



African American Clergy Recommendations to Enhance the Federal Plan to End the HIV Epidemic: A Qualitative Study

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Abstract

African Americans in the southern United States continue to be disproportionately affected by HIV. Although faith-based organizations (FBOs) play important roles in the social fabric of African American communities, few HIV screening, care, and PrEP promotion efforts harness the power of FBOs. We conducted 11 focus groups among 57 prominent African American clergy from Arkansas, Mississippi, and Alabama. We explored clergy knowledge about *the Ending the HIV Epidemic: A Plan for America* (EHE); normative recommendations for how clergy can contribute to EHE; and how clergy can enhance the HIV care continua and PrEP. We explored how clergy have responded to the COVID-19 crisis, and lessons learned from pandemic experiences that are relevant for HIV programs. Clergy reported a moral obligation to participate in the response to the HIV epidemic and were willing to support efforts to expand HIV screening, treatment, PrEP and HIV care. Few clergy were familiar with EHE, U = U and TasP. Many suggested developing culturally tailored messages and were willing to lend their voices to social marketing efforts to destigmatize HIV and promote uptake of biomedical interventions. Nearly all clergy believed technical assistance with biomedical HIV prevention and care interventions would enhance their ability to create partnerships with local community health centers. Partnering with FBOs presents important and unique opportunities to reduce HIV disparities. Clergy want to participate in the EHE movement and need federal resources and technical assistance to support their efforts to bridge community activities with biomedical prevention and care programs related to HIV. The COVID-19 pandemic presents opportunities to build important infrastructure related to these goals.

Keywords HIV prevention · African American · Clergy · Church · South

Introduction

Nearly half of new HIV infections occur in the Southeastern United States [1–3]. In 2017, Mississippi had the 7th highest rate of new HIV diagnoses and the highest rate of AIDS-related mortality in the country [4]; Arkansas ranked 20th in the nation for the highest rate of new HIV diagnoses [5]; and Alabama ranked 11th in the United States for the highest rate of new HIV diagnoses [6, 7]. In Arkansas, Mississippi, and Alabama infection rates are high in certain rural areas [7–9]. Little HIV research has been conducted in rural areas in these states, and many rural communities with significant HIV burden are medically underserved [10].

There is tremendous unmet need for HIV education, screening, prevention, and care services in these southern states [11], particularly in geographic hotspots of HIV infection.

Ending the HIV Epidemic: A Plan for America (EHE) was developed by agencies across the U.S. Department of Health and Human Services to end the HIV epidemic in the United States by 2030 [11]. The first phase of the EHE targets 48 jurisdictions where HIV transmission occurs most frequently, several with a large rural HIV disease burden, including in Arkansas, Mississippi, and Alabama [11]. The EHE “whole-of-society” approach leverages community, academic, government, and healthcare organizations as a strategy to reduce incidence cases of HIV in the United States. Partnering with faith-based organizations (FBOs) located in geographic areas with higher HIV rates is an important component of the EHE “whole-of-society” approach to ending the HIV epidemic.

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Most new infections in the South are among African Americans [1–3]. African Americans have poorer outcomes than White individuals in the entire continua of HIV and Pre-exposure prophylaxis (PrEP) care [12]. Reducing racial disparities in HIV infection requires addressing complex social, structural, and behavioral factors that raise African Americans' HIV acquisition risks and related clinical outcomes [13–15]. PrEP can reduce HIV infection by over 90% [16]; however, there are numerous barriers to achieving optimal levels of PrEP use among African Americans [13, 17–22]. These barriers include lack of education around PrEP and HIV risk, stigma, medical mistrust, and lack of access to PrEP or financial assistance to pay for PrEP. Similar barriers contribute to the disparities in HIV treatment. African Americans are less likely than Whites to receive antiretroviral therapy (ART), to be adherent and persistent with ART, or to achieve viral suppression [23, 24]. Reducing HIV disparities will require addressing the negative influences that impact health disparities, including paralyzing stigma that undermines HIV screening, prevention, treatment and care. Reducing disparities also requires leveraging the cultural capital and strengths of the African American community.

African Americans are more likely than other Americans to believe in God, attend church, and support religious engagement with sociopolitical issues [25]. African American churches played important roles in the Civil Rights Movement and African American voting efforts in the United States, ultimately culminating in important civil rights legislation. Further, African American Faith-based Organizations (FBOs) have been a place of refuge and healing and have served as a gateway to reach African Americans through partnerships with public health agencies and medical institutions [26]. African American FBOs have long been recognized as critical partners for delivering social services, health-related behavior change interventions, and chronic disease interventions [27–30]. Moreover, church-based health promotion interventions have improved health outcomes for African Americans when conducted in culturally congruent ways [27]. FBOs and spirituality can have a positive impact on health outcomes of people living with HIV [31, 32]; however, few HIV screening, prevention (including PrEP) and care efforts harness the power of FBOs for normalizing HIV-related interventions.

