HIV and the African American church: millennial faith leader's perspectives.

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HIV AND THE AFRICAN AMERICAN CHURCH: MILLENNIAL FAITH LEADERS’ PERSPECTIVES

By

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M.P.H., Tennessee State University, 2015

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Dissertation Approved on

April 20, 2022

By the following Dissertation Committee

Jelani Kerr, PhD – Dissertation Chair

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Winston Husbands, PhD
DEDICATION
This dissertation is dedication to my grandparents

Nehemiah Burton, Josephine Burton, Tommie Woods, and Doris Woods.
ACKNOWLEDGEMENTS

First and foremost, I want to thank God for whom all blessing flow. Thank you, God, for surrounding me with the love and support of my family, friends, my dissertation committee, and church family. This process has been a constant reminder that through Christ all things are possible.

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African Americans are disproportionately impacted by HIV compared to other racial groups. Stigma surrounding HIV has created challenges for effective HIV prevention and stigma reduction programs. The African American church has been criticized for its slow and stigmatizing response to the HIV epidemic. Despite this, African American faith leaders play significant roles in guiding the perspective of the community. Numerous studies examine African American pastors’, faith leaders’, and ministers’ perspective about HIV and other HIV-related topics. However, there is no research that specifically examines young African American pastors’ perspectives of addressing HIV, stigma, and prevention.

The purpose of this dissertation study is to explore the perspectives of HIV/AIDS and stigma among African American millennial faith leaders. This study consists of: 1) a systematic literature review to identify perspectives of HIV/AIDS and stigma among African American faith leaders; and 2) descriptive qualitative interviews with African American millennial faith leaders to explore their perspectives about HIV, stigma, and
how they believe they should be addressed in the African American community. Grounded theory techniques informed the data collection and analysis of qualitative data.

The results of the study show faith leaders have struggled to address HIV because of lack of knowledge and awareness and because of stigmatizing views. Faith doctrines and theological perspectives have created challenges for addressing HIV. Some faith leaders possess nontraditional views about sex and sexuality, which impact their approach to addressing HIV. Partnering with experts and AIDS service organizations (ASOs) have improved HIV knowledge and reduced stigma, although faith leaders suggest more assistance is needed. Faith leaders also recommend experts and ASOs provide HIV resources and material that are tailored to the doctrinal perspective of the congregation.
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CHAPTER 1: INTRODUCTION AND BACKGROUND

Chapter Overview

In this chapter, I will present the problem that this study will address. First, I present statistics on HIV in the U.S. and its impact among subgroups within the African American population. Next, I provide a definition of HIV stigma and the mechanisms through which people living with HIV (PLWH) and other risk groups experience it. Following this, I introduce the African American church culture and its influence on stigma and HIV. I also discuss African American pastors and their influence on the African American community. I conclude this chapter by discussing my study and its significance to addressing HIV and stigma with the African American community.

HIV Statistics

Although there has been a decline in HIV rates, African Americans are still disproportionately impacted by HIV compared to other racial groups (Center for Disease Control and Prevention, 2021c). In 2019, the Centers for Disease Control and Prevention (CDC) reported that African Americans accounted for 42% of HIV diagnoses while comprising only 13% of the United States (U.S.) population (Center for Disease Control and Prevention, 2021c). According to the U.S. minority health report, in 2019, African Americans were 8 times more likely to be diagnosed with HIV infection compared to white Americans (U.S. Department of Health and Human Services Office of Minority Health, 2019). African American men are 6 times as likely to die from HIV infection compared to white men, and African American women are 15 times as likely to die from
HIV infection as white women (U.S. Department of Health and Human Services Office of Minority Health, 2019). Even with the advancements of medical innovations such as Pre-Exposure Prophylaxis (PrEP), there is low uptake among the African American community (Center for Disease Control and Prevention, 2021c). The impact of HIV is even more dire among subgroups within the African American community, such as men who have sex with men (MSM) and African American youth.

**African American MSM**

African American men, specifically men who have sex with men (MSM), are disproportionately affected by HIV (Center for Disease Control and Prevention, 2021b). In 2019, African American MSM accounted for 1% of the U.S. population, but an estimated 26% of new HIV diagnoses (Center for Disease Control and Prevention, 2021b). Among all MSM in the U.S., African American MSM accounted for an estimated 37% of new HIV diagnoses (Center for Disease Control and Prevention, 2021b). Although there was a decline in HIV rates among this population between 2015 and 2019, this trend varied among age groups. HIV diagnosis increased by 6% among African American MSM between the ages of 25 to 34 years old. In 2019, the CDC reported 3 of 4 African American MSM who received an HIV diagnosis were between the ages of 13 and 24 (Center for Disease Control and Prevention, 2021b). Among all individuals diagnosed with HIV, African American MSM have lower viral suppression rates. According to the CDC, for every 100 African American MSM diagnosed with HIV in 2019...
there were 75 who received some HIV care, 55 who were retained in care, and 62 who were virally suppressed (Center for Disease Control and Prevention, 2021b).

*African American Women*

African American women are also disproportionately impacted by HIV. African American women account for the majority of new diagnoses among all women (Center for Disease Control and Prevention, 2021a). According to the CDC, African American women and adolescents accounted for 13% of the female population but 55% of HIV diagnoses among all women in 2019 (Center for Disease Control and Prevention, 2021a). The rate of new diagnoses for African American women are 15 times the rate of white women (U.S. Department of Health and Human Services Office of Minority Health, 2019). African American women are also 14 times as likely to die from HIV compared to white women (U.S. Department of Health and Human Services Office of Minority Health, 2019). Even among transgender women, African American transgender women accounted for 46% of HIV diagnosis in 2019 (Center for Disease Control and Prevention, 2021a).

*African American Adolescents and Young Adults*

African American youth are also highly impacted by HIV compared to their white peers. Approximately 21,000 infections are estimated to occur each year among African Americans (Centers for Disease Control and Prevention, 2019b). Among this group, 34% of infections are usually expected to occur among youth between the ages of 13 to 24 years (Centers for Disease Control and Prevention, 2019b). African American youth who have been diagnosed with HIV are less likely to receive or seek care and treatment (Centers for Disease Control and Prevention, 2014). A CDC study found that only 21% of persons living with HIV (PLWH) aged 18-24 years were prescribed antiretroviral
treatment and 18% had their virus under control (Centers for Disease Control and Prevention, 2014). According to the CDC, one factor for the disproportionate HIV rates among African Americans is HIV stigma.

Stigma

HIV stigma is the negative attitudes and beliefs about HIV and people living with HIV (PLWH) (Center for Disease Control and Prevention, 2021d; Earnshaw et al., 2013). HIV stigma derives from the misconceptions about HIV transmission, and social norms and beliefs about sexual behavior and sexuality (Mahajan et al., 2008). HIV stigma impacts the health and well-being of PLWH (Earnshaw et al., 2012), and members of HIV high risk groups such as MSM and injection drug users.

*How Stigma Impacts People Living With HIV (PLWH)*

There are several mechanisms in which PLWH can experience stigma, including enacted stigma, anticipated stigma, and internalized stigma (Treves-Kagan et al., 2017; Turan, Budhwani, et al., 2017; Turan, Hatcher, et al., 2017). Enacted stigma is the discrimination experienced by PLWH and may include acts of violence and marginalization (Treves-Kagan et al., 2017; Turan, Budhwani, et al., 2017). Anticipated stigma is awareness of negative social perceptions towards HIV and the expectation that a person living with HIV will experience prejudice and discrimination in the future (Treves-Kagan et al., 2017; Turan, Budhwani, et al., 2017). Internalized stigma refers to the endorsement of negative beliefs, views and feelings of oneself as it relates to one’s HIV-positive status (Turan, Budhwani, et al., 2017).
Stigma can occur within multiple social domains, including health care environments, schools, the workplace, and the church. This kind of stigma is referred to as structural stigma (Kay et al., 2018; Turan, Hatcher, et al., 2017). Structural stigmas are the attitudes in societies, practices, structures, and laws that work to the disadvantage of minority groups (Kay et al., 2018).

Studies on HIV show PLWH have been denied care or treatment within health care settings (Kay et al., 2018; Treves-Kagan et al., 2017; Turan, Hatcher, et al., 2017). These experiences can have a serious impact on PLWH and may discourage them from seeking health care services and social support, which can further impact their health (Katz et al., 2013).

Stigma toward PLWH can impact their decision to disclose their status to friends and family, and hiding their status can create low social support and social isolation (Lee et al., 2015; Saki et al., 2015). This has also been linked to low medication adherence, low self-esteem, depression, anxiety, and internalized stigma (Rueda et al., 2016; Turan, Budhwani, et al., 2017).

*Combination of HIV Stigma and Other Social Stigmas*

PLWH can also experience stigma and discrimination for other social identities. African Americans and sexual and gender minorities living with HIV experience stigma not only because of their status, but also for their racial/ethnic identity and their sexual and gender identity. PLWH who are injection drug users can experience stigma and discrimination for their use of drugs. HIV stigma coupled with the stigmas of other social identities can create barriers to prevention services, such as testing (Earnshaw et al., 2013; Logie et al., 2013). For African American PLWH, racial discrimination within
society, specifically within health care settings, has a tremendous impact on their health and well-being. Racial discrimination within the health care setting has been linked to lack of trust of the U.S. health care system among African American patients (Cuffee et al., 2013; Greer, 2010; Jacobs et al., 2006). Lack of trust in medical providers and the health care system prevent patients from seeking health care resources, such as prevention, and from following the recommendations and advice of medical providers (Halbert et al., 2006).

Since the beginning of the HIV epidemic, the stigmatization of PLWH and sexual and gender minorities, primarily MSM, have been well documented. One of the biggest misconceptions about HIV is that it exists because of “immoral lifestyles,” such as promiscuity, drug use, and same-gender loving relationships. This has influenced stigma among these groups, but mostly sexual and gender minorities (Harris, 2010). This has prevented same-gender loving individuals from disclosing their sexual identity because they fear being rejected by family and friends. Members of these communities may forgo prevention methods, such as testing (Earnshaw & Chaudoir, 2009), to avoid being associated with HIV and being gay.

Stigma may prevent injection drug users from disclosing their behaviors and lifestyle because they fear being criminalized or arrested (Capitanio & Herek, 1999; Crandall, 1991; Logie et al., 2013). This may prevent them from seeking HIV prevention services or treatment. As previously mentioned, the shame and fear of rejection can prevent a person from disclosing their HIV status, sexuality, and behaviors. This can encourage social isolation and internalized stigma, which
can lead to mental health illness such as depression (Lee et al., 2015). The African American church has been criticized for its negative responses to HIV in the beginning of the epidemic and for perpetuating HIV stigma and other stigmas associated with HIV (i.e., homophobia).

The African American Church

Even as religious affiliations within the U.S. have declined, African Americans remain the most religious racial group in the country (Pew Research Center, 2015). One of the reasons why public health experts and researchers utilize the African American church to address health outcomes is its influence on the African American community. Throughout the history of America, the African American church has been a cornerstone for African American progress (Lincoln & Mamiya, 1990). Many African American leaders for racial, social, and political movements in the U.S. have been men and women of religious faith. Their religious backgrounds have often guided their strategies toward social change in this country.

Several HIV prevention efforts have utilized African American churches to implement HIV education programs (Berkley-Patton, Moore, et al., 2013; Berkley-Patton et al., 2016; Derose et al., 2016; Francis et al., 2009; Lindley et al., 2010; Nunn et al., 2013). Programs and initiatives focused on reducing HIV stigma have also been implemented within African American church (Berkley-Patton, Moore, et al., 2013; Berkley-Patton et al., 2016; Nunn et al., 2013). These programs and interventions have improved attitudes and perceptions about HIV and PLWH.

Although the church has been impactful in helping African Americans progress socially and politically, (i.e., civil rights), the church has also been criticized for
perpetuating HIV stigma and others stigmas associated with HIV (stigma toward same sex relationships) (Fullilove & Fullilove III, 1999; Harris, 2010; Miller Jr, 2007). The effectiveness of HIV efforts within the African American church is questioned, because of the churches negative and slow response to HIV in the beginning of the epidemic (Cohen, 2009). Several studies regarding HIV and the African American church have cited struggles with discussing HIV and its related topics, such as sex, sexuality, and contraception (Berkley-Patton, Thompson, et al., 2013; Smith et al., 2005). Faith leaders have reported trepidations and fear of promoting messages within the church that go against religious beliefs and doctrines (Bryant-Davis et al., 2016; Harris, 2010; Roman Isler et al., 2014). This has often made it difficult for some churches to adopt HIV ministries and organize HIV education programs.

**African American Pastors**

African American pastors play a vital role in guiding the perspective of the community. Their influence extends beyond the pulpit and the pews of the church and reach the community. This makes them a vital instrument in addressing health outcomes of diseases, such as HIV (Quinn et al., 2016; Stewart, 2015a). African American pastors serve as gatekeepers and/or environmental change agents (Baruth et al., 2015; Bopp & Fallon, 2011; Demark-Wahnefried et al., 2000). African American pastors have the authority to decide what programs and initiatives their church participates in (Baruth et al., 2015). Previous studies have found pastoral involvement and support to be important factors for
successfully implementing health promotion programs in faith-based settings (Bopp et al., 2012; Campbell et al., 2007; Catanzaro et al., 2007).

Dissertation Study

Several studies have assessed ideologies and perspectives about HIV and stigma among African Americans pastors and faith leaders (Aholou et al., 2011; Nunn et al., 2018; Quinn et al., 2016; Wilson et al., 2011). Similarities and differences exist among pastors on how to address HIV and stigma in the church and in the community (Quinn et al., 2016; Wilson et al., 2011). In a 2018 study by Nunn and colleagues (2018), the majority of African Americans pastors believed it is important for the church to be a part of HIV prevention efforts (Nunn et al., 2018). Some believed the church and pastors have a moral responsibility to address HIV in the African American community (Alder et al., 2007; Moore et al., 2012; Nunn et al., 2018). As previously mentioned, churches struggle with discussing HIV topics within their church.

There is no study that examines the perspectives of millennial African American pastors on HIV and stigma. Among the studies that assess perspectives and ideologies of African American pastors regarding HIV, the youngest participant was 32 years old (Quinn et al., 2016). The average age of pastors reported in studies on HIV and the church is 40 years old or older (Otey & Miller, 2016; Pichon et al., 2016; Roman Isler et al., 2014; Stewart, Hanlon, et al., 2017). Millennials have ideologies and perspectives about social issues that differ from previous generations (Howe & Strauss, 2000; P. Taylor et al., 2014). It is unclear if faith leaders who are millennials or younger have a different perspective on addressing HIV and stigma than previous generations. Perhaps understanding their perspectives can help identify new approaches for addressing HIV
within faith-based settings. This descriptive qualitative study will explore the perspectives of African American millennial faith leaders to understand their symbolic meanings and influences related to HIV and stigma.

Research Questions

This study seeks to answer three questions.

- Research Question 1- What are ideologies and perspectives of African American faith leaders regarding HIV and stigma within the church?
- Research Question 2- What are the ideologies and perspectives of African American millennial faith leaders in the U.S.?
- Research Question 3- What are the perspectives of millennial African American faith leaders on addressing HIV and HIV stigma within the African American community?
CHAPTER 2: LITERATURE REVIEW

Chapter Overview

In this chapter, I provide an overview of several bodies of literature that include:

the history of the African American church and its significance within the African American community, the significance of the African American church in the 21st century, the African American church and public health, the African American church efforts related to HIV and stigma, African Americans pastors’ influence on the African American community, the African American church contributions in the 21st century, and why it’s important to examine the perspectives of African American millennial pastors.

History of the African American Church

Spirituality and faith have always been the cornerstone of the African American community in the United States (U.S.) (Barnes, 2005; Gaines II, 2010; Lincoln & Mamiya, 1990; Swain, 2008). Historically, the church has served as a place of refuge and social activism for African Americans (Barnes, 2005; Lincoln & Mamiya, 1990). Faith, spirituality, and the church have been key factors for social and political change, and the African American church has aided in mobilizing African American communities.

African American pastors play a significant role in guiding the perspectives of the community (Gaines II, 2010; Lincoln & Mamiya, 1990; Swain, 2008). The majority of African American social movements have been led by preachers whose social agendas have been driven by their spirituality and faith (Cone, 1970; Gaines II, 2010; Morris & Staggenborg, 2004; Nelsen & Nelsen, 1975).
During slavery, enslaved Africans were prohibited from attending church services by their slave owners because they were viewed as property and souls unworthy of saving (Raboteau, 2004). When slaves were allowed to attend church services, white clergy generally preached about obedience to justify and sustain the institution of slavery (Lincoln & Mamiya, 1990). Certain messages within the protestant faith resonated with African slaves (Barnes, 2005; Dwyer, 2017; Mitchell, 2004; Smith, 1972), where the message, “all of God’s people are created equally,” gave slaves hope and made them feel God did not look at them like their white slave owners (Smith, 1972).

Outside of these worship experiences, Africans held their own secret spiritual gatherings. Scholars refer to these secretive worship services as the invisible institution (Mitchell, 2004; Raboteau, 2004). In these hidden services, slaves created songs known as Negro spirituals, which told their stories of struggle, resistance, and their hope for freedom (Nelsen & Nelsen, 1975; Raboteau, 2004). Throughout the period of slavery, Negro spirituals and the art of preaching would be used as mechanisms to communicate strategies for escape and revenge (Hayes, 2012; Raboteau, 2004). The Negro spirituals and passionate preaching would become key elements of African American church culture (Hayes, 2012; Lincoln & Mamiya, 1990). These elements of worship would be passed down many generations, giving African Americans hope and empowering them to fight fearlessly against injustices in their communities.

One of the earliest examples of these church elements being exhibited was during the southern slave revolts. In 1822, Denmark Vesey, a preacher and co-founder of the African Methodist Episcopal church (A.M.E.), led the first slave revolt in South Carolina. Vesey started his own church after buying his freedom and once had the second largest
A.M.E. church in the U.S. (over 1000 members) (Egerton, 2004; Lofton & Hoffer, 2013; Robertson, 2009). He used religious rhetoric to galvanize enslaved men and women to revolt against white slave owners in South Carolina (Johnson, 2001; Lofton & Hoffer, 2013; Robertson, 2009).

Denmark Vesey often preached sermons utilizing scriptures from the Old Testament, specifically the book of Exodus (Egerton, 1999; Schipper, 2019), which tells the story of Moses delivering the people of Israel from slavery. A specific verse Vesey utilized was, “He who stealeth a man shall be put to death [Exodus Chapter 21].” Like Moses and the Israelites, Vesey and his followers believed they were the chosen people by God, and God would punish those who enslaved them with death (Egerton, 1999; Schipper, 2019). Before the revolt could be executed, Vesey and his team were arrested and killed (Egerton, 1999, 2004; Johnson, 2001). White southerners began to worry about African Americans and their worship experiences. As a result, many African churches were burned, and laws were written prohibiting African Americans from participating in religious gatherings unless supervised by a white minister.

Although Vesey and his co-conspirators ignited fear among white southerners, slaves continued to worship and revolt because of Denmark Vesey. One of the bloodiest and most notable slave revolts was Nat Turner’s Rebellion. Like Vesey, Nat Turner was an African American preacher who was inspired by his faith to organize a revolt against slave owners in Virginia (Styron, 2010 & Greenburg, 2003). He utilized his sermons to communicate his strategy and gain support for the revolt. In August of 1831, Turner and his men held a 2-day rebellion, killing over 50 white people in Southampton, Virginia.
(Greenberg, 2003; Styron, 1968). This rebellion scared white southerners immensely and historians say it expedited the American Civil War (Styron, 1968).

The African American preachers in the south were not the only ones fighting for freedom. Before the Civil War, there were African American preachers in the north who also preached about the horrific circumstances of southern Black life. Maria Stewart was one of these preachers. Stewart was not only a prolific evangelist, but the first African American female political writer (Bartlow, 2007; Richmond, 2006). She mainly preached in front of a mixed audience and was the first women to do so during the antebellum period (Bartlow, 2007). In her work and in her speeches, she used religious and biblical rhetoric to convince white audiences about the sin of slavery and the oppression of African American people (Bartlow, 2007; Rycenga, 2005). Although her actions put her life in danger, and her career as an evangelist was cut short, her work influenced white northerners to become more vocal about the ethics of slavery. Northerners questioning the ethics of slavery created more division within the U.S., which led to the Civil War and the Reconstruction era in the U.S.

During Reconstruction, the number of African American churches grew and so did the memberships of these churches. The church became more than a place of worship, but a portal for education, political engagement, and social interaction for African Americans. For example, Historically Black Colleges and Universities (HBCUs) were created to provide educational opportunities to newly freed slaves (Allen et al., 2007; Jewell, 2007). These institutions were founded by African American social leaders and white philanthropists who strongly believed
in Blacks being educated (Anderson, 1988; Ballard, 1973; Jewell, 2002). The majority of the early graduates from these institutions became preachers or teachers. Most of these schools began in old schoolhouses, homes of teachers, or the basement of churches (Allen et al., 2007). In fact, several HBCUs were founded by religious organizations, such as the Methodist Church, the Catholic Church, and the National Baptist Convention (Jewell, 2007; Redd, 1998).

Along with educational opportunities, over 30 African American men were elected to U.S. Congress during the Reconstruction era (McKinney, 1971). African American preachers played a vital role in politics during this time. Most of the newly elected African American officials were former ministers. African American ministers and preachers who ran for political office depended upon the African American church and their leaders for support (Gaines, 2012). Those ministers who did not run for public office encouraged their constituency to support those who did (Gaines, 2012).

The first African American to be elected to the U.S. Senate was Hiram Revel of Mississippi (Primus, 2005; Thompson, 1994). Before he was a Senator, Revel was a A.M.E. preacher who traveled the country teaching and preaching to African American people (Gravely, 1970). As a Senator, his oratorical skills as a preacher and his conviction as a Christian emboldened him to speak out against racial segregation. Hiram Revel believed segregation would create and sustain racial animosity in the U.S. (Primus, 2005; Thompson, 1994).

The advancements in education and public service granted African Americans the opportunity to progress socially and politically within the U.S. One of the major outcomes of these advancements was the right to vote for African American men. Social
and political changes like this intensified the racial hate and divide in the country. Black institutions, such as the African American church and HBCUs, were either burned down or denied financial opportunities (Allen et al., 2007; McKinney, 1971). African American men were lynched for exercising their legal rights to vote. The Ku Klux Klan (KKK) began committing heinous acts of violence towards African Americans who spoke out against racism and the injustices of African American people in the south (Foner, 2006; Lincoln & Mamiya, 1990). Progressive legislation, such as civil rights, were rejected and denied (Foner, 2006; Lincoln & Mamiya, 1990), and Jim Crow laws were created to sustain racial segregation and Black oppression (Foner, 2006; Lincoln & Mamiya, 1990).

Although these actions stifled African American civic engagement, the African American communities continued to strive for social change (Lincoln & Mamiya, 1990). Because African Americans were discouraged from voting, the African American churches became a training grounds for the political arena. In the church, African Americans could vote and practice political debates because they selected their own preachers and leaders of their denominations. Preachers with political astuteness were elevated to roles such as Bishop, Reverend, or Deacon (Lincoln & Mamiya, 1990). In these positions, African American men and women were able to organize and galvanize large portions of African American communities to support particular social issues and be civically engaged (Lincoln & Mamiya, 1990).

This training would prepare the African American community for the Civil Rights Movement (CRM), led by Dr. Martin Luther King Jr. Although
world renowned as a social justice leader, before leading the CRM, Dr. King was a Baptist preacher from Georgia. He came from a lineage of African American preachers and his spirituality and faith motivated him to lead the CRM. Dr. King saw the fight for racial and social justice as a Christian duty, and although a devout Christian, he adopted a strategy of non-violence from Mahatma Gandhi, the Hindu leader against the British nationalist movement in India.

Elements of the African American church also permeated throughout the movement. For example, at every march, Dr. King and his followers sang Negro spirituals. Like the African American preachers before him, Dr. King spoke passionately, eloquently, and boldly to the world about the racial discrimination of African Americans (Henry, 2010). African American churches worked with organizations like the Southern Christian Leadership Conference (SCLC), Student Nonviolent Coordination Committee (SNCC), and the Congress on Racial Equity (CORE) to organize non-violent activities, such as the lunch counter sit-ins in Nashville, Tennessee (Morris, 1996, Barnes, 2005). African American churches raised funds to support the activities of the movement and were headquarters for planning protests (Calhoun-Brown, 2000; Gaines II, 2010; McKinney, 1971). At times, they were clinics and hospitals for those who were wounded during a protest.

The African American Church in the 21st Century

Participation in organized religion, specifically Christianity, has declined over the years; however, religious affiliation and participation is highest among African Americans (Pew Research Center, 2015). According to the Pew Research Forum, approximately 79% of African Americans identify as a Christian (Pew Research Center,
African Americans attend church more often than their white counterparts and are more likely to pray (R. J. Taylor et al., 2014) (Taylor, Chatters & Brown, 2014). Over 70% of African Americans in both major political parties (Democrat and Republican) identify as Christians (Pew Research Center, 2015). Although religious affiliation among millennials is comparatively lower than previous generations, African American millennials are more likely to pray and believe that a higher power exists than other races (Pew Research Center, 2018b).

It has been suggested that, because of the social and political advancements of African Americans in the U.S., the African American church is no longer interested in social activism (Glaude, 2010). Some religious scholars argue that African American churches, specifically African American megachurches, have adopted a model that is no longer interested in community progression but focused on individualism (Harvey, 2010; Speakes-Lewis et al., 2011). Although this may be true for some churches, there are still African American churches and African American preachers who continue the legacy of social justice. In these modern times, the African American church has continued to play a role in the social and political movements. During the Black Lives Matter Movement (BLMM), the African American church was criticized for not being involved (Brown, 2017). Yet, there were many African American pastors and faith leaders working with the movement.

African American clergy men and women, such as Dr. Traci Blackmon, Rev. Osagyefo Uhuru Sekou, Rev. Heber Brown, and Rev. Brenda Salter McNeil, have all been recognized individually for their participation in BLLM. Each of
them has been vocal about police brutality and racial injustice within the criminal justice
system and in their community (Harris & Ulmer, 2017). They have urged their
congregants and other clergy to participate in BLMM activities and allowed the
movement to use their churches and worship space to organize protests, marches, and
demonstrations.

Prominent voices within the African American church arena have also supported
the BLMM. In 2014, Bishop Charles E. Blake Sr., the presiding bishop of the Church of
God in Christ, Incorporated encouraged African American churches in the U.S. to host a
televangelist and pastor of one of the largest megachurches in the U.S. (estimated 17,000
member), held a special prayer service for BLMM leaders and followers (House, 2018).
Like other clergy men and women, they, too, encouraged the congregation to support the
BLMM movement.

Outside of police brutality, there are African American preachers and churches
that have addressed social issues, such as economic empowerment, environmental justice,
gender equality, and LGBTQ rights. Reverend Delman Coates, the senior pastor of Mt.
Ennon Baptist church in Clinton, Maryland, is the founder of The Black Church Center
for Justice and Equality. This organization not only focuses on addressing racial,
economic, and environmental disparities by helping churches establish social justice
ministries, but also provides resources for social justice activities and connects
community organizations with church groups to enhance social justice efforts. In the last
year, Reverend Coates has also started the “Our Money Campaign” to address the racial
wealth gap in the country (The Black Church Center for Justice & Equality, 2020).
In Dallas, Texas, Reverend Frederick Douglass Haynes III and his church, Friendship West Baptist Church, developed the Broughton Wells Justice Center. This center focuses on the social justice issues impacting women and girls of color, specifically gender pay gap, sex trafficking, domestic violence, and child marriage (The Black Church Center for Justice & Equality, 2020). In San Francisco, Bishop Yvette Flunder has been a vocal advocate for LGBTQ rights and inclusivity. Through her ministries, she has developed several nonprofit organizations to address HIV and to provide a safe space for same-gender loving people (Lewin, 2018).

