores the importance of churches as community settings and faith leaders as vital partners for HIV prevention efforts that include stigma reduction and increased support for PLWHA (Office of National AIDS Policy 2010).

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Compliance with Ethical Standards

Conflicts of interest The findings and conclusions in this report are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention. The authors have no financial conflicts of interest relevant to this study.
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