Clergy are willing to partner in efforts to respond to the HIV epidemic [33–37] and are aware of their powerful influence to addressing stigma related to HIV [33, 38, 39]. Recent research finds that clergy report a moral obligation and willingness to promote HIV screening and support HIV related biomedical interventions and anti-stigma efforts [33]. Further, clergy frame HIV as a social justice issue, affirm the value and dignity of people living with HIV, and support

positive messages about treatment initiation and medication adherence [33, 34, 40, 41].

Although many clergy understand HIV affects their congregations and communities, clergy report barriers to being able to provide prevention services directly [42]. Many clergy understand how HIV is transmitted, but do not have the resources to educate themselves or their congregations about “treatment as prevention (TasP),” “Undetectable = Untransmittable (U = U),” and PrEP [33, 34]. TasP refers to the population impacts associated with initiating antiretroviral therapy; individuals who are virologically suppressed have 99% lower chances of transmitting HIV to others than those who are not suppressed [43]. Similarly, U = U refers to the concept that HIV positive individuals who maintain a suppressed viral load for at least six months do not transmit HIV to sexual partners [44]. Although clergy support biomedical interventions, they often have little understanding of these interventions, limited financial support, and no existing partnerships with Community health centers (CHCs) that offer screening, PrEP, HIV treatment, and care [33]. Ongoing HIV stigma compounds technical challenges associated with involving clergy in disseminating these complex public health messages [45].

The Bible Belt is a region of the Southern United States in which church attendance is higher than the nation's average and Christianity has a strong influence on society and politics. CHCs are key potential EHE partners for scaling HIV screening, PrEP, and HIV care in the Bible belt. Despite the importance of faith, spirituality, and religious practice in the lives of many African Americans and the role CHCs play in HIV treatment and prevention, there has been little scientific investment exploring how to bring African Americans' faith institutions and CHCs together to address stigma and promote uptake of HIV prevention and care interventions. Leveraging the power of African American faith institutions in rural communities in the Bible Belt presents a public health opportunity to reduce stigma and racial disparities in the HIV and PrEP care continua. We explored clergy opinions about these topics and solicited their normative recommendations about how to engage clergy in partnerships with CHCs in the Bible Belt.

Methods

Sample

We used a purposeful sampling strategy and recruited clergy serving primarily African American congregations in geographic HIV hotspots within Bible Belt states: Little Rock, Arkansas; Memphis, Tennessee (on the Arkansas side); Jackson, Mississippi; and Tuscaloosa, Alabama. We completed 11 focus groups in May and June of 2020 with 57

prominent African American clergy from Arkansas ($n=18$), Mississippi ($n=20$), and Alabama ($n=19$), 79% were male. Focus groups had an average of 6 participants and were conducted by trained African American moderators via HIPPA compliant secure zoom. The clergy sampled had varying levels of exposure to and familiarity with HIV; some clergy had been involved with previous faith-based HIV initiatives, and others had limited or no experience. All participants in the study were over 18 years of age, spoke and read English, and provided oral consent. Each participant received a \$100 gift card. All focus groups were digitally recorded and later transcribed. In accordance with grounded theory, we completed focus groups until we reached saturation, when no new data were discovered [46]. The Brown University Institutional Review Board approved this study.

Data Collection

Semi-structured focus groups lasted approximately 90 min and assessed how clergy might help normalize uptake of biomedical interventions and support improvements to the HIV care continua and PrEP initiation efforts. We explored: clergy knowledge about HIV/ HIV transmission, TasP, U = U, and the EHE federal plan; as well as clergy willingness to discuss HIV, treatment, and prevention/PrEP in faith-based settings. We solicited their normative feedback regarding how FBOs can best address stigma related to HIV, partnering with clinics, hosting and developing social marketing campaigns related to TasP and U = U, and overcoming potential obstacles. Lastly, because our focus groups took

place during the COVID pandemic, we briefly discussed how to integrate clergy suggestions about HIV programming during the COVID-19 crisis, and opportunities to combine HIV programs with COVID-19 prevention programs.