Over the years, more African American churches are becoming engaged in social issues related to mental health. Bishop Charles Edward Blake Sr., presiding bishop of The Church of God in Christ Inc., opened a full-time counseling center in the heart of Crenshaw in West Los Angeles. Although these efforts seem individualistic to these leaders and their congregation, there are smaller churches that are following their causes and starting ministries themselves. These efforts are an illustration of the African American church’s commitment to serving the African American community in the U.S.

HIV/AIDS

Although the African American church has received praise for its role in advancing the African American community, it has also been criticized for being a barrier to HIV prevention (Cohen, 2009). In fact, the African American has been criticized for perpetuating HIV stigma and stigma related to HIV (i.e., homophobia) (Cohen, 2009; Harris, 2010). Religious beliefs about sex and HIV
priority groups and sexual and gender minorities created challenges for African American leaders within the church. Despite the African American church’s reluctancy to address HIV in the beginning of the epidemic, researchers and health experts have utilized African American congregations and faith leaders to address HIV and stigma (Cohen, 2009; Cunningham et al., 2011; Fullilove & Fullilove III, 1999; Harris, 2010; Wilson et al., 2011; Wooster et al., 2011).

Numerous studies, interventions, and programs regarding HIV and stigma have been developed and implemented within African American churches (Berkley-Patton et al., 2016; Derose et al., 2014; Griffith, Campbell, et al., 2010; Husbands et al., 2020). These interventions and programs have increased HIV knowledge and education and helped reduce HIV stigma with African American communities. Faith-based HIV prevention programs within African American churches have also helped to increase HIV testing rates among African Americans and testing for other sexually transmitted illnesses (STIs) (Berkley-Patton et al., 2010; Wingood et al., 2011).

Faith based HIV efforts have been designed to address subgroups within the African American community. This includes African American women, African American youth, and persons engaged in substance use. Little programming has been conducted to specifically target the largest subgroup in the African American population at risk for HIV, which is African American men who have sex with men (AAMSM).

Stigma

One factor for disproportionate rates of HIV within the African American community is stigma. HIV stigma is the negative behaviors, attitudes, judgments, and beliefs about HIV, PLWH, and HIV high-risk groups (Center for Disease Control and
Prevention, 2021d). It is important to address HIV stigma because it can impact treatment for PLWH and access to prevention resources (Earnshaw et al., 2012). PLWH can experience stigma in various ways. Individual level stigmas include enacted stigma, anticipated stigma, and internalized stigma (Treves-Kagan et al., 2017; Turan, Hatcher, et al., 2017).

For PLWH and HIV priority groups, enacted stigma is the experience of discrimination and unfair treatment by others because of HIV status (Treves-Kagan et al., 2017; Turan, Budhwani, et al., 2017; Turan, Hatcher, et al., 2017). Anticipated stigma is the expectation and belief that discrimination and prejudice treatment will be directed towards oneself because of HIV status or sexual behaviors (Treves-Kagan et al., 2017; Turan et al., 2017). Internalized stigma refers to the endorsement of negative beliefs, views, and feelings of oneself as it relates to one’s HIV-positive status (Turan, Budhwani, et al., 2017). Structural stigmas related to HIV within the health care industry can also impact the health and well-being of PLWH (Kay et al., 2018; Turan, Hatcher, et al., 2017). Structural stigmas refer to the social norms, culture, institutional practices, and policies/laws that work to the disadvantage of minority groups (Kay et al., 2018). PLWH have been denied care and services within hospitals and health clinics because of their HIV status (Kay et al., 2018; Treves-Kagan et al., 2017; Turan, Budhwani, et al., 2017; Turan, Hatcher, et al., 2017). This kind of experience for PLWH can impact their overall well-being and discourage the seeking of treatment and health care services.
Social discrimination and stigma among PLWH can also impact their decision to disclose their status to friends and family. Not sharing or hiding their status has been linked to low social support and social isolation (Lee et al., 2015; Saki et al., 2015). Studies show PLWH with low social support are more likely to experience low medication adherence, low self-esteem, and internalized stigma (Rueda et al., 2016; Turan, Hatcher, et al., 2017). The combination of stigma and low social support can lead to mental health illnesses like depression and anxiety (Turan, Budhwani, et al., 2017).

Stigma not only impacts the lives of those living with HIV, but also people who are at risk for HIV. HIV has always been linked to sexual minorities because the majority of PLWH are gay and bisexual men (Airhihenbuwa et al., 2002; Center for Disease Control and Prevention, 2021c). However, one of the biggest misconceptions about HIV is that it exists because of same-sex relationships. This is not true and is further stigmatizing to PLWH and the LGBTQ community. Negative perceptions like this creates fear and prevents individuals at risk from seeking prevention methods like testing (Earnshaw & Chaudoir, 2009). This kind of fear also encourages individuals to hide their sexuality and sexual behaviors (Airhihenbuwa et al., 2002).

The intersection of different types of stigma along with HIV also creates barriers to prevention (Logie et al., 2013). Injection drug users experience stigma because of social stigma and criminalizing factors associated with drug use. The stigmas related to drug use can encourage a person to be silent about their behavior and prevent them from seeking HIV prevention services (Capitanio & Herek, 1999; Logie et al., 2013). Studies show HIV stigma, depression, racism, and gender discrimination are significantly correlated with each other (Logie et al., 2013).
For PLWH, stigma can influence their decision to disclose their status and seek social support (Lee et al., 2015; Saki et al., 2015). Low social support among this population can impact HIV medication adherence and foster low self-esteem and internalized stigma (Rueda et al., 2016; Turan, Budhwani, et al., 2017). The combination of stigma and low social support can lead to mental health illnesses like depression and anxiety (Turan et al., 2017).

**African American church and stigma**

HIV stigma within the African American community and in the church remains a significant barrier to HIV engagement. It is also a factor for the slow uptake and negative responses to HIV efforts among African American churches. As stated earlier, the African American leaders and the church has been criticized for perpetuating HIV stigma within the African American community (Cohen, 2009; Harris, 2010). The African American church also showed little interest in addressing HIV in the beginning of the epidemic (Cohen, 2009; Fullilove & Fullilove III, 1999; Harris, 2010; Muturi & An, 2010; Nunn et al., 2019). The lack of interest was associated with HIV stigma and other related stigma (i.e., homophobia) (Harris, 2001). The stigma was a result of the church’s and Black leaders’ religious beliefs and perceptions about HIV high-risk groups such as sexual minorities and injection drug users (Cohen, 2009).

Same-sex relationships and drug use were viewed, and in some faith communities are still viewed, as immoral and unaligned with the religious doctrine of the church (Harris, 2010; Helminiak, 2008). Members of the faith community believed PLWH who were sexual minorities or used injection drugs
could only blame themselves for their aliment (Cohen, 2009; Fullilove & Fullilove III, 1999). HIV was also considered a punishment for immoral behavior (Olaore & Olaore, 2014; Singh, 2001). This kind of perception of HIV in the church influenced social discrimination, marginalization, and mistreatment among PLWH, individuals in same-sex relationships, and persons who used drugs (Berkley-Patton, Thompson, et al., 2013; Harris, 2010; Stewart, 2014a). For members of these communities, being within a non-affirming environment creates internalized stigma and self-hate (Barnes & Meyer, 2012; Bowers et al., 2010; Tobin & Moon, 2020) forcing individuals to hide their sexuality for fear of being judged.

Within the church, there have been reports of discrimination and marginalization of African American LGBTQ individuals. In several studies, African American gay males have reported experiencing homophobic slander and humiliation, even as leader in the church (Balaji et al., 2012; Jeffries et al., 2017; Stanford, 2013; Valera & Taylor, 2011). This perspective has not only made it difficult to educate Africana Americans about their HIV risk, but also has impeded on efforts to address the disparity among African American gay and bisexual males (Stanford, 2013).

Even churches that decide to address HIV struggle with addressing HIV-related topics, such as sex (Derose et al., 2016; Francis & Liverpool, 2009; Lindley et al., 2010). These trepidations come from the fear of promoting messages within the church that go against religious beliefs and doctrines (Harris, 2010; Quinn et al., 2016; Roman Isler et al., 2014) making it difficult for some churches to adopt HIV education or risk reduction programs (Brown & Williams, 2006; Stewart & Dancy, 2012).
The discrimination and marginalization of African American same-gender loving people in church has caused some individuals to leave the African American church (Foster et al., 2011). However, African American and Latino LGBTQ individuals are more religious than their white counterparts (Barnes & Meyer, 2012). They are also more likely to believe and pray to a higher being than other racial groups. In fact, religion has been used to counter internalized homophobia and cope with societal stigma (Pitt, 2010). Even among African American PLWH, studies show they are more religious and spiritual compared to their white counterparts (Balaji et al., 2012; Barnes & Meyer, 2012; Jeffries et al., 2014; Lassiter & Parsons, 2016). PLWH utilize their spirituality and religious faith practices to cope with HIV diagnoses and the societal stigmas that ostracize them (Balaji et al., 2012; Barnes & Meyer, 2012; Jeffries et al., 2014; Lassiter & Parsons, 2016).

African American Pastors

There are several reasons why understanding the perspectives and ideologies of African American pastors is important to HIV and stigma prevention. First, African American pastors play a vital role in guiding the perspective of the community. African American pastors have significant influence over their congregation and their surrounding community. This makes them a vital instrument in addressing health outcomes related to HIV (Quinn et al., 2016; Stewart, 2015a). Their influence extends beyond the pulpit and the pews of the church and reaches the community.
Second, within public health research, there is evidence of the pastoral authority. African American pastors have significant authority within their church (Baruth et al., 2013; Corbie-Smith et al., 2010; Lumpkins et al., 2013). They often serve as gatekeepers and/or environmental change agents (Baruth et al., 2013; Williams et al., 2012). Some African American pastors have reported that they can decide what programs and initiatives their church participates in (Baruth et al., 2013; Williams et al., 2012). Previous studies suggest pastor involvement and support are important factors in the successful implementation of health promotion programs and general community-based programs placed within churches (Bopp et al., 2013; Campbell et al., 2007; Catanzaro et al., 2007; Harmon et al., 2018).

Several studies have assessed the ideologies and perspective about HIV and stigma among African Americans pastors and faith leaders (Aholou et al., 2011; Nunn et al., 2018; Quinn et al., 2016; Wilson et al., 2011). Similarities and differences exist among pastors on how to address HIV and stigma in the church and in the community (Quinn et al., 2016; Wilson et al., 2011). In a study by Nunn et al., 2018, the African American pastors said it was important for the church to be a part of HIV prevention efforts (Nunn et al., 2018). In other studies, pastors believed they and the church had a moral responsibility to address HIV in the African American community (Alder et al., 2007; Moore et al., 2012; Nunn et al., 2018). However, discussing HIV-related topics like sex, sexuality, condom use, and drug use is a challenge for African American pastors and the African American church (Nunn et al., 2012). This has created barriers and challenges for some HIV and stigma reduction programs and interventions.
There are pastors who believe some of the HIV-related topics do not align with the religious doctrines and beliefs of many churches (Adimora et al., 2019). Pastors worry that discussing them would cause congregants to believe they are condoning behaviors that are against their beliefs (Bryant-Davis et al., 2016). This has discouraged some pastors from discussing HIV overall. For those who have tried to deliver messages about HIV, some have been successful with the collaboration and partnerships of community organizations. Community partners and academic researchers have developed HIV material and resources that align with doctrine of African American churches. This has helped churches find their balance of addressing HIV and staying true to their beliefs (Stewart et al., 2016). In fact, pastors have reported the need for more experts to help them address HIV (Stewart et al., 2016). However, in some interventions in which experts have helped deliver messages about HIV, some pastors still struggled with covering HIV-related topics, specifically homosexuality (Derose et al., 2014).

Qualitative studies that have examined the perspective and ideologies of African American pastors have revealed there may be a shift among African American pastors. There are pastors within the African American church culture who believe there needs to be more openness within the church (Nunn et al., 2018; Quinn et al., 2016; Stewart et al., 2016). They believe the church needs to be honest and real about its influence on this disease and the perception of African American communities (Nunn et al., 2018; Quinn et al., 2016; Stewart et al., 2016).
There are only a few studies that have examined African American pastors’ ideologies and perspectives in the U.S. and have documented the ages of their participants (Nunn et al., 2018; Pichon et al., 2020; Quinn et al., 2016; Stewart et al., 2016). Although these studies do not assess ideologies and perspectives among a certain age group, statements and comments like those previously discussed came from pastors and clergy who younger in the sample. However, there were older clergy who had similar perspectives. These perspectives illustrate that there is a potential shift among African American pastors when it comes to discussing and addressing HIV prevention and stigma in the church.

Millennial African American Pastors

As HIV prevention efforts progress, it is important to acknowledge that the HIV disparity among African Americans still exists. Within research, it is critical to continue to seek new ways of thinking and find new approaches to address HIV. Within the literature, there is no study that specifically discusses the perspectives of young African American pastors. Among the studies that assess perspectives and ideologies of African American pastors regarding HIV, the youngest participant was 32 years old. For most of the studies, the average age of the participants was 40 years old or older. Pastors who are millennials or younger may have a different perspective on addressing HIV and stigma than previous generations.

According to the Pew Research Center, the millennial generation consists of individuals born between 1980 and 1997 (Pew Research Center, 2019; P. Taylor et al., 2014). This generational group is the largest, most educated, and racially diverse. The diversity among millennials suggests they are more liberal than previous generations.
This means they are more open and accepting to nontraditional ideologies and perspectives. Millennials are found to be more accepting and tolerable of racial and ethnic diversity, and it has been noted that millennials are the most accepting of same-gender loving people (Tillman et al., 2019; Twenge et al., 2015). Over 50% of millennials believe premarital sex is “not at all wrong,” and comprehensive sex education should be offered (Twenge et al., 2015). This is important as it relates to HIV. The social perspectives of the LGBTQ community and premarital sex have often caused trepidations in discussing HIV. Having a younger generation become more open to these perspectives allows for more open and honest conversations about HIV.

It is important to understand if millennial pastors have the same perspectives as their generational cohort, especially because religious organizations have a historically rejected same-gender loving relationships. They have also struggled to address HIV due to fear of condoning premarital sexual behaviors. Understanding the perspectives of millennial African American pastors could help identify new ways of addressing HIV within the African American community.

It is uncertain if millennial faith leaders’ perceptions about HIV and stigma align with their generational cohort. They are governed by faith doctrines that present clear stances on social issues like sex and sexuality. It is possible for theological stances and perspectives to evolve because of social interactions and societal evolution. For example, the Bible was used to justify the institution of
slavery. Abolitionists were able to use the Bible to condemn slavery and eventually change the social perceptions about the enslavement of African Americans. It is unclear if millennial faith leaders present perspectives that are different from the theological stances of their church. The purpose of this study is to explore African American millennial faith leaders’ perspectives and to see if they possess more enabling ideologies for addressing HIV within African American faith-based settings.

Exploring millennial faith leaders’ perspectives could provide understanding of the African American church and faith-based HIV programming. Understanding their perspectives could lead to more programming and opportunities to address the most at-risk group, which is black men who have sex with men (BMSM). They could provide a more open and inclusive conversation and help eliminate some of the barriers churches face when addressing HIV.

Knowing African American millennial pastors’ perspectives could lead to policy changes within national denominations and encourage more churches to be active in HIV efforts and adopt HIV ministries. It could even help with addressing barriers, such as talking about sex and sexuality, and prevention methods, such as condoms and pre-exposure prophylaxis (PrEP). It’s important to know their perspectives because African American millennial pastors are the future leaders of the African American church. They will take on leadership roles within the denominations that dictate the stance and ideologies of the religious community. If these perspectives are favorable to causes such as HIV and stigma, then it provides even more opportunities to eliminate HIV.

The study research questions are:
Research Questions

This study seeks to answer three questions.

- Research Question 1- What are ideologies and perspectives of African American faith leaders regarding HIV and stigma within the church?
- Research Question 2- What are the ideologies and perspectives of African American millennial faith leaders in the U.S.?
- Research Question 3- What are the perspectives of millennial African American faith leaders on addressing HIV and HIV stigma within the African American community?
CHAPTER 3: THEORY

The following chapter describes the theories and framework that inform the research design and analysis for my dissertation - Symbolic interactionism, Intersectionality, and social identity theory.

Symbolic Interactionism

Symbolic interactionism (SI) is a sociological theory that assumes people construct selves, society, and reality through interaction (Blumer, 1969; Charmaz, 2014; Hughes & Sharrock, 2007). SI focuses on dynamic relationships between meaning and actions and addresses the active processes through which people create and mediate meanings (Blumer, 1969; Carter & Fuller, 2016; Charmaz, 2014). Rather than addressing how common social institutions define and impact individuals, symbolic interactionists shift their attention to the interpretation of subjective viewpoints and how individuals make sense of their world from their unique perspective (Carter & Fuller, 2016). They are more concerned with subjective meaning and how repeated, meaningful interactions among individuals come to define the makeup of society (Carter & Fuller, 2016). This theory emerged in the mid-20th century and was heavily influenced by American philosopher and pragmatist George Herbert Mead (Carter & Fuller, 2016; Collins, 1994).
George Herbert Mead never published work on symbolic interactionism, but his student, Herbert Blumer, coined the term symbolic interactionism. Blumer identified four tenets of the theory: (1) individuals act based on the meanings objects have for them; (2) interaction occurs within a particular social and cultural context in which physical and social objects (persons), as well as situations, must be defined or categorized based on individual meanings; (3) meanings emerge from interactions with other individuals and with society; and (4) meanings are continuously created and recreated through interpreting processes during interaction with others (Blumer, 1969).

Blumer suggested the best way to understand people and their understanding of the world is through qualitative inquiry. By engaging in in-depth interviews with participants, I can gain an understanding of the social influences and interactions shaping African American millennial faith leaders’ perceptions about HIV/AIDS and stigma. I can also gain an understanding of the symbolic meanings within the African American church culture influencing perceptions about HIV/AIDS, stigma, and vulnerable populations impacted by HIV and stigma. By applying SI within this study, a deeper understanding and explanations for “why/why not” millennial faith leaders address HIV/AIDS in their church could emerge. This study could highlight barriers millennial African American faith leaders face when addressing HIV/AIDS and stigma.

Intersectionality

Intersectionality is a theoretical framework for understanding how multiple social identities such as race, gender, sexual orientation, socioeconomic
status (SES), and disability intersect at the micro level of individual experience to reflect interlocking systems of privilege and oppression (i.e., racism, sexism, heterosexism, classism) at the macro social-structural level (Bowleg, 2012; Crenshaw, 1991; Davis, 2008). Intersectionality is rooted in black feminist thought (Collins & Bilge, 2016). The concept of this theory was first introduced during the first wave of the feminist movement, specifically 1851. It was during this time Sojourner Truth, a former slave and women’s rights activist, gave her infamous speech “Ain’t I a Woman” (Haynes et al., 2020). In her speech, Truth highlighted the interlocking of identities of people and the unfair treatment of black women in the first feminist movement and throughout American society (Collins & Bilge, 2016; Haynes et al., 2020).

In the 1970s and ‘80s, during the second wave of the feminist movement, the concept of Intersectionality gained popularity again. Feminist scholars and activists, such as Patricia Hill Collins and bell hooks, began writing and highlighting how gender-only and race-only approaches to inequality failed to acknowledge the extent and scope of oppressions experienced by women of color in the USA (Collins, 2002; Collins & Bilge, 2016; Haynes et al., 2020). In the 1990s, Kimberlee Crenshaw, a legal scholar, coined the term intersectionality after conducting critical work on discrimination among black women in the U.S (Crenshaw, 1989, 1991). Crenshaw positioned intersectionality as a theory to explain life experiences and modes by which people experience oppression and privileges (Crenshaw, 1989, 1991).

As a theory, intersectionality has been used across multiple disciplines, including public health, to understand a variety of social issues like HIV/AIDS and stigma. Within the study of HIV/AIDS prevention the term intersectional stigma has been used to
explain the associations between social identities and inequities in HIV/AIDS (Berger, 2010; Logie et al., 2011; Turan, Hatcher, et al., 2017). Turan et al. (2017), have shown that intersectional stigma can occur within multiple social domains, including the interpersonal, community, and structural levels (Turan, Hatcher, et al., 2017). Intersectional stigma can come from sources such as friends, family, or health care providers (Turan, Hatcher, et al., 2017).

There are three assumptions underpinning work driven by intersectionality. The first assumption is that social identities are not independent and unidimensional but multiple and intersecting. The second assumption is people from multiple historically oppressed and marginalized groups are the focal or starting point for examining intersectionality. The final assumption is that multiple social identities at the micro level (i.e., race, gender, SES) intersect with macrolevel structural factors (i.e., poverty, racism, sexism) to illustrate or produce disparate health outcomes.

African American millennial faith leaders living within the U.S. hold multiple identities as members of a marginalized group; however, they possess social power as faith leaders in their community. Analyzing their perspectives using the lens of intersectionality can explain how their social identities, such as race, social positions, gender, religious affiliations, and age, shape their perspective and ideology regarding HIV/AIDS and stigma. By utilizing Intersectionality theory in this study, the forms oppression and privileges among African American millennial faith can be better understood and further explain their perceptions and responses to HIV/AIDS and stigma.
Social Identity Theory

Social Identity Theory (SIT) was introduced by social psychologist Henri Tajfel, and is used to understand how people define themselves and others based on social categories and group membership (i.e., male vs. female; student vs no student; gay vs. straight; upper class vs lower class) (Tajfel, 1981; Tajfel & Turner, 1979). The social groups and categories in which we define ourselves shape us. It guides our behaviors and shapes our perspectives of ourselves and of the world (Haslam et al., 2009). Individuals can belong to multiple social categories, and a person might act differently in certain social contexts according to the groups they belong to (Tajfel, 1981; Tajfel & Turner, 1979; Turner & Tajfel, 1986).

Within SIT is the concept of In-groups and Out-groups. When a person perceives themselves as part of a group, that is an in-group for them. Other comparable groups that person does not identify with are called out-groups. According to Tajfel, in-groups discriminate against out-groups to boost their self-esteem or group beliefs and to prove their in-group is more favorable. Individuals can belong to multiple categories (Tajfel, 1981). A person’s behavior and perspectives can be shaped and defined by the social norms and beliefs of their categories (Abrams & Hogg, 2010; Tajfel, 1981; Tajfel & Turner, 1979).

There are three processes that create this ingroup versus outgroup mentality: Social categorization, social identification, and social comparison. Social categorization is how a person categorizes themselves and others based on their social environment (Turner & Tajfel, 1986). For example, people are categorized based on their age (child/adult/senior citizen), race/ethnicity (Black/African American or white/Caucasian), and
their political ideology (Democrat or Republican) (Turner & Tajfel, 1986). Some categories are already ascribed at birth. Self-categorization is suggested to help define ourselves and others, and these categories influence behavior and interaction with members of the in-groups and members of out-groups (Turner & Tajfel, 1986).

Social identification is when a person adopts the identity of the group they feel they belong to. Once this happens, an individual begins to mimic the behaviors of other in-group members (Turner & Tajfel, 1986). A result of social identification is developing emotional significance to that identification, and the individual’s self-esteem becoming dependent on it (Turner & Tajfel, 1986). The third process for creating an in-group versus out-group mentality is social comparison. To maintain self-esteem, individuals may compare their groups to others. They may highlight the favorable aspects of their own group and the unfavorable aspects of others (Abrams & Hogg, 2010; Tajfel, 1981; Tajfel & Turner, 1979). It is suggested that this process helps explain prejudice and discrimination because a group will tend to view members of competing groups negatively to increase self-esteem.

It has been suggested that the SIT process might not be operative of all groups (Hinkle & Brown, 1990; Liebkind, 2004). According to Hinkle and Brown, this would depend on the prevailing level of individualism or collectivism in the group or group members, on the one hand, and their inclination to engage in intergroup comparisons, on the other (Brown, 2000; Hinkle & Brown, 1990; Liebkind, 2004). Group comparisons may be more important for relational groups (e.g., sports teams) and less important for autonomous groups (e.g., families).
SIT recognizes that certain social groups are fixed and are not fluid. Escaping certain social groups is impossible for some groups. When it comes to social comparisons and trying to escape social groups, the theory suggests that in-group members might directly confront the dominant group’s superiority by protesting for social change (Brown, 2000; Liebkind, 2004).

The SIT has been applied within studies to understand conflicts and interprofessional teamwork, as well as prejudice and discrimination. According to SIT, group processes are considered highly influential and impactful to an individual. As previously mentioned, it is possible for individuals to identify with multiple groups based on their profession and on their position in the social hierarchy. This is called the salience of social categorization (Blanz, 1999; Turner et al., 1994). Power differentials reflect social structures in SIT (Tajfel & Turner, 1979). Depending on the social structure, those who hold power within that structure can affect relationships between groups with different statuses (Kreindler et al., 2012). They also can change social structures and perspectives (Kreindler et al., 2012).

Within the African American church culture, faith leaders hold power; therefore, they can impact social structures and relationships within the church culture. This theory will be applied by asking participants questions related to their role as a faith leader and how they view themselves within and outside of the context of the church. They will also be asked about their experiences within the church and with HIV/AIDS and how these experiences influence who they are.

Understanding their social identity, and which ingroup they identify, will explain how they view themselves within the African American community. Based on their
perspectives of their in-groups and out-groups, we can potentially understand how millennial faith leaders view HIV/AIDS, stigma, PLWH, and vulnerable populations mostly impacted by HIV/AIDS.
CHAPTER 4: METHODOLOGY

Chapter Overview

The first section of this chapter is dedicated to research question 1. In this section, I provide an overview of the systematic review protocol based on the PRISMA guidelines. This includes the eligibility criteria, information sources/electronic databases, search strategy, and screening process. The following section is dedicated to research questions 2 & 3. In this section, I discuss the generic qualitative approach. I also discuss the inclusion criteria for research participants, research strategy, recruitment strategy, research setting, data analysis, rigor and trustworthiness, and lastly, limitations. This study was approved by the Institutional review board (IRB) at the University of Louisville.

Section 1- Systematic Review Protocol

• Research Question 1- What are ideologies and perspective of African American faith leaders regarding HIV/AIDS and stigma within the church?

To answer Research Question 1, I conducted a systematic literature review using the Preferred Reporting Items for Systemic Reviews and Meta-Analysis (PRISMA) standards. According to PRISMA, a systematic review is a review of a clearly formulated question that uses systematic and explicit methods to identify, select, and critically appraise relevant research, and to collect and analyze data from the studies that are included in the review (Moher et al., 2009). Several
researchers have already examined the perceptions of African American leaders. However, it is uncertain how many studies have been conducted examining the perspectives and ideologies among millennial or younger faith leaders, especially regarding HIV/AIDS and stigma. The purpose of the systematic review is to look closely at ideologies and perspectives of HIV/AIDS and stigma among African American faith leaders in the U.S. This systematic review also seeks to identify any studies assessing the perspectives of younger or millennial African American faith leaders.

