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Developing FAITHH: Methods to Develop a Faith-Based HIV Stigma-Reduction Intervention in the Rural South

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Human immunodeficiency virus (HIV) disproportionately affects Blacks/African Americans, particularly those residing in the southern United States. HIV-related stigma adversely affects strategies to successfully engage people in HIV education, prevention, and care. Interventions targeting stigma reduction are vital as additional tools to move toward improved outcomes with HIV prevention and care, consistent with national goals. Faith institutions in the South have been understudied as partners in HIV stigma-reduction efforts, and some at-risk, Black/African American communities are involved with southern faith institutions. We describe the collaborative effort with rural, southern faith leaders from various denominations to develop and pilot test Project Faith-based Anti-stigma Initiative Towards Healing HIV/AIDS (FAITHH), an HIV stigma-reduction intervention that built on strategies previously used with other nonrural, Black/African American faith communities. The eight-module intervention included educational materials, myth-busting exercises to increase accurate HIV knowledge, role-playing, activities to confront stigma, and opportunities to develop and practice delivering a sermon about HIV that included scripture-based content and guidance. Engaging faith leaders facilitated the successful tailoring of the intervention, and congregation members were willing participants in the research process in support of increased HIV awareness, prevention, and care.

Keywords: *HIV; stigma; faith-based intervention; church-based health promotion; African Americans*

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The southern United States is disproportionately affected by human immunodeficiency virus (HIV), accounting for 45% of persons living with HIV in 2015 (Centers for Disease Control

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and Prevention [CDC], 2017). However, only 37% of the U.S. population resides in the South (U.S. Census Bureau). Blacks/African Americans (hereafter referred to as African Americans) disproportionately reside in the southern United States and are heavily affected by HIV diagnoses there, accounting for 54% of new HIV diagnoses in 2016 (CDC, 2017). Additionally, African Americans living in the southern United States experience later initiation of antiretroviral therapy and greater HIV-related morbidity and mortality, compared with non-Hispanic Whites (Meditz et al., 2011). National goals to address HIV have included reducing new infections, increasing linkage to care for people living with HIV (PLWH), and reducing HIV-related racial and ethnic disparities (White House Office of National AIDS Policy, 2015). Activities include partnering with trusted community partners and leaders, including faith-based institutions, especially in the southern region of the United States (White House Office of National AIDS Policy, 2015).

The explanation for racial/ethnic and regional HIV disparities between populations is complex (McCree et al., 2016). In addition to individual-level factors, such as HIV awareness, attitudes, and beliefs, there are a number of external factors, such as poverty and access to care, that influence health and are commonly referred to as social determinants of health (World Health Organization, Commission on Social Determinants of Health, 2008). One important social determinant for HIV transmission is HIV stigma (Grossman & Stangl, 2013). HIV stigmatization has been described as a social process by which negative beliefs about and attitudes toward PLWH devalue the person's social positioning and adversely affect their interactions with others (Parker & Aggleton, 2003). PLWH's negative beliefs about themselves (internalized stigma), expectations of negative views or treatment from others (felt, perceived, anticipated stigma) or discriminatory experiences (enacted stigma) can contribute to diminished health and quality of life (Logie & Gadalla, 2009). For example, HIV-related stigma has been associated with depression (Emlet, 2007), fear of disclosure (Obermeyer, Baijal, & Pegurri, 2011), and compromised treatment adherence (Katz et al., 2013). Consequently, addressing social determinants, including stigma, in collaborative research and programmatic efforts nationwide has been prioritized (National Institutes of Health, Office of AIDS Research, 2015; White House Office of National AIDS Policy, 2015).

Previous research among African Americans living in the rural South suggests that both depression (Vyavaharkar et al., 2010) and disclosure decisions (Gaskins, 2006) may have significant relationships with HIV-related stigma within this population. Therefore, given the disproportionate rates of HIV infection among rural African Americans, and the potential role of HIV-related stigma in efforts to control this epidemic, developing comprehensive approaches to HIV prevention that intentionally target HIV-related stigma could bolster health promotion efforts and increase congruence with the World Health's Organization's (WHO) definition of health as "a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity" (WHO, 1946, p. 100). Unlike some social determinants that contribute to HIV-related disparities, such as incarceration (Khan et al., 2009), stigma may be more amenable to change in the short term because it requires fewer structural alterations, such as policy changes, to achieve progress.