Data Analysis

A general inductive approach guided the analysis of data, which allowed for the data to be formulated into themes and categories [47]. Four trained coders individually reviewed and coded the transcribed data using Dedoose software (Data Coders: TA, LKF, YM, DG). Open and axial coding were then used to outline concepts among coders and combine themes that overlapped. Each theme and sub-theme were assigned a code and compiled in a codebook [48]. At least two coders independently coded the first 27% of the transcripts to increase reliability of codes. Discrepancies in interpretation were resolved among the research team before final coding commenced.

Results

Table 1 below summarizes clergy knowledge of HIV treatment as prevention, U = U, and EHE and willingness to discuss HIV, treatment, and PrEP in faith-based settings. These themes are also explored in more detail below.

Table 1 African American clergy knowledge about HIV, TasP, U = U, EHE and PrEP

Themes	Sub-themes
Knowledge about Treatment as Prevention, U = U, Ending HIV Epidemics, & PrEP	<ul style="list-style-type: none"> Clergy understand how HIV is transmitted All participants know someone living with or affected by HIV No clergy had heard of the federal Ending HIV Epidemic Plan No clergy were familiar with U = U concepts Clergy knew little about TasP Few clergy knew about Ryan White free care services and several expressed concerns about high perceived cost of HIV treatment Most clergy had never heard of PrEP
Willingness to Address Stigma & Discuss HIV, Treatment, & PrEP	<ul style="list-style-type: none"> Clergy believe they have a moral obligation to address HIV and HIV stigma Most clergy are willing to discuss and address HIV stigma from the pulpit and to respond to the HIV crisis Clergy were even more willing to be involved in HIV programs after participating in the focus groups Clergy were willing to get involved in efforts to promote treatment, TasP, and to promote PrEP with local CHCs
Current Health Promotion Efforts and Clinical Partnerships	<ul style="list-style-type: none"> Some churches have health ministries and already conduct HIV testing Many churches have existing informal collaborations with health organizations; few have formal partnerships with any clinics or CHCs No churches had support programs for HIV positive persons or efforts to link HIV-positive persons to HIV care

Knowledge About Treatment as Prevention, U = U, Ending the HIV Epidemic, & PrEP

Overall, clergy reported understanding how HIV is transmitted. Many clergy have congregation members who are living with HIV or impacted by HIV; however, most were still unaware of the gravity of the current HIV epidemic in their surrounding communities. Importantly, many noted that HIV has affected members of their congregations. One pastor commented:

I personally know someone who became HIV positive. It was not somebody who was promiscuous. It was not somebody who was with a lot of sex partners. It was an elderly lady from a church who married a deacon and at 68 years of age became HIV positive.

None of the clergy had ever heard of EHE or the U = U movement. Nearly all clergy reported that U = U has not been effectively marketed to their communities, and noted that new, culturally tailored messages would resonate better with their congregations. Several clergy remarked:

I'm one of these people who is aware of things. I read a lot. I pay attention! I have not heard of this, so it hasn't been marketed very well.

This information, the Undetectable = Untransmittable, is something that I don't think a lot of people know, so this is definitely somewhat eye-opening. As a matter of fact, I know a lot of people don't know this in my church or in my community, that anyone who is HIV positive and maintains an undetectable viral load cannot transmit HIV!

Some clergy reported learning about HIV treatment from television commercials, but otherwise reported knowing little about treatment and TasP. A few noted that the pharmaceutical commercials are not framed in ways that would resonate with their congregations:

I've seen the different medications that are available and those type of commercials. We're in the Bible Belt. It's a very conservative area, and I think that is one thing that might limit the effectiveness of those ads resonating with people.

Furthermore, clergy were not sure how the medications worked and worried that medications might not be affordable for those in their congregations. Clergy wanted congregations to be empowered by information so they can stay healthy but wanted to make sure that people also had access to the medication. Few knew that HIV treatment could be provided free of charge by the federal Ryan White HIV care program. Some clergy recalled high costs of medications earlier in the epidemic:

My mind goes back to a few years ago, that for people with AIDS, the medication was very, very expensive. They were not able to afford the medication.

Most clergy reported they had never heard of PrEP. Upon learning about PrEP for the first time, most clergy were very eager for more information and wanted to offer this resource to those in their congregation and communities. Two clergy remarked:

I would love to have some literature as it relates to PrEP because this is my first time hearing of it. No, I haven't heard of that particular medication [PrEP], but I think if it works, let's get it out there.

Others were eager to learn more about PrEP but felt hesitant dispensing information to congregations before learning more about what it is, how it works, and any potential side effects.

I've seen the commercials about PrEP, but I would definitely want to know what I'm talking about. I think it's worth knowing more.

Willingness to Address Stigma and Discuss HIV, Treatment, and PrEP

There was an overwhelming consensus that clergy believe they have a moral obligation to get involved in HIV treatment and prevention efforts, and to help eradicate stigma.