According to PRISMA, before conducting a systematic review, a protocol should be prepared (Liberati et al., 2009; Moher et al., 2009). The protocol is used as a guide to carry out the review and it describes the rationale, hypothesis, and planned methods of the review (Liberati et al., 2009; Moher et al., 2009). The PRISMA guidelines protocol requires developing an eligibility criterion, identifying information sources/electronic databases, developing a search strategy, and screening process (Liberati et al., 2009; Moher et al., 2009). Figure 1 is a flowchart illustrating PRISMA’s guidelines utilized for this systematic review process.
Eligibility criteria

The criteria for this systematic review included articles that were: 1) published after 1995; 2) based on studies conducted in the U.S.; 3) written in the English language;
and 4) examined perceptions and beliefs about HIV/AIDS, HIV/AIDS stigma, or both among African American faith leaders (pastors, clergy, lay leaders, ministers, and/or religious leader). This included quantitative and qualitative studies.

I decided to collect articles published after 1995 because this is the year highly active antiretroviral therapy was introduced in the U.S. By the end of 1995, approximately 500,000 HIV/AIDS cases had been reported in the U.S., and in 1996, HIV/AIDS was no longer the leading cause of death among all Americans aged 25 to 44 years (Center for Disease Control and Prevention, 1995 & Kaiser Family Foundation, 2018). However, it became the leading cause of death among African Americans in this age group (Center for Disease Control and Prevention, 1995). Analyzing articles starting after 1995 allows us to understand the possible social factors for the disproportionate rates of HIV/AIDS within the African American community.

**Information Sources/Electronic Database**

The following databases were used to identify and collect articles for the review: PubMed, PsycINFO, ProQuest, Google Scholar, University of Louisville inline Library database, and Medline. These databases were chosen because they are academic search systems that are well suited for evidence synthesis in the form of a systematic review (Gusenbauer & Haddaway, 2020).

**Search strategy**

I searched for articles that discussed HIV/AIDS, HIV stigma, faith leaders, and the African American church using the following keywords in each database: HIV/AIDS, stigma, African Americans, Black, black church, faith-based organizations, religious community, pastor, clergy, preacher, African American church. A combination of these
words was entered into each database to identify articles. An outline was developed to determine order and word combinations for the search.

A spreadsheet was created to organize and to manage articles collected. Within this spreadsheet, I recorded the title, year of publication, authors, journal titles, study design, target population, the number of participants, sampling methods, independent variables, dependent variables, outcome variables, abstracts, key findings, and keywords of each article.

**Screening Process**

Articles were screened in two phases. In phase one, I reviewed the abstract of each article to ensure eligibility. Articles were excluded if they did not meet the criteria mentioned above. In phase two, articles that passed phase 1 were read in entirety to further eliminate articles. Articles were excluded from the review if they were duplicates, published before 1996, or the target population was not African American faith leaders and churches. Articles were also excluded if they were focused on developing, implementing, or evaluating an HIV program or intervention and did not capture perceptions about HIV/AIDS and stigma among faith leaders.

Papers with a multiracial sample of churches were excluded if they did not provide any clear indication of African American faith leader perceptions about HIV/AIDS and stigma. Articles within phase 2 were shared with another researcher to ensure reliability and validity of the review. Once the articles for the review were identified, each article was reviewed again. I read the articles and recorded key findings and major themes of each article. Additional articles were identified by screening the reference lists of articles collected. I analyzed the methods and results section of each paper to identify faith leader perspectives. See Appendix I for systematic review table.
Section 2- Qualitative Study: Examining How Perspectives on HIV are Formed

Research Question 2- How do millennial African American faith leaders form their perspectives on HIV/AIDS within the African American community?

Research Question 3- What are the perspectives of millennial African American faith leaders on addressing HIV/AIDS and HIV/AIDS stigma within the African American community?

To answer research questions two and three, I used a descriptive qualitative research approach. Similar to other qualitative approaches, descriptive qualitative research also seeks to understand how people interpret, construct, or make meaning from their world and their experiences (Kahlke, 2014; Merriam & Grenier, 2019). However, this descriptive qualitative research is not guided by an explicit set of philosophic assumptions in the form of one of the established qualitative methodologies (phenomenology, grounded theory, and ethnography) (Caelli et al., 2003; Kahlke, 2014). Instead, this approach borrows techniques and procedures from other qualitative approaches at the method level. (Hunt, 2009; Kahlke, 2014; Thorne et al., 2004). This approach is appropriate for this study because of the use of grounded theory techniques, such as line-by-line coding, constant comparison, and thematic analysis in this study. However, the analytic goal of my study was to explore perspectives of faith leaders and not to develop a substantive theory (Kahlke, 2014).

Data Collection

I conducted in-depth, semi-structured interviews with African American faith leaders between the ages of 18 and 40 years. Semi-structured interview methods allow
reciprocity between the interviewer and participant and helps the interviewer to improvise follow-up questions based on participants’ responses (Galletta & Cross, 2012; Kallio et al., 2016). This interview style allows the participant to elaborate and provide significant detail to their responses (Salazar et al., 2015). Interviews were conducted on the video conference call platform ZOOM. Interviews were audio recorded with the recording function of the ZOOM platform. Interviews were conducted from December 2020 until March 2021. The length on the interviews ranged from 30 minutes to one hour. Notes were taken during the interview to capture new thoughts and ideas as they emerged during conversation. First impression memos were written after interviews to capture my initial thoughts and understanding of participants and their responses. Participants were not compensated because there was no funding for this study.

Saturation

I conducted interviews with participants until I reached saturation. Saturation of the data refers to the quality and quantity of information in a qualitative research study (Morse, 2015; Saunders et al., 2018). A researcher has encountered saturation when there has been an exhaustive exploration of the topic being studied or if no new information is being presented in the data (Morse, 2015; Saunders et al., 2018). I anticipated approximately 30 to 40 interviews based on guidelines provided within the literature (Morse, 2015; Salazar et al., 2015). However, because of saturation, I did not reach 30 interviews.

I assessed saturation by comparing interview responses, notes, and memos. As new information and ideas emerged from the data, I continued to conduct interviews. Interviews were concluded when interview responses became consistent and there were
no new themes emerging from the data. For example, saturation for perceptions about sex and sexuality in the church within the church was reached after interview #5; however, I continued to explore the perceptions about sex and sexuality within the church until interview #14, when no new information about this topic emerged.

*Interview guide*

I developed a semi-structured interview guide containing closed- and open-ended questions to collect data. Open-ended questions allowed discussion and conversation with participants. I developed the interview guide using the theoretical sensitizing concepts of social identity theory, symbolic interactionism, and intersectionality theory. The interview guide was reviewed by my dissertation committee to ensure the guide captures and assess the intended constructs of the study. Changes were made to the interview guide based on the committee’s feedback.

Based on the interview guide (see appendix for interview guide), participants were asked about their role as a faith leader, their perceptions about HIV/AIDS and stigma, the universal church’s response to the HIV epidemic, their perceived reasons for racial/ethnic HIV/AIDS disparities, their experiences with addressing HIV/AIDS programming, and reasons for why or why not addressing HIV/AIDS within their church. Participants were also asked to share what local organizations could do to help faith leaders facilitate HIV conversations in their church. A second round of interviews was conducted with four participants for member checking.
Study participants

Participants were eligible for the study if they met the following criteria: 1) identified as African American or Black; 2) served as a faith leader at a predominantly African American church; and 3) were a millennial (born between 1980-1996).

Faith leaders are defined as the authority figures of religious institutions. They provide religious guidance to followers and oversee the operations of the church. Faith leaders are responsible for deciding which ministries and programs the church will provide to their community and congregation. Faith leaders do not always possess senior leadership. Some faith leaders are assistant faith leaders or ministers and provide support to senior level faith leaders. Assistant faith leaders and ministers were able to participate in the study because they have influence within their church. Some faith leaders may oversee certain ministries or programs, such as the health ministry or HIV/AIDS ministry. Some of the faith leaders in this position have the potential of becoming a senior pastor.

Ordination was not a criterion for participants. Ordination is a process in which individuals are elevated to the level of clergy and granted leadership within the church and authority over religious ceremonies. I decided to include faith leaders who have not been ordained because I perceived young faith leaders to be in the process of ministerial training. Within some denominations, ordination status has no impact on being a senior pastor or preaching. I did not want ordination status to be a barrier for participation.

Sampling

Participants were recruited through a purposive sampling approach. This sampling method requires selecting participants based on specific characteristics and the objective
of the study (e.g., age, gender, race/ethnicity, denomination) (Charmaz, 2014; Corbin, 1998). The snowball sampling method, which involves initial participants recommending additional participants, was also utilized in this study.

*Recruitment Strategies*

I proposed four recruitment strategies (developing a contact list, creating a flyer for passive recruitment, and attending religious conferences); however, I was only able to implement three recruitment strategies.

Strategy 1- Developing a contact list

The first strategy involved utilizing existing relationships with three millennial African American faith leaders. These faith leaders served historically African American churches in the U.S. in 3 different regions of the country (Southern, Midwestern, and Northern) and were active in religious life in their communities. Each of the faith leaders had a Master of Divinity (MDiv), which is considered a terminal degree in the study of religion. Two faith leaders held leadership positions within ministerial associations in their city and were professors at their local divinity schools.

Their connections within the religious community and their academic experiences were helpful in identifying faith leaders and ministers within their social and professional networks. I met with the three faith leaders individually and explained the study and its purpose. I also explained to them that I needed their assistance with identifying millennial faith leaders. They provided names and contact information of faith leaders they knew, and I developed a contact list of ten potential participants. I reached out to participants via phone call, email, or text message using a prewritten recruitment script.
Strategy 2- Passive Recruitment

For strategy 2, I developed a flyer and recruitment scripts for divinity schools and seminary schools. These schools are usually housed within another college/university or independent institutions of higher education. These schools provide educational training to religious scholars and leaders. Most of the schools offer graduate degrees and religious studies courses. I assumed millennial faith leaders would be enrolled in these institutions for degree and qualification purposes. I emailed a flyer to four divinity schools (Howard University Divinity School, Virginia Union University-Samuel DeWitt Proctor School of Theology, Yale Divinity School, and American Baptist College). I did not receive any responses from these institutions.

Strategy 3- Connecting Within Divinity School and Seminaries

This strategy involved identifying and connecting with a faculty member or administration at several divinity school or seminaries in the city of Louisville. I was unable to meet any of the faculty at Louisville seminaries because the methods of recruitment, such as strategy 1, were more successful in recruiting participants.

Strategy 4- Religious conferences

The final strategy consisted of me attending religious conferences. This strategy could not be implemented because conferences were cancelled due to the coronavirus pandemic.

Additional recruitment

I did not propose to use social media for recruitment, but after several other strategies did not generate results, I decided to use the social media platform Instagram. Five participants were recruited through this social media platform. I used the hashtags
#millennialpastor, #blackpreacher, and #blackpastors on Instagram to identify participants. These hashtags led to several posts related to faith leaders who were millennials in the African American church. I also searched for Instagram accounts dedicated to African American faith leaders to identify participants. I sent a recruitment script containing the study purpose, background, and eligibility requirements to potential participants. Once a participant expressed interest of participation, they were screened, and if eligible, an interview was scheduled.

Participants also were recruited through a colleague close to the study. A colleague who knew faith leaders presented three names of African American and millennial faith leaders, and I reached out to them via text message and email using the recruitment script. The most effective method of recruitment was through snowball sampling. Snowball sampling generated nine participants. The first three participants submitted contact information of other millennial faith leaders. They also reached out to other participants and recommended they reach out to me.

**Screening Process**

The screening process for this study included asking participants a set of questions related to the inclusion criteria for participation. Participants were asked if they identified as African American or Black, their age, and if they were a member of the clergy. If participants answered yes to all questions, an interview day and time was scheduled. Most participants were screened via text message, email, or phone call.

**Recruitment Tracking System**

To track the number of participants, I created an excel spreadsheet. The spreadsheet included the participant’s name, participant ID#, pseudonyms, age, gender
identity, denomination affiliation, the number of years they’ve been a pastor, the number of years they’ve served their current church, city and state of their church, level of education, the date and time of interview, and recruitment mode. This information was collected through a demographic form. The demographic form was given to participants before the interview. The spreadsheet also asked if they have been through the screening process and completed consent form.

Consent

Prior to conducting an interview, participants completed a consent form that aligns with the Institutional Review Board (IRB) standards. The purpose of the consent form was to ensure participants were aware their participation was voluntary and that they had the option to withdraw from the study. The consent form also informed participants they were being recorded and their responses were being used for research purposes. Consent forms were emailed to participants before the interviews. The content of the consent form was reiterated to participants right before the interview.

Interview Setting

All qualitative interviews for this study were conducted via the ZOOM video conference call platform. This was the most efficient method of conducting interviews for this study. Interviews were conducted in December 2020 until March 2021, which was during the Coronavirus global pandemic. Conducting virtual interviews allowed for the participants and I to meet safely face to face. The ZOOM platform also has a recording function, which allowed me to record interviews for transcription purposes.
Data Analysis

Although this was a descriptive qualitative study, grounded theory coding strategies and analytic techniques were used for this study. The following sections describe the methods used for analysis, which includes coding (initial coding, focus coding, and thematic coding), constant comparison method, and memo writing.

Coding- Initial coding, focus coding and thematic coding
Each interview was recorded and transcribed. The automatic transcription service, Rev.com, was used to transcribe interview data. I transcribed three interviews. I also reviewed and cross-checked transcripts that were transcribed from the automatic transcription services for accuracy. I read and re-read the first 10 transcripts to gain familiarity with the data. I conducted a line-by-line coding to identify initial codes of the data. Initial coding is defined as the early process of engaging with and defining the data (Charmaz, 2014). Initial codes, also called gerunds, were created to help identify actions and processes within the data (Charmaz, 2014). Gerunds consist of using words ending with “-ing” and are constructed from verbs and used as nouns (Charmaz, 2014). This coding strategy was helpful because it provided another opportunity to engage with data granularly. By coding each line of the data using gerunds, the researcher is forced to examine the data without imposing preexisting perspectives onto the data. It also prevents the researcher skipping over data and focusing on personal interests.

The second round of coding involved using initial codes to develop focused codes by searching for frequency and significance. Focused codes were then tested among a large batch of data and the codes demonstrating analytic strength were developed into categories. Transcripts were compared to identify consistent themes. A codebook was developed, which contained definitions for each focus code.
Interview transcripts were uploaded in Dedoose, a qualitative data management software. This software was designed to help researchers organize and analyze research data. The first ten transcripts were coded using the focused codes. The researcher assessed intercoder reliability using Cohen’s kappa measure. This required another qualitative researcher to code the first half of transcripts. The coded data excerpts were compared to coded data excerpts by the primary researcher. The kappa test generated a substantial score of 0.83, which is considered to be “excellent agreement.” Following this, the other 11 interviews were coded.

After developing tentative categories from the data, I conducted thematic coding. Thematic coding is a form of qualitative analysis that involves identifying patterns and themes within the transcript data. This requires the researcher to draw conclusions from the categories and identify relationships within the data.

**Constant Comparison**

As I completed interviews, I engaged in constant comparison method. This kind of method usually occurs during the collection and the analysis of the data. During data collection, when concluding interviews, I compared interview notes and memos to previous interview notes and memos. After conducting initial coding on the first interview transcript, I would compare it to the second interview transcript. From then on, all transcript data were compared against the previous, subsequent, and following transcript data. This helped to understand the clusters and patterns within the data.

**Memos**

Charmaz, the developer of constructivist grounded theory, encourages researchers to write analytic memos or first impression memos. The purpose of the first impression
memos was to capture my initial thoughts and understanding about the participants and their responses and highlight significant and unexpected information (Charmaz, 2014). Throughout the analysis process, I wrote memos related to my research question. These memos served as an opportunity for me to reflect on the participants and their interview and how their stories are related to my research questions. These memos helped identify what was missing in my data to help inform the direction of the study.

Rigor/Trustworthiness

According to Morse et al, 2002, without rigor, research is worthless and becomes fiction and loses it use (Morse et al., 2002). To ensure there is rigor in this study, additional steps were taken to meet the criteria of trustworthiness (credibility, transferability and dependability) of research findings (Lincoln & Guba, 1985). Trustworthiness refers to quality, authenticity, and truthfulness of qualitative research findings. It relates to the degree of trust, or confidence, readers have in results (Lincoln & Guba, 1985). The first criterion is credibility. Credibility ensures the fit between respondent’s views and the researcher’s representation of them (Nowell et al., 2017). It is when the researcher’s interpretation of the data reflect the social reality of the participants (Lincoln & Guba, 1985; Maher et al., 2018).

To meet credibility standards, I engaged in member checking with several study participants. The participants I selected for member checking reflected the multiple perspectives of my sample. They were the participants with strong responses who were easy to connect with after our first interview. Member-checking meetings consisted of explaining my interpretation of interview responses and findings. Participants and I were able to discuss the findings and the range of experiences and perspectives about
HIV/AIDS and stigma in the African American church among millennial African American faith leaders.

Along with credibility, transferability is another element of trustworthiness. Transferability relates to the ability of the findings to be transferred to other contexts or settings (Lincoln & Guba, 1985; Maher et al., 2018). In this dissertation, I provide a detailed description of the study and highlight the context and time of which data and results are being reported. This is so other people can take on the information within this study and apply it to other research studies. Dependability is another element of trustworthiness. This element ensures the process is described in enough detail to facilitate another researcher to repeat the work (Lincoln & Guba, 1985; Maher et al., 2018). One of the most common ways to ensure dependability is an audit trail. I created an audit trail consisting of steps and decision made throughout the study, including interviews with participants, meeting with coder for interrater reliability, and any changes that occurred.

Reflexivity/Positionality statement

Reflexivity and positionality are critical to the rigor of qualitative research. Reflexivity is the degree of influence that the researcher exerts, either intentionally or unintentionally, on the research findings. This process involves the researcher acknowledging their social standpoint and how they connect to research study. To be reflexive, a researcher must analyze their decisions throughout the research process. They must also analyze their interpretations and how their interests, positions, and assumptions influence their research. This is an ongoing process throughout the research study. In this section, I will discuss my positionality and standpoint regarding this study and the
African American church. I will also explain my self-reflection process to minimize subjectivity during data collection and analysis.

My immediate connection to this study is my life experience within the African American church culture. As a child, it was important to my parents that my sister and I developed a healthy religious and spiritual life. As a family, we attended church every Sunday, and throughout the week, I was active in numerous church activities. When I moved away from home, I remained active in the African American church culture. As a college student, I served as a chapel assistant at my university and read the litany every Sunday during chapel service. Today, I continue to attend church service and have gained personal and professional relationships with pastors of various different denominations.

My Christian faith is essential to who I am as a person and my Christian experiences have shaped how I view the world. It is through these experiences I have witnessed the ability of African American church culture to enhance the lives of those who are marginalized in our society. Also, knowing young African American pastors and hearing the social perspectives within and outside of the religious spaces has sparked my interest in understanding how they would address HIV/AIDS and stigma in this day and time.

I chose this research topic because of the empirical evidence of effective faith-based HIV/AIDS prevention and stigma reduction efforts. My interest in this topic was further enhanced by participating in HIV/AIDS Sundays at my church and personally seeing the impact faith-based interventions had on African American communities. As such, I have grown an affinity for faith-based health programs and interventions within
the African American church culture. My professional and research experiences were also important influences for this study.

Throughout my graduate school experiences, I have developed skills in qualitative research methods, and I’ve had the opportunity to exercise these skills as a graduate assistant. I recognize these experiences and my engagement in the literature about HIV/AIDS and a faith-based setting can have an influence on my interpretation and understanding of the data. Knowing this, I must remain open and grounded in the responses of my participants and not impose my own preconceived ideas.

To combat any bias, preconceived judgment, or misinformed knowledge that may come from my life experiences and to ensure trustworthiness of the interpretation of the data, I wrote self-reflexive journals/memos. These journals served as a mechanism to acknowledge my bias and preconceived ideas. These memos were written periodically throughout the data collection process. I also engaged in four member-checking interviews. The purpose of member checking is to ensure my interpretations are accurate and reflect the truth of the participants. Member checking involved sharing research findings with participants. The four member-checking participants were selected because they represented the various perspectives of HIV and stigma within the data. Within member-checking interviews, participants and I discussed the interviews responses and whether or not they agreed or disagreed with research findings.

Data Management

All audio recorded data were saved in an encrypted file on a flash drive. Data were transcribed through an automated transcription service Rev.com. Data was also placed on the Dedoose platform. Through these services, each company ensures data
cannot be reached unless individuals have access to the password and username of the Rev.com account and Dedoose account. To ensure the identity of participant was not compromised, all identifying information within transcripts was deleted and replaced with pseudonyms. As previously mentioned, participants were given an ID# on the day of interview. A list with ID#'s, the participants’ names and contact information, consent forms, and demographic forms was saved on the flash drive with encrypted files. I am the only person with access to the flash drive, Rev.com account, and Dedoose account. These steps were taken to manage data and maintain confidentiality of participants.
CHAPTER 5: RESULTS

The following chapter presents three papers/articles based on the results of this study. Paper one provides the results for the systematic review, which was conducted to answer research question one. Papers two and three provide the results of the qualitative interviews for research questions two and three.

Paper 1- African American Faith Leaders’ Perspectives About HIV/AIDS and Stigma: A Systematic Review

Introduction

African Americans are disproportionately impacted by HIV compared to other racial/ethnic groups. According to the Centers for Disease Control and Prevention (CDC), African Americans account for 42% of new HIV diagnoses while comprising only 13% of the United States population (Center for Disease Control and Prevention, 2021c). In 2018, the rate of new HIV diagnoses per 100,000 among African American adults (47.5) was eight times that of whites (5.6) (Center for Disease Control and Prevention, 2021c). The HIV rate for African American men (74.8) was the highest of any group, and African American women (23.1) had the highest rate among all women (Center for Disease Control and Prevention, 2021c). Even with the medical advancements in HIV prevention and control (e.g., pre-exposure prophylaxis (PrEP); achieving undetectable viral loads to prevent transmission), there is still lower uptake of these prevention methods among African Americans (Center for Disease Control and Prevention, 2021a).
Such stigma derives from misconceptions about HIV/AIDS transmission and from social norms and beliefs about sexual behavior and sexuality (Mahajan et al., 2008). HIV/AIDS stigma impacts the health and well-being of PLWH (Earnshaw et al., 2012) and members of high-risk groups, such as men who have sex with men (MSM) and injection drug users. Researchers have found stigma to have an adverse impact on uptake of prevention resources among vulnerable groups and on medical adherence among PLWH (Earnshaw et al., 2015; Treves-Kagan et al., 2017).

There are ways in which a person can experience HIV stigma: enacted stigma, anticipated stigma, and internalized stigma (Earnshaw et al., 2013; Treves-Kagan et al., 2017; Turan, Hatcher, et al., 2017). Enacted stigma may include acts of violence and marginalization (Treves-Kagan et al., 2017; Turan, Hatcher, et al., 2017). Anticipated stigma is awareness of negative social perceptions towards HIV/AIDS and the expectation of prejudice and discrimination (Treves-Kagan et al., 2017; Turan, Budhwani, et al., 2017). Internalized stigma refers to the adoption of negative beliefs and feelings about oneself as being HIV positive (Turan, Budhwani, et al., 2017; Turan et al., 2016).

Structural stigma arises from social and legal practices that work to the disadvantage of minority groups and can occur within multiple social domains, including health care environments, schools, the workplace, and the church (Kay et al., 2018). Studies on HIV/AIDS show PLWH have been denied care or treatment within health care settings (Kay et al., 2018; Treves-Kagan et al., 2017; Turan, Hatcher, et al., 2017). These experiences can have a serious impact on
PLWH and may discourage them from seeking health care services and social support, which can further impact their health (Katz et al., 2013).

The African American church has been criticized for its slow response to the HIV epidemic and perpetuating stigma related to HIV/AIDS (Coleman et al., 2016; Drumhiller et al., 2018). However, studies show African American clergy and their congregations are increasingly willing to engage in addressing HIV/AIDS (Nunn et al., 2018). The influence of faith leaders can determine churches’ uptake of HIV programming. Historically, African American religious spaces have served as a place of refuge and social activism within the African American community (Brewer & Williams, 2019; Lincoln & Mamiya, 1990; Mahajan et al., 2008). The African American church has also been engaged and effective in addressing other health outcomes impacting African Americans (Brewer & Williams, 2019; Butler-Ajibade et al., 2012; Campbell et al., 2007; Scandrett, 1996).

African American faith leaders have significant influence on their congregations and communities (Baruth et al., 2015; Campbell et al., 2007; Quinn et al., 2016). Their sermons and messages affect the beliefs and behaviors of their parishioners as well as the surrounding community (Baruth et al., 2015; Campbell et al., 2007). Faith leaders utilize their pulpits to educate their community about the social issues confronting African Americans. Messaging from the pulpit about HIV and people living with HIV can shift perceptions about HIV among congregations (Ransome et al., 2018). There is a great deal of literature about HIV/AIDS, the African American community, and attitudes among African American pastors and church culture (Baker, 1999; Beadle-Holder, 2011; Berkley-Patton et al., 2010; Brewer & Williams, 2019; Bryant-Davis et al., 2016; Eke et
al., 2010; Flórez et al., 2017; Fulton, 2011; Khosrovani et al., 2008; Wilson et al., 2011). However, few studies examine the perspectives and ideologies of HIV/AIDS specifically among millennial or younger faith leaders.

Faith leaders who are millennials or younger may have a different perspective about addressing HIV/AIDS and stigma than those of previous generations. Millennials’ ideologies and perspectives on social issues generally differ from older generations (P. Taylor et al., 2014). The millennial generation consists of individuals born between 1980 and 2003 (Howe & Strauss, 2000; P. Taylor et al., 2014; Twenge et al., 2012; Winograd & Hais, 2011). This generational cohort is the largest, most educated, and racially diverse (Howe & Strauss, 2000). The diversity among millennials suggests they are more liberal than previous generations (Thornton & Young-DeMarco, 2001; Tillman et al., 2019; Twenge et al., 2015) and more open to and accepting of such as racial and ethnic diversity and the LGBTQ+ community (P. Taylor et al., 2014; Tillman et al., 2019; Twenge et al., 2015). Over 50% of millennials believe premarital sex is “not at all wrong” and that comprehensive sex education should be offered in schools (Twenge et al., 2015). This has important implications for addressing HIV/AIDS. The broader sexual mores and perspectives regarding sexual and gender minorities have made churches leery of discussing HIV/AIDS. A younger generation that is more accepting and affirming of these marginalized populations allows for expanded conversations about HIV/AIDS.

It’s important to learn whether African American millennial faith leaders share the perspectives of other ethnicities in their generational cohort. They are
the rising leaders of a religious community that has not, historically, been affirming of sexual and gender minorities. Faith communities have also struggled to address HIV/AIDS and related topics (e.g., condom use, sex, drug use) due to fear of condoning behaviors perceived to be antithetical to their beliefs. Understanding the perspectives of millennial African American pastors could help identify new ways of addressing HIV and stigma within the African American community. Their perspectives could provide insight into the possibility of new roles for the African American church and faith-based HIV/AIDS programming. This systematic review explores the public health literature and attempts to understand African American—specifically millennial—faith leaders’ perspectives on addressing HIV and associated stigma.