An institution that may be poised to help address HIV stigma is the Black Church (churches that minister to predominantly African American congregations). According to the Pew Research Center (2015), the majority (91%) of African Americans report religion as an important part of their lives. Of the 75% reporting religion is very important, 58% said they attend services at least once a week. Because the Black Church has a history of involvement in health promotion (Campbell et al., 2007) and is embedded in many of the communities at highest risk for infection, churches provide an appropriate setting for education and cultivating compassion for those infected or affected by HIV. Building churches' capacity to address the range of factors that contribute to HIV can strengthen faith-based HIV prevention efforts (Abara, Coleman, Fairchild, Gaddist, & White, 2015).

However, the Black Church has been criticized for not being more involved in HIV prevention and has been viewed by some as contributing to the stigmatization of PLWH (Eke, Wilkes, & Gaiter, 2010; Sutton & Parks, 2013). Since its emergence in the United States in the early 1980s, HIV has been viewed by many segments of society, including many African Americans, as a disease affecting homosexual and sexually promiscuous people or drug users. It has been argued that African American communities and churches were hesitant to address HIV because doing so could exacerbate negative stereotypes of their racial/ethnic group (Cohen, 1999). Additionally, some have suggested that conservative church doctrine regarding sexuality and sexual behavior or drug use may limit the types of HIV prevention activities that congregations engage in (Derose et al., 2011; Sutton & Parks, 2013). However, despite disagreement with another's

beliefs about sexuality and sexual behavior or difficulty reconciling involvement in certain prevention-related efforts (e.g., condom distribution), individuals and congregations with conservative views of scripture are capable of showing compassion for PLWH in ways that do not require them to abandon their convictions. Consequently, engaging churches in dialogue about reducing HIV stigma and discrimination is an achievable goal.

It should be noted that any commentary regarding the Black Church, as a whole, is not necessarily applicable to all individuals or congregations. In pursuit of a stronger collective response to HIV, the National Association for the Advancement of Colored People (NAACP, 2013) created the Black Church & HIV Social Justice Imperative initiative to engage the Black Church in combating the growing HIV epidemic in many African American communities. This initiative was developed to connect faith leaders, religious institutions, and community members with the goal of establishing the Black Church as a change agent to overcome stigma through faith leader trainings, and the integration of HIV messages into church activities.

In recent years, there has been increased recognition of the detrimental effect of failing to adequately address HIV stigma and discrimination (Grossman & Stangl, 2013). Intervention research regarding HIV stigma and discrimination in the United States is limited. Recent reviews show researchers have intervened with PLWH, family members of PLWH, nurses, high school or college students, parents and children, and women participating in a Women, Infants and Children (WIC) program (Sengupta, Banks, Jonas, Miles, & Smith, 2011; Stangl, Lloyd, Brady, Holland, & Baral, 2013). Furthermore, some HIV stigma-reduction interventions have been developed for delivery in faith-based settings (Aaron, Yates, & Criniti, 2011; Berkley-Patton et al., 2013; Derose et al., 2016; Griffith, Pichon, Campbell, & Allen, 2010; Lindley, Coleman, Gaddist, & White, 2010; Nunn et al., 2013; Szaflarski et al., 2014), only one of which was based in the South (Lindley et al., 2010). We sought to add to this body of literature by describing the process for developing a faith-based HIV stigma-reduction intervention with African American churches in rural Alabama. Because churches, faith-based organizations, or practitioners may be less familiar with the practical application of scientific theories or models, we aim to provide a concrete example of how one model, ADAPT-ITT (Wingood & DiClemente, 2008), can be used to guide the process for adapting an HIV stigma-reduction intervention for use with the populations they serve.