I do believe it's a moral duty that we should educate. I think it all ties in to knowledge and understanding. I believe this is part of our purpose.

I think too often the church tries to over spiritualize that which it doesn't want to address or is afraid to address so we'll say, That's not the church's responsibility. Christ's ministry was holistic. He didn't just address spiritual issues. He addressed sickness, he addressed poverty, he addressed inequity. We as pastors need to do the same. It's not always comfortable or easy, but God didn't give us an easy calling.

Further, clergy were aware of their potential to reduce HIV stigma among their congregations and the overwhelming majority committed to efforts to address stigma barriers to HIV testing and prevention. Clergy understood their potential influence with their congregations and underscored the importance of relatable messages:

I think one of the most influential people is the pastor, and I think pastors have an opportunity to be real with their parishioners. We don't talk about that, [HIV] but we have to be real. I incorporate different topics in my bible study to share with folk, to be real with them.

Just because you ignore it, doesn't mean it's going away. As faith-based leaders, the things that are important to leadership will become important to congregations.

Traditionally, particularly in the African-American church, people tend to respond to their leaders, if you can get these leaders on board with discussing HIV, then perhaps we can make better inroads and get the message out.

Overall, clergy were eager to learn more about HIV incidence rates in their communities, new and existing prevention and treatment modalities, and solicited technical assistance and information about available resources for their congregants. Clergy were often passionate about getting involved and emphasized the need for far more information to disseminate to their communities.

I think HIV could be incorporated in teaching, whether it is a health program or across the pulpit to give the congregation an understanding. One of the problems in my view, is that there is a lack of information in rural areas. It's hard to talk about what you don't know about!

My interaction locally in HIV has been very, very limited, so I'm trying to hear what we can do better in engaging our community.

I'm 100 percent behind whatever avenue we can go down in reference to getting people educated about it. Will I preach about it? Absolutely.

Clergy provided a variety of different ways they could get involved, suggesting several opportunities for fighting stigma and raising awareness. Willingness to talk about HIV spanned forms of communication, various types of ministries and age groups. Two clergy suggested:

We have to train our parents. We've got to train the old folks so that when they go home, they could sit down, and talk about condoms, or about the PrEP pill. The scripture said, train up a child in the way they should go, and when they grow old, they won't depart from it. We have got to train them, so I'm going to take my pastor hat off and put my parent hat on right now.

Last year, in our vacation bible school, we focused on the children, and we brought the information to them to—so that they could be informed about AIDS and sexually transmitted diseases.

Most clergy were willing to discuss PrEP with their congregations. Some clergy acknowledged that the message of PrEP wouldn't be popular because they believed it might be perceived as a tacit endorsement of premarital or extramarital sex. Other clergy noted that they would ask members of the congregation to help provide the education.

The message of PrEP and condom usage can be spread broadly in the congregation—it's not a popular message, but it needs to be shared.

I think PrEP is a great idea, and I would probably solicit those members that I know in the congregation that are part of the community to help me educate the congregation and talk about prevention.

Current Health Promotion Efforts and Clinical Partnerships

Many clergy reported existing health promotion efforts at their churches. Many churches also reported existing informal collaborations with other health organizations, but few had formal partnerships with any clinics or CHCs.

I hold HIV testing events at my church, and so I'm very aware of it. It's nothing to be afraid of or anything like that.

Well, we don't any memorandum of understandings or any type of documents in writing, but we partner with various organizations. At one point in time, they were bringing their trucks out to our church on a monthly basis for HIV screenings.

Additionally, clergy reported hosting health fairs or offering transportation to health clinics. Some clergy reported offering incentives to help people in the community attend health fairs.

We do a health fair in conjunction with a school supply and school uniform giveaway. One of the prerequisites is that they must go through the health fair in order to receive the school supplies. It's not like you just come and get your school supplies—you gotta at least get three things checked, blood pressure, glucose, weight, BMI, whatever. You have to engage someone, and so that's how we currently do it.

Some clergy also reported incorporating sexual health education into Bible study. One pastor described how he encourages the teachers at his church to take time to provide sexual health education.

What I've been challenging our church, our denomination to do is to take out time, to take a few minutes out of Sunday school lesson and empower children about issues like HIV and AIDS, about coronavirus, about any other issues that we face in our community.

Table 2 below summarizes the normative recommendations provided by the African American clergy for FBOs partnering with clinics, hosting social marketing campaigns, and overcoming potential obstacles.

