

# AFRICAN AMERICAN CLERGY PERSPECTIVES ABOUT THE HIV CARE CONTINUUM: RESULTS FROM A QUALITATIVE STUDY IN JACKSON, MISSISSIPPI

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Mississippi has some of the most pronounced racial disparities in HIV infection in the country; African Americans comprised 37% of the Mississippi population but represented 80% of new HIV cases in 2015. Improving outcomes along the HIV care continuum, including linking and retaining more individuals and enhancing adherence to medication, may reduce the disparities faced by African Americans in Mississippi. Little is understood about clergy's views about the HIV care continuum. We assessed knowledge of African American pastors and ministers in Jackson, Mississippi about HIV and the HIV care continuum. We also assessed their willingness to promote HIV screening and biomedical prevention technologies as well as efforts to enhance linkage and retention in care with their congregations. Four focus groups were conducted with 19 African American clergy. Clergy noted pervasive stigma associated with HIV and believed they had a moral imperative to promote HIV awareness and testing; they provided recommendations on how to normalize conversations related to HIV testing and treatment. Overall, clergy were willing to promote and help assist with linking and retaining HIV positive individuals in care but knew little about how HIV treatment can enhance prevention or new biomedical technologies such as pre-exposure prophylaxis (PrEP). Clergy underscored the importance of building coalitions to promote a collective local response to the epidemic. The results of this study highlight important public health opportunities to engage African American clergy in the HIV care continuum in order to reduce racial disparities in HIV infection. *Ethn Dis*. 2018; 28(2): 85-92; doi:10.18865/ed.28.2.85.

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## INTRODUCTION

The Southern United States has among the most pronounced racial disparities in HIV infection in the country accounting for 51% of HIV infections reported in 2015 and 52% of new AIDS diagnoses.<sup>1</sup> Mississippi has some of the most pronounced racial disparities in HIV infection in the country: African Americans comprised 37% of the general population but represented 80% of the new HIV cases in 2015.<sup>2</sup> A recent report by Centers for Disease Control and Prevention (CDC) ranked Mississippi sixth for rates of new HIV diagnoses. Mississippi has among the highest rates of AIDS-related mortality in the nation.<sup>3</sup> In fact, Jackson, Mississippi has the sixth highest rate of people living with HIV (PLWH) among met-

ropolitan areas in the United States.<sup>2</sup> Many individuals in Mississippi are diagnosed concurrently with HIV and AIDS, suggesting most are testing late in the course of their HIV disease. More than 50% of HIV positive individuals in Mississippi are not in care.<sup>4</sup>

The HIV Care Continuum is a public health framework that outlines the steps of HIV medical care.<sup>5</sup> This continuum includes HIV diagnosis, linkage to care, beginning anti-retroviral therapy, retention in care, and ultimately achieving virological suppression, or an undetectable level of HIV in the body. Individuals with suppressed viral RNA have longer life expectancies and are less likely to transmit HIV to others.<sup>6</sup> It is estimated that only 30% of PLWH have suppressed HIV viral loads. Improving outcomes along the HIV

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continuum of care may reduce racial disparities in HIV outcomes, including: late presentation to screening; late diagnosis; medication adherence; retention in HIV care; and ultimately, virological suppression.

African American churches in the South have long been involved in the social, cultural and political fabric of the African American community, including the civil rights movement of the 1960s.<sup>7-9</sup> More recently, African American churches have been

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involved in public health interventions and research programs, including those related to nutrition, cancer prevention, smoking cessation, and stroke prevention,<sup>10-18</sup> but the public health response to the HIV/AIDS epidemic has been lacking. Many factors influence participation of faith leaders in HIV/AIDS programs, including stigma, homophobia, lim-

ited resources, reluctance to discuss human sexuality in a faith setting, and insufficient knowledge about the epidemic.<sup>19,20</sup> While research indicates that African American clergy are willing to participate in HIV prevention activities within their congregations and offer HIV testing at their churches,<sup>21-25</sup> little research has explored how to most effectively engage African American clergy in enhancing outcomes along the HIV Care Continuum beyond HIV screening; these could include linkage and retention in HIV care and ultimately, suppression of HIV RNA. To address this gap, we conducted focus groups with African American clergy in Jackson, Mississippi to assess clergy knowledge of the HIV care continuum and their willingness to engage in activities that promote HIV diagnosis, linkage and retention in HIV care.

## METHODS

### Study Design

In April 2016, we convened four focus groups with 19 African American clergy members from Mississippi. Professionally trained African American moderators facilitated each focus group. Eligibility criteria for participation included being aged >18 years and identifying as an African American clergy member of an African American church in Mississippi.

We employed a focus group guide that was informed by our 10 years of experience working with this population, the existing scientific literature on this topic, and by key informant interviews with 40 African American clergy members from Mississippi.