METHOD

Intervention Development Process

The primary aim of this research was to develop a culturally appropriate HIV stigma reduction intervention for delivery in churches in rural Alabama. Starting with an HIV prevention framework that included stigma, fear, and denial (Foster, 2007), and incorporating aspects of stigma reduction theory (Parker & Aggleton, 2003), we obtained feedback from PLWH and local faith community members as part of the intervention development process. In this framework, HIV-related stigma is targeted and potentially decreased through sharing accurate information, community empowerment, cultural competence, skill development, direct or indirect contact with PLWH, and social action. Therefore, it was important that the Project FAITHH (Faith-based Anti-stigma Initiative Towards Healing HIV/AIDS) intervention approach and content reflected the pastors' and congregants' identities as Christian African Americans, and the context of their lives in the rural South. To achieve this aim, we involved members of the community in the development process. Wingood and DiClemente's (2008) ADAPT-ITT model provided a methodological framework for engaging the community and appropriately leveraging the strengths of all partners. ADAPT-ITT is a systematic process used to modify an existing intervention for use with a new population through eight phases: Assessment, Decision, Administration, Production, Topical experts, Integration, Training, and Testing. This approach has demonstrated usefulness in adapting interventions for a variety of health topics, populations, and settings (e.g., Copenhaver, Chowdhury, & Altice, 2009; Druss et al. 2010; Pekmezaris et al, 2016). The application of the model as it applied to Project FAITHH is described below.

Phase 1: Assessment

The aim of the assessment phase was to develop an understanding of the population and context in which the intervention would be implemented. The South, which includes Alabama, has the highest burden of HIV and higher diagnoses rates in rural areas compared with other regions (CDC, 2016). HIV stigma has been noted as a key determinant in prevention and care efforts in the region (Adimora, Ramirez, Schoenbach, & Cohen, 2014). We conducted formative research with local and national faith leaders from a range of denominations to better understand the specific context in which the FAITHH stigma-reduction intervention may be delivered. Although historically Black denominations

with whom many African Americans are affiliated were of particular interest (e.g., African Methodist Episcopal Zion, Baptist, and Christian Methodist Episcopal; Pew Research Center, 2015), other denominations that may have predominately African American congregations were also included.

Methods. The principal investigator (PI) attended local and regional denominational conferences and spoke with faith leaders before engaging in recruitment of local Alabama pastors for this study. To ensure nuances of the Alabama context were captured adequately, the PI recruited four ministerial liaisons (by visiting over 10 churches and national faith leadership conferences) to gain preliminary insight and develop a plan for recruiting congregational partners. Ministerial liaisons, the research team, and denominational leaders helped identify local churches in rural Alabama to approach. A snowball sampling approach resulted in meetings with approximately 30 to 40 faith leaders in order to meet our goal of enrolling 12 churches (based on power analysis). A list was compiled of 12 churches and two alternates interested in participating. The two alternate churches became participants when two churches on the primary list could not participate. The final sample included 12 churches that were enrolled for the study by the Senior Pastor (the head pastor of the church), three from each of the following denominations: African Methodist Episcopal Zion, Baptist, Christian Methodist Episcopal, and Disciples of Christ. The research protocol was approved by the University of Alabama's institutional review board.

In-depth interviews were conducted with 10 Senior Pastors from the 12 participating churches (age range: 30-70 years; 90% male); scheduling conflicts prevented two of the pastors from participating in an interview in the established timeframe. Eligibility criteria for the interview included self-identifying as African American, being at least 19 years of age, and holding the position of Senior Pastor of a predominately African American congregation (at least 88% African American) in rural Alabama (as defined by the Health Resources and Services Administration, 2015). During the 60- to 90-minute semistructured interviews, pastors were asked about their own HIV knowledge, HIV attitudes, and HIV testing behaviors, as well as their perceptions of their congregation's attitudes toward and interactions with PLWH.

Findings. We learned from the pastors that HIV stigma was prevalent, but the pastors believed that Black Churches have an important role to play in addressing HIV in the African American community. A more detailed account of the qualitative findings from the interviews is provided elsewhere (Aholou et al., 2016). Pastors also provided demographic information about their congregation and any HIV prevention activities conducted at their churches. Last, the interviewers solicited recommendations regarding the best strategies for intervention implementation with their congregation (as a single session, over two sessions, or eight weekly sessions as an additional hour after church service).