Table 2 Normative recommendations from African American clergy to end the HIV epidemic

Themes	Sub-themes
Partnering with Community Health Centers (CHCs)	Clergy should establish partnerships with CHCs Clinic partners should approach churches to form collaborations Congregations and clergy should be provided information for medical payment assistance programs
Stigma Reducing Social Marketing Campaigns with Churches	HIV messages about PrEP, TasP, and U=U could be bundled with other health messages to help reduce stigma Clergy should be provided more educational materials and ongoing technical assistance about HIV treatment and prevention Clergy should participate in HIV marketing campaigns to mitigate stigma and improve HIV outcomes Medical professionals should present HIV information at churches People living with HIV could offer testimonials at churches to mitigate stigma
Overcoming Obstacles & Stigma	Clergy recommend ongoing resources and technical assistance with efforts to expand HIV services Other church leaders (not just clergy) should be engaged in HIV dialogue to help overcome stigma and improve access to HIV services

Partnering with Community Health Centers (CHCs)

While most clergy reported not having partnerships with clinics, they reported being highly willing to establish partnerships with health clinics to bolster access and uptake of HIV prevention and treatment services. However, nearly all clergy expressed that they need to know far more about what local resources are available to help their congregations get tested for HIV.

I'm interested in having relationships in place that we can use for good referrals, because HIV affects a lot of folks.

We need resource lists. We need resources to be able to help facilitate getting our people tested, getting our people educated.

Many clergy expressed low confidence in explaining the technical details about biomedical aspects of HIV prevention and care to their congregations, and many preferred to partner with outside agencies to deliver education and other clinical and support services.

The church cannot do it on its own, especially if we don't have the trained professionals that can teach and share the information correctly. It's about partnership to get the proper information out, and then to help to develop a strategy to engaging our church and community.

Although clergy are willing to create partnerships with clinics, most clergy noted that it would be helpful if clinics approached them to begin these partnerships. Clergy emphasized that someone physically coming into the church to offer education can be a powerful tool in reducing stigma and building clinical partnerships:

A lot of people ask for the church to come outside of the walls, but the other side of that is that sometimes the church needs outsiders to come into the walls because it gives your clinical organization more credibility as well.

Clergy also recommended that partnerships with clinics consistently offer updated healthcare information to the church. Clergy are often stretched thin for time and don't always have the time to commit to researching updated information.

Pastors are the ones who certainly don't mind preaching these types of sermons in our pulpits. I think one of the issues is the consistency that comes from entities and agencies that are doing the clinical work. It would be helpful if they could keep us consistently informed and engaged with the latest resources, the latest of data, so that we aren't having to research this ourselves in order to pull together a series.

Clergy emphasized that guaranteeing confidentiality to congregations about partnering with clinics could help alleviate stigma, get screened, or to disclose their HIV status to others.

If there's a way of partnering with folks to make sure that drugs are affordable and that you can have a very confidential testing or screening, where in the same day, if you tested positive, you can get whatever you need, and no one else needs to know about it. That can help deal with the stigma issue.

Recommendations for Stigma Reducing Marketing Campaigns with Churches

Clergy were overwhelmingly willing to participate in social marketing campaigns to promote U=U and TasP. Specifically, clergy said:

The ability to communicate via Facebook and other platforms is tremendous right now. To answer the question directly [about promoting U=U or TasP], the way I feel about it in reference to how do we get the word out or how can we be more effective, I think that has to be the starting point.

There's going to have to be a real approach to this, and it's going to have to be filled with a balance of information and the gospel. My suggestion is that the U equals U movement is coupled with a screening message. If I'm saying to people, all right, listen. We want to hold screenings. I know you're concerned, but here's [U=U] what you can look forward to, if by chance you're positive.

They noted that current U=U campaigns and TasP efforts to date would not resonate with their congregations, and noted that campaigns needed to be culturally tailored to the African American community in the South:

The campaign [U=U] has not been marketed in such a way where we know about it, and so I would suggest maybe we need to do campaigning that actually speaks to how it's impacting all of us. For a long time when HIV first came out, it was associated as being a white gay male disease. Most Black folks didn't pay attention to that because it was a white gay male disease.

Some clergy reported that it might also be helpful to have a trained health professional present HIV information or offer testimonials related to PrEP, TasP, and U=U. Several noted that congregations might be more open to discussing these topics with someone who is not a church member:

I think also it would ease the embarrassment. People think, "I don't want my pastor look at me like that." They're more open to a health care professional than they are the pastor on certain issues.

I think presenting PrEP has to be done by someone who is trained, skilled, and overseen by someone who knows that local congregation because otherwise, you can cross a lot of lines.