Purposeful and snowball sampling methods were used to recruit focus group participants. We used mailing lists of denominational organizations, personal relationships, and clergy member organizations to recruit participants. We also used flyers, telephone calls, emails, face-to-face visits to churches and community-based venues, listserv messages, and meetings at church conventions to recruit participants. We developed a targeted list of African American clergy who identified other potential recruits. The Miriam Hospital (Providence, RI) Institutional Review Board approved the study protocol. Participants provided written informed consent and received \$50 for participation.

Participants in the focus groups were asked whether the church had health and/or HIV/AIDS ministries. Information solicited from the focus groups also included: clergy knowledge about the Mississippi HIV epidemic; knowledge about HIV transmission; willingness to incorporate HIV programs into local health ministries; and potential barriers to engaging congregations in efforts to reduce HIV transmission and improve HIV-related health outcomes. We also explored the clergy members' personal understandings, beliefs and perspectives about the HIV Care Continuum, including: HIV testing, diagnosis; linkage to care; adherence to HIV medication; retention in care; and virological suppression. In addition, to ensure the development of a culturally appropriate focus group guide and study protocol, we conducted 40 key informant interviews with African American clergy from Mississippi.

## Data Collection and Analysis

Data collection and analysis were iterative and guided by grounded theory.<sup>26,27</sup> Each focus group lasted approximately 90 minutes. The focus group discussions were digitally recorded and professionally transcribed. All transcripts were de-identified and verified for accuracy.

Data were analyzed using De-doose, a qualitative software program. Transcripts were initially read to identify emerging codes and themes using an open coding scheme. Trained research assistants coded data using the finalized coding scheme, and coding was checked to ensure reliability and validity by the principal investigator (PI). Discrepancies were then resolved among the data coders and the PI.

## RESULTS

Fifteen of the clergy members were senior pastors, and four were associate pastors. Most participants were male (16) and from the Jackson metropolitan area (17) (Table 1). Four associate pastors oversaw children's or social justice ministry within larger churches. The majority of participants represented non-denominational congregations (8), followed by Baptist (6). The average age of participants was 49 years old. Many participants noted that their churches had health ministries. Three participants reported never having addressed HIV with their congregations.

Several important themes emerged. First, clergy noted pervasive stigma associated with HIV/AIDS. Second, clergy believed they

**Table 1. Participant demographics**

Average age, yrs	49
Sex	
Male	16
Female	3
Role in church	
Senior pastor	15
Assistant pastor/minister	4
Religious tradition	
AME	2
Baptist	6
Pentecostal	1
Methodist	2
Non-denominational	8

had “a moral imperative” to address challenges with enhancing outcomes in the HIV care continuum, such as promoting HIV awareness, HIV testing and treatment. Many clergy noted that they believed in leading by example when promoting HIV testing. Clergy also provided suggestions for strategies to normalize conversations about HIV testing and treatment. Clergy were willing to assist with and promote linking and retaining HIV positive individuals in care but knew little about how treatment can enhance prevention. Clergy underscored the importance of building coalitions to promote collective response to the epidemic.

### Pervasive Stigma in the Deep South

Many clergy cited the pervasive stigma associated with HIV in the Deep South. One clergy member explained the stigma experienced by people living with HIV in his congregation:

*People who approach me about HIV often do it very fearfully. We somehow have to get over the stigma of being isolated and fearing being treated differently by the*

*community—both when living with the disease and getting tested.*

Another pastor highlighted one congregant's fear about learning his HIV status: *He's afraid to say, "I need an HIV test." If he's positive, he's afraid to say, "I need to be linked to care," and he's afraid to say, "I need to start taking medication." Then he's afraid to say, "I'm going to take the medication every single day."*

Citing pervasive stigma, several clergy mentioned that they had advised their congregants not to disclose their HIV status to others. One clergy member explained: *I said to my congregation, "The first thing I want you to know, when you come to prayer meeting on Wednesday night, you don't get up and testify about this. I said because the church should be a loving place, but it can a mean place to be when you're hurt."*

### Knowledge and Activities Related to the HIV Care Continuum

#### HIV Screening

Most participants knew how HIV was transmitted, but many were surprised about the alarming rates of HIV infection in Mississippi, and in their own more local communities more specifically. One pastor noted:

*If HIV is right here in my community where my church is, right there in the front door...I am definitely willing to be one of the first to be a part of the movement.*

Many clergy stressed the importance of leading by example by undergoing HIV screening at church, noting that could help mitigate HIV-related stigma. One pastor commented:

*A very important powerful way to ease stigma is to have the pastor and other noted leaders in the church actually get tested in the church, using the rapid test. They'll say, "I think I'm going to get tested since Pastor got tested." One way I've seen a lot of churches around the country reduce stigma and promote HIV care is by offering screening and linkage to care services at church.*

