RESEARCH HIGHLIGHT

The Role of Urban Congregations in Addressing HIV

With their extensive social reach and influence across diverse communities, faith-based organizations have an exceptional opportunity to help address human immunodeficiency virus (HIV) worldwide. But in these efforts, many congregations face constraints, including limited size and resources, as well as competing social needs and ministries.

Until recently, the roles that faith-based organizations might play have not been clearly defined. In a carefully designed series of studies conducted over eight years, RAND researchers sought to better understand the capacity of urban congregations for HIV prevention and care, specifically in the areas of stigma reduction and HIV testing.

The research was conducted collaboratively with community-based partners, including faith and public health leaders. It had three main phases: (1) research to understand the roles that congregations have played throughout the various stages of the HIV epidemic; (2) development of a multi-component, church-based program to address HIV stigma and promote HIV testing in African American and Latino churches; and (3) an evaluation to assess how the program worked in real-world settings.

Key findings:

- **Through an eight-year collaboration with faith and public health leaders in Los Angeles, RAND developed and evaluated an intervention to reduce HIV stigma and promote HIV testing in African American and Latino churches and found the intervention feasible to implement and acceptable to congregants.**
- **The intervention reduced HIV stigma and mistrust in the participating Latino churches and increased HIV testing across African American and Latino congregations.**
- **Stigma reduction and HIV testing seemed to work in synergy.**

Phase One: How Have Urban Congregations Addressed the HIV Epidemic?

The research team conducted in-depth case studies of congregations across various areas of Los Angeles County to understand the diverse roles that congregations have played, and continue to play, over several decades of the HIV epidemic and to identify the factors that helped or hindered their work.

Interviews with local experts. The team interviewed local religious and public health leaders to help design the case study procedures and select potential congregations. The community experts highlighted a range of factors that influenced whether and how a congregation participated in HIV-related activities—for example, whether the leaders focused "inwardly," prioritizing the spiritual health of the congregation, or "outwardly," focusing on broader social issues. They also noted that some congregations associated HIV with behavior that did not align with scriptural teachings—for example, same-sex sexual behavior among men—and this made addressing the issue sensitive in congregational settings.

Community advisory board. The RAND team recruited a diverse community advisory board (CAB) to ensure that the work accurately reflected community needs and perspectives. The CAB comprised some of the experts who were interviewed, as well as other local religious and public health leaders.

Throughout the eight-year research effort, RAND worked closely with the CAB, benefiting from its members' intimate knowledge of the communities and their diverse social networks.

Case studies of congregations. Through a screener survey and CAB input, 14 urban congregations were selected for the case studies, including six predominantly African American, four predominantly Latino, two predominantly white, and two of mixed race-ethnicity. The congregations were also diverse in terms of size, faith tradition (various Christian subgroups and Jewish), and levels of HIV activity and involvement.

Profiles of health and HIV-related activities. The team created a profile of each congregation's health and HIV-related activities by integrating information from multiple sources. These included an initial recruitment meeting with church leaders, subsequent in-depth interviews with clergy and lay leaders, and basic information about the congregation's membership and resources. The team also observed religious services and health or HIV-related activities that took place at each congregation.

Previous research has focused mostly on the role of urban congregations in prevention education. However, the case studies identified efforts that spanned a wider range, including care and support, prevention and education, and awareness and advocacy. Partnership with public health organizations was key to the success and sustainability of these efforts. The case studies also identified reducing HIV stigma and promoting HIV testing as two types of activities that many congregations would feel comfortable addressing. The CAB encouraged the team to develop an integrated intervention to address these priorities.

Phase Two: What Kind of Program Could Reduce HIV Stigma and Promote HIV Testing in African American and Latino Churches?

The team conducted an extensive review of prior studies and consulted with community partners to develop a program to address HIV stigma and promote HIV testing in African American and Latino churches. RAND worked closely with the CAB, clergy consultants, and a local health department to develop and pilot-test all program materials.