Methods

This study followed the current preferred reporting items for systematic review and meta-analysis guidelines (PRISMA). PRISMA is an evidence-based minimum set of items for reporting in systematic reviews and meta-analyses (Moher et al., 2009; Page et al., 2021). PRISMA primarily focuses on the reporting of reviews evaluating the effects of interventions but can also be used as a basis for reporting systematic reviews with objectives other than evaluating interventions (e.g., evaluating etiology, prevalence, diagnosis or prognosis) (Moher et al., 2009; Page et al., 2021). A systematic review seeks to answer a clearly formulated question using systematic and explicit methods to identify, select, and critically appraise relevant research, and to collect and analyze data from the studies that are included in the review (Moher et al., 2009; Page et al., 2021). Figure 2 provides the PRISMA flowchart for this systematic review.

Eligibility Criteria
To be considered for this review, studies must have been conducted in the United States, written in English, published after 1995 (when highly active antiretroviral therapy was introduced in the U.S.), and focused on perceptions and beliefs about HIV/AIDS, HIV/AIDS stigma, or both among African American faith leaders (pastors, clergy, lay leaders, ministers, and or religious leaders).

**Search Strategy**

PubMed, PsycINFO, ProQuest, Google Scholar, University of Louisville inline Library database, and Medline were used to identify and collect articles for the review. The following keywords were used in each database: HIV/AIDS, stigma, African Americans, Black, black church, faith-based organizations, religious community, pastor, clergy, preacher, African American church. The researcher created a spread sheet recording the following information for each article: title, year of publication, author(s), journal title, study design, target population, number of participants, sampling methods, independent variables, dependent variables, outcome variables, abstracts, key findings, and keywords.

**Screening Process**

Articles were screened in two phases. In phase one, the researcher reviewed the abstract of each article to ensure eligibility. Articles were excluded if they did not meet the criteria mentioned above. Phase 1 excluded 34 articles. In phase two, articles that passed phase 1 were read in entirety. Duplicate articles were excluded, as were articles focused on developing, implementing, or evaluating HIV programs or interventions and did not capture perceptions about HIV/AIDS and stigma among faith leaders. Papers with a multiracial sample of
churches were excluded if they did not provide any clear indication of African American faith leaders’ perceptions about HIV/AIDS and stigma. Phase 2 eliminated another 64 articles. The remaining 87 articles were reviewed for reliability by another researcher. The second review discarded 27 articles and added two. Of the 211 articles collected, 62 were included in the review. The researcher read these and recorded key findings and major themes.
Results

Several themes emerged regarding African American faith leaders’ perceptions about HIV/AIDS: HIV/AIDS knowledge and awareness, HIV stigma,
doctrinal/theological perspective, geographical location, community collaboration, and funding.

Faith Leaders’ Age

No study exclusively examined young or millennial African American faith leaders. Among the studies that addressed the perspectives and ideologies of African American faith leaders regarding HIV/AIDS, the youngest participant was 32 years old (Quinn et al., 2016). The average age of the participants in the various studies ranged from mid-forties to late fifties (Otey & Miller, 2016; Pichon et al., 2016; Rowland & Isaac-Savage, 2014; Stewart, Hanlon, et al., 2017).

A few studies mention clergy age and HIV/AIDS engagement (Quinn et al., 2016; Stewart, Hanlon, et al., 2017). Quinn and colleagues (2016) found that younger faith leaders were perceived to be more liberal or progressive and open to topics related to HIV/AIDS, such as sex and sexuality and condom use. In contrast, Stewart and colleagues (2017) found that churches with older pastors were 4.4% more likely to have HIV/AIDS programming. Pichon and colleagues (2012) found no correlation between faith leaders’ age and willingness to discuss HIV/AIDS prevention and sexual health within the church.

HIV Knowledge and Awareness

HIV knowledge refers to faith leaders’ understanding of methods of HIV/AIDS prevention and transmission. Lack of knowledge or low HIV knowledge is considered a barrier to HIV/AIDS programming within African American church culture (Adimora et al., 2019; Berkley-Patton, Thompson, et al., 2013; Francis et al., 2009; Otey & Miller, 2016; Payne-Foster et al., 2011; Smith et al., 2005; Stewart et al., 2016). Studies
have found HIV knowledge to be a factor influencing HIV/AIDS discussion and programming within churches (Adimora et al., 2019; Coleman et al., 2012). Faith leaders and congregations with experience in HIV efforts and greater knowledge about the HIV/AIDS epidemic are more inclined to address HIV and stigma than those who are less knowledgeable (Adimora et al., 2019; Bryant-Davis et al., 2016; Moore et al., 2012; Pichon et al., 2012; Stewart & Dancy, 2012). A training consisting of improving HIV knowledge helped faith leaders to become more comfortable addressing HIV and related topics (Pichon et al., 2012).

Sometimes faith leaders do not discuss HIV/AIDS because they are unaware of the HIV/AIDS disparity in their community (Adimora et al., 2019; Nunn et al., 2012; Nunn et al., 2018). Participants in one study report the African American community is also unaware of the HIV/AIDS disparity (Stewart, 2014b). Some faith leaders and churches were unaware of HIV/AIDS resources within their community (Nunn et al., 2012; Stewart et al., 2018). Lack of HIV/AIDS awareness hinders participation in HIV/AIDS prevention and education efforts.

African American faith leaders expressed uncertainty about how to address HIV/AIDS. Those who reported no or low participation in HIV/AIDS programming also expressed being uncomfortable or inexperienced discussing HIV/AIDS topics or starting HIV programming (Adimora et al., 2019; Beadle-Holder, 2011; Brown & Williams, 2006; Smith et al., 2005; Stewart, 2015b). Faith leaders have reported wanting to learn and know more about HIV to help inform their congregation (Berkley-Patton, Thompson, et al., 2013). Faith-based interventions and programs have been designed to increase knowledge and awareness about HIV and help to reduce HIV
stigma (Berkley-Patton, Moore, et al., 2013; Bradley et al., 2018; Derose et al., 2016; Griffith, Campbell, et al., 2010; Griffith, Pichon, et al., 2010; Grigsby, 2018; Lindley et al., 2010; Payne-Foster et al., 2018). Community partnerships, HIV/AIDS workshops with local health departments, and talking with health professionals increased HIV/AIDS knowledge and awareness among African American faith leaders (Abara et al., 2015; Alio et al., 2014; Coleman et al., 2012; Grigsby, 2018; Stewart, 2015a). Faith leaders who have relationships with people living with HIV/AIDS tend to be more knowledgeable about HIV/AIDS and more likely to participate in HIV/AIDS efforts (Lewis, 2015; Payne-Foster et al., 2011). Increased knowledge of HIV among faith leaders help faith leaders to feel comfortable addressing these topics and become better HIV/AIDS resources for their community (Grigsby, 2018).

**HIV/AIDS Stigma**

HIV stigma is defined as the negative attitudes and beliefs about HIV/AIDS, PLWH, and HIV high-risk populations, such as sexual and gender minorities and substance users (Goffman, 1963; CDC, 2021). HIV stigma, specifically stigmas related to sex and sexuality, have been cited as barriers to discussion among African American faith leaders and their churches (Berkley-Patton, Thompson, et al., 2013; Fulton, 2011; Smith et al., 2005; Teti et al., 2011; Williams et al., 2011). African American faith leaders report that there are strong beliefs and social norms about sex and sexuality and discussing sex related topics in church is taboo (Adimora et al., 2019; Harris, 2010; Otey & Miller, 2016; Teti et al., 2011). Some faith leaders expressed non-affirming attitudes toward same-sex relationships and believed sex should occur only within
heterosexual marriage (Harris, 2010; Kouame, 2016; Quinn et al., 2016; Wilson et al., 2011).

Research suggests that the association of HIV/AIDS with sexual and gender minorities has hindered Black churches’ responses to the HIV/AIDS epidemic and racial/ethnic disparity (Harris, 2010; Nunn et al., 2012; Quinn et al., 2016; Reese, 2011). Other studies have suggested African American faith leaders and congregations have often been sources of stigma, homophobia, and heterosexism (Aholou et al., 2016; Harris, 2010; Miller Jr, 2007; Stewart, 2014b; Teti et al., 2011). Even faith leaders with high HIV knowledge scores still scored highly on stigma measures related to homosexuality (Stewart, Hong, et al., 2017). Some African American faith leaders have viewed HIV/AIDS as a punishment for immoral sexual behaviors (Aholou et al., 2016; Wilson et al., 2011). Other faith leaders worry discussing HIV would condone behaviors not in accord with their beliefs (Adimora et al., 2019; Bryant-Davis et al., 2016; Roman Isler et al., 2014; Woods-Jaeger et al., 2015). They also fear being rejected by their congregation and religious community (Adimora et al., 2019; Nunn et al., 2012). Education about HIV/AIDS can help demystify the virus for church leaders and congregations (Stewart, 2015a).

Some studies found that faith leaders with lower stigma scores and higher empathy for PLWH were more willing to adopt HIV programming (Welch & Hughes, 2020). However, stigma levels are not always a barrier or prerequisite for HIV/AIDS involvement among African American faith leaders and their churches (Bluthenthal et al., 2012; Bryant-Davis et al., 2016; Stewart, 2014b). African American faith leaders who held stigmatizing views were still open to addressing HIV/AIDS within their church
(Bluthenthal et al., 2012; Bryant-Davis et al., 2016; Wooster et al., 2011). It’s important to point out there are faith leaders who disagree with the stigmatizing perspective commonly found within the church (Jeffries et al., 2017; Leong, 2006; Lewis, 2015). Faith leaders also acknowledged that stigma prevents participation in HIV/AIDS efforts and undermines the church’s historical role as a refuge (Leong, 2005, 2006; Lewis, 2015).

**Doctrinal Perspective**

African American religious spaces are not monolithic. There are multiple perspectives on HIV/AIDS and its related topics among African American faith leaders. Bluthenthal and colleagues (2012) found that HIV and stigma did not impact faith leaders’ and congregations’ involvement in addressing HIV/AIDS. However, doctrine and theological interpretation can influence people’s perceptions of HIV/AIDS and how it should be addressed (Adimora et al., 2019; Bluthenthal et al., 2012; Davis et al., 2014; Fulton, 2011; Harris, 2010; Quinn et al., 2016).

Understanding faith leaders’ theological stance—their interpretation of scripture—is important. A majority of faith leaders stated they rely or would rely on scripture or spiritual practices to deliver HIV and sexual health messaging (Jeffries et al., 2017; Lumpkins et al., 2013; Payán et al., 2017). They also rely on scripture to inform their views of sexuality and sex. Faith leaders use sermons both to express their biblical interpretations and to discuss HIV/AIDS and other health disparities (Derose et al., 2011; Lumpkins et al., 2013; Stewart & Dancy, 2012). Such sermons can influence their congregation’s perceptions about HIV.

*Conservative theological perspectives*
Within the literature, it is often assumed most African American religious spaces are conservative and align within the traditional Christian views on sex and sexuality (Barnes, 2009; Harris, 2010). Conservative African American faith leaders believe in discussing HIV/AIDS as a health issue and in promoting HIV testing, and they advocate compassion toward those living with HIV/AIDS (Quinn et al., 2016; Stewart et al., 2017). However, they also believe in promoting abstinence and sexual purity (Beadle-Holder, 2011; Quinn et al., 2016), and thus refrain from discussing sex and sexuality outside of the context of heterosexual marriage (Adimora et al., 2019). Some faith leaders see the HIV/AIDS epidemic and disparity as a result of sexual promiscuity and immoral behaviors (Aholou et al., 2011; Barnes, 2009). A small number believe the church is not the space to discuss HIV (Bryant-Davis et al., 2016).

Some studies have found that conservative religious views undermine HIV prevention and stigma-reduction efforts (Wooster et al., 2011) and that such churches were less willing to address HIV. Other articles have found that conservative African American churches are still more likely to engage in social activism and discuss HIV/AIDS disparity than their white counterparts (Pichon et al., 2020; Wooster et al., 2011).

Liberal theological perspectives

Liberal faith leaders are affirming and accepting of sexual and gender minorities (Beadle-Holder, 2011; Leong, 2006; Lewis, 2015; Stewart & Dancy, 2012) and believe the best way to address HIV is to discuss sex and sexuality within the church (Quinn et al., 2016; Wilson et al., 2011). These leaders were more likely to acknowledge that their parishioners were sexually active and to support promoting healthy sexual
practices regardless of marital status, including condom distribution in their church (Adimora et al., 2019; Wilson et al., 2011). Because liberal faith leaders believe the HIV/AIDS disparity has resulted from churches’ perpetuation of stigmas related to sex and sexuality (Lewis, 2015), they have challenged the homophobic and traditional views about sex common in Black religious spaces and encourage their congregations to be prophetic spaces for PLWH (Beadle-Holder, 2011; Leong, 2006; Lewis, 2015; Stewart & Dancy, 2012).

Other African American faith leaders are moderates who promote abstinence while also encouraging safe sex practices, such as condom use (Beadle-Holder, 2011; Nunn et al., 2012; Pichon et al., 2013; Roman Isler et al., 2014; Woods-Jaeger et al., 2015). They acknowledge individuals are not abstinent and engage in premarital sex, but they still want them to be safe. Faith leaders may disagree with the traditional perspective on HIV/AIDS but want to remain faithful to their doctrine (Woods-Jaeger et al., 2015). For example, some feel comfortable talking about safe sex practices with congregants privately but not from the pulpit (Stewart, 2014a).

Denomination does not determine theological perspectives or level of HIV/AIDS engagement (Cunningham et al., 2011). African American churches, regardless of their denomination or theological lens, are more willing to engage in HIV/AIDS programming than their white counterparts (Fulton, 2011). Koch & Beckley (2006) studied an HIV/AIDS ministry at a church affiliated with a conservative denomination. The pastor used biblical principles and the denomination’s values to argue for the need for this ministry. There were no other HIV services in the community. In taking on this role, the church created opportunities for other churches in the
denomination to help address HIV through monetary support without having to engage directly in activities with which they felt less comfortable, such as needle exchanges or condom distribution (Koch & Beckley, 2006; Williams et al., 2011). Although HIV/AIDS involvement cannot be predicted by denomination, theological perspective can help determine the extent of HIV programming.

*Geographical Location*

External factors such as location also influence faith leaders’ perceptions of and involvement in HIV/AIDS efforts. African American churches in the North, specifically New York, were first to respond to the HIV epidemic, partly due to the early diagnosis of HIV in that region (Harris, 2010; Wilson et al., 2011). The Northeastern and Western regions of the U.S. are the most liberal areas of the country and were the first to support same-sex marriage and comprehensive sex education. It stands to reason that religious leaders and organizations in these regions tend would also have more progressive views on HIV, sex, and sexuality. Most of the research examining African American faith communities’ views on HIV/AIDS has been conducted in more progressive cities (Baltimore, Los Angeles, Kansas City, New York City, and Philadelphia) (Pichon et al., 2020). Findings from these studies create a narrative that Black people of faith are adopting a less conservative stance on sex and HIV (Pichon et al., 2020). However, the level of comfort among faith leaders within progressive settings cannot necessarily be extrapolated to faith communities in other regions.

African American faith leaders in the generally conservative U.S. South have to tread more carefully. However, some southern African American faith leaders are eager to address the HIV/AIDS epidemic (Koch & Beckley, 2006; Nunn et al., 2019; Nunn et
al., 2018; Payne-Foster et al., 2011; Pichon et al., 2020). Fulton (2011) found that southern Black congregations are 12 times more likely to have an HIV/AIDS outreach than those in other regions, and nonurban congregations are eight times more likely to sponsor a program than those in urban settings (Fulton, 2011).

Historically, Black churches addressed issues affecting their neighborhood and surrounding community (Cunningham et al., 2011; Davis, 2017); if HIV/AIDS is an issue, faith leaders and their churches often feel compelled to address it (Koch & Beckley, 2006; Mendel et al., 2014; Stewart, 2014b). Usually HIV/AIDS activities conducted within faith settings are targeted toward the congregation and surrounding community (Derose et al., 2011). However, other health and social issues can overshadow HIV/AIDS (Davis, 2017). African American faith leaders in low-income communities may prioritize poverty and mental health.

Community Collaborations and Funding

Community collaborations have been extremely helpful for African American faith leaders trying to deliver messages about HIV (Berkley-Patton, Thompson, et al., 2013; Derose et al., 2016; Nunn et al., 2013; Pichon et al., 2012; Wingood et al., 2011). Working with community partners has helped churches balance the need to address HIV with staying true to their beliefs (Derose et al., 2011; Stewart et al., 2016). In fact, pastors have reported the need for more experts to help them address HIV (Francis et al., 2009; Stewart, 2014a; Stewart et al., 2016) in ways that respect their views and the church’s mission (Alder et al., 2007; Stewart, 2014a). Such collaborations have been found to be effective (Derose et al., 2014).
Financial funding or church income is a limiting factor for HIV/AIDS engagement among African American faith leaders and their churches (Alio et al., 2014; Bryant-Davis et al., 2016; Nunn et al., 2012; Stewart et al., 2016; Teti et al., 2011; Welch & Hughes, 2020). More money is needed for personnel and materials for HIV education and prevention programs (Bryant-Davis et al., 2016; Mendel et al., 2014; Stewart et al., 2016). The potential for community partnerships that can assist in providing both money and expertise ignited interest in such programs among African American congregations (Teti et al., 2011).

Discussion

The purpose of this systematic review was to explore and understand the perspectives on HIV/AIDS among African American faith leaders in the U.S. To our knowledge, this is the first systematic review to do so. The results revealed a number of themes related to African American faith leaders' views on HIV/AIDS: level of knowledge and awareness about HIV/AIDS, stigma surrounding sexual behavior, doctrinal perspective, geographical location, and community collaboration and funding. Unfortunately, no studies specifically assessed the views of young African American faith leaders.

The results of this review show the majority of African Americans faith leaders and their congregations believe it is important for the church to be a part of HIV prevention efforts (Nunn et al., 2018) and even that they have a moral responsibility to address HIV in the Black community (Alder et al., 2007; Moore et al., 2012; Nunn et al., 2012; Nunn et al., 2018; Woods-Jaeger et al., 2015). Homophobia and stigma among African American faith communities are one of the biggest barriers to establishing HIV/AIDS ministries (Berkley-Patton et al., 2013; Smith et al., 2005; Williams et al.,...
The religious community traditionally permits sexual activity only in the context of heterosexual marriage. Because HIV is sexually transmitted and is associated with sexual and gender minorities, it is difficult for some faith leaders to discuss. Some faith leaders limit their discussion of HIV to testing and private conversations about safe sex practices.

Doctrinal perspectives can increase or decrease stigmatizing views (Davis et al., 2014; Fulton, 2011; Harris, 2010; Quinn et al., 2016). Liberal faith leaders are more open to discussing sex, sexuality, and condom use, and are affirming to the LGBTQ community. Conservative faith leaders believe in promoting abstinence outside of marriage. Some faith leaders hold traditional views about sex but acknowledge that is not the reality for their congregation or community. Most African American faith leaders support HIV testing and advocate compassion for PLWH. Regardless of doctrine, African American churches and their faith leaders are more inclined to engage in HIV efforts than their white counterparts.

Collaborations and partnerships between African American churches and community organizations increased engagement. Working with health experts and public health professionals work increases African American congregations’ knowledge and understanding of HIV and helps reduce stigma. Destigmatizing HIV/AIDS encourages faith communities to become more engaged. African American faith leaders report needing assistance to address HIV/AIDS (Francis et al., 2009; Stewart, 2014a; Stewart et al., 2016), but health experts must respect their level of readiness to discuss HIV/AIDS.
This review is consistent with previous literature that suggests African American faith leaders and their congregations are a vital asset in efforts to end the HIV epidemic (Aholou et al., 2016; Husbands et al., 2020; Moore et al., 2012; Wooster et al., 2011). Other studies also suggest tailoring interventions to fit churches’ doctrines and comfort levels (Bradley et al., 2018; Williams et al., 2011). Going forward, researchers must recognize and respect the various perspectives within the African American religious community when addressing HIV with these institutions. As society evolves, so do the social institutions within it. Future studies should continue to assess African American faith communities’ perspectives about HIV/AIDS. Being abreast of shifting perspectives could provide new approaches to discussing HIV/AIDS and promoting prevention methods such as pre-exposure prophylaxis (PrEP) and the new HIV/AIDS injection.

It is also important to point out that millennial faith leaders’ perspectives have not been specifically examined. Understanding the perspectives of younger pastors may help predict the trajectory of HIV prevention within the African American faith-based setting and provide insight into the potential attitudinal shifts regarding HIV. It can also help identify new methods of utilizing the church to address HIV and other health conditions impacting African Americans.

Limitations
There are several limitations to this study. First, the researcher focused on peer-reviewed articles and did not include technical reports or commentaries. There are several religious media outlets that provide information about social issues and the perspectives of religious leaders. These publications could provide more insight and other perspectives
about HIV/AIDS among African American faith leaders. Second, six databases were searched using the given key words. Although this review is thought to be exhaustive, it is possible more publications could have been identified using other databases and other search terms. Third, the review excludes articles published after 1996. Previous perspectives may have been different. Fourth, the review did not capture the perspective of Black faith leaders in Canada, whose religious cultural experiences are similar to those of their U.S. counterparts.

Conclusion
Understanding the perspectives of African American faith leaders is vital to addressing HIV/AIDS disparity. Faith leaders have influence within their church and the surrounding community. African American faith leaders and their congregation might struggle with discussing HIV/AIDS and related topics, but they are willing to address them. Health experts and public health professionals must work with these communities to improve HIV education and help eliminate stigma while remaining mindful of the various perspectives within the African American religious community. Researchers should continue to explore African American faith leaders’ perspectives on HIV, particularly those of the rising generations.

Paper 2 - Exploring the Perspectives of HIV/AIDS and Stigma Among Millennial African American Faith Leaders: A Descriptive Qualitative Study

Introduction
Rates of HIV have declined in the United States (U.S.); however, there are still disparities among African Americans. The Centers for Disease Control and Prevention (CDC) reported that African Americans accounted for 42% of new HIV diagnoses, while
comprising only 13% of the U.S. population (Center for Disease Control and Prevention, 2021c). In 2018, the rate of new HIV diagnoses per 100,000 among African American adults (47.5) was 8 times that of white adults (5.6) (Center for Disease Control and Prevention, 2021c; Kaiser Family Foundation, 2020). Of all adults with HIV, rates are highest among African American men (74.8), and African American women (23.1) have the highest rate among all women (Center for Disease Control and Prevention, 2021c; Kaiser Family Foundation, 2020). Even with the medical advancements of HIV prevention (pre-exposure prophylaxis [PrEP]; achieving undetectable viral loads to prevent transmission), there is still lower uptake of these prevention methods among African Americans (Center for Disease Control and Prevention, 2021c).

HIV/AIDS stigma is the negative attitudes and beliefs about HIV/AIDS and people living with HIV (PLWH) (Center for Disease Control and Prevention, 2021c). HIV stigma derives from the misconceptions about HIV/AIDS transmission and social norms about sex and sexuality (Mahajan et al., 2008). HIV stigma creates barriers to prevention and impacts the health of PLWH and vulnerable groups such as men who have sex with men (MSM) and injection drug users (Earnshaw et al., 2012). HIV stigma is connected to low medication adherence among PLWH and internalized stigma (Katz et al., 2013; Mahajan et al., 2008). The African American religious community has been criticized for perpetuating HIV stigma in the community and for its slow response to the HIV/AIDS epidemic (Fullilove & Fullilove III, 1999; Miller Jr, 2007; Miller, 2007). Despite criticism, researchers consider African American churches to be vital resources for addressing the HIV/AIDS disparity.
Studies show African American churches are great partners for HIV education and stigma reduction efforts. African American faith leaders are also influential in their church and community (Quinn et al., 2016; Stewart, 2015b). There is a great deal of literature examining African American faith leaders’ perspectives about HIV (Adimora et al., 2019; Alio et al., 2014; Grigsby, 2018; Mendel et al., 2014; Nunn et al., 2012; Nunn et al., 2013; Pichon et al., 2020; Pichon et al., 2013; Quinn et al., 2016). However, to our knowledge, there is no study examining young African Americans pastors’ perspectives about HIV and stigma.

The millennial generation (individuals born between 1980 and 2000), is the largest, most educated, and racially diverse generation (Howe & Strauss, 2000). According to Twenge et al., over 50% of millennials believe premarital sex is “not at all wrong,” and comprehensive sex education should be offered (Twenge et al., 2015). This generation is also suggested to be more accepting of sexual and gender minorities. This is important regarding HIV/AIDS because topics related to sex and sexuality have been reported as barriers for HIV discussions within faith-based settings (Adimora et al., 2019; Mendel et al., 2014; Smith et al., 2005; Stewart, 2014b). If a younger generation is expressing different ideological perspectives about HIV and stigma, it could provide new mechanisms for addressing HIV in the African American community. It could also provide insight on how to eliminate barriers faith communities experience when discussing HIV. Therefore, the purpose of this study is to explore African American millennial faith leaders’ perspectives about HIV and stigma in the African American community.

Methods
A descriptive qualitative research approach informed by grounded theory techniques was used to explore African American millennial faith leaders’ perspectives about HIV/AIDS and stigma. According to Caelli et al., 2003 this approach is not guided by an explicit set of philosophic assumptions in the form of one of the established qualitative methodologies (phenomenology, grounded theory, and ethnography) (Caelli et al., 2003; Kahlke, 2014). This approach borrows techniques and procedures at the method-level and draws on the strengths of established methodologies while maintaining flexibility (Hunt, 2009; Kahlke, 2014; Thorne et al., 2004). Like other qualitative approaches, descriptive qualitative research also seeks to understand how people interpret, construct, or make meaning from their world and their experiences (Kahlke, 2014; Merriam & Grenier, 2019). This approach is appropriate for this study because the researcher utilizes grounded theory techniques to explore and understand the perspectives about HIV/AIDS and stigma among African American millennial faith leaders. However, the researcher does not derive substantive theory (Cousins, 2012; Kahlke, 2014).

Study participants

Participants were eligible for the study if they 1) identified as African American or Black; 2) served as a faith leader, defined as an authority figure of a religious institution, at a predominantly African American church; and 3) were a millennial (between the ages of 18 and 40 years old).

Recruitment and Sampling

Participants were recruited through a purposive sampling. A contact list of African American millennial faith leaders was generated from three African American faith leaders prior to the study. Participants were contacted via email and phone call.
Snowball sampling was also conducted. The first three participants submitted contact information of other millennial faith leaders. Five participants were recruited through the social media platform Instagram. The hashtag #millennialpastor was used to identify participants. After identification, a recruitment script containing the study purpose, background, and eligibility requirements was sent. Once a participant expressed interest of participation, they were screened, and an interview was scheduled if the participant was eligible.

**Procedures**

A semi-structured interview guide containing closed- and open-ended questions was used to collect data. Closed ended questions allowed discussion and conversation with participants. The interview guide was developed using the theoretical sensitizing concepts of social identity theory, symbolic interactionism, and intersectionality theory. Participants were asked about their role as a faith leader, their perceptions about HIV/AIDS and stigma, the universal church’s response to the HIV epidemic, their perceived reasons for the HIV/AIDS disparity, their experiences with addressing HIV/AID programming, and reasons for why or why not addressing HIV/AIDS within their church. (Please see Appendix II for interview guide).