Phase 2: Decision

The purpose of the decision phase was to identify an evidence-based intervention (EBI) that could be adopted (used in original form) or adapted to fit the aims of the study and needs of the population. The PI attended a Faith and HIV Workshop at Duke University in 2014, which provided an update of domestic faith and HIV prevention initiatives at the time. A search of the peer-reviewed literature (using PubMed, Google Scholar, and OVID) was also conducted to identify potential EBIs using keywords such as HIV, AIDS, faith, religion, African American, Black, southern United States, prevention. Given the state of the science on faith-based HIV stigma-reduction interventions at that time, the search yielded few results. We identified Project FAITH (Fostering AIDS Initiatives that Heal), a statewide demonstration project in South Carolina that funded 22 African American churches or faith-based organizations to reduce stigma in churches and communities through education and services (Lindley et al., 2010). Two additional interventions developed in collaboration with churches to directly address HIV-related stigma that were conducted in Flint, Michigan (Griffith et al., 2010) and the Kansas City metropolitan area (Berkley-Patton et al., 2010) also appeared in the literature. However, information regarding intervention efficacy was not available for any of the interventions, only anecdotal evidence from interviews with pastors or other leaders regarding their perceptions of reductions in congregants' attitudes exhibiting HIV stigma (Coleman, Lindley, Annang, Saunders, & Gaddist, 2012; Griffith et al., 2010). Therefore, at the onset of the development process there were no identifiable EBIs that addressed the intersection of stigma and faith in the peer-reviewed literature.

Additionally, we identified a faith-based, anti-stigma curriculum developed by the Christian Council of Ghana (CCG, 2010) in the gray literature. The PI met with CCG leaders while in Ghana to learn more about the curriculum and to discuss a collaborative curriculum to test with churches in the rural southern United States. The CCG seven-module curriculum uses relevant

scriptures and teachings from the Christian faith to directly address HIV stigma from a Christian perspective and adopts a social-ecological perspective in the discussion of the impact of stigma on individuals, families, and broader communities. Additionally, it incorporates a combination of information and skills-building components, an approach found to be more effective than providing information alone (Brown, Macintyre, & Trujillo, 2003). Some aspects of the CCG intervention required revision to maximize relevance for congregations in rural Alabama, so we selected it for adaptation, and revised it based on feedback from academic subject matter experts, local ministerial liaisons, and content from the NAACP's (2013) The Black Church and HIV: Social Justice Imperative.

Phases 3 and 4: Administration and Production

During the administration and production phases, the original intervention was evaluated to determine which aspects required adaptation, and a draft of the adapted intervention was produced. Due to time and resource constraints, we were unable to conduct preliminary testing of the intervention (theater testing) with members of the priority population. However, technical support was provided by scientific mentors from CDC for production of the first iteration of the adapted intervention. A postdoctoral research fellow with experience in intervention development and implementation, including in African American church settings, and a Project FAITHH staff member with experience in health communications, led the adaptation process. The CCG curriculum was reviewed to identify where modifications to the original intervention would be needed in the surface structure (e.g., language, images) or deep structure (e.g., scenarios relevant to cultural context; Resnicow, Baranowski, Ahluwalia, & Braithwaite, 1999) and to identify areas where additional content should be created to address gaps.

Since the CCG curriculum had not been evaluated for efficacy, we were unable to identify core elements of the intervention that should be preserved in the adaptation process. However, to ensure a sound scientific approach to the adaptation we searched the literature on stigma to identify key intervention strategies. Four intervention approaches were identified and used in the adaptation: information-based, skills-building, contact with PLWH, and advocacy (Brown et al., 2003; Heijnders & Van Der Meij, 2006).