The program was based on social psychological theories on how to reduce stigma. In this framework, efforts to reduce stigma should include both informational and contact components. Providing information can address misconceptions about the disease, which often stem from incomplete or incorrect understanding of how HIV is transmitted, as well as mistrust of public health information. Direct or indirect contact with people living with HIV may be more powerful in changing negative attitudes toward HIV and people affected. In concert, these approaches can promote empathy toward people living with HIV. Reducing the stigma associated with the disease could make the congregation more accepting of people living with HIV and could make it easier to promote prevention behaviors, such as HIV testing.

How the program was structured. Working with the CAB and drawing on the experience of religious and public health advisers, the team designed a church-based program to reduce HIV-related stigma in the following ways, using both informational and contact components:

- *HIV education workshops.* These group efforts were designed to raise awareness of HIV, increase knowledge about the disease and testing, and generate compassion for people living with HIV.
- *Peer leader workshops.* Structured role-playing helped congregants learn how to discuss HIV stigma and testing with other members of the congregation and with the community.
- *Sermon and imagined scenario.* Each pastor or priest was asked to give a sermon explaining how HIV-related stigma affected the community, highlighting the importance of showing compassion for people living with HIV. They were asked to incorporate a story or an imagined scenario about meeting someone with HIV to help engender empathy among congregation members.
- *Congregation-based HIV testing.* The health department conducted rapid (~20 minutes) HIV testing in a mobile clinic stationed at the church during services over several weeks, and the congregation promoted testing by making announcements from the pulpit and encouraging people to get tested.

The program was intentionally designed to operate at multiple levels, reaching not only individuals who participated in the workshops but also the entire congregation through the sermon and HIV testing. The educational workshops were implemented largely through ministry groups in the congregations (e.g., women's groups, social justice groups, prayer groups); the program structure was intended to integrate HIV awareness raising, stigma reduction, and testing with ongoing church activities.

Phase Three: How Well Did the Program Work in Real-World Settings?

RAND conducted a rigorous and thorough evaluation to assess how this program worked in real-world settings—in this case, three Latino and two African American churches in an area of Los Angeles County that was highly affected by HIV. The goal was to learn whether an intervention to reduce HIV stigma and medical mistrust would be feasible to implement in urban congregations, acceptable to congregants, and effective in promoting testing. The study's inclusion of Latino churches was unique because studies of congregation-based HIV interventions have focused overwhelmingly on African American churches.

The four smaller churches were randomly assigned to receive the intervention or serve as a nonintervention church to provide a comparison. No comparison was available for the fifth church—a large Catholic congregation. However, this church was included because most Latinos are Catholic, and much could be learned about the feasibility and acceptability of the intervention in such a congregation even in the absence of a comparison church. All materials were professionally translated into Spanish, and translations were reviewed by the principal investigator and other bilingual team members.

How the program affected HIV-related stigma. To evaluate the program, the team surveyed members of the congregation before and after the program was implemented, using previously developed measures of stigma and mistrust that captured stigma's multiple manifestations.

Looking across all the congregations before the program was implemented, there were moderate levels of HIV stigma

and mistrust. When comparing congregations after the intervention was implemented, average levels of stigma and mistrust (i.e., across both African and Latino church pairs) did not change more in intervention churches than in non-intervention churches.

However, looking at the change within individual churches, the team found significant decreases in HIV stigma and mistrust in both Latino intervention churches (Pentecostal and Catholic). To find significant reductions in HIV stigma and mistrust with a relatively small study was especially compelling because, to date, no other church-based interventions have been found to effectively reduce HIV stigma. Further, few HIV interventions have been tested in Latino churches.

How the program affected HIV testing. The Latino and African American intervention churches had higher rates of HIV testing after the intervention was implemented. Efforts to reduce stigma seem to have created an environment in which HIV testing was more acceptable because it was seen as part of a church's ongoing efforts to promote its congregation's health. Further, many of those who were tested at the Latino churches were being tested for the first time, and they were uninsured. Thus, free, on-site testing in a trusted environment appeared to reduce access barriers for this population. Stigma reduction and HIV testing seemed to work in synergy.