Interviews were audio recorded and conducted via video conference call. Interview length ranged from 30 minutes to 1 hour. The researcher took notes and wrote first impression memos for each interview. Writing notes allowed the researcher to record new thoughts and information that emerged in the interviews. Memos served as an opportunity for the researcher to reflect on the interview and to compare and contrast participants interviews and responses (Charmaz, 2014).
Interviews were concluded when the researcher achieved saturation, that is, when no new information is emerging from the data (Glaser & Strauss, 2017; Morse, 2015; Saunders et al., 2018). Saturation was assessed by comparing interview responses, notes, and memos. Interviews concluded when responses became consistent and no new themes emerged from data.

**Data Analysis**

Each interview was recorded, and three interviews were transcribed by the researchers. The other interviews were transcribed using an automatic transcription service. A line-by-line coding technique was used to identify initial codes, also called gerunds, of the data, which were created to help move forward analytically and identify actions and processes within the data (Charmaz, 2014).

The second round of coding used initial codes to develop focused codes by searching for frequency and significance. Focused codes were then tested among a large batch of data and the codes demonstrating analytic strength were developed into categories. Transcripts were compared to identify consistent themes and a codebook containing definitions for each focus code was developed.

Interview transcripts were uploaded in Dedoose (a qualitative and mixed methods data management software), the first ten transcripts were coded using the focus codes, and intercoder reliability using Cohen’s kappa measure was conducted. The kappa test generated a substantial score of 0.83, and the other 11 interviews were coded.

**Trustworthiness**

Additional steps were taken to ensure the credibility, transferability and dependability, of research findings (Lincoln & Guba, 1985). To meet credibility
standards, the researcher engaged in member checking with several participants in the study. The researcher explained their interpretation of interview responses and findings, and participants were able to share if they agreed or disagreed with research findings. The participants and researcher also engaged in discussions about the diversity of perspectives among faith leaders within the African American religious community.

A detailed description of the research findings and methods were reported to establish transferability. This is so other researchers can apply the findings and methods of this study to other situations and populations. Another criterion for trustworthiness is dependability. This criterion ensures reliability of the research (Maher et al., 2018). An audit trail including research methods and study decisions was developed to meet the dependability criteria.

Results

A total of 26 interviews were conducted. The majority of participants were male (16/22), between the ages of 31 and 40 years old, and affiliated with the Baptist denomination (Table 1). One participant identified as African American and Latinx. Participants lived in the Southeastern, Midwestern, and Northeastern regions of the U.S. Demographic information regarding sexual identity was not collected, but two participants self-identified as queer in their interview.
Table 1. Demographic characteristics of African American millennial faith leaders.

<table>
<thead>
<tr>
<th>Demographic Indicator</th>
<th>Number</th>
<th>Percentage</th>
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<tbody>
<tr>
<td><strong>Age</strong></td>
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</tr>
<tr>
<td>18-30</td>
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</tr>
<tr>
<td>31-40</td>
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<td>86%</td>
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<td><strong>Gender Identity</strong></td>
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<tr>
<td>Female</td>
<td>7</td>
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<tr>
<td>Males</td>
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<td><strong>Race/Ethnicity</strong></td>
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<tr>
<td>Black/African American</td>
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<td>95%</td>
</tr>
<tr>
<td>African American and Latinx</td>
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<td>4.5%</td>
</tr>
<tr>
<td><strong>Education Level</strong></td>
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<tr>
<td>College Graduate</td>
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<td>4.5%</td>
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<tr>
<td>Graduate Degree or Advanced (Master’s degree or advanced)</td>
<td>21</td>
<td>95%</td>
</tr>
<tr>
<td><strong>Denomination</strong></td>
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<tr>
<td>Baptist</td>
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<td>4.5%</td>
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<tr>
<td>African Methodist Episcopal (A.M.E.)</td>
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<td>4.5%</td>
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<tr>
<td>Lutheran</td>
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<tr>
<td>Non-denominational</td>
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<tr>
<td><strong>Are you ordained</strong></td>
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<td></td>
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<tr>
<td>Yes</td>
<td>19</td>
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</tr>
<tr>
<td>No</td>
<td>3</td>
<td>14%</td>
</tr>
<tr>
<td><strong>Years served at current church</strong></td>
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<td></td>
</tr>
<tr>
<td>Less than 1 year</td>
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<td>4.5%</td>
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<tr>
<td>1-5</td>
<td>16</td>
<td>73%</td>
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<tr>
<td>6-9</td>
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<tr>
<td>10+ years</td>
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<td>9%</td>
</tr>
<tr>
<td>Currently not serving</td>
<td>2</td>
<td>9%</td>
</tr>
<tr>
<td><strong>Membership size</strong></td>
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<tr>
<td>Less than 100 people</td>
<td>5</td>
<td>23%</td>
</tr>
<tr>
<td>101-500 people</td>
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<td>36%</td>
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<tr>
<td>500-1000 people</td>
<td>4</td>
<td>18%</td>
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<td>More than 1000 people</td>
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<td>14%</td>
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<tr>
<td>Not serving</td>
<td>1</td>
<td>4.5%</td>
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<tr>
<td><strong>Average Sunday service attendance</strong></td>
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<td>Less than 100</td>
<td>4</td>
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<td>101-500 people</td>
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<td>500-1000 people</td>
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<td>More than 1000 people</td>
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<td>Not serving</td>
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Participants served congregations of varies sizes. Most participants (36%) had a membership size of 101-500. The majority of participants (73%) have served at their current church for less than 5 years. Two participants have been pastor of their church for 10+ years. Majority of participants were licensed or ordained in the ministry.

Sixteen participants were senior pastor of their church, and six participants were assistant or associate ministers. The majority of participants were ordained or licensed to preach by their respected denominations. Three participants were not ordained but were still recognized as a religious leader in his church. Most participants were faith leaders at a predominantly African American church. Four participants were pastors of a multiracial congregation. At the time of the interview, one participant had just taken leadership at a predominantly White congregation. The participant was eligible because most of their experience was among African American congregations.

A total of 9 participants stated they had experience in conducting HIV/AIDS programs or initiatives in their church. Three participants also worked in HIV/AIDS prevention and research. Qualitative results revealed four major themes (stigma, lack of HIV/AIDS knowledge and misinformation, silence about sex, and injustices and medical mistrust) that African American millennial faith leaders identified as reasons for disproportionate rates of HIV/AIDS among the African American community.

*Homophobia and stigma*

Participants expressed various perceptions about HIV/AIDS and stigma. The majority admit homophobia and stigma exist and are the greatest barriers to HIV/AIDS
engagement. Participant “Hellen,” one of the youngest pastors and one of the few female pastors in the African Methodist Church stated, “The greatest stigma surrounding HIV/AIDS in the church is homosexuality, which I think also causes the church to be more quiet than they might otherwise be.” “Warren,” the youngest pastor in his small town in rural Ohio, said, “I think there's obviously still a stigma to sexuality in general, in the black community.” Another participant, “Andre,” one of the few African American and millennial pastors in the Presbyterian church stated, “The social stigmas attached to the disease have allowed it to run rampant in our communities at higher levels, than it may have if it had a more holistic well-rounded, nonjudgmental response particularly early on.”

Participants reported that, historically, the religious community does not condone sex outside the context of heterosexual marriage. Because HIV/AIDS is associated with sexual and gender minorities, and is mostly transmitted sexually, faith communities struggle to address or discuss HIV. Participant “Howard,” a faith leader living in Virginia, explained, “We the black church have never done well with conversations around human sexuality across the board. And I think, you know, it being an STD, there wasn't space to have conversations around, STDs.”

This also impacts how HIV/AIDS is perceived within the community and religious spaces. “Louis,” another participant who identifies as queer and lives in Massachusetts stated “…it continues to make it a difficult problem to talk about…, it for us, it's still labeled as the gay disease.” Perceiving HIV/AIDS as a “gay man’s disease” not only impacts perceptions about HIV/AIDS, but it has also caused members of the faith community to perceive HIV/AIDS as a punishment for sexual immorality.
According to participants, this also impacts the faith community’s ability to address HIV and provide support PLWH. According to participant “Davis”:

And so, because we viewed it [HIV/AIDS] from such a heavy sin lens and perspective, it becomes difficult to then see the human value in someone who may have contracted the virus and then the need for us to throw our arms around them, love on them, and then figure out how we provide support in terms of access to care and resources.

Within this study, some millennial African American faith leaders rejected traditional views (sex exclusively in the context of heterosexual marriage). They reported early rhetoric and language about HIV/AIDS and sexuality from the church were detrimental to the black community. Specifically, participants discussed how HIV/AIDS being promoted as punishment for sin demonized African American sexual and gender minorities and African Americans living with HIV. Some of the participants in this study believe the religious community is responsible for perpetuating some of the stigma. According to “Andre”:

I think that we are responsible for internalized stigmatization as well. I think that there are brothers and sisters and non-binary folk who show up to our churches and diet on our messaging to the point that they, also carry those negative stigmas around, around self and others who are positive.

Even faith leaders who possess a traditional perspective and are non-affirming sexual and gender minorities perceived that previous approaches and rhetoric about HIV,
PLWH, and priority groups were not helpful or beneficial to addressing the HIV/AIDS epidemic. “Warren” states:

> When I was coming up in the 90's as a kid, preacher's kid, my own father, great guy, but he's a product of his time, right? They couldn't talk about it [HIV/AIDS] without talking about those gays or spreading it. And dah, dah, dah, dah, dah. That was the language of the day. Uh, so I think our new generation, we know how to talk about these things as a neutral health issue. It was, very dogmatic on some level, as opposed to now. I think all that remains true, but I think there is also a little bit more of a sensitivity and an awareness to the nuances of people’s lives and how certain people find themselves in certain situation.

Although millennial faith leaders identified stigma and homophobia as barriers to HIV/AIDS engagement, the majority were still open to discussing HIV/AIDS within the church. Some of the participants report the African American church culture should reexamine their perspectives about sexuality and become more accepting of sexual and gender minorities. Traditional faith leaders suggest avoiding the topic of sexuality and address HIV/AIDS as a general health issue, like diabetes or heart disease.

*Lack of HIV knowledge and misinformation*

Lack of knowledge was another factor participants identified for high HIV/AIDS rates within the African American community. When asked, “What do you think has caused high rates of HIV/AIDS in the African American community,” participant “Franko,” a self-proclaimed progressive preacher, stated, “There's an illiteracy around HIV and AIDS that exists that bead into the stigma.” Another participant, “Abby,” a
preacher from New York said, “When I think about how individuals can contract HIV, it’s typically this lack of knowledge.”

Participants say not only lack of knowledge, but misinformation about HIV impact perceptions of HIV/AIDS in the African American community. As participant “Gus,” a pastor in the Christian Methodist denomination, stated, “I think that there’s a lot of miscommunication around exactly what AIDS is and what it looks like.” “Howard” stated:

So many things I think have contributed to the high rates of HIV and AIDS, in the African American community. I think misinformation is at the top of the list, and sort of our perceptions over time, how it was transmitted.

According to participants, the lack of HIV/AIDS knowledge combined with stigmatizing views of sex and sexuality not only creates misinformation but perpetuates homophobia and stigma. According to “Lucas,” a millennial faith leader in Chicago:

Black churches homophobia… which I think is at the center of like, why there is so much misinformation and why there is so many cases that go undiagnosed. …and there is still a stigma because there's still this problem that we have this animosity against queer folks that I think that is important too.

Although every participant was familiar with HIV/AIDS, some participants admitted to having limited knowledge about HIV/AIDS themselves. For example, “Stewart,” a self-reported traditional pastor, stated in their interview, “I want to start off by saying I am not an expert in this category [HIV/AIDS].” “Trevor”, a pastor from Minneapolis, acknowledged their limited perspectives about HIV when explaining reasons for higher rates, stating, “So from the narrow scope of research that I do know,
um, I think education.” Other participants expressed similar sentiments acknowledging they were inexperienced and not well informed about HIV/AIDS.

Although many faith leaders said they were comfortable discussing HIV/AIDS, they admit their lack of knowledge, prevented them from conducting HIV/AIDS programming in their church. When asked, have you ever conducted HIV/AIDS efforts in your church,” participant “Smith” said, “No,” and stated, “I don't think I felt like I had the, the tools that were giving me the responsible kind of rhetoric that I would need to offer.” Some participants noted that it would be irresponsible for them to discuss topics like HIV/AIDS because they weren’t knowledgeable. This sentiment was expressed by “Hellen” who said:

You know, I'm of the conviction that I don't preach about anything that I cannot readily answer a question. Right. And so there are topics that I try not to touch that may even be biblical, right?...I don't touch them in a sermonic moment because you can't raise your hand and get clarification. And I believe that topics like this [HIV/AIDS], like PrEP, like condom use… and I think all of this even goes to, you know, sexuality period, right. That entire umbrella, those topics I believe are best suited for small group or workshop setting, where there is an opportunity for not just explanation.

The majority of participants suggested the need for more educational opportunities for themselves and their congregation. Some suggest working with health professionals and local AIDS service organizations to discuss HIV/AIDS. For millennial
faith leaders, these efforts would be beneficial in educating the community, reducing stigma, and eliminating misinformation.

Silence within the church

Participants noted that there are strong views about HIV/AIDS and sex, but the church rarely discusses sex or sexuality. According to participants, conversations related to sex within the church are “taboo.” Participants suggest this is detrimental to the well-being of the African American community because it prevents opportunities to discuss and educate individuals about HIV. As “Hellen” explained, “I think that does contribute [silence], because when there is a lack of discussion, there's a lack of opportunity for knowledge to be shared around the topic.”

Andrew” a self-reported traditional pastor from the south, stated, “I think that because we're not able to talk about sex and sexuality, we're not able to talk about sexually transmitted diseases, infection, viruses. We're not able to talk about those things,” and “Taylor,” a clergyman who works for a public health organization, said, “Sometimes people don't have the understanding or the, uh, knowledge about PrEP and other, uh, resources that exist because nobody would talk to them.

When sex and sexuality is discussed within church, it is usually in the context of abstinence and heterosexual marriage. Some participants believe that abstinence is not effective for addressing HIV and other sexually transmitted diseases (STDs). According to participants, abstinence does not address the reality of sexual behaviors among congregants and the community. “Macon,” a pastor who considered themselves progressive, stated;
We have pushed this abstinence purity culture, that I think has been detrimental to having comprehensive sexual health conversations with people that equip them with tools, information, knowledge, and resources, so that they can make the best decisions for themselves and their bodies.

Participants discussed that silence about HIV/AIDS, sex, and sexuality in the church and the promotion of abstinence created stigma within the church. According to participants, community members don’t feel comfortable disclosing their behaviors or HIV status because the church has not provided a safe space for those conversations. Some faith leaders suggest the stigma within the church has caused internalized stigma and social isolation. As “Andre” stated:

And as a result of that, people have been left to really fend for themselves as it relates to this information and for a large swath of people, they are making, um, unhealthy decisions, decisions that are not safe as a result of that. I think because of the church’s standpoint to LGBTQ issues, we have also pushed so many brothers and sisters in the closet.

“Franko” shared:

Sometimes it [silence] causes us to be self-avoided that there is a level of denial that I think some people can live in because of just how painful it is to be honest. About how one arrived at a particular health status and how one arrived at a particular, lifestyle around sex. Particularly the down low culture as it has traditionally been, called, I think the church has, has directly contributed to that.
Even faith leaders who align with the traditional views of the church believe there should be more recognition of HIV/AIDS and conversations about safe sex practices. “Trevor” stated:

I am also very comfortable in having a conversation with our congregation about practicing safe sex. Ideally as a faith leader my job is to encourage people to live as Jesus has called us to live. I personally believe that the Bible supports withholding or abstaining from sex other than in the context of marriage with your spouse. So, I want to encourage and teach and challenge our people to do that, but I also understand the reality that doesn't always happen.

Many of the participants recognize the silence about HIV is hindering the opportunity to be effective in addressing HIV and stigma. Although some of them state they need additional training, the majority of participants state they are comfortable discussing sex and related topics. This signifies a potential shift within the African American church culture. Being more open to discuss topics related to sex and HIV/AIDS creates more opportunity to expand HIV/AIDS initiatives and interventions.

**Systemic Racism and Medical mistrust**

Although the millennial faith leaders recognize that the church is partially responsible for HIV stigma and homophobia, they also acknowledge barriers within society that impact the HIV/AIDS disparity. Participants provided criticism of the general American health care system and identify social determinants, such as poverty as causes for disproportionate rates of HIV. As “Luis” stated:
I think another thing that has promoted it [HIV/AIDS] is the issue that the African American community at large has with the health industry. I don't even want to call it health care right now, 'cause I don't know who in the hell they caring for. I think it's a healthcare industry because it is definitely guided, promoted, and controlled by economics.

Participants discussed how medical mistrust among African Americans is impacting uptake in HIV prevention methods. “Grant,” another faith leader who works for a national organization focused on HIV prevention, stated:

It is an uphill battle because mistrust. Distrust is so real. I mean, I went to Tuskegee, I would never deny that mistrust around like medical systems, providers, pharmaceutical industry partners. I mean, look at PrEP. PrEP utilization among black people is so abysmal, its low.

Participants also discussed how economic disparities and poverty have impacted the HIV/AIDS disparities within African American communities. According to some of the participants, poverty has prohibited access to accurate information about HIV/AIDS and prevention resources. “Taylor,” who also works in the HIV/AIDS research field, said, “…HIV and AIDS was founded as a disease of poverty, and majority of the people in poverty in this country are people of color, particularly Black people. So that's obviously one factor.” “Taylor” goes on to discuss the impacts of racism and discrimination within American society, “The other factor is racism and discrimination. Discrimination, stigma, racism against people of color in this country, and that includes, individual racism, but also systemic racism, has contributed to the disproportionate rates of HIV in communities of color.”
These sentiments were echoed by “Brittany,” a pastor of an inner-city church in Washington D.C.:

And that’s probably why the HIV rates are higher just in poverty. You don’t have access, or if you do have access, you are so busy trying to survive. For the very poor you’re so busy trying to survive your food stamps, get cut off. I just dealt with a family whose food stamps got cut off because of this happened. Our food ministry is always busy.

The participants who work in the HIV/AIDS research field also acknowledged how government funding is not easily accessible to African American communities or organizations who work to address HIV/AIDS in Black communities. “Grant” states:

A greater neglect from the federal government and state governments, to truly invest and also to really do something meaningful about this problem [HIV/AIDS]. I mean, there's millions and even billions of dollars that are addressing HIV, but much like everything else in this country, the money is held up within a small group of white people.

“Grants” goes on to say, “Money is a part of it, policy is a part of it, but what good is that policy or those resources, if you're not directing them into places that Black and Brown people say they need to be directed.”

Faith leaders recognize that the church can be a vital resource for educating and reducing stigma within the community. However, they also recognize that the church is not solely responsible for addressing HIV. According to participants, barriers within our society must be addressed to eliminate the HIV/AIDS disparity among African Americans. If researchers and local organizations can identify African American
religious spaces as entry points for HIV/AIDS knowledge and stigma reduction efforts, they should not be overlooked for opportunities such as funding.

Discussion

The purpose of this study was to explore African American millennial faith leaders’ perspectives about HIV and stigma. To our knowledge, no other study has examined the perspectives of HIV/AIDS among this group. Participants report why they believe the HIV disparity among African Americans exists. The following themes were identified as factors for the HIV/AIDS disparity: homophobia and stigma, lack of knowledge, silence about sex and sexuality, medical mistrust, and societal barriers. Previous research has also identified these factors as barriers to HIV/AIDS prevention within faith-based settings (Adimora et al., 2019; Beadle-Holder, 2011; Eke et al., 2010; Pichon et al., 2020).

Homophobia and stigma were reported as the biggest barriers to addressing HIV. Participants recognize the religious community perpetuated HIV stigma, which marginalized sexual and gender minorities. According to participants, stigma within the church exists because of the traditional views about sex and sexuality. Other studies have also identified homophobia and stigma as barriers to addressing HIV within African American faith-based settings (Nunn et al., 2012; Quinn et al., 2016; Reese, 2011; Smith et al., 2005). Some participants believe the church should be accepting of sexual and gender minorities.

Misinformation and lack of HIV education were cited as additional factors for the HIV disparity and stigma. Participants suggest HIV education is needed to improve
perceptions about HIV. They also admit to having limited HIV knowledge themselves. Previous research has found HIV knowledge to be a factor for influencing HIV/AIDS discussion and programming within churches (Adimora et al., 2019; Coleman et al., 2012). Studies have also found that African American faith leaders and congregations with greater knowledge about the HIV/AIDS epidemic are more comfortable and inclined to address HIV and stigma, compared with those less knowledgeable (Adimora et al., 2019; Bryant-Davis et al., 2016; Moore et al., 2012; Pichon et al., 2012; Stewart & Dancy, 2012). Participants also acknowledge that the church rarely discusses sex and sexuality. Silence about sex and sexuality was reported as a factor in HIV/AIDS outcomes among participants. According to participants, HIV silence is related to social stigmas about sex within the church. Participants admit the silence has caused misinformation and miscommunication about HIV/AIDS, and participants suggest it has prevented participants from seeking prevention resources.

Participants in this study also discussed how the HIV disparity is not a result of stigma within the religious community, but societal neglect of the African American community. Participants state improper allocations of funds for HIV prevention resources from governmental entities have impacted HIV/AIDS disparity. Structural racism has been identified as the root of health disparities impacting the African American community (Jaiswal & Halkitis, 2019; Levy et al., 2014; Yearby, 2020). According to Levy et al., structural barriers impact access HIV prevention resources such as HIV/AIDS testing among the most vulnerable group within the African American community, MSM (Levy et al., 2014).

Limitations

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There are several limitations to this study. First, HIV and related topics are sensitive to discuss in church. Some participants also reported being unfamiliar and uninformed about HIV. To minimize discomfort, the researcher decided to conduct individual interviews to give participants the ability to speak freely about their perspectives. Third, this sample of participants may have come from the same social network because they were recommended by one of their colleagues in the sample. This study also had limited representation of queer-identifying participants. Potential understanding of how sexual and gender minorities navigate the religious spaces may also be vital to addressing HIV and informing faith-based approaches to HIV for this community.

Conclusion

This study is unique because it examines the perspective of a group rising to leadership within an influential institution of the African American community. It also provides insight into potential ideological shifts within the African American religious community and its approach to HIV/AIDS. Examining the perspectives of African American millennial faith leaders contributes to current literature related to addressing HIV/AIDS within the faith-based setting. Future studies should continue to explore millennial faith leaders’ perspectives as it relates to HIV and stigma. Researchers should seek to understand how millennial faith leaders would address HIV and stigma and the factors that influence their perspectives.

Participants in this study expressed similar and contrasting views about HIV/AIDS. Researchers and health experts should keep this in mind when tailoring HIV/AIDS programs and initiatives. African American faith leaders are open to
addressing HIV/AIDS regardless of their stance on sex and sexuality and level of stigma and HIV knowledge; however, HIV/AIDS initiatives should fit the readiness and level of comfort for the congregation and faith leader.

Paper 3- Understanding Millennial African American Faith Leaders’ Approaches to Addressing HIV/AIDS and Stigma Within the Church: A Descriptive qualitative Study

Introduction

Although African Americans represent an estimated 13% of the U.S. population, they accounted for approximately 42% of HIV infection cases in 2019 (Center for Disease Control and Prevention, 2021c). According to the U.S. Minority Health Report, in 2019, African Americans were eight times more likely to be diagnosed with HIV infection compared to white Americans (U.S. Department of Health and Human Services Office of Minority Health, 2019). African American men are six times as likely to die from HIV infection compared to white men, and African American women are fifteen times as likely to die from HIV infection as white women (U.S. Department of Health and Human Services Office of Minority Health, 2019). Uptake of medical innovations such as pre-exposure prophylaxis (PrEP) and anti-retroviral therapy is lower among African Americans (Center for Disease Control and Prevention, 2021c). Research suggests that HIV stigma plays a vital role in the HIV disparity (Earnshaw et al., 2015; Earnshaw et al., 2013).

HIV stigma is the negative attitudes and beliefs about HIV and people living with HIV (PLWH) (Center for Disease Control and Prevention, 2021c). It derives from the misconceptions about HIV transmission (Earnshaw et al., 2013; Turan et al., 2016). HIV stigma has been linked to low medication adherence among PLWH and it undermines
access to prevention resources among vulnerable groups (Katz et al., 2013; Sweeney & Vanable, 2016; Van der Elst et al., 2013). The African American church has been criticized for perpetuating HIV stigma in the community (Fullilove & Fullilove III, 1999; Harris, 2010). Due to HIV transmission routes, including sex, conversations around HIV prevention have been challenging in African American churches (Harris, 2010; Pryor et al., 2015).

Although faith communities struggle with discussing HIV, researchers find African American congregations to be great partners for addressing health outcomes impacting the African American community, including HIV (DeHaven et al., 2004; Eng et al., 1985; Quinn et al., 2016). Historically, the African American church has served as a place of healing and refuge for African Americans in the U.S. (Lincoln & Mamiya, 1990). African American churches are trusted spaces for receiving education about health and behavior change (Adimora et al., 2019; Campbell et al., 2007; Taylor et al., 2000). African American pastors/faith leaders have also been instrumental in the community (Collins, 2015). Studies have found pastoral engagement in HIV efforts impact the outcome of the HIV efforts within faith-based settings (Rowland & Isaac-Savage, 2014; Williams et al., 2012). Several studies have examined the perspectives of African American faith leaders (Alio et al., 2014; Nunn et al., 2012; Nunn et al., 2013; Pichon et al., 2020; Quinn et al., 2016). However, to our knowledge there is no research focused on the perceptions of millennial faith leaders. Understanding millennial faith leaders’ perspective could provide insight into new or different perspectives about HIV within the church. This could lead to new mechanism of addressing HIV within faith-based settings.
The millennial generation (individuals born between the years of 1980-1996) is the largest, most educated, and racially diverse generation in American history (Howe & Strauss, 2000). According to Twenge et al., 2015, over 50% of millennials believe premarital sex is “not at all wrong,” and comprehensive sex education should be offered (Twenge et al., 2015). This generation is also suggested to be more accepting of sexual and gender minorities. This is important regarding HIV because topics related to sex and sexuality have been reported as barriers for HIV discussions within faith-based settings (Adimora et al., 2019; Mendel et al., 2014; Smith et al., 2005; Stewart, 2014b).

If a younger generation is expressing different perspectives about HIV, it could provide new mechanisms for addressing HIV and stigma in the African American community. Understanding their perspectives is important because they are the next generation of leaders within the African American religious community. The purpose of the study was to qualitatively explore the perspectives of African American millennial faith leaders regarding HIV and stigma.

Theory

Theories that informed the research design and analysis for this study are Symbolic Interactionism (SI), Intersectionality, and Social Identity Theory (SIT). SI theory assumes people construct selves, society, and reality through interaction (Blumer, 1969; Charmaz, 2014; Hughes & Sharrock, 2007). SI focuses on dynamic relationships between meaning and actions and addresses the active processes through which people create and mediate meanings (Blumer, 1969; Charmaz, 2014). Intersectionality is a theoretical framework for understanding how multiple social identities, such as race, gender, sexual orientation, socioeconomic status (SES), and disability, intersect at the
micro level of individual experience to reflect interlocking systems of privilege and oppression (i.e., racism, sexism, heterosexism, classism) at the macro social-structural level (Bowleg, 2012; Collins, 2002; Crenshaw, 1991; Davis, 2008). SIT is used to understand how people define themselves and others based on social categories and group membership (i.e., male vs. female; student vs no student; gay vs. straight; upper class vs lower class (Tajfel, 1981; Tajfel & Turner, 1979).