Much of the content from the original CCG intervention was included in the initial draft, but was tailored and enhanced with content from the NAACP's (2013) The Black Church & HIV initiative's Activity Manual and Pastoral Brief designed to reduce the impact of HIV on the African American community for better cultural relevance and congruence with rural Alabama churches. Revisions consisted of changes to images, language, or activities, and the addition of supplemental materials to enhance the original content (Table 1).

Phases 5 and 6: Topical Experts and Integration

The topical experts and integration phases entailed refining the first draft of the adapted intervention based on expert feedback to produce the draft to pilot test. After an initial draft was completed, CDC staff and Project FAITHH team members with expertise in HIV and faith communities in rural Alabama reviewed the draft of the adapted intervention and provided additional feedback. The Project FAITHH team finalized the draft based on local structures and identified needs. Additionally, project staff met with the four ministerial liaisons to conduct a debriefing session where each proposed module was reviewed; feedback from this meeting was used to further increase the relevance of the curriculum to the local population. The end result of this process was an eight-module, group-based intervention titled FAITHH (Table 1). Senior pastors were also able to provide feedback during the training phase.

Phase 7: Training

In the training phase, study staff were trained for their respective roles. University of Alabama Project FAITHH team members and leaders of CCG in Ghana met using remote teleconferencing technology. CCG provided feedback and discussed a plan for formal training of Project FAITHH staff members. Although technical difficulties prevented further teleconference training opportunities, CCG leaders were able to provide feedback by e-mail.

The ministerial liaisons received a 1-day training from the PI and other Project FAITHH staff persons during a national public health conference, so they could fully understand the goals of the intervention and provide feedback about the content and how to deliver the intervention to their churches.

For churches implementing the FAITHH curriculum ($N = 4$), the Senior Pastor was recruited to work with a Project FAITHH team member to help lead exercises and activities based on knowledge and comfort level. Prior to a scheduled site visit, project staff communicated with the Senior Pastor by telephone to review planned activities and answer any questions. Copies of the curriculum manual were also provided. In addition,

TABLE 1
Project FAITHH: Anti-Stigma Intervention Framework Summary, Rural Alabama, 2015

Module	*Topic*	*Main Objectives*	*Intervention Adaptations*	*Approach*
1	HIV facts, stats, and social context	– Increase knowledge of HIV transmission and national, state and county-level statistics – Explain how social issues impact HIV – Emphasize importance of HIV testing	Created module using AIDS Vu Maps and information from local health departments; handouts on HIV testing, common myths, and social drivers of HIV from NAACP; video clip on HIV testing (http://biomed.brown.edu/hiv-testing-video/information)	Information
2	Naming the problem	– Define stigma – Identify forms, causes, and effects of stigma – Develop empathy for PLWH	Adapted CCG Module 1 Added discussion of non-HIV-related stigma (homelessness and incarceration) and POZ magazine articles	Information, skill-building, contact
3	More understanding, less fear	– Help participants articulate fears about HIV – Establish link between fear and stigma and discriminatory behaviors toward PLWH – Clarify modes of HIV transmission	Adapted CCG Modules 2 and 3 Revised and updated list of high-risk (e.g., breastfeeding) and low-risk (e.g., blood transfusion) activities	Information
4	Impact of HIV infection on families	– Facilitate open discussion of how HIV impacts families – Identify critical issues related to living with and caring for PLWH without stigmatizing	Adapted CCG Module 4 Created culturally relevant vignettes for discussion or role-play CDC's Act Against AIDS video clips showing support for PLWH: http://www.youtube.com/embed/lLxTg6aZ_dg http://www.youtube.com/embed/ct3XJh6-WRQ http://www.youtube.com/embed/R5Uh3Vp55rA	Information, skill-building, contact
5	Sex, morality, shame, and blame	– Discuss the power of their words – Develop empathy for PLWH	Adapted CCG Module 5 Modified list of groups at increased risk for HIV to better reflect the U.S. epidemic	Information
6	Stigma and religion	– Explore some religious beliefs that may fuel stigma – Identify biblical text that demonstrates compassion toward PLWH – Encourage and promote HIV testing	Adapted CCG Module 6 Added handout NAACP's sermon ideas for addressing HIV stigma	Information, skill-building, advocacy

(continued)