An Evolving Role for Faith-Based Organizations in Addressing HIV

Testing and early treatment have gained strategic prominence in addressing the HIV epidemic, as HIV has gone from a fatal disease to a chronic condition. Medications, when taken as prescribed, can now reduce viral load (a measure of the amount of HIV in the blood), thereby improving health and quality of life for those with the condition and reducing the risk of transmitting the virus to others. In effect, treatment has become prevention. As a result, identifying HIV-positive individuals as early as possible, linking and retaining them in care, and ensuring that they are able to take their medications as prescribed are public health priorities. Adherence to treatment is essential for both individual and population health. Thus, a vital role for faith-based organizations would be to engage with people living with HIV and with the community to ensure adequate access to testing and treatment and promote high levels of adherence.

For some congregations, this might mean partnering with public health departments and acquired immunodeficiency syndrome (AIDS) service organizations to do on-site testing. Such efforts may be particularly effective in reaching populations least likely to be tested—for example, Latinos. Other congregations may choose to raise awareness and promote testing but refer individuals to testing in other community or health care settings.

Urban churches are uniquely positioned to link their members' needs with appropriate community resources. Church leaders are often sought for assistance, not only by their congregants but also by the community at large. Thus, in addition to promoting testing, faith-based organizations could help identify unmet needs among people living with HIV and help them obtain needed resources—for example, those related to housing or food security, both of which have been shown to strongly influence adherence to HIV treatment.

Congregations may have limited resources to address larger, structural issues, such as unstable housing conditions or food insecurity. However, partnering with other community-based, health care, and even governmental organizations can create powerful synergies, supported by the web of trust that churches have carefully woven with their membership and communities.

The research was funded by Grant Number R01HD050150 (Derose) from the Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD). The contents of this brief are solely the responsibility of the authors and do not represent the official views of NICHD. The authors gratefully acknowledge the support of Susan Newcomer, a program officer at NICHD.

The RAND team thanks the members of the long-standing Community Advisory Board, especially the Reverend Dr. Clyde Oden, the Reverend Michael Mata, Delis Alejandro, Deborah Owens Collins, the Reverend Chris Ponnet, Mario Pérez, Sophia Rumanes, Renee Stampolis, and Richard Zaldivar, who provided excellent guidance and counsel throughout the multiple phases of this work.

This research highlight summarizes RAND Health research reported in the following publications (by study and in chronological order):

Learning About Urban Congregations and HIV/AIDS (2005–2008)

Derose KP, Mendel P, Kanouse D, Bluthenthal R, Castaneda LW, Hawes-Dawson J, Mata M, Oden CW. Learning about urban congregations & HIV/AIDS: Community-based foundations for developing congregational health interventions. *J Urban Health.* 2010;87(4):617–630.

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Facilitating Awareness to Increase Testing for HIV (2009–2014)

Derose KP, Bogart LM, Kanouse DE, Felton A, Collins DO, Mata M, Oden CW, Domínguez BX, Flórez KR, Hawes-Dawson J, Williams MV. An intervention to reduce HIV-related stigma in partnership with African American and Latino churches. *AIDS Educ Prev.* 2014;26(1):28–42.

Bogart LM, Derose KP, Kanouse DE, Griffin BA, Haas AC, Williams MV. Correlates of HIV testing among African American and Latino church congregants: The role of HIV stigmatizing attitudes and discussions about HIV. *J Urban Health.* 2015 Feb;92(1):93–107.

Flórez KR, Derose KP, Breslau J, Griffin BA, Haas A, Kanouse DE, Stucky BD, Williams MV. Acculturation and drug use stigma among Latinos and African Americans: An examination of a church-based sample. *J Immigr Minority Health.* 2015 Dec;17(6):1607–1614.

Derose KP, Kanouse DE, Bogart LM, Griffin BA, Haas A, Stucky BD, Williams MV, Flórez KR. Predictors of HIV-related stigmas among African American and Latino religious congregants. *Cultur Divers Ethnic Minor Psychol.* 2016 Apr;22(2):185–195.

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RB-9941 (2017)