Clergy also recommended having people living with HIV give testimonials in order to address stigma and provide learning opportunities about people's lived experiences:

Testimony is a powerful thing. If there were individuals who were diagnosed with HIV who are willing to

come to churches, I think that would speak volumes. Share whatever they would like to share as it relates to the disease, including the various treatments that are available, preventive methods. I think that would go a long way.

Further, clergy report that although they think clergy should be involved in the education process, having a medical expert there to answer questions would buttress clergy messaging and provide more important technical information. One clergy remarked:

We partner to do immunizations and prescreening and all that stuff. I think it will be definitely easier if a partner presented that information rather than us.

When asked about how to raise awareness about PrEP, TasP and U=U with social marketing campaigns, clergy offered several recommendations. Some suggested bundling HIV messages with other health promotion messages to decrease stigma.

Not that you want to just talk about HIV alone, but I'm saying once you add it in with the other illnesses that affect the African American community, I think that'll also be good.

In our Health and Wellness Ministry, we address high blood pressure, diabetes, different things. HIV falls in that. It's not being separated out from everything else. I think part of eliminating the stigma is not to always separate it out but to include it in normal conversation. That's emotionally, that's spiritually, physically, part of being whole.

Clergy Recommendations for Overcoming Obstacles and Stigma

Clergy explained they needed more technical information about U=U, and that having dialogue with their congregations about HIV treatment would help them overcome stigma.

Once we get past the stigma, and having that powerful, empowering knowledge and information that we can share not only with our youth, but with adults as well, then we can talk about safely get to U=U. We have to have that knowledge dialog. We've got to get past the stigma of HIV and ensuring that the community understands that you're being empowered with knowledge.

A few clergy expressed apprehension about discussing pre-marital sex or tacit implications that they are endorsing pre-marital sex by discussing PrEP. However, they all acknowledged that foregoing conversations about sex was also unrealistic:

Our preference would be that young people not have sex. Our preference would be that they abstain and wait till marriage and do it the God way, but we have got to get to the point where we're not afraid in our churches with our young people to talk about the other alternative. If you're not gonna wait, then you need to protect yourself.

I think we have to be very careful how we present PrEP. It may be perceived as counter to many church teachings about abstinence, which nobody is doing anymore.

I'm sure some of the members may have some push-back about it, but I think at most of our churches there are young people there, and we want to get all the information to them that we can provide so they will have a choice.

We had a sex talk and I brought in someone to talk to them [the youth] and I got e-mails. I almost got kicked out of the church because I was promoting sex to our kids. I wasn't. I think abstinence is the way to go, but I got kids who are pregnant, so that's not working.

While some clergy acknowledged challenges associated with discussing sexuality at church, the overwhelming majority endorsed having conversations about HIV, PrEP and human sexuality. One pastor noted:

You can't be a good follower of Christ if you're not willing to go to the other side of town and pass your brother by on the road if you are a Christian who loved your fellow brother or sister. Theologically, we have enough sermonettes to deal with that. It's just that being willing to deal with those concerns and people saying, 'Maybe he's promoting something.' That's okay. If being blamed or being labeled one way is gonna save two or three lives, I think it's worth that. We should be willing' to run the risk of that.

The more it's talked about, the more it resonates with the people. In the African American community, the less you talk about something,, the less it is observed. Whatever you want to bring to the forefront, you hammer it. You talk about it. Talk about it from the head to the toe, until it sinks down in our soul. Then we will take aggressive measures. When the White community started to talk about AIDS, their numbers dropped!

Church Experiences with COVID-19 and Lessons for HIV

Many clergy discussed how COVID-19 had influenced their church operations and highlighted how lessons from COVID-19 could be applied to HIV. While in-person attendance has faltered due to COVID-19-related infection

concerns and social distancing policies, churches have been able to expand their reach by leveraging video streaming and social media platforms. Many churches reported a large increase in church attendance online during the pandemic, and noted that social media participation increased, which might present opportunities for ongoing education for other health topics.

We are not in our building for worship services. We stream all of our services and everything else at this point. We're learning how to serve without benefit of a building, but I would say all of that's been good.

We had a virtual revival in which we probably reached thousands of individuals throughout the country. I think we had four different countries, nations who were tuned in to that revival.

Several clergy suggested using the public health momentum of COVID-19 discussions to revitalize conversations related to HIV.

The old cliché says an ounce of prevention is better than a pound of cure. If we had more testing going on, we could slow HIV spread, and then we could look at ways of cascading the information out about treatment and other things.