TABLE 1 (CONTINUED)

Module	Topic	Main Objectives	Intervention Adaptations	Approach
7	Coping with stigma	– Discuss the importance of emotional well-being of PLWH – Identify ways to promote emotional health of PLWH – Identify ways to challenge stigma and assist PLWH to cope with the effects of stigma	Adapted CCG Module 7 Added discussion of “A Modern Day Parable” from NAACP’s Pastoral Brief	Information, skill-building, contact, advocacy
8	Using advocacy to challenge stigma and promote social justice	– Identify action steps participants can take to advocate for PLWH – Identify constructive ways to counter challenges to HIV activism and social justice	Adapted CCG Module 7 Added presentation and discussion of stages of advocacy based on NAACP’s Activity Manual	Advocacy

NOTE: FAITHH = Faith-based Anti-stigma Initiative Towards Healing HIV/AIDS; HIV = human immunodeficiency virus; AIDS = acquired immunodeficiency syndrome; NAACP = National Association for the Advancement of Colored People; CCG = Christian Council of Ghana; PLWH = people living with HIV. Consistent with Brown et al.’s (2003) definition, indirect contact with PLWH (e.g., video testimonial) was classified as contact.

project staff met among themselves prior to each site visit as a planning and review session.

Phase 8: Testing

The newly adapted FAITHH intervention was pilot tested using a small randomized trial with 12 churches. Churches were randomly assigned to one of three conditions: (1) FAITHH anti-stigma condition, (2) standard HIV knowledge–based condition, or (3) control condition (passive placement of brochures at church). Across conditions, 199 African American congregants (M = 51.1 years, SD = 16.9 years) recruited via church announcements, brochures, or word-of-mouth participated in the pilot study. Analyses of brief assessments completed before and after the intervention by 164 participants showed a reduction in congregants’ personally held HIV stigma for the FAITHH intervention compared with the control condition (adjusted $p < .05$). A more detailed description of the pilot outcomes is reported elsewhere (Payne-Foster et al., 2018).

Postintervention feedback from session evaluations completed by participants from the FAITHH anti-stigma condition (N = 64) suggested the adapted intervention was received well. Participants provided brief, written responses to four open-ended items: (1) What was the most important thing you learned from this intervention? (2) What did you enjoy most about the intervention? (3) Was anything unclear about the curriculum? (4) Do you recommend any changes for the intervention? Content analysis was employed to categorize and quantify response data and to identify themes (Vaismoradi, Turunen, & Bondas, 2013).

Regarding the most important thing learned during the sessions, responses were most commonly categorized as stigma reduction or advocacy focused (56%), which comprised the theme of showing compassion and support for PLWH or people living with AIDS. One participant said, “The most important [thing] that I learned was not to stereotype and stigmatize HIV/AIDS patients. Show support and love.” Similarly, another participant said, “It’s a wonderful and godly thing to show love . . . to everyone no matter what they’re going through.” Regarding advocacy, one participant commented that they learned ways to support HIV prevention efforts and to support people who have HIV. Another common theme was the importance of having accurate knowledge about HIV and AIDS. Approximately 28% made reference to obtaining more accurate information about HIV-related topics, including transmission, testing, and treatment, through their participation in the FAITHH intervention. One participant stated, “I learned to let go of some of the incorrect thoughts I had about HIV/AIDS.” Only three participants reported being unclear about something after completing the intervention, including how an individual church can

take action concerning HIV and AIDS, how to get true support and not be judged, and the role of monkeys in the history of HIV.

It is also worth noting that the intervention format was received well. The main theme regarding which aspect of the intervention was most enjoyable was cultivating an interactive learning environment with opportunities to apply concepts and engage with others. Many (38%) of the responses were related to the format of the intervention, specifically noting enjoying the interaction (19%), discussions (8%), and activities (11%). Participants were also given the opportunity to provide feedback to improve the intervention. Suggestions included expanding to include younger participants, conducting separate groups for younger and older participants, and improving transitions between activities.