By engaging in interviews with participants, the researcher was able to gain an understanding of the social influences and interactions shaping African American millennial faith leader’s perceptions about HIV and stigma. Analyzing faith leaders’ perspectives using an intersectionality lens can help explain how their social identities, such as race, social positions, gender, religious affiliations, and age, shape their perspective and ideology around HIV and stigma.

Within SIT is the concept of in-groups and out-groups. When a person perceives themselves as part of a group, that is an in-group. Other comparable groups that person does not identify with are called out-groups. According to Tajfel, in-groups discriminate against out-groups to boost their self-esteem or group beliefs and to prove their in-group is more favorable. Individuals can belong to multiple categories (Tajfel, 1981). A person’s behavior and perspectives can be shaped and defined by the social norms and beliefs of their categories (Abrams & Hogg, 2010; Tajfel, 1981; Tajfel & Turner, 1979). This theory was applied by asking participants questions related to their role as a faith leader and how they view themselves within and outside of the context of the church. They were also asked about their experiences within the church and with HIV and how these experiences influence who they are.
Methods

A descriptive qualitative research approach informed by grounded theory techniques was used to conduct this study. According to Kahlke, 2014, this kind of approach does not claim full allegiance to any one established methodology (i.e., phenomenology, ethnography, grounded theory) or follow the guidelines or intent of established methodology (Kahlke, 2014). Instead, researchers borrow techniques and practices of one of two qualitative approaches, (Hunt, 2009; Kahlke, 2014; Thorne et al., 2004). For this study, the researcher used grounded theory techniques (i.e., line-by-line coding and constant comparison) for analysis, but the researcher did not develop or construct theory as intended in the grounded theory approach.

Study participants

Participants were eligible for the study if they 1) identified as African American or Black; 2) served as a faith leader at a predominantly African American church; and 3) was classified as a millennial (born between 1980-1996). Faith leaders are defined as the authority figures of religious institutions. They provide religious guidance and are responsible for deciding the churches ministries and programs. Some faith leaders are assistant faith leaders or ministers and provide support to senior level faith leaders.

Recruitment and Sampling

Participants were recruited through a purposive sampling approach. This sampling technique involves identifying and selecting individuals or groups of individuals that are knowledgeable or experienced with a phenomenon of interest (Creswell & Plano Clark, 2011). A contact list of African American millennial faith leaders was generated from three African American faith leaders prior to the study. The researchers contacted
participants via email, phone call, and text message. Five participants were generated from the list. Snowball sampling was also conducted and generated nine participants. The first three participants submitted contact information of other millennial faith leaders. Five participants were recruited through social media platform Instagram. The researcher used the hashtag #millennialpastor to identify participants. Three participants were recruited through a colleague close to the study.

Data Collection

A semi-structured interview guide containing closed- and open-ended questions was used to collect data. The interview guide was developed using the theoretical sensitizing concepts of SIT, SI, and intersectionality theory. Participants were asked about their role as a faith leader, their perceptions about HIV and stigma, the church’s response to the HIV epidemic, their perceived reasons for racial/ethnic HIV disparities, their experiences with addressing HIV programming, and reasons for why or why not addressing HIV within their church. Participants were also asked to share what local organizations could to help faith leaders facilitate HIV conversations in their church (see appendix for interview guide). A second round of interviews were conducted with four participants for member checking.

Interviews were audio recorded and conducted via video conference call. The length on the interviews ranged from 30 minutes to one hour. The researcher took notes during the interview to capture new thoughts and ideas as they emerged during conversation. First impression memos were written after interviews to capture the researcher’s initial thoughts and understanding of participants and their responses. Writing memos allowed the researcher to reflect and engage in comparison evaluations of
participant interviews (Charmaz, 2014). The researcher used pseudonyms when reporting interview data.

Interviews were conducted until the researcher reached saturation. Saturation was assessed by comparing interview responses, notes, and memos. As new information and ideas emerged from the data, the researcher continued to conduct interviews. Interviews were concluded when interview responses became consistent and there were no new themes emerging from the data. For example, saturation for perceptions about sex and sexuality in the church within the church was reached after interview #5; however, the researcher continued to explore the perceptions about sex and sexuality within the church until interview #14, when no new information about this topic emerged. This study was approved by the IRB at the University of Louisville.

Data Analysis

An automatic transcription service was used to transcribe interview data. The researcher transcribed three interviews and cross-checked remaining transcripts from the automatic transcription services for accuracy. The researcher read and re-read the first 10 transcripts to gain familiarity with the data. The researcher used a line-by-line coding technique to identify initial codes of the data. Initial coding is defined as the early process of engaging with and defining the data (Charmaz, 2014). Initial codes, also called gerunds, were created to help the researcher move forwards analytically and identify actions and processes within the data (Charmaz, 2014).

The second round of coding involved using initial codes to develop focused codes by searching for frequency and significance. Transcripts were compared to identify consistent themes. The researcher developed a codebook which contained definitions for
each focus code. Interview transcripts were uploaded in Dedoose, a qualitative data management software. The first ten transcripts were coded using the focused codes. The researcher assessed intercoder reliability using Cohen’s kappa measure. This required another qualitative researcher to code the first half of transcripts. The coded data excerpts were compared to coded data excerpts by the primary researcher. The kappa test generated a substantial score of 0.83 which is considered to be “excellent agreement.” Following this, the other 11 interviews were coded.

Trustworthiness

Additional steps were taken to ensure the credibility, transferability, and dependability of research findings (Lincoln & Guba, 1985). The researcher engaged in member checking with several study participants to meet credibility standards. The researcher explained their interpretation of interview responses and findings. The researcher and participants engaged in in-depth discourse about the various perspectives of addressing HIV and stigma among millennial African American faith leaders.

Transferability relates to the ability of the findings to be transferred to other contexts or settings (Lincoln & Guba, 1985; Maher et al., 2018). The researcher provides a detailed description of the study so other researchers can apply the study methods and results to other research studies. An audit trail was created to meet the dependability standard of trustworthiness. Dependability ensures the study methods can be replicated by other researchers (Lincoln & Guba, 1985; Maher et al., 2018).

Results

A total of 26 interviews were conducted, which includes four-member checking interviews, with 22 participants. The majority of participants were male (n = 16) and
between the ages of 31 and 40 years old. The most represented denomination was Baptist (Protestant) (45%) (Table 1). Participants lived in the Southeastern, Midwestern, and Northeastern regions of the U.S. One participant identified as biracial (African American and Latinx). The majority of participants reported an education level of graduate degree or advanced degree (master’s, doctorate, or professional degree). Demographic information regarding sexual identity was not collected, but two participants self-identified as queer in their interview. One participant shared that they were HIV positive.

Sixteen participants were senior pastors of their church, and six participants were assistant or associate ministers. Most participants were faith leaders at a predominately African American church. Four participants were pastors of a multiracial congregation. At the time of the interview, one participant had just taken leadership at a predominantly white congregation. The participant was eligible because the majority of their experience was among African American congregations.

A total of nine participants stated they had experience in conducting HIV programs or initiatives in their church. Three participants were clergy, but also worked for nonprofit and community organizations that addressed HIV prevention. One participant was an academic researcher whose research focused on addressing the HIV disparity within the African American community.

Qualitative results revealed several themes on how HIV engagement in African American religious spaces can be enhanced (Figure 2). First, participants discussed collaborating with AIDS service organizations and experts. Second, nontraditional faith leaders (believe premarital sex is not a sin; affirming to sexual and gender minorities) suggest the church rethink its perspectives about sex and HIV to become more actionable
in HIV efforts. Third, traditional faith leaders (premarital sex is a sin; sex is for heterosexual married couple) believe HIV programming is appropriate for small groups and not Sunday morning worship service. All participants offer a few recommendations for AIDS service organizations.

| Demographic Composition of Sample of African American Millennial Faith Leaders |
|-----------------------------|-------------------|-------------------|
| **Demographic Indicator**   | **Number**        | **Percentage**    |
| **Age**                     |                   |                   |
| 18-30                       | 3                 | 14%               |
| 31-40                       | 19                | 86%               |
| **Gender Identity**         |                   |                   |
| Female                      | 7                 | 32%               |
| Males                       | 15                | 68%               |
| **Race/Ethnicity**          |                   |                   |
| Black/African American      | 21                | 95%               |
| African American and Latinx | 1                 | 4.5%              |
| **Education Level**         |                   |                   |
| College Graduate            | 1                 | 4.5%              |
| Graduate Degree or Advanced | 21                | 95%               |
| **Denomination**            |                   |                   |
| Baptist                     | 10                | 45%               |
| National Progressive Baptist| 1                 | 4.5%              |
| Pentecostal                 | 1                 | 4.5%              |
| Christian Methodist Episcopal (C.M.E.) | 1 | 4.5% |
| African Methodist Episcopal (A.M.E.) | 1 | 4.5% |
| United Methodist            | 3                 | 13%               |
| United Church of Christ     | 1                 | 4.5%              |
| Presbyterian                | 1                 | 4.5%              |
| Lutheran                    | 1                 | 4.5%              |
| Non-denominational          | 2                 | 9%                |
| **Are you ordained**        |                   |                   |
| Yes                         | 20                | 90%               |
| No                          | 2                 | 9%                |
| **Years served at current church** |       |                   |
| Less than 1 year            | 1                 | 4.5%              |
| 1-5                         | 17                | 77%               |
| 6-9                         | 0                 | 0%                |
| 10+ years                   | 2                 | 9%                |
| Currently not serving       | 2                 | 9%                |
| **Membership size**         |                   |                   |
| Less than 100 people        | 4                 | 18%               |
| 101-500 people              | 8                 | 36%               |
| 500-1000 people             | 4                 | 18%               |
| More than 1000 people       | 4                 | 18%               |
| Not serving                 | 1                 | 4.5%              |
| **Average Sunday service attendance** | |                   |
| Less than 100               | 4                 | 18%               |
| 101-500 people              | 10                | 45%               |
| 500-1000 people             | 4                 | 18%               |
African American millennial faith leaders in this study acknowledged a small portion of African American churches and faith leaders have been engaged in HIV efforts. “Howard” acknowledged the church he attended as a child, which started an HIV ministry in Baltimore, MD in the 1990s:

I'm from Baltimore, we're kind of the hub for HIV AIDS cases, and certainly on the East coast and, churches like my home church, other smaller congregations

Acknowledging the History and Legacy of the Black Church in HIV Prevention and Care

Figure 3- Participants approach to addressing HIV and stigma
took seriously the work of building these HIV, ministries and partnerships with local groups that were also doing the work. And so, it was taboo at that time, but they were giving condoms and, having conversations around HIV, that, that weren't widespread, certainly not in, in white church spaces and maybe not in bigger church spaces. So, I want to, I want to give kudos to smaller local Black church congregations, who I think had been on the ground doing the work for a long time.

In addition to acknowledging what churches have done in the past to address HIV, participants also acknowledged how they and their fellow clergy have discussed HIV. Some of them highlighted faith leaders getting tested for HIV in front of their congregation, participating in the National Week of Prayer for HIV, and wearing red ribbons on the first Sunday in December to celebrate World AIDS Day. Faith leaders shared they have encouraged HIV-positive congregants to share their story with the congregation. “Lucas,” a pastor in Chicago, shared the following:

One Sunday, World AIDS Day fell on a Sunday. And one of my choir members, you know, was open about her testimony that she had AIDS. And so, she shared a powerful testimony about her journey, how she was ostracized from her family. And I think that that was the first time that was back in 2017.

Participant “Abby,” a pastor starting a new church in the northeast, stated, “I’ve often seen the first Sunday in December doing the red pins and acknowledging, you know, World AIDS day. That’s something I’ve always done.”

As previously mentioned, discussing HIV within faith communities can be challenging. Facilitators for addressing HIV include recognizing and understanding how
HIV is impacting the community, knowing someone who is impacted by HIV, and identifying as queer. Barriers for addressing HIV include, feeling inexperienced to discuss HIV, HIV knowledge, and being a new pastor (serving one to two years at current church). Participant felt HIV efforts within the African American church could be enhanced with collaborations and partnerships with health experts.

**Partnerships and Collaboration**

Some participants expressed they were knowledgeable about HIV transmission, prevention, or PLWH. Most participants, specifically those who did not work in the HIV field, were not aware of the HIV disparity among African Americans. HIV was perceived as a health concern of the 80s and 90s. To increase HIV knowledge and awareness, participants suggested partnerships and collaborations with experts and AIDS service organizations. As “Curtis” stated:

I think what churches probably could be doing a little bit better job of doing is partnership. And what I mean by that is a lot of times the church tries to take on issues that we're not equipped to deal with instead of partnering with organizations that are equipped to deal with it. Um, so we take on issues that are of clinical concern or medical concern, and we're not doctors, but we could, we could partner with someone who does know.

Some participants also wanted to know more about HIV disparities within the African American community. Specifically, they wanted to know its impact among youth and young adults. They also wanted to understand the factors of transmission and how HIV can be prevented. Participants also wanted to know more about the HIV rates in
their community. “Marvin,” a participant who expressed traditional views (sex is only for heterosexual married couples), stated:

I’m a firm believer in deferring to the expert. I am not an expert in this field [HIV]. With that in mind, I would very much want to see local organizations come in and have the conversations from a health perspective and offer insight into the nuances of the disease and the nuances of how people can protect themselves and be safe. I would love for them to be able to provide the research, the data, to talk about how it disproportionately affects a certain population of our society. I would love for them to offer insight and nuance into us as a city. I would love to know some of the local city data as well. It's not something I'm familiar with.

Participants in the study suggested health experts provide HIV workshops to educate clergy and their congregation about HIV. “Franko,” a nontraditional faith leader (affirming or sexual and gender minorities; believes premarital sex is not a sin), stated:

We need to be exposed to, uh, medical professionals and also researchers who are coming in and doing the kind of workshopping, doing the clinics around how churches can be helpful, but also helping to de-stigmatize the virus in persons with the virus.

Participants also expressed wanting information on how to talk about HIV with their congregants and how to start a HIV ministry. They also expressed having easily accessible resources online, such as a portal to access information or curricula. Participants also recommend education material be easily adaptable to current ministry because of competing priorities in the church. “Howard,” stated:
There is so much competing for your time and attention and energy that you often focus on what is easiest. So, I'm excited to hear about scholars and experts who are doing this research, because I would love to bring them in and say, Hey, do you have a pre-packaged curriculum? Do you have conversation guides and template? ……give me the foundation upon which I start.

Faith leaders acknowledge they and their church need help discussing HIV; however, some participants felt the African American church culture also needed to reexamine perceptions about sex and sexuality.

*Rethinking Sex and Sexuality*

The majority of nontraditional faith leaders (those believing premarital sex is not a sin; affirming to sexual and gender minorities) in this study believed the church needs to reexamine its theology and perspective about sex and sexuality, and specifically, about same-sex relationships. According to these participants, the current stance on sex and sexuality within the church is a hindrance to HIV programming. When asked what has been the Black church’s response to HIV, “Davis” stated:

It really is rooted in an uneducated unexamined theology around sex and sexuality, right? Because if we're honest, HIV and AIDS was viewed, and in some faith communities are still viewed, as a gay man's disease, which means that we then have to evaluate what we feel about LGBTQ issues, same sex issues.

Participants with this perspective also believe the promotion of abstinence impacts the perceptions of HIV among African Americans. According to participants, this aids in the silence about sex and HIV in the church. “Louis” said, “I think the teaching of abstinence is a part of the HIV AIDS epidemic pandemic, um, the teaching of
abstinence is bullshit. We do not need to teach that.” Participants believe it prevents opportunities to learn about HIV prevention resources. “Macon” states:

We have pushed this abstinence purity culture, um, that I think has been detrimental to having comprehensive sexual health conversations with people that equip them with tools, information, knowledge, and resources, so that they can make the best decisions for themselves and their bodies.

Some faith leaders stated the African American church culture needed to speak to the reality of people having sex and stop being silent about sex and HIV. “Franko” stated:

So I think our silence and our stigma spreading is what’s hurting, our communities. I think any honest informed, science-based, progressive conversation around sex and sexuality, but also around the virus [HIV] itself and impacted communities, I think that will always help.

Participants challenged African American congregations to be more intentional and create safe spaces to support PLWH and to have conversations about sex and HIV, rather than just attending to the aftermath of an AIDS-related death in their community.

“Candace” stated:

So a lot of times we do these one-off things, right? Those things are good. I’m not going to take away from them because they do help for those who are right there in that moment, but when it's ingrained in the programming……. So a lot of churches have like grief support ministry. Right. Being intentional to create a safe space….because you can grieve the loss of life as you knew it, once you get a positive diagnosis.
Nontraditional faith leaders present a perspective that is opposite of traditional religious perspectives about sex and sexuality (i.e., sex is permissible only in the context of heterosexual marriage). According to nontraditional participants, the church should recognize that people are having sex. Participants report that not talking about HIV, sex, and sexuality is preventing access to accurate information and HIV prevention resources. Traditional faith leaders present a different perspective and provide insight on how the HIV information should be presented in the church.

Crafting an Approach

Participants expressed multiple perspectives of how HIV should be addressed. Although some faith leaders believed the church needed to stop being silent about HIV, sex, and sexuality, some traditional faith leaders believed HIV needed to be addressed as a general health issue in the vein of diabetes and high blood pressure. According to participants, whatever approach taken to address HIV must be crafted to fit the culture and readiness of the congregation.

For some participants, the topic of sexuality should be left out when discussing HIV. “Warren,” the youngest faith leader in his rural community, explained:

Well, yeah, I think the church should respond to HIV and AIDS in the same manner of a health issue and a social issue as we have done others. And that's why I say we move the messy sexuality conversation from it and treat it like a health issue that is a threat to the community and to our people just in general, because we care about the well-being of people.

Participants with this perspective wanted to avoid topics of sexuality because they felt they would be inappropriate to discuss in church and they did not want to offend or
ostracize congregants. Participants also state that they know their congregation’s level of
tolerance and readiness for discussing HIV. Those with this perspective suggested
distributing pamphlets with accurate information about HIV and where to get tested.

“Hellen,” shared:

So education testing, you know, maybe just pamphlets, giving churches the space
to decide their pace. You know our congregations, we're like a family, you know
your own family, you know what you can handle. You know, so maybe my
church isn't doing the condom giveaway.

Some participants believed HIV-focused conversations are not fitting for the
entire congregations. Some participants believed it would only be appropriate for youth
and young adults but not older congregants. One participant believed it would be
inappropriate to discuss HIV on Sunday in a sermon. “Curtis” shared:

I think that that type of conversation [HIV and sexual conversation] would be best
placed, um, in a setting of young adults and even older adults. Right. I don't think
it will be helpful for my senior generation, you know, except to make them more
palatable to the conversation. I think that maybe a Saturday workshop, but I don't
think Sunday morning is the place for it.

As “Warren” stated, “People forget that it's not just an institution [Black church]
like a company, you know, it's a culture it's very deep. So, you got to let people move at
their own pace.”

Participants felt discussing HIV and related topics in front of older congregants
would be uncomfortable and inappropriate. Faith leaders acknowledge HIV and related
topics are taboo in the church and how HIV is presented is important. Faith leaders felt
HIV presentations have to fit the culture of the congregation.

Participants provided recommendations for AIDS service organizations when
partnering with African American congregations. According to participants, health
professionals should respect the church’s readiness and theological stance on discussing
HIV and related topics. Participants in this study, particularly the three who worked in
HIV research, recommended partnering with churches regardless of their readiness.
“Taylor,” an HIV expert from a community health organization, stated:

Most churches still might have one foot in and one foot out [as it relates to
discussing HIV], but at least it's not two feet out. Right. So, you know, let's take
that one foot and see if we can work together to get the other foot in the door.

They acknowledged their church may not be receptive to certain information.
According to participants, experts need to tailor their approach to the level of readiness,
culture, and doctrine of the congregation. “Hellen” stated:

If I say, I'm having the health forum and I'm willing to allow you to be one of the
presenters, but I don't want the whole day about HIV and AIDS, then say, okay.

Or, you know what, they're not ready to talk about it, and so I want to kind of start
scratching the surface by just giving out pamphlets. Okay. Here are the
pamphlets, like being willing to, to step in at whatever level the church is ready.

This was also echoed by “Grant,” another clergy within experience in HIV
prevention:

One thing that I did, and I still do at times like in a non-paid consultant kind of
capacity is help to really create curricula. That are respectful. I mean, that's the
reality. Like you have to kind of respect whatever the pastor and what they want to do in that mosque and church that align with those teachings.

Discussion

The purpose of this study was to explore millennial faith leaders’ perspectives about addressing HIV and stigma in the African American church. Interviews were conducted with 22 African American faith leaders between the ages of 18 and 40 years. Qualitative data produced several themes: partnership and collaboration, rethinking sex and sexuality, and crafting an approach. Most of the participants believed that addressing HIV starts with educating themselves and their congregations. Similar to previous research, participants in this study suggested partnerships with health experts and organizations to improve HIV knowledge and awareness (Stewart et al., 2016; Wingood et al., 2011). Participants suggested workshops and health clinics and developing online curricula to assist them with addressing HIV. They also recommended that HIV resources and materials should be easily accessible and adaptable to current ministry.

Some faith leaders in the study believe the church should reevaluate its perspective about sex and sexuality, i.e., abstinence-only teachings. However, traditional faith leaders believe sexuality should be excluded from the conversation about HIV. It is not uncommon for faith-based organizations to avoid HIV-related topics such as sexuality. The traditional view of the church prohibits sexual activity outside of the context of heterosexual marriage. This perspective has been found to be a barrier for faith-based HIV prevention (Bryant-Davis et al., 2016).

Faith leaders in the study provided recommendations to AIDS service organizations when working with Black congregations. They suggested to respect the church’s level of readiness to address HIV. Participants stated in their interview that they
know their congregation’s level of readiness and tolerance for addressing HIV. According to participants, HIV material must align with the culture of the congregation. This is important for gaining congregational support for implementing HIV programming. For example, in their study on an HIV-focused intervention strategy across several churches, Coleman et al., (2012) found that a factor for successful implementation was organizational buy-in (Coleman et al., 2012). This meant getting support from the pastor, other leaders in the church (deacons), and congregants (Coleman et al., 2012).

This study was informed by three different theoretical frameworks: SI, intersectionality, and SIT. Through qualitative interviews, the researcher was able to explore faith leaders’ symbolic meaning and interpretations about HIV and stigma and how it should be addressed. Through this process, the researcher was able to understand how their experiences as faith leaders impacted their perceptions about HIV and stigma. Knowing someone who is HIV positive, knowing someone who is gay, and having experience in HIV shaped nontraditional faith leaders’ perceptions about being affirming to sexual and gender minorities, challenging the church’s perspectives about sex and sexuality, and incorporating HIV efforts into their ministry.

Intersectionality allowed the researcher to analyze the multiple social identities of participants and how that shaped their perspectives about HIV and stigma and how it should be addressed. Faith leaders in this study possess multiple social identities. In addition to being African American, millennial, and faith leaders, participants were also HIV health experts, academic researchers, activists, the youngest in their denomination, female, and queer identifying. One participant was HIV positive. In the interviews, some
participants reported being “progressive” or traditional. Participants even considered themselves prophetic. These identities influence not only their perceptions about HIV, but also their theological stances about sex and sexuality, which ultimately impacted their perceptions of approach for addressing HIV and stigma.

The multiple social identities among participants also meant participants ascribed to multiple social groups. As assumed in SIT, participants categorized themselves into groups (progressive faith leader, traditional faith leader). They also adopted the social identification of these groups, which shapes how they conduct their ministry or church approach to HIV. What is not consistent is how they compare social groups as described in SIT. Participants do address the cultural and historical differences of African American church culture compared to other racial congregations in their interview; however, they do not ascribe a level of hierarchy, such as “them” vs “us” mentality, as SIT suggests.

Previous studies have examined the perspectives of African American faith leaders, but to our knowledge, there is no study examining the perspectives of millennial or young African American faith leaders on HIV. Previous generations took a conservative stance in their approach to addressing HIV. This included promoting abstinence and being non-affirming to sexual and gender minorities. The majority of millennial faith leaders in this study wanted the church to address sex, sexuality, and safe sex practices within the church. Some disagreed with abstinence and believed the church needed to become more accepting and affirming to sexual and gender minorities.

Participants in this study believed the church can be a vital resource for addressing the HIV disparity and stigma. Like faith leaders in other research, each
participant wanted to address HIV within their church regardless of their perspective (traditional or nontraditional) (Bluthenthal et al., 2012; Wooster et al., 2011). Going forward, researchers should continue to build relationships with African American religious organizations and assist them with HIV discussions. Researchers should also continue to assess HIV readiness when partnering with African American faith leaders and congregations. Researchers should focus on developing HIV curricula and programs for faith-based organizations that are easily accessible and simple to implement. The perspectives of millennial faith leaders should be further explored. Future research should explore barriers and facilitators to addressing HIV as millennial faith leaders.

Limitations

There are several limitations to this study. First, the sample size of this study limits its generalizability. Second, HIV and related topics are sensitive topics to discuss with religious leaders. To minimize discomfort, the researcher decided to conduct individual interviews to give participants the ability to speak freely about their perspectives. The researcher also informed participants that no prior knowledge about HIV was needed to participate in the study. Third, many in this sample of participants may have come from the same social network because they were recommended by one of their colleagues in the sample. However, the researcher was intentional about interviewing participants of different denominations, theological perspectives, gender identity, and sexual orientation to capture diversity of millennial faith leaders within the African American religious space. This was also done by recruiting from social media and other networks.

Conclusion
There are various perspectives about HIV and stigma and how they should be addressed among African American millennial faith leaders. Ultimately, faith leaders want support and assistance from health experts and AIDS service organizations. For faith leaders, this will help them to address HIV and stigma and to improve their level of HIV knowledge. When working with African American faith leaders and their congregations, ASO and experts must respect a congregation’s level of readiness and make sure HIV material is fitting to the culture of the church. Overall, researchers should continue to assess millennial faith leaders’ perspectives to further understand new mechanisms of addressing the HIV disparity.
CHAPTER 6: DISCUSSION, LIMITATION AND IMPLICATIONS

The purpose of the study was to explore and examine the perspectives of HIV/AIDS and stigma among African American millennial faith leaders. The researcher conducted a systematic review using the PRISMA guidelines. Based on the inclusion criteria for the review, 62 articles were examined. The results of the systematic review revealed various perspectives of HIV/AIDS and stigma. However, no article examined the perspectives of African American millennial faith leaders, thereby highlighting the paucity of information on HIV stigma among the next generation of African American faith leaders. The researcher then conducted qualitative interviews with millennial African American faith leaders. The researcher engaged in in-depth interviews with 22 faith leaders between the ages of 18 and 40 years old. Based on the systematic review and interviews, the most consistent themes were lack of HIV knowledge and a desire for collaboration and partnerships with AIDS Service Organizations (ASOs) and health experts.

This study revealed that faith leaders believe the African American religious community is still an asset for addressing HIV disparities among African Americans. African American faith leaders and their congregations are willing to address HIV and stigma, but they face barriers to HIV engagement. The most significant barrier is lack of HIV knowledge. The majority of faith leaders were familiar with HIV as a sexually transmitted illness and perceived it to be a health issue impacting minorities in the 1980s
and 1990s. Their limited understanding about HIV transmission and prevention made them feel inexperienced and unequipped to address HIV.