Both HIV and COVID-19 are viruses. You can probably pick up on some of the momentum of COVID-19 and bring back the momentum of HIV. That might help you gain some ground that has been established in the COVID-19 scare. Whatever we do, it has to be packaged well.

Discussion

This is among the first studies to explore how African American clergy in the South can advance the EHE goals. Although a few pastors reported apprehension about discussing pre-marital sex, all were willing to partner to overcome HIV stigma and acknowledged their moral calling to respond to the HIV epidemic. Clergy from several geographic areas with high rates of HIV in the South understood HIV transmission but knew little about U = U, TasP, the EHE plan, or PrEP. Clergy were overwhelmingly willing to lend their voices to social marketing campaigns and suggested culturally tailoring prevention messages to the African American community. Nearly all participants solicited technical assistance to bolster their HIV knowledge, and more resources to support partnerships with local CHCs.

These findings support previous research that notes that clergy are willing to participate in HIV treatment and prevention efforts and echoes previous findings about clergy's

declared moral obligations to respond to the HIV epidemic [33–37, 42, 49]. Notably, while the EHE was first announced on February 5, 2019, most of the clergy had never heard of the plan by mid 2020 [11]. This suggests far greater efforts are needed to engage African American clergy in EHE efforts. With appropriate resources, African American clergy could provide education about U=U, TasP, and PrEP to congregations; host HIV testing events; utilize social media platforms to provide education about HIV treatment and prevention; and target stigma related to HIV.

Clergy reported similar experiences about TasP and U=U; few understood these important HIV prevention concepts. A recent study in the United States found that learning about U=U from a provider may decrease stigma and increase trust and engagement in care [50]. Another study assessed the impact of exposure to U=U information from a non-healthcare provider among people living with HIV in 25 countries and found that the effects were beneficial and may positively impact health outcomes [51]. Clergy signaled important commitments to promote these concepts, but solicited technical assistance in understanding and disseminating messaging, and strongly suggested messages be re-crafted for an African American audience. Taken together, these findings suggest that more efforts are needed to develop new messaging to promote U=U and TasP that are tailored to the African American community.

As found elsewhere, clergy understood their influence on those in the congregation in addressing stigma and health promotion [38]. Clergy offered concrete suggestions for overcoming stigma, suggesting that preaching about HIV and patient testimonials could help mitigate stigma surrounding HIV testing, disclosing HIV status, and treatment. Other studies have found that African Americans are more likely to discuss health concerns with spiritual leaders than medical professionals [52]. Given high rates of medical mistrust in some African American communities, there is also a public health opportunity to train clergy in how to deliver the most updated biomedical treatment and prevention messages, and to harness their positive influence with their congregations. Clergy participants further noted that these trainings and more inclusive practices that involve clergy in the EHE plan would help mitigate HIV stigma. The experiences of stigma impair not only HIV treatment but also prevention efforts such as PrEP [53, 54] and COVID-19 vaccinations [55]. Clergy also suggested focusing on holistic health messages and bundling HIV messages with other health promotion messages rather than just HIV; that approach has been successful elsewhere [38].

Many churches have successful histories partnering with clinics and community organizations to provide health screenings for heart disease, hypertension, and cancer [56]. Many clergy reported having health promotion programs related to these chronic diseases; however, few had

any formal partnerships with clinical institutions about any health programs, and particularly not about HIV. Clergy suggested that they would be highly willing to partner with clinics; this has also been found elsewhere [57]. However, clergy suggested clinics reach out to them to solicit more formal partnerships. Evidence from patient navigation programs supported by the Ryan White CARE Act suggest that providing navigation for HIV treatment can result in positive downstream HIV outcomes, including improved medication adherence and retention in related clinical care [58–60]. Involving clergy in similar efforts to support PrEP and treatment persistence might have positive impacts on the PrEP and HIV care continua.

Lastly, the COVID-19 pandemic has prompted many congregations to engage with their congregations online for worship services, educational campaigns, and many new communications. There is public health opportunity to use new digital infrastructure for social marketing and EHE epidemic activities.

Our findings are subject to several limitations. This was a qualitative study among 57 influential clergy whose churches are in southern geographic hotspots; our findings may not be generalizable to all African American clergy. We also did not quantify HIV stigma in this study.

Conclusion

Our findings highlight that many African American clergy are willing and able to be involved in the US EHE plan and to help overcome persistent HIV stigma. Clergy recommended culturally tailoring biomedical messages to African American audiences in the South, linking churches to CHCs implementing EHE programs, and providing technical assistance related to HIV biomedical interventions. Far greater federal investments are needed to support these important activities.

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Data Availability All data and materials support our published claims and comply with field standards.

