Feature

African American Church Engagement in the HIV Care Continuum

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*Providing comprehensive services across the HIV care continuum through African American churches may improve HIV treatment outcomes for African Americans. We explored the feasibility of a church-led HIV care program in six churches in Baltimore, Maryland. Church leaders (*n *= 57) participated in focus groups and eight pastors participated in interviews. Data were analyzed by qualitative hybrid thematic analysis. Findings revealed eight themes: four themes were related to linkage to care: being unaware of community resources, concerns about HIV-associated regulations, ongoing personalized contact with HIV-infected persons, and desire for integration of spiritual education; four themes were related to HIV care and support services, including existing church infrastructure, provision of HIV support groups, using the church as an HIV care resource hub, and prevention education for uninfected people. These findings can support initiatives and efforts to promote delivery of HIV services along the HIV care continuum through African American churches.*

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African Americans remain the racial/ethnic group most affected by HIV, with a high infection rate approximately eight times that of Whites (Centers for Disease Control and Prevention [CDC], 2016a; Siddiqi, Hu, & Hall, 2015). The disproportionate prevalence of HIV has been magnified in several African American-populated metropolitan areas, such as Baltimore, Maryland. The City of Baltimore has been ranked fifth in highest proportion of an African American population and 10th in highest prevalence of newly diagnosed HIV of any major metropolitan area in the United States (CDC, 2016b). A number of challenges may contribute to the epidemic among African Americans, including lack of awareness of HIV status, lack of access to HIV care, and poverty (CDC, 2016a). These racial and geographical inequities led to the national priority of increasing access to care and improving health outcomes for people living with HIV (PLWH; White House Office of the Press Secretary, 2013).

The HIV Care Continuum, often referred to as the HIV treatment cascade, outlined sequential steps of HIV health care from initial diagnosis to achieving the goal of viral suppression (White House Office of the Press Secretary, 2013). Despite efforts to intervene to improve the numbers in the HIV care continuum, African American rates of linkage to care (74.9%), treatment (48.0%), and viral suppression (35.2%) remain below the goal (CDC, 2014). Research focused on reaching care continuum goals for African Americans highlights the following as

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the most common barriers: (a) depression/mental illness, (b) HIV-associated illness, (c) competing life activities, (d) expensive and unreliable transportation, (e) stigma, and (f) insufficient insurance (Yehia et al., 2015). Conversely, the following are considered as common facilitators: (a) social support, (b) patient-friendly clinic services (transportation, co-location of services, scheduling/reminders), and (c) positive relationships with providers and clinic staff (Yehia et al., 2015). Community also influences care engagement at each stage of the continuum by impacting levels of stigma and available social support (Mugavero, Amico, Horn, & Thompson, 2013). Thus, community and social support may be a necessary condition to increase the African American transition through the care continuum.

Among community-based institutions, churches may be uniquely positioned to intervene in the HIV care continuum, especially for African Americans who, as a group, present a stronger religious affiliation than other racial groups (Pew Research Center, 2009; Wingood et al., 2013). African American churches have long provided a wide range of social services for their congregants and neighboring communities, including counseling related to employment, housing, finances, and health care (Barber, 2015). Therefore, encouraging churches to become more involved in HIV prevention, screening, and treatment for African Americans remains an important strategy, particularly in HIV high-prevalence areas (Pingel & Bauermeister, 2017). Thus, offering church-led HIV services from prevention for uninfected people to care for PLWH can be a vital step in community-based approaches.

Several studies have found barriers to and facilitators of implementing church-based HIV programs in racial/ethnic minority communities; however, the research questions for these studies were derived from congregant perspectives on HIV-related stigma, HIV prevention, or HIV screening promotion interventions (Berkley-Patton, Moore, et al., 2013; Berkley-Patton, Thompson, et al., 2013; Pichon & Powell, 2015; Pichon, Powell, Ogg, Williams, & Becton-Odum, 2016; Pryor, Gaddist, & Johnson-Arnold, 2015; Williams et al., 2016). These studies left many unanswered questions about church leader perspectives on the feasibility of a focus on HIV care in African American churches. Therefore, two objectives were set for our study: (a) to explore views on African American church involvement in the entire HIV Care Continuum, and (b) to understand the factors that influence successful church-based HIV care interventions, as perceived by pastors and church leaders in Baltimore. The objectives resulted in two main research questions: (a) In what ways are church-based linkage to care and support for remaining in HIV care impeded or facilitated within Christian African American churches in Baltimore? and (b) What resources in church communities can be used for such services? To answer these questions, the perspectives of pastors and church leaders were studied. Church leaders were included because their support is often critical to the success of HIV programs and interventions.

Methods

Design and Sample

We used an exploratory-descriptive approach for this qualitative study, which allowed for an in-depth study of the feasibility of integrating services along the HIV care continuum in African American churches. We collected qualitative data from eight interviews with pastors and six focus groups with church leaders ($n = 57$) across six churches in Baltimore. Of the participating churches, four were Baptist, one was Episcopal, and one was nondenominational. For purposes of our study, church leaders were defined as those identified by the pastor as having a leadership role that could impact implementation of HIV testing and care interventions in the church.

We used a convenience sampling strategy (Jupp, 2006) by handing out postcards, reaching out to African American church leaders and congregants, attending several events designed for faith leaders, and going door-to-door to churches in the targeted areas to identify potential churches for participation. Inclusion criteria for the churches from which participants were recruited were that the church had to (a) have an African American population of greater than or equal to 60%, (b) be in the Baltimore metropolitan area, and (c) have a pastor willing and able to provide support for collecting data within the church. Inclusion criteria for the pastor were that s/he had to be