Most participants were unfamiliar with biomedical HIV prevention strategies such as PrEP or treatment as prevention. Participants were also unsure where to get HIV information and resources. Participants reported that misinformation and miscommunication in the community is the result of a lack of HIV knowledge. Misinformation about HIV transmission and risk also impacted HIV-related stigmas such as homophobia. Participants suggested collaboration and partnerships with ASOs and health experts to improve the understanding of HIV transmission and prevention.

Collaboration with health experts and ASOs were reported to be helpful to African American faith leaders and their congregations. Faith leaders report that talking with experts about HIV helped them to become more comfortable discussing HIV in their churches. Partnerships with academic institutions and health experts increased HIV knowledge and helped to reduce stigma among African American religious communities. This also encouraged engagement in HIV/AIDS efforts and the development of HIV ministries. Faith leaders suggested that more collaboration and help from HIV experts is needed to continue addressing HIV/AIDS within African American, faith-based settings.

Participants provided recommendations for health experts partnering within African American congregations to address HIV. Faith leaders suggested health experts and ASOs recognize there are various perspectives about HIV and stigma within the African American religious community. This means churches possess different levels of readiness for addressing HIV. ASOs and health experts should develop and present HIV materials that meet the level of readiness for individual congregations and communities.
Participants also suggested that HIV material and resources for African American congregations should be easily accessible and adaptable to current church ministries.

Discussion

In addition to the lack of HIV knowledge and collaborations and partnerships with ASOs and health experts, other common themes of the study were homophobia and stigma, theological perspectives about sex and sexuality, and silence about sex and sexuality. Homophobia and stigma were reported as a major barrier for HIV engagement among participants in this study. According to the results of this study, homophobia exists because of social norms and beliefs about sex and sexuality. Previous studies have often identified homophobia and stigma as barriers to HIV prevention within faith-based communities (Coleman et al., 2016; Davis, 2017; Davis et al., 2014; Nunn et al., 2012; Quinn et al., 2016). Many Christian-based faith traditions have historically been non-affirming to sexual behavior outside the context of heterosexual marriage. Within this study, the younger generation of faith leaders seem to have moved away from viewing HIV as sin or a disease only for sexual minorities. However, they acknowledge that homophobia and stigma exist.

Faith leaders in the qualitative interviews discussed how homophobic and stigmatizing views in the church marginalized African American sexual and gender minorities. According to participants, homophobia and stigma force members of the community to be secretive about their sexual behaviors. It also created a barrier to prevention resources and receiving accurate information about HIV. Similar findings were reported in studies examining African American MSM and their experiences within the religious community (Quinn et al., 2016; Robert L. Miller, 2007; Watkins et al.,
2016). Not only has the church perpetuated stigma, but it has also caused African American MSM and other sexual minorities to internalize stigma (Balaji et al., 2012; Lanzi et al., 2019; Pingel & Bauermeister, 2018). Homophobic and stigmatizing perspectives about HIV in the church are the result of specific theological perspectives and faith doctrines.

Theological perspectives impact perceptions about HIV and how it should be addressed within the church. Previous research has identified faith doctrines and theological stances as barrier to HIV engagement (Adimora et al., 2019; Pichon et al., 2020; Wooster et al., 2011). Interview participants used “liberal/progressive” or “conservative” to describe themselves and their colleagues’ theological stance about HIV and related topics. This kind of language was also found within the literature (Beadle-Holder, 2011; Bryant-Davis et al., 2016; Fulton, 2011; Quinn et al., 2016; Stewart, Hanlon, et al., 2017; Wilson et al., 2011).

“Liberal/progressive” was used to describe faith leaders who believed in a nontraditional approach to addressing HIV. This includes discussing condom use, being affirming to sexual and gender minorities, promoting comprehensive sex education, and adopting an HIV/AIDS ministry. In this study, “liberal/progressive” faith leaders challenged perceptions about sex and sexuality in the church and pushed for an affirming religious community. Affirming churches are interested in not only providing safe worshiping environments for sexual and gender minorities, but also addressing HIV and stigma. In a study by Lewis et al., (2015), affirming pastors not only preached against homophobia, but they educated clergy in their community that homophobic rhetoric was not justifiable for addressing HIV (Lewis, 2015).
In addition to providing resources and combating stigma, affirming congregations also offer social and psychological support to sexual and gender minorities and other HIV vulnerable groups. In a study by White et al., (2020), LGBTQ-affirming churches helped sexual and gender minorities with self-acceptance and healing from emotional traumas (White et al., 2020). These churches have also been spaces for modeling healthy and loving romantic relationships for sexual and gender minorities (White et al., 2020).

Providing a supportive social network, like a church, can reduce negative outcomes across the HIV care continuum (Bouris et al., 2017; Kelly et al., 2014; White et al., 2020).

“Conservative” faith leaders were positioned as more non-affirming to the identities and sexual practices of sexual and gender minorities. They often endorsed an abstinence-only approach and were less supportive of condom distribution in the church. Some conservative faith leaders believed the HIV interventions and programs in the church may only be appropriate for youth and young adults. Some also believed HIV presentations were appropriate for a Saturday workshop and not a Sunday morning worship service.

Although conservative faith leaders were not affirming, they did not support the use of homophobic rhetoric or language within the church. Conservative faith leaders focused on testing, providing accurate information about transmission through educational pamphlets, and showing compassion to PLWH. It is assumed that religious communities are mostly conservative. However, throughout this study, there were representations of faith leaders who are nontraditional (“liberal/progressive”) and traditional (conservative). Previous research has found theological perspective and faith
doctrine not to be an insurmountable barrier to some degree of HIV engagement (Pichon et al., 2020).

It has been reported that conservative ideology undermines HIV efforts (Wooster et al., 2011). However, based on this study, being conservative impacts the extent of HIV engagement and the nature of interventions, but not willingness to engage in HIV intervention. According to qualitative interviews and the systematic review, African American participants who ascribed to a conservative perspective were still willing to address HIV. Some conservative faith leaders supported teaching safe sex practices such as condom use. Studies show that some faith leaders preach abstinence and do not support premarital sex, but privately provide resources such as condoms to congregants in need (Beadle-Holder, 2011; Nunn et al., 2012; Woods-Jaeger et al., 2015). These faith leaders acknowledge that community members are not abstinent and believe they should know how to protect themselves and their partners.

Faith leaders in the study also acknowledged there is silence about HIV because there is silence about sex and sexuality. Participants state that it is “taboo” to address HIV and related topics in church. According to participants, being silent and not addressing HIV and related topics, such as sex and sexuality, prevents opportunities to educate the community about HIV and dispel HIV stigma. There were faith leaders in this study who believe the church should be more engaged in HIV efforts and speak to the reality that people are having premarital sex. Silence about sex and sexuality is also a result of homophobia and stigma.

This study is unique because it explores the perspectives of millennial faith leaders. No other study has examined the generational cohorts of African American faith
leaders regarding HIV. Although other generational perspectives have not been examined, the current systematic review provides perspectives of HIV among all African American faith leaders.

Faith leaders within the review and in the interviews both reported that stigma exists within the church, especially related to PLWH and sexual and gender minorities. There were also faith leaders in both populations of the study who expressed being unaware of or lacking knowledge about HIV/AIDS and stigma. Both groups believed HIV and stigma is an issue the church should be engaged in addressing and collaborations and partnerships are essential for improving HIV knowledge and engagement. However, the difference between millennial faith leaders and faith leaders of previous generations is in their approach to addressing HIV.

Faith leaders in the review sometimes avoided addressing HIV because they feared that congregants would believe they were condoning sexual behaviors outside of their doctrines. They also had fear of being stigmatized. The majority of faith leaders in the systematic review took on a conservative stance in their approach to HIV. This included promoting abstinence and being non-affirming to sexual and gender minorities. The majority of millennial faith leaders, however, wanted the church to address sex and sexuality and safe sex practices within the church. Some disagreed with abstinence and believed the church needed to become more accepting and affirming to sexual and gender minorities.

It is important to examine the perspectives of millennial faith leaders because they are the emerging leaders of the African American religious community. This study revealed that the African American religious community is still valuable to ending the
HIV epidemic. It also helped to understand the trajectory of HIV prevention within the African American, faith-based setting. These findings provide insight into the ideological shifts in regard to HIV and sexual and gender minorities in African American churches. This study could help HIV researchers and prevention specialists reimagine how to address HIV within faith-based settings, and potentially expand HIV approaches in African American churches. Researchers and experts can focus on developing faith-based approaches to discussing condom use, PrEP, sexuality, and healthy relationships.

Limitations

There are several limitations to this study. The researcher used specific terms within the six databases to identify articles, and this list may not have captured the totality of research on HIV and African American faith communities. Although the review is most likely exhaustive, there is a possibility that additional publications could have been identified using other databases and other search terms.

The review excludes articles published before 1996, as it was important to capture perspectives after the advent of HAART, given its potential to help address stigma. Nevertheless, African American faith leaders may have expressed different perspectives of HIV and stigma during that time.

Regarding the qualitative interviews, there were several limitations. First, HIV and related topics are sensitive topic to discuss in church and thus subject to social desirability bias. Some participants also reported being more unfamiliar and underinformed about HIV. Second, several participants from this sample may have come from the same social networks, given the snowball sampling recruitment strategy. The
researcher was intentional about interviewing participants of different denominations, theological perspectives, gender identity, and sexual orientation to capture the diversity of millennial faith leaders within the African American religious space.

Additionally, the researcher sought African American millennial faith leaders from various regions of the U.S. The majority of the qualitative interview participants were pastors of churches within urban metropolitan cities. Only one participant was a pastor of a church in a rural community. Although other participants are from various regions of the U.S., millennial faith leaders in rural communities may face different perspectives and challenges as it relates to discussing HIV. Perhaps future studies could examine the perspectives of millennial faith leaders in rural communities.

This study also had limited representation of queer-identifying participants. Only two participants self-identified as queer. Understanding of how sexual and gender minorities who are active in their religious community and navigate religious spaces can also be vital to addressing HIV. Knowing their experience and hearing their voices could inform faith-based approaches to HIV for sexual and gender minorities.

Implications

Going forward, researchers must recognize and respect the various perspectives within the African American religious community when addressing HIV in these institutions. Although some perspectives within the African American church may conflict with some public health recommendations regarding HIV and related topics, this study reveals that there is opportunity for HIV engagement. ASOs and experts can continue to learn about the differences in HIV approaches between African American congregations and gain better understanding for addressing HIV by working with faith
communities. It also allows for multiple approaches in addressing HIV to be developed within the African American community. Future studies should continue to assess African American faith communities’ perspectives about HIV/AIDS. Being abreast of the shifting perspectives could provide new approaches to discussing HIV/AIDS and promoting prevention methods such as pre-exposure prophylaxis (PrEP).

Researchers should also explore the perspectives of African American millennials who are not faith leaders, but active church goers. Although participation in organized religion has declined in the U.S., African Americans are still the most religious racial community (Mohamed et al., 2021). Examining their perspectives and their influences could provide insight into how this generation perceives HIV. It also could provide insight on what topics African American faith leaders may need to address within their congregation. Additionally, it could provide insight on how to connect with other community members and improve HIV messaging in the African American community.

Community collaboration was suggested as a helpful mechanism for addressing HIV within African American, faith-based communities. The support and assistance these congregations need go further than just collaborating with health experts and ASOs. Financial support is needed for African American congregations to sustain HIV ministries and programming. The African American religious community has been found to be invaluable to ending the HIV epidemic, but more advocacy for federal and state funding is needed to support these congregations and their leaders. Academic researchers should continue to partner within these congregations and expand their efforts from congregational-based to community-based efforts.
Conclusion

Millennial African American faith leaders express various perspectives about HIV and stigma and how it should be addressed. However, faith leaders need assistance with improving their knowledge about HIV transmission and prevention. Partnerships and collaboration with ASOs and health experts can help improve knowledge about HIV and help reduce stigma within the African American church. Health experts and ASOs should continue to work with African American faith communities in addressing HIV and stigma. Researchers should continue to examine millennial faith leaders’ perspectives to gauge the trajectory of perspectives within the African American church. Overall, the African American church is still a vital resource for ending the HIV epidemic.
REFERENCES


https://doi.org/10.1016/s1055-3290(06)60344-0

https://doi.org/10.1089/apc.2012.0177


https://doi.org/10.1007/s10943-014-9924-1


https://doi.org/10.1007/s12111-011-9159-0


https://doi.org/10.1521/aepa.2010.22.3.218

https://doi.org/10.7448/IAS.16.3.18644

Berkley-Patton, J., Thompson, C., Martinez, D., Hawes, S., Moore, E., Williams, E., & Wainright, C. (2013). Examining church capacity to develop and disseminate a religiously appropriate HIV tool kit with African American


https://doi.org/https://doi.org/10.1016/B0-12-657410-3/00209-9


https://doi.org/10.1093/her/cyu006


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### Table 2- Articles included in the systematic review

<table>
<thead>
<tr>
<th>Title</th>
<th>Year of Publication</th>
<th>Authors</th>
<th>Journal Title</th>
<th>Study Design</th>
<th>Target population</th>
<th># of participants</th>
<th>sampling method</th>
</tr>
</thead>
<tbody>
<tr>
<td>A developing framework for the development, implementation, and maintenance of HIV interventions in the African American church</td>
<td>2015</td>
<td>Jennifer M. Stewart</td>
<td>Journal of health care for the poor and undeserved</td>
<td>qualitative-ethnography</td>
<td>African American church</td>
<td>1 church- researchers interviewed pastors, lay leaders and congregants (9)</td>
<td>N/A</td>
</tr>
<tr>
<td>A Mid-South Perspective: African American Faith-based Organizations, HIV, and Stigma</td>
<td>2016</td>
<td>Tamara D. Otey &amp; Wendy Renee Miller</td>
<td>The Journal of the Association of Nurses in AIDS Care: JANAC</td>
<td>qualitative-interviews</td>
<td>African American, faith leaders in areas with high rates of HIV in Memphs</td>
<td>30</td>
<td>Purposive</td>
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<tr>
<td>A Multi-Level Approach for Promoting HIV Testing Within African American Church Settings</td>
<td>2015</td>
<td>Jennifer M. Stewart</td>
<td>AIDS Patents Care and STDs</td>
<td>qualitative</td>
<td>African American churches</td>
<td>4 churches</td>
<td>purposeful</td>
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<tr>
<td>Title</td>
<td>Year of Publication</td>
<td>Authors</td>
<td>Journal Title</td>
<td>Study Design</td>
<td>Target population</td>
<td># of participants</td>
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<tr>
<td>A religiously tailored, multilevel intervention in African American churches to increase HIV testing: Rationale and design of the Taking It to the Pews cluster randomized trial</td>
<td>2019</td>
<td>J. Berkley-Patton, C. Bowe Thompson, K. Goggin, D. Catley, M. Bermand, A. Bradley-Ewing, K.P. Derose, K. Resnicow, J. Allsworth, S. Simon</td>
<td>Contemporary Clinical Trials</td>
<td>CBPR approach cluster randomized control design</td>
<td>African American churches</td>
<td>14 churches</td>
<td>Convenience</td>
</tr>
<tr>
<td>African American Church Based HIV Testing and Linkage to Care: Assets, Challenges, and Needs</td>
<td>2016</td>
<td>Jennifer M. Stewart, Keitra Thompson, and Christopher Rogers</td>
<td>Culture, Health, and Sexuality</td>
<td>mixed methods 4 focus groups, 4 interviews, 116 surveys</td>
<td>African American churches</td>
<td>4 pastors, 39 church leader, 116 congregants</td>
<td>purposive</td>
</tr>
<tr>
<td>African American Church Engagement in the HIV Care Continuum</td>
<td>2018</td>
<td>Jennifer M. Stewart, Hyejeong Hong, Terrinieka W. Powell</td>
<td>Journal of Associated Nurses AIDS Care</td>
<td>exploratory-descriptive approach-qualitative study (Interview and focus groups)</td>
<td>African American churches</td>
<td>8 pastors, 57 church leaders</td>
<td>convenience</td>
</tr>
<tr>
<td>African American clergy Perspectives About the HIV care continuum:results from A Qualitative</td>
<td>2018</td>
<td>Amy Nunn, Sharon Parker, Katryna McCoy, Mauda Monger, Melverta Bender, Joanna</td>
<td>Ethnicity and Disease</td>
<td>qualitative-focus group</td>
<td>African American Clergy in Jackson, Mississippi</td>
<td>4 focus groups (19 clergy)</td>
<td>purposeful and snowball</td>
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<tr>
<td>Title</td>
<td>Year of Publication</td>
<td>Authors</td>
<td>Journal Title</td>
<td>Study Design</td>
<td>Target population</td>
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<tr>
<td>study in Jackson, Mississippi</td>
<td></td>
<td>Poceta, Julia Harvey, Gladys Thomas, Kendra Johnson, Yusuf Ransome, Cassandra Sutten Coats, Phil Chan, and Leandro Mena</td>
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<tr>
<td>African American religious community’s involvement with HIV/AIDS education</td>
<td>2016</td>
<td>Julien Kouame</td>
<td>Journal of Community Medicine and Health Education</td>
<td>qualitative</td>
<td>African American pastors, ministers, and churchgoers</td>
<td>9-pastors and 8 churchgoers</td>
<td>Purposeful</td>
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<tr>
<td>An Exploration of Faith Leaders’ Beliefs Concerning HIV Prevention Thirty Years Into the Epidemic</td>
<td>2013</td>
<td>Latrice C. Pichon, Terrinieka T. Williams, and Bettina Campbell</td>
<td>Family &amp; Community Health</td>
<td>mixed methods</td>
<td>African American Faith leaders</td>
<td>29</td>
<td>participants were recruited from the 52 FBO who participated in the YBH program</td>
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<tr>
<td>Title</td>
<td>Year of Publication</td>
<td>Authors</td>
<td>Journal Title</td>
<td>Study Design</td>
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<tr>
<td>As I see it: a study of African American pastors' views on health and health education in the black church</td>
<td>2014</td>
<td>Michael L. Rowland, E. Paulette Isaac-Savage</td>
<td>Journal of Religion and Health</td>
<td>Quantitative-questionnaire</td>
<td>African American clergy</td>
<td>100</td>
<td>Convenience</td>
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<tr>
<td>Title</td>
<td>Year of Publication</td>
<td>Authors</td>
<td>Journal Title</td>
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<tr>
<td>Attitudes and beliefs related to HIV/AIDS in urban religious congregations: Barriers and opportunities for HIV-related interventions</td>
<td>2012</td>
<td>Ricky N. Bluthenthal, Kartika Palar, Peter Mendel, David E. Kanouse, Dennis E. Corbin, Kathryn Pitkin Derose</td>
<td>Social Science &amp; Medicine</td>
<td>Qualitative-Case Study</td>
<td>Religious Congregations in LA</td>
<td>14 congregation (6 African American, 4 Latino, 2 White, and 2 Mixed) A total of 57 lay leaders across all congregations.</td>
<td>purposive sample</td>
</tr>
<tr>
<td>Barriers and facilitators to providing HIV-related services in Bostonian African American</td>
<td>2011</td>
<td>Michelle Teti, Mari-Lynn Drainoni, Anita Raj, Yvette C. Cozier, Cynthia</td>
<td>Journal of HIV/AIDS &amp; Social Services</td>
<td>qualitative 6 focus groups</td>
<td>African American religious leaders and</td>
<td>46- 17 religious’ leaders, 9 MSM, 4 Males IDU. 4 Female IDU, and 12 partner of IDU</td>
<td>purposeful</td>
</tr>
<tr>
<td>Title</td>
<td>Year of Publication</td>
<td>Authors</td>
<td>Journal Title</td>
<td>Study Design</td>
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<td>American churches: a focus group study of clergy and community members</td>
<td></td>
<td>Harris, Donna Bright &amp; Seth L. Welles</td>
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<td>community members</td>
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<td>Black Churches Creating Safe Spaces to Combat Silence and Stigma Related to AIDS</td>
<td>2011</td>
<td>Michelle Beadle-Holder</td>
<td>Journal of African American Studies</td>
<td>Qualitative</td>
<td>African American churches</td>
<td>8</td>
<td>purposive and snowball sampling</td>
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<tr>
<td>Black Pastors’ Views on preaching about sex: barriers, facilitators, and opportunities for HIV prevention messaging</td>
<td>2017</td>
<td>Adaora A. Adimora, Moses V. Goldman, Tamera Coyne-Beasley, Catalina B. Ramirez, Gilbert A. Thompson, Danny Ellis, Joe L. Stevenson, Jerry M. Williams, Daniel L. Howard &amp; Paul A. Godley</td>
<td>Ethnicity and Health</td>
<td>qualitative</td>
<td>African American pastors</td>
<td>39</td>
<td>purposeful</td>
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<tr>
<td>Capacity Building Among African American Faith Leaders to Promote HIV Prevention and Vaccine Research</td>
<td>2014</td>
<td>Amina P. Alio, Cindi A. Lewis, Catherine A. Bunce, Steven Wakefield, Weldon G. Thomas, Edwin</td>
<td>Project MUSE</td>
<td>Quantitative-Surveys, Seminars and trainings (Pre-test Post-test intervention)</td>
<td>African American faith leaders in Rochester NY</td>
<td>47 at baseline; 19 completed the intervention</td>
<td>Invitations were extended to Rochester’s black church leadership and a full range of community-based AIDS</td>
</tr>
<tr>
<td>Title</td>
<td>Year of Publication</td>
<td>Authors</td>
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<td>Study Design</td>
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<tr>
<td>Development of a Framework for HIV/AIDS Prevention Programs in African American Churches</td>
<td>2011</td>
<td>Jason D. Coleman, Lisa L. Lindley, Lucy Annang, Ruth P. Saunders, Bambi Gaddist</td>
<td>AIDS Patient Care and STDs</td>
<td>qualitative-focus groups and interviews</td>
<td>African Churches and pastors</td>
<td>6 focus groups</td>
<td>Stratified sample</td>
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<td>Title</td>
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<td>Authors</td>
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<td>Dissonance and Accord Between Black Faith Leaders’ and Community Members’ Perceptions of Structural and Institutional Barriers in HIV</td>
<td>2015</td>
<td>Jennifer Phillips</td>
<td>Scholar Works@ Georgia State University</td>
<td>mixed methods- qualitative focus groups and quantitative interviews</td>
<td>Faith Leaders and community members in Atlanta, GA</td>
<td>41 interviews and 4 focus groups with 31 people</td>
<td>purposive</td>
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<tr>
<td>Examining Church Capacity to Develop and Disseminate a Religiously Appropriate HIV Tool Kit with African American Churches</td>
<td>2012</td>
<td>Jannette Berkley-Patton, Carole Bowe Thompson, David Alfonso Martinez, Starlyn Montez Hawes, Erin Moore, Eric Williams, and Cassandra Wainright</td>
<td>Journal of Urban Health</td>
<td>mixed methods- survey and focus groups</td>
<td>African American churches</td>
<td>124 participants; n=58 churches represented by senior pastors</td>
<td>convenience sample</td>
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<tr>
<td>Title</td>
<td>Year of Publication</td>
<td>Authors</td>
<td>Journal Title</td>
<td>Study Design</td>
<td>Target population</td>
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<td>Facilitators and Barriers to HIV Activities in Religious Congregations: Perspectives of Clergy and Lay Leaders from a Diverse Urban Sample</td>
<td>2014</td>
<td>Peter Mendel, Kathryn Pitkin Derose, Laura Werber, Kartika Palar, David E. Kanouse, Michael Mata</td>
<td>Journal of Religion &amp; Health</td>
<td>Case study</td>
<td>African American clergy and lay leaders</td>
<td>14 churches represented (57 people total) 6 churches were black, 4 Latino. 2 white and 3 mixed</td>
<td>purposive</td>
</tr>
<tr>
<td>Factors contributing to the development of an HIV ministry within an African American church</td>
<td>2012</td>
<td>Jennifer Stewart &amp; Barbara L. Dancy</td>
<td>The Journal of the Association of Nurses in AIDS Care</td>
<td>qualitative (ethnography) interviews and surveys, observation</td>
<td>the member of an African American church in a Midwest urban community with an HIV ministry.</td>
<td>9- members responsible for implementing and maintaining HIV ministry and 50 members in the general congregation</td>
<td>purposeful</td>
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<tr>
<td>Factors Influencing Black Churches’ Readiness to Address HIV</td>
<td>2016</td>
<td>Latrice C. Pichon, Terrinieka Williams Powell, Siri A. Ogg, Andrea L. Williams, Nicole Becton-Odum</td>
<td>Journal of Religion and Health</td>
<td>descriptive qualitative research-CBPR</td>
<td>African American Faith leader</td>
<td>26- 4 focus groups</td>
<td>Convenience</td>
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<td>Faith Leaders’ Comfort Implementing an HIV Prevention</td>
<td>2012</td>
<td>Latrice C. Pichon, Derek M. Griffith, Bettina</td>
<td>Journal of Health Care for the Poor</td>
<td>Cross sectional study</td>
<td>African American Faith leaders</td>
<td>52- from 42 Faith based organization</td>
<td>N/A</td>
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<tr>
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<td>Authors</td>
<td>Journal Title</td>
<td>Study Design</td>
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<tr>
<td>Curriculum in a Faith Setting</td>
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<td>Campbell, Julie Ober Allen, Terrineika T. Williams, Angela Y. Addo</td>
<td>and Underserved</td>
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<tr>
<td>HIV in Faith Communities: Utilizing Clergy as opinion leaders to reduce HIV/AIDS stigma</td>
<td>2018</td>
<td>Sheila R. Grigsby</td>
<td>Journal of HIV/AIDS and Social Services</td>
<td>This was a research brief-Authors used clergy opinions to develop HIV training</td>
<td>African American clergy</td>
<td>125</td>
<td>N/A</td>
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<td>HIV/AIDS and the Black Church: What Are the Barriers to Prevention Services?</td>
<td>2005</td>
<td>Justin Smith, BA; Emma Simmons, MD, MPH; and Kenneth H. Mayer, MD</td>
<td>Journal of The National Medical Association</td>
<td>quantitative-25-item questionnaire</td>
<td>African American ministers Rhode Island</td>
<td>18</td>
<td>the ministers selected to participate in the study were members of the only clergy organization representing black/African American clergy in Rhode Island.</td>
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<tr>
<td>Title</td>
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<tr>
<td>How African-American ministers communicate HIV/AIDS-related health information to their congregants: a survey of selected black churches in Houston, TX</td>
<td>2008</td>
<td>Masoomeh Khosrovania, Reza Poudéha and Rochelle Parks-Yancy</td>
<td>Mental Health, Religion, and Culture</td>
<td>Quantitative</td>
<td>African American churches and ministers</td>
<td>319- church members and 12 ministers</td>
<td>purposive sampling method</td>
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<tr>
<td>Ideologies of Black churches in New York City and the public health crisis of HIV among Black men who have sex with men</td>
<td>2011</td>
<td>Patrick Wilson, Miguel Munoz-Laboy, Richard Guy Parker</td>
<td>Global Public Health</td>
<td>qualitative</td>
<td>African American churches with HIV ministries</td>
<td>81</td>
<td>convenience</td>
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<tr>
<td>Implementation of Evidence-Based HIV Interventions for Young Adult African American Women in Church Settings</td>
<td>2014</td>
<td>Jennifer M. Stewart</td>
<td>Journal of Obstetric, Gynecologic &amp; Neonatal Nursing</td>
<td>mixed methods cross-sectional design</td>
<td>African American pastors, church leaders, and young adult women ages 18 to 25.</td>
<td>142</td>
<td>purposive</td>
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<tr>
<td>Title</td>
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<td>Authors</td>
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<td>Study Design</td>
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<td>F.A.I.T.H. Churches in South Carolina</td>
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<tr>
<td>Keeping the Faith: African American Faith Leaders’ Perspectives and Recommendations for Reducing Racial Disparities in HIV/AIDS Infection</td>
<td>2012</td>
<td>Amy Nunn, Alexandra Cornwall, Nora Chute, Julia Sanders, Gladys Thomas, George James, Michelle Lally, Stacey Trooskin, Timothy Flanigan</td>
<td>PLoS One</td>
<td>qualitative-focus group</td>
<td>African American Pastors and Imamans</td>
<td>38</td>
<td>purposeful</td>
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<td>Obstacles and Options to Faith-Based HIV Service Delivery to Low-Income Inner City Residents: Perspectives of Black Clergy With</td>
<td>2014</td>
<td>Sarita K. Davis, Nicholas Forg, Mary Anne Adams, Richard Rothenberg</td>
<td>Journal of Black Studies</td>
<td>Qualitative-focus groups</td>
<td>Clergy servicing commuter congregations in 5 specific zip codes in Atlanta</td>
<td>16</td>
<td>purposive</td>
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<tr>
<td>Title</td>
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<td>Authors</td>
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<td>Commuter Congregations</td>
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<tr>
<td>Opening Up Their Doors: Perspectives on the Involvement of the African American Faith Community in HIV Prevention in Four Communities</td>
<td>2011</td>
<td>Joanna Wooster, Ariela Eshel, Andrea Moore, Meenoo Mishra, Carlos Toledo, Gary Uhl, and Linda Wright-De Aguero,</td>
<td>Health Promotion Practice</td>
<td>qualitative-interviews</td>
<td>HIV project Director, Prevention planning cochair, opinion leader, and faith leaders</td>
<td>113 (24 were faith leaders of African American churches) 4 sites (Chicago IL, Harlem NY, Jackson MS, Phoenix AZ)</td>
<td>Purposive</td>
</tr>
<tr>
<td>Pastor and Lay Leader Perceptions of Barriers and Supports to HIV Ministry Maintenance in an African American Church</td>
<td>2012</td>
<td>Jennifer M. Stewart</td>
<td>Journal of Religion and Health</td>
<td>qualitative ethnographic case study</td>
<td>African American clergy and lay leaders</td>
<td>5</td>
<td>Purposeful</td>
</tr>
<tr>
<td>Perspectives on Efforts to Address HIV/AIDS of Religious Clergy Serving African American and Hispanic Communities in Utah</td>
<td>2007</td>
<td>Stephen C. Alder, Sara Ellis Simonsen, Megan Duncan, John Shaver, Jan DeWitt, Benjamin Crookston</td>
<td>The Open AIDS Journal</td>
<td>Qualitative-Focus groups</td>
<td>Clergy serving African American and Hispanic communities in Utah</td>
<td>11 participants; 3 focus groups (2 with Catholic clergy serving Hispanic congregations and 1 with protestant clergy serving African American congregations)</td>
<td>Potential participants were sent a letter of invitation followed by a telephone call for those that did not respond to the initial request.</td>
</tr>
<tr>
<td>Title</td>
<td>Year of Publication</td>
<td>Authors</td>
<td>Journal Title</td>
<td>Study Design</td>
<td>Target population</td>
<td># of participants</td>
<td>sampling method</td>
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<tr>
<td>Predictors of HIV/AIDS Programming in African American Churches: Implications for Prevention, Testing and Care</td>
<td>2017</td>
<td>Jennifer M. Stewart, Alexandra Hanlon, Bridgette Brawner</td>
<td>Health Education and Behavior</td>
<td>qualitative interviews</td>
<td>African American clergy, staff, congregation leaders</td>
<td>193</td>
<td>Purposeful</td>
</tr>
<tr>
<td>Public health and church-based constructions of HIV prevention: black Baptist perspective</td>
<td>2014</td>
<td>Malika Roman Isler, Eugenia Eng, Susanne Maman, Adaora Adimora, Bryan Weiner</td>
<td>Health Education Research</td>
<td>qualitative-focus groups and interviews</td>
<td>Black churches in North Carolina-Baptist only</td>
<td>12 churches leaders and 36 focus group participants</td>
<td>purposive</td>
</tr>
<tr>
<td>Religious Congregations’ Involvement in HIV: A Case Study Approach</td>
<td>2010</td>
<td>Kathryn Pitkin Derose, Ricky N. Bluthenthal, Blanca X. Domínguez, Clyde W. Oden, Peter J. Mendel, Kartika Palar, Laura Werber Castaneda, Jennifer Hawes-Dawson, David E. Kanouse, Dennis E. Corbin, Michael A. Mata</td>
<td>AIDS Behavior</td>
<td>Qualitative-Case Study</td>
<td>religious congregations, lay leaders and clergy in LA</td>
<td>6 predominantly African American churches, 4 Latino (3 primarily Spanish-speaking and 1 English-speaking), 2 white, and 2 were of mixed composition (i.e., no racial-ethnic group C70%). 57 people were interviewed</td>
<td>A list of 80 churches was compiled by community and team members. The list was created based on churches past and current HIV activities and participation demographics. To be considered as a case, congregations had to have conducted health</td>
</tr>
<tr>
<td>Title</td>
<td>Year of Publication</td>
<td>Authors</td>
<td>Journal Title</td>
<td>Study Design</td>
<td>Target population</td>
<td># of participants</td>
<td>sampling method</td>
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<tr>
<td>Sex, Stigma, and the Holy Ghost: The Black Church and the Construction of AIDS in New York City</td>
<td>2010</td>
<td>Angelique Harris</td>
<td>Journal of African American Studies</td>
<td>qualitative-interviews</td>
<td>Black churches in New York</td>
<td>28</td>
<td>purposeful sampling</td>
</tr>
<tr>
<td>Social Determinants of HIV-Related Stigma in Faith-Based Organizations</td>
<td>2016</td>
<td>Jason D. Coleman, Allan D. Tate, Bambi Gaddist, and Jacob White</td>
<td>American Journal of Public Health</td>
<td>quantitative</td>
<td>African American congregants</td>
<td>1747</td>
<td>Purposeful</td>
</tr>
<tr>
<td>Title</td>
<td>Year of Publication</td>
<td>Authors</td>
<td>Journal Title</td>
<td>Study Design</td>
<td>Target population</td>
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<tr>
<td>Taking it to the pews: A CBPR-guided HIV awareness and screening project with black churches</td>
<td>2010</td>
<td>Janette Berkly-Patton, Carole Bowe-Thompson, Andrea Bradley-Ewing, Starlyn Hawes, Erin Moore, Eric Williams, David Martinez, David Martinez, Kathy Goggin</td>
<td>AIDS Education and Prevention</td>
<td>CBPR approach-randomized control</td>
<td>African American Churches in Kansas City Kansas and Missouri</td>
<td>12 churches ((7 Baptist, 4 nondenominational, and 1 Methodist) 26 church leaders and 3200 church members)</td>
<td>convenience sample</td>
</tr>
<tr>
<td>The Influence of Black Church Culture: How Black Church Leaders Frame the HIV/AIDS Discourse</td>
<td>2009</td>
<td>Sandra L. Barnes</td>
<td>Interreligious Dialogue</td>
<td>Qualitative-Focus group</td>
<td>Black Church leaders</td>
<td>35 participants</td>
<td>Purposeful</td>
</tr>
<tr>
<td>The influence of pastors’ ideologies of homosexuality on HIV prevention in the Black Church</td>
<td>2016</td>
<td>Katherine Quinn, Julia Dickson-Gomez, and Staci Young</td>
<td>Journal of Religion and Health</td>
<td>qualitative interviews</td>
<td>Pastors of black churches in Milwaukee</td>
<td>21</td>
<td>purposive</td>
</tr>
<tr>
<td>The Organization of HIV and Other Health Activities within Urban Religious Congregations</td>
<td>2012</td>
<td>Kartika Palar, Peter Mendel, and Kathryn Pitkin Derose</td>
<td>Journal of Urban Health: Bulletin of the New York Academy of Medicine</td>
<td>Qualitative-Case Study</td>
<td>urban congregation in LA</td>
<td>14 congregations-57 people interviewed</td>
<td>purposive</td>
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<tr>
<td>Title</td>
<td>Year of Publication</td>
<td>Authors</td>
<td>Journal Title</td>
<td>Study Design</td>
<td>Target population</td>
<td># of participants</td>
<td>sampling method</td>
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<tr>
<td>The Role of Structure Versus Individual Agency in Churches’ Responses to HIV/AIDS: A Case Study of Baltimore City Churches</td>
<td>2011</td>
<td>Shayna D. Cunningham, Deanna L. Kerrigan, Clea A. McNeely, Jonathan M. Ellen</td>
<td>Journal of Religion and Health</td>
<td>Qualitative interviews</td>
<td>church leaders in Baltimore</td>
<td>20</td>
<td>The pool of churches from which the sample was recruited was identified through the phone book, Internet, driving tours of the city, and recommendations of local community agencies.</td>
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<tr>
<td>Title</td>
<td>Year of Publication</td>
<td>Authors</td>
<td>Journal Title</td>
<td>Study Design</td>
<td>Target population</td>
<td># of participants</td>
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<tr>
<td>Under the Radar: AIDS Ministry in the Bible Belt</td>
<td>2006</td>
<td>Jerome R. Koch and Robert E. Beckley</td>
<td>Review of Religious Research</td>
<td>Qualitative-Case Study</td>
<td>A multi racial church lead by an African American pastor. The church has a ministry dedicated to helping people living with HIV/AIDS. Historically, the church started as majority African American congregation. At the time of this study the church was 50% white, 40% African American, and 10% Latino.</td>
<td>3- interviewed the pastor of the church, health professional, and a former participants of the program.</td>
<td>The church was selected because of it HIV/AIDS program and the churches denomination</td>
</tr>
<tr>
<td>Understanding Barriers and Solutions to the Black Church</td>
<td>2017</td>
<td>Sarita K. Davis</td>
<td>Association for the Study of African</td>
<td>Qualitative-focus group</td>
<td>Faith leaders living and working in 5</td>
<td>16</td>
<td>purposive</td>
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<td>Title</td>
<td>Year of Publication</td>
<td>Authors</td>
<td>Journal Title</td>
<td>Study Design</td>
<td>Target population</td>
<td># of participants</td>
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<td>Providing HIV Services in a Southern Urban City</td>
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<tr>
<td>Wake Up! HIV is at Your Door”: African American Faith Leaders in the Rural South and HIV Perceptions: A Qualitative Analysis</td>
<td>2016</td>
<td>Tiffiany M. Aholou, Eric Cooks, Ashley Murray, Madeline Y. Sutton, Zaneta Gaul, Pamela Payne-Foster</td>
<td>American Life History</td>
<td>Qualitative-Interviews</td>
<td>zip codes in Atlanta</td>
<td>10</td>
<td>purposive sampling method</td>
</tr>
<tr>
<td>Title</td>
<td>Year of Publication</td>
<td>Authors</td>
<td>Journal Title</td>
<td>Study Design</td>
<td>Target population</td>
<td># of participants</td>
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<td>YOUR Blessed Health: an HIV-prevention program bridging faith and</td>
<td>2010</td>
<td>Derek M. Griffith, Bettina Campbell, Julie Ober Allen, Kevin J.</td>
<td>Public Health Reports</td>
<td>Pilot intervention-Quantitative-</td>
<td>African American churches faith leaders and</td>
<td>12 churches</td>
<td></td>
</tr>
<tr>
<td>public health communities</td>
<td></td>
<td>Robinson, Sarah Kretman Stewart</td>
<td></td>
<td>pretest posttest</td>
<td>adults</td>
<td></td>
<td></td>
</tr>
<tr>
<td>African American Clergy Share Perspectives on Addressing Sexual</td>
<td>2009</td>
<td>Tiffiany M. Cummings Aholou, Jerry E. Gale, LaTrina M. Slater</td>
<td>Journal of Religion and Health</td>
<td>Qualitative</td>
<td>African American clergy</td>
<td>7</td>
<td>purposeful convenience sampling technique (non random)</td>
</tr>
<tr>
<td>Health and HIV Prevention in Premarital Counseling: A Pilot Study</td>
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Appendix II: Interview Guide