Clergy members suggested incorporating HIV testing into church conversations promoting annual health checkups:

*That could be something that's on the list. HIV test, you know, of your screening, once a year. . . . Just make it tangible and in your face.*

#### *Treatment and HIV Care*

Clergy members also noted that simply discussing treatment helps normalize conversations about the importance or staying engaged in HIV care. A pastor commented:

*We're looking at people... if you are living with HIV/AIDS, have you been back to the doctor? Have you done what you were supposed to do? Do we need to help you [get medical care]?*

Clergy expressed their support for HIV-positive parishioners and their desire to help facilitate engagement in HIV-related medical care. Most clergy understood HIV

is no longer considered a "death sentence" and that people infected with HIV are able to live long and healthy lives. One participant stated:

*"But even... if you come to me and say, you know what? I have HIV. Then my answer is," let's get you some treatment. Let's get you to a qualified doctor."*

Another participant recounted a similar conversation with a congregant:

*I have a member of my church who came to me and said Pastor, I have AIDS. So, I say okay. Do you know how you got it? Yes. Okay. Are you okay? I'm fine. Have you been to the doctor? Yes, I have. Are you taking medication? Yes.*

While there was a general appreciation for HIV treatment, clergy knew little about how treating HIV positive individuals could reduce the chances of transmitting HIV to others. However, one pastor noted:

*They still have needs and desires. So, it's very important for them to be able to get treatment so they don't spread the virus.*

Additionally, many participants also knew little about the newest one-pill, once-a-day HIV treatments. Clergy also knew little about technologies that can reduce HIV transmission risks, including pre-exposure prophylaxis (PrEP), male circumcision and vaginal microbicides.

#### *Retention in Care Efforts*

When asked about how to enhance efforts to retain their congregants in HIV care to help patients

achieve virological suppression, many clergy noted that their core competencies were in providing spiritual support rather than clinical support. Nevertheless, several clergy noted the importance of patient navigators or clinical outreach coordinators for maintaining patients in HIV care:

*We make the connection between the pastors and the testing person or agency so we can provide direct referrals rather than just saying "go find a clinic." We need to have a bridge, a liaison, between us and the patient... That is one thing pastors need.*

#### *The Moral Imperative for Promoting HIV Testing and Treatment*

All participants agreed about the importance of greater involvement of African American churches in responding to the HIV epidemic. Many noted that several of their congregants living with HIV had disclosed their HIV status and asked for moral support. Most participants stated that African American clergy had a moral responsibility to address HIV in their communities. One participant noted:

*This is a moral issue about HIV. There is a lot of mis-education and misperceptions about HIV. The reality is, we, as pastors, have heard of situations where churches even refused to officiate funerals of people who died from AIDS! We have a moral responsibility to address the HIV epidemic.*

#### *Feasibility of Addressing the HIV Care Continuum in Faith Settings*

Overall, clergy agreed that promoting HIV screening, treatment

and care was feasible. Several clergy suggested bundling HIV screening and care interventions with other screening services at health fairs:

*We have hosted many health fairs that address many different health concerns. We've addressed heart disease, blood pressure, and diabetes. We can test for those diseases together. That's one lesson we've learned: we don't think we're going to have as hard a time next year with our health fair if we bundle HIV screening with one more disease, because we're helping people understand their overall health.*

Many clergy also stressed the importance of leading by example, and noted that as community leaders, they can help jumpstart conversations about screening. One clergy member stated:

*We can start the conversation because a lot of things have been brought to the pastor... members feel a sense of trust when they bring things to the pastor. And pastors can step out and start having different conversations... we are building relationships that no one else can build. I think discussing screening is a great opportunity for pastors to step out.*

Another pastor stated: *As pastors, I don't believe in sugar coating anything. You just come out and tell people, "you all need to make sure you go to your doctors. If you have not been tested, you need to get tested, and these are the reasons why." Just put the information out there. There's no easier way of saying it.*

Although many clergy members and church leaders felt willing to engage in conversations about HIV prevention, testing, treatment, and care with their congregation, they also believed that coalitions were important for collective action in the response to HIV/AIDS, and to help fight stigma. Several clergy members noted they had already recruited other clergy to the movement; one pastor noted:

*We must use the most influential among us to address HIV in Mississippi.*

Another pastor recommended:

*We have to come up with strategies of how we can work with those churches and pastors who are not onboard.*

Another clergy member stated:

*HIV is right here in my community where my church is, right there in the front door...I am definitely willing to be one of the first to be a part of the movement.*

## DISCUSSION

To our knowledge, our study is among the first to examine how African American churches might enhance outcomes in the HIV care continuum, including HIV diagnosis, retention in HIV care, and ultimately HIV virological suppression. Clergy acknowledged the pervasive stigma associated with living with HIV in Mississippi, and nearly all endorsed a moral imperative for clergy to respond to the HIV/AIDS epidemic in the Deep South. Many clergy were also willing to

lead by example, including promoting HIV screening from the pulpit.