DISCUSSION

Few studies appear in the published literature regarding interventions that were developed in collaboration with churches to directly address HIV-related stigma (Aaron et al. 2011; Berkley-Patton et al., 2013; Derose et al., 2016; Griffith et al., 2010; Lindley et al., 2010; Nunn et al., 2013; Szaflarski et al., 2014), only one of which was based in the South (Lindley et al., 2010). To address this gap, we partnered with 12 churches in rural Alabama to develop and pilot test a faith-based HIV stigma reduction intervention using the ADAPT-ITT model (Wingood & DiClemente, 2008). The result of this partnership was the FAITHH intervention, an eight-module curriculum that was culturally relevant, factual, and consistent with the teachings of the Christian faith. Participants responded favorably to the FAITHH intervention. Pilot testing also suggested delivery of the intervention is feasible. Preliminary results suggest the intervention shows promise and should be tested further.

Several important lessons were learned during the adaptation process. It was highly beneficial to involve members of the rural Alabama faith community in the formative research and to train several members to co-facilitate group sessions. Doing so provided an insider perspective about prevailing congregational or community norms and beliefs that may have been missed otherwise. Furthermore, some members were empowered to educate their peers, and others were inspired to integrate HIV education into their church ministries. Several congregants and pastors suggested that the intervention was strongly needed with their younger adolescent family and community members; efforts are underway to secure additional support to expand this as an HIV prevention strategy within the churches that implemented the intervention.

During the process, we encountered some challenges, including recruitment of pastors, creating buy-in for this HIV awareness and prevention research and maintaining congregant interest throughout the process. Following up with the pastors also created some logistics challenges with implementation, which were later resolved when pastors engaged a church liaison who was often a member of the health ministry. We learned that the ideal intervention delivery scheduling also needs to be flexible as each church has different needs.

On a positive note, however, we also learned that despite commonly held beliefs that rural, southern Black churches would be reluctant to address HIV as an issue, there was high interest and great receptivity among the pastors and congregants we encountered. We were able to also dispel myths about the Black church collectively not being supportive of open discussions about HIV education and prevention and stigma. Engaging denominational leadership and gaining pastor support early in the research process, before any contact with specific churches, was also crucial to our ability to create trust with faith leaders and have their support during the study process.

Limitations of this adaptation study were the lack of stigma-reduction EBIs appropriate for adaptation with our population, and the inability to theater test the CCG curriculum to obtain feedback from congregants prior to pilot testing to ensure their perspective was adequately captured, due to time and funding constraints. While community engagement was inhibited by these obstacles, the challenges associated with time and funding limitations are not unique to this study. As noted by other researchers, community engagement is an extremely valuable, yet resource-intensive, endeavor that does not always lend itself well to some research constraints (Blumenthal, 2011; Minkler, Blackwell, Thompson, & Tamir, 2003). Therefore, it may be advantageous for funding agencies to consider such challenges when establishing time lines and allocating resources for studies with a community engagement component.

To date, the preliminary findings from Project FAITHH have been shared at a 2015 World AIDS Day dissemination event and at a national HIV scientific conference (Aholou, Payne-Foster, Cooks, Sutton, & Gaskins, 2015). Feedback from over 80 faith leaders and congregants in attendance at these events showed enthusiasm for the information and underscored the importance of HIV stigma-reduction interventions like Project FAITHH, especially in the rural south, an area that has been hit hard by the HIV epidemic.

CONCLUSIONS

Reducing HIV-related stigma will play a vital role in reducing rates of new HIV infections, and disparities in HIV diagnosis, treatment, and care. African American churches, which are already integrated in some of the communities most heavily affected by disparities (e.g., African Americans in the South), are valuable partners in addressing gaps in knowledge and cultivating compassion that can bolster efforts to reduce HIV stigma and discrimination. As evidenced by high attendance and interest by faith leaders at national forums and HIV prevention conferences, faith leaders are increasingly engaged and wanting to be a part of the solution toward decreased HIV in highly affected communities of color. Additional research is needed to develop efficacious, faith-based, stigma-reduction interventions that are medically accurate and culturally congruent, which may be a key component of domestic HIV prevention efforts.

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