Introduction- Hello and thank you for taking the time to talk with me today. My name is Kelsey Burton, and I am a PhD candidate at the University of Louisville. Today I will discuss HIV/AIDS, stigma, and the African American community. Your responses will be used to help address HIV/AIDS within the African American Community.

I want to remind you that this conversation is being recorded and used for research purposes. Feel free to speak open and honestly. All identifiable information will be removed from the transcripts of this conversation. If at any point you want to stop or discontinue the conversation, please let me know.

Do you have any questions?

Let’s get started!

1. First tell me about yourself and your congregation?

The following questions are used to answer research question 2

Research Question 2- How do millennial African American faith leaders form their perspectives on HIV/AIDS within the African American community?
- Explore symbolic meanings and influences related to HIV/AIDS and stigma among millennial African American faith leaders.

2. As a faith leader, what has been your biggest influence?
3. What do you think has led to high rates of HIV/AIDS within the African American community?
   a. Do you believe the church has contributed to the high rates of HIV/AIDS?

4. As a faith leader, how do you feel about discussing HIV/AIDS related topics such as, abstinence, sexuality, pre-exposure prophylaxis (PrEP), and condom use in your church?

5. What has been the churches response to HIV/AIDS?
   a. Do you agree with its response?
      i. Tell me why you feel that way?

(Do not read out loud to participant) The following questions are used to answer sub aim for research question 3- What are the perspectives of millennial African American
faith leaders on addressing HIV/AIDS and HIV/AIDS stigma within the African American community?

1. Are you familiar with HIV/AIDS stigma?
   a. If no- Explain what stigma is.
   b. If yes- What does stigma mean to you?

2. Do you believe HIV/AIDS stigma exist within the church?
   a. If yes- How is HIV/AIDS stigma exhibited in the church?
   b. If no- How has the church prevented HIV/AIDS stigma from happening in the church?

3. What is the best way to address HIV/AIDS and stigma within the Black church?

4. Has the perspective within the Black church helped discussions or programming about HIV/AIDS and stigma? If so, how?

5. Has the perspective within the Black church hindered discussions or programming about HIV/AIDS and stigma? If so, how?

6. Have you addressed HIV/AIDS prevention, education, or stigma in your church?
   a. If yes- Can you tell me about you experience?
      i. Tell me your biggest challenge or barriers?
      ii. How did you overcome your challenges or barriers?
      iii. What would you do to improve your program or initiative?
      iv. What influenced you to address HIV/AIDS in your church?
   b. If no- Would you ever host an HIV/AIDS program at your church?
      i. If yes- What concerns do you have or would have if you decided to host an HIV/AIDS program at your church?
      ii. What do you think would be your biggest challenges?
      iii. How would you overcome those challenges?
      iv. Who would you involve to address HIV prevention?
      v. If no- Please tell me why?
1. What concerns do you have or would have if you decided to host an HIV/AIDS program at your church?
2. What do you think would be your biggest challenges?
3. How would you overcome those challenges?
4. What has influenced you to not address HIV/AIDS?

Appendix III: Demographic Form

1. Has the participant completed the consent form? If, no complete consent form before completing this form.
   
   Yes or No

2. Recruitment Mode
   a. Contact List
   b. Flyer
   c. Conference
      a. Which conference ____________________________________________
   d. NACCP Black Church Initiative list

3. How old are you?
   a. 18-30
   b. 31-40

4. What is your racial/ethnic identity?
   a. Black/African American
   b. Non-Hispanic White
   c. Hispanic American
   d. Asian/Pacific Islander

5. What is gender identity do you most identify?
   a. Female
   b. Male
   c. Transgender female (Male to Female)
   d. Transgender male (Female to Male)
   e. Gender non-conforming
   f. Not listed _________________________________________________

6. What current state and city do you live in?
   City_________________________________________ State________

7. What is the highest level of education that you have completed?
   a. GED
   b. High School diploma
   c. Some college

180
d. College graduate
e. Graduate degree or advanced. (Master’s degree or advanced)

8. What is your denomination affiliation?

____________________________________________________________

9. Are you an ordained minister or faith leader? 
   Yes or No
   a. If yes, What year were you ordained as a minister or faith leader?
      
10. How many years have you served your current church?

11. How many people are members of your church?
   a. Less than 100
   b. 101-500
   c. More than 500 people

12. What is the average number of persons who attend your church services on Sunday?
   a. Less than 100
   b. 101-500
   c. More than 500 people
CURRICULUM VITAE

Kelsey LeAnn Burton
1800 Telluride Way Apt #102
Louisville KY, 40223
Phone: (901) 496-2197
Email: K0BURT01@louisville.edu

EDUCATION/CERTIFICATION/TRAINING:
University of Louisville, School of Public Health and Information Sciences- 2016- Present
PhD Candidate
Concentration: Health Promotion and Behavioral Sciences
Dissertation Title- HIV and the African American Church: Millennial Faith Leaders’ Perspectives

Tennessee State University-2015
Master of Public Health
Concentration: Behavioral Science

Fisk University- 2012
Bachelor of Arts
Major: Biology

ACADEMIC EXPERIENCE
Teaching Assistant- 2019
University of Louisville, Department of Health Promotion and Behavioral Science
Course: Social Determinants of Health

PUBLICATIONS


**PROFESSIONAL/ RESEARCH EXPERIENCE:**
University of Louisville, School of Public Health and Information Sciences- 2016- Present

*Graduate Research Assistant*
- Assisted with qualitative and quantitative data collection for HIV prevention studies.
- Help coordinate activities and events for research teams and community participants.
- Conducted literature reviews and assisted with analyzing research data.
- Contributed to developing research and community presentations and reports.
- Responsible for recruiting research participants.
- Established relationships with local community organizations.

*Examining Stigma and Care Continuum Participation among HIV Positive Ex-offenders – 2016-2017*
- Administered audio computer assisted self-interviews focused on stigma and HIV care continuum participation among formerly incarcerated African Americans living with HIV.

*Examining Stigma, Stress, and HIV Care Utilization among African American Elders - 2017*
- Conducted interviews with African Americans elders living with HIV to examine how stigma and stress impact their HIV care.
- Contributed to analyzing interview data and developing monologues based on the life experiences of African Americans elders living with HIV.
- Assisted in planning and organizing a community event for monologue performances. This included hiring actors and securing performance venue. The community event not only show-cased the monologues but aided in educating the local community about HIV/AIDS and reducing stigma among people living with HIV.
- Helped coordinate meetings with research team and study participants.
- Responsible for distributing and collecting stigma questionaries for the monologue performances.
Increasing Pre-exposure Prophylaxis among High-risk African Americans in Louisville, KY - 2018-2020
- Facilitated focus group discussions with African American young adults in Louisville, KY about their perceptions of HIV/AIDS and PrEP.
- Administered audio computer assisted self-interviews with African American young adults to examine HIV risk behaviors and their knowledge and perceptions about PrEP and HIV/AIDS.
- Contributed to the analyzing qualitative research data which included transcribing and coding focus group data using Dedoose software and conducting inter-rater reliability test.
- Conducted Chi-square statical analysis to understand barriers and awareness of PrEP among African American young adults in Louisville, KY.
- Contributed to developing a multi-media PrEP awareness campaign within the city of Louisville, KY.
- Assisted with developing an advisory committee and facilitating advisory committee meetings. Community advisory committee meeting aided in providing the theme and image of the PrEP campaign material.
- Managed social media platforms for PrEP media campaign. Developed social media content which included photos and videos. Learned how to utilize social media platforms for participant recruitment and retention.

Examining HIV-related Stigma and HIV Testing among Formerly Incarcerated African American Youth – 2020-Present
- Administered audio computer assisted self-interviews focused on HIV related stigma and testing among African American young adults who’ve experienced jail or prison.
- Contributed to Beta testing survey instrument.
- Developed social media recruitment strategy to identify local organizations and groups that provide services to formerly incarcerated individuals in Louisville, KY.
- Manage FIAAY social media platforms (Instagram and Facebook). Responsible for creating social media content, developing strategies to increase following, and...

University of Louisville, Kent School of Social Work
Research Assistant
- Increasing Alzheimer and Dementia resources among African American’s in Louisville-2019
  - Facilitated focus group with African American dementia caregivers living in Louisville, KY to explore the resources they need to support themselves and their loved ones.
  - Contributed to analysis phase of the study, which included transcribing and coding focus group data using Dedoose software.
• MATCH Study- Addressing Maternal Health in Louisville- 2018
  • Developed a participant recruitment strategy to help the research team to recruit African American women within their 3rd trimester. This included contacting birthing centers, nurses at the University of Louisville Women’s Hospital, and African America churched in the city of Louisville, KY.

Tennessee State University, Office of Institutional Effectiveness and Research- 2015- 2016
Data Analyst

• Provided technical and analytical support for institutional research and evaluation.
• Organized and extracted data for analysis.
• Prepared quantitative and qualitative reports upon request for internal entities, as well as external stakeholders.

Tennessee State University, Center for Prevention Research, The Nashville CHEW (CHildren Eating Well) Project- 2015
Research Analyst

• Responsible for recruiting over 50 women and children enrolled in the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).
• Administered quantitative interviews utilizing REDCap software.
• Responsible for managing and organizing CHEW research data.

Research Assistant

• Contributed to developing an HIV/AIDS needs assessment survey for people living with HIV and in rural communities to examine gaps in accessing HIV resources in middle Tennessee.
• Assisted with developing focus group questions and facilitating focus group discussions with individuals living with HIV/AIDS and residing in a rural community.
• Transcribed and Analyzed focus group data using ATLAS.ti software.

Task Force Leader

• Oversaw the planning and implementation of National Youth HIV/AIDS Awareness Day in the Nashville community. This event was created to increase awareness and knowledge about HIV/AIDS among youth within the Nashville community.
• Developed Youth HIV/AIDS Awareness Day Task force. The task force was responsible for creating and implementing Youth HIV/AIDS Awareness day. The task force consisted of community members from local AIDS service organizations, sexual health organizations, and public health entities in Nashville.
• Over saw the activities of volunteers and task force members.
• Responsible for reserving event space and entertainment and getting local organizations to come and provide material and resources to the youth who attend.
• Developed promotional material for the event.

Intern/Volunteer

• Contributed to writing an Emergency Financial Assistance grant for the Ryan Write Program.
• Developed a program evaluation instrument for the Early Intervention Services program.
• Developed a program evaluation instrument for the Technology Assistance Care program. This program assisted clients living with HIV and were enrolled in a alcohol and drug recovery program.

Tennessee State University, Office of First Year Students- 2012- 2014
Graduate Assistant

• Coordinated and implemented a grant funded program titled “Tiger Mentoring Program”. The purpose of this program was to increase the retention rates of freshmen students and help freshmen reach academic success after one year in college.
• Responsible for recruiting students to participate in program
• Responsible for hiring faculty members serves as mentors.
• Planned and organized all program activities and events.
• Managed programs budget.
• Analyzed data and assisted with writing reports on student success.
• Served as an Administrative Assistant to the Director of First Year Experience.
• Assisted with New Student Orientation preparations and other first year initiatives for freshman students.

Nashville CARES, Education Department- Nashville, TN- Spring 2014
Intern

• Assisted with implementing an HIV/AIDS prevention program for African American Women called SISTA (Sister’s informing Sister’s About Topics on AID’s).
• Assisted with planning and implementing a sex education program for high school students in the Nashville community titled Survivor Club.
• Conducted HIV/AIDS test for patients and guest, at Saint Thomas Midtown Hospital.

CONFERENCE & COMMUNITY PRESENTATIONS

AFYA Project- Increasing PrEP Awareness Among African American Young Adults
2021 U.S. Conference on HIV/AIDS
Washington, D.C.

Examining the relationship between health information sources and perceived HIV susceptibility among young African Americans in Louisville, Kentucky
2021 American Public Health Association Annual Meeting & Expo- Co-Author
Denver, CO 2021

*Culture of Dementia Care and Service Needs Among African American Caregivers of People with Dementia in Kentucky: A Mixed Method Pilot Study*

25th Society for Social Work Research Conference- Co-Author
San Francisco, CA (Virtual) 2021

*The far-reaching impact of stigma on PrEP and HIV perceptions among African American young adults living in Louisville, KY*

11th Annual International Conference on Stigma- 1st Presenter
Howard University, Washington, DC (virtual) 2020

*The impact of stigma on PrEP uptake among African American young adults in Louisville, KY.*
Public Health Seminar Series- Speaker
School of Public Health and Information Sciences SGA
University of Louisville, Louisville, KY 2020

*Utilizing Qualitative research to create performative arts monologues that help reduce HIV stigma*
Advanced Qualitative Research Course- Guest Lecturer
University of Louisville, Kent School of Social Work
Louisville, KY 2019

*Innovative Approaches to Sexual Health for African American Youth: The Afya Project*
AFYA Community PrEP meeting- Speaker
House of Ruth, Louisville, KY 2019

*African American Pastors perspective on addressing HIV and stigma: A systematic review*
Research! Louisville Conference- Poster Presentation
University of Louisville, Louisville, KY 2018

*HIV Basic’s*
Louisville PrEP Summit- Speaker
Redeemer Lutheran Church, Louisville, KY 2018

*Assessing the Factors Contributing to Sexual Concurrency and Increase in Sexual Partners Among African, Caribbean, and Black Women Living in Windsor, Ontario, Canada*
Research! Louisville Conference- Poster Presentation
University of Louisville, Louisville, KY 2017

*What is HIV/AIDS and how can I get it?*
Teen Summit- Presenter
Burnett Ave Baptist Church, Louisville, KY 2016, 2017, 2018

*What Is Public Health?*
Core 100 course- Guest Lecturer

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ADDITIONAL EXPERIENCE

Journal of Sex Research
Peer Reviewer- 2022
- Read and review submitted manuscripts.
- Provide recommendation and feedback to accept or reject submitted manuscripts.

Journal of Healthcare, Science and Humanities
Tuskegee, AL
Peer Reviewer- 2021 – Present
- Read and review submitted manuscripts.
- Provide recommendation and feedback to accept or reject submitted manuscripts.

Burnett Ave. Baptist Church- Teen Summit
Louisville, KY- Summer 2017, 2018, 2019
Health Instructor-
- Conducted a seminar on sexual health to teenagers at Burnett Avenue Baptist Church.
- Assisted teenagers with conducting research projects on the Civil Rights Movements.

Louisville Sex Education Now (LSEN)
Louisville, KY- 2018
Volunteer
- Advocating for the expansion of comprehensive sex education curriculum within Jefferson County Public Schools.

Heart to Hand dinner
Louisville, KY- 2019 – Present
Volunteer
- Assist with preparing meals for people living with HIV in the Louisville community.
- Assist with games and other activities

HONORS AND AWARDS
University of Louisville Graduate Dean’s Citation- 2022
Alpha Kappa Mu Honor Society-2013
Volkswagen Scholar-Fisk University- 2010
Fisk University Emerging Young Leaders Award-2010-2012