Most clergy understood the importance of HIV treatment for enhancing clinical outcomes. Several knew about the positive spillover effects of suppressing viral RNA on the broader health of the community. However, clergy were generally less knowledgeable about "treatment as prevention" and new treatment regimens than about HIV screening. However, most clergy were willing to partner with clinical organizations and other non-profit organizations to enhance HIV

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*Our findings highlight the important public health opportunities for engaging clergy in HIV prevention.*

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screening, treatment, and care. Clergy were also eager to learn about biomedical interventions such as PrEP. Some clergy believed that partnering church health ministries with patient navigators and HIV/AIDS service agencies could help improve the HIV care continuum. These collaborations could both provide clergy with more guidance in developing HIV testing, treatment and linkage to care programs in their own churches and also provide support services to help refer members of their congregations to relevant clinical services.

Our findings highlight the important public health opportunities for engaging clergy in HIV prevention. Clergy suggested expanding

HIV screening efforts and were willing to work collectively and with coalitions to help raise awareness about the importance and gravity of the HIV epidemic in the Deep South. However, knowledge about new HIV prevention modalities such as PrEP and “treatment as prevention” was quite limited. Because clergy were willing and committed to working both in their own congregations and as coalitions, new programs and research about these issues may be important. Taken together, our findings suggest that partnering with African American clergy to enhance the HIV care continuum is feasible and timely. Current efforts to promote HIV screening could be enhanced by educational programs about the importance of “treatment as prevention” and promoting knowledge and awareness about PrEP.

Our results support findings from other studies that demonstrated the important role African American churches can play in advancing HIV awareness and encouraging engagement in HIV testing, linkage to care and treatment.<sup>21-25,28</sup> Many clergy members in this study noted that HIV stigma was a barrier to successfully implementing HIV related programs in their churches—a challenge that is well documented in the literature.<sup>25,29-31</sup> As cited elsewhere,<sup>32</sup> clergy in this study were aware of their potential positive social influence regarding HIV screening, prevention and care.

Williams, Palar, and DeRose conducted a review of the existing research on HIV programs in religious settings and found that stigma could be overcome by tailoring HIV programs to incorporate church doctrine

and by launching educational campaigns.<sup>31</sup> Other research has found that using many distinct types of communication (eg, educational fliers, one-on-one discussion), stressing the importance of protecting the well-being of congregants while also reducing stigma, and showing love and compassion toward those affected by HIV, can also be effective strategies to eliminate stigma.<sup>33</sup>

In this study, clergy reported using two distinct strategies to increase awareness related to HIV testing, linkage to care and treatment: 1) leading by example and publicly engaging in routine HIV testing; and 2) normalizing HIV by incorporating HIV messaging into regular conversations with congregants. However, many clergy members understood that some of their parishioners might not be ready to willingly accept HIV-positive individuals into their church. Many church leaders felt it was important to balance progressing the discourse around HIV/AIDS with the realities of discrimination and stigma their congregants may face upon disclosing their HIV status. Our findings therefore also support the need to tailor communication and stigma reduction strategies to each congregation; tailoring programs with input from church leadership also promotes each leader's investment in church programs.

### Study Limitations

This study is subject to several limitations. Data were collected among a small number of African American clergy members in the Deep South. The overwhelming majority of participants were male, and the findings may not be generalizable to all African

American clergy or to clergy in the South. Moreover, clergy's belief may not reflect their congregations' understanding of the issues presented here.

## CONCLUSIONS

Our findings suggest that African American clergy members in the Deep South may be very willing to promote HIV testing, linkage to care and treatment with their congregants. Nearly all clergy agreed that there is a moral imperative for clergy and churches to take action to enhance outcomes in the HIV care continuum. While most clergy understood how HIV is transmitted and were willing to promote and help normalize HIV screening, few clergy understood the importance of “treatment as prevention” or knew about pre-exposure prophylaxis (PrEP). This suggests there is indeed tremendous public health opportunity to engage African American clergy in the Deep South in efforts to enhance the broader HIV care continuum; this could help mitigate the South's alarming racial disparities in HIV infection.

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### CONFLICT OF INTEREST

No conflicts of interest to report.

### AUTHOR CONTRIBUTIONS

Research concept and design: Nunn, Parker; Acquisition of data: Nunn, Parker, Monger, Harvey; Data analysis and interpre-

tation: Nunn, Parker, Harvey; Manuscript draft: Nunn, Parker, McCoy, Monger, Bender, Pocera, Harvey, Thomas, Johnson, Ransome, Suttan Coats, Chan, Mena; Statistical expertise: Nunn, Parker; Acquisition of funding: Nunn; Administrative: Nunn, Parker, Suttan Coats; Supervision: Nunn

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