Declarations

Conflict of interest Authors have no conflicts or competing interests to disclose.

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References

- Rosenberg ES, Purcell DW, Grey JA, Hankin-Wei A, Hall E, Sullivan PS. Rates of prevalent and new HIV diagnoses by race and ethnicity among men who have sex with men, U.S. states, 2013–2014. *Ann Epidemiol*. 2018;28(12):865–73.
- Rosenberg ES, Grey JA, Sanchez TH, Sullivan PS. Rates of prevalent HIV infection, prevalent diagnoses, and new diagnoses among men who have sex with men in US States, metropolitan statistical areas, and counties, 2012–2013. *JMIR Public Health Surveill*. 2016;2(1):e22.
- Centers for Disease Control and Prevention. HIV Surveillance Report, 2018 (Updated); vol. 31. <http://www.cdc.gov/hiv/library/reports/hiv-surveillance.html>. Published May 2020.
- National Center for HIV/AIDS, Viral Hepatitis, STD, TB Prevention (NCHHSTP). HIV Surveillance Report 2017. Atlanta, GA. Report No. 29.
- Centers for Disease Control and Prevention. HIV Prevention: Arkansas. HIV Surveillance Report, 2018 (Updated); vol. 31. <http://www.cdc.gov/hiv/library/reports/hiv-surveillance.html>. Published May 2020.
- Centers for Disease Control and Prevention. HIV Prevention: Alabama. HIV Surveillance Report, 2018 (Updated); vol. 31. <http://www.cdc.gov/hiv/library/reports/hiv-surveillance.html>. Published May 2020.
- Alabama Department of Public Health. HIV Surveillance Report. 2016. <https://www.alabamapublichealth.gov/hiv/hiv-and-pregnancy.html>.
- Stopka TJ, Brinkley-Rubinstein L, Johnson K, Chan PA, Hutcheson M, Crosby R, et al. HIV Clustering in Mississippi: Spatial Epidemiological Study to Inform Implementation Science in the Deep South. *JMIR Public Health Surveill*. 2018;4(2):e35.
- 2017–2021 Integrated HIV Prevention and Care Plan Statewide Coordinated Statement of Need. Little Rock, AR; 2016. https://www.healthy.arkansas.gov/images/uploads/pdf/AR_Integrated_HIV_Prevention_and_Care_Coordinated_Plan.pdf
- Schafer KR, Albrecht H, Dillingham R, Hogg RS, Jaworsky D, Kasper K, et al. The continuum of HIV care in rural communities in the United States and Canada: what is known and future research directions. *J Acquir Immune Defic Syndr*. 2017;75(1):35–44.
- Fauci AS, Redfield RR, Sigounas G, Weahkee MD, Giroir BP. Ending the HIV epidemic: a plan for the United States. *JAMA*. 2019;321(9):844–5.
- Centers for Disease Control and Prevention. HIV among African Americans in Atlanta, Georgia: HIV Surveillance Report, 2018 (Updated); vol. 31. <http://www.cdc.gov/hiv/library/reports/hiv-surveillance.html>. Published May 2020.
- Arnold T, Brinkley-Rubinstein L, Chan PA, Perez-Brumer A, Bologna ES, Beauchamps L, et al. Social, structural, behavioral and clinical factors influencing retention in Pre-Exposure Prophylaxis (PrEP) care in Mississippi. *PLoS ONE*. 2017;12(2):e0172354.
- Chan PA, Mena L, Patel R, Oldenburg CE, Beauchamps L, Perez-Brumer AG, et al. Retention in care outcomes for HIV pre-exposure prophylaxis implementation programmes among men who have sex with men in three US cities. *J Int AIDS Soc*. 2016;19(1):20903.
- Nunn A, Barnes A, Cornwall A, Rana A, Mena L. Addressing Mississippi's HIV/AIDS crisis. *Lancet*. 2011;378(9798):1217.
- Chou R, Evans C, Hoverman A, Sun C, Dana T, Bougatsos C, et al. Preexposure prophylaxis for the prevention of HIV infection: Evidence report and systematic review for the US Preventive Services Task Force. *JAMA*. 2019;321(22):2214–30.
- Chan PA, Glynn TR, Oldenburg CE, Montgomery MC, Robynette AE, Almonte A, et al. Implementation of pre-exposure prophylaxis for HIV prevention among men who have sex with men at a New England sexually transmitted diseases clinic. *Sex Transm Dis*. 2016;43(11):717.
- Corneli A, Wang M, Agot K, Ahmed K, Lombaard J, Van Damme L, et al. Perception of HIV risk and adherence to a daily, investigational pill for HIV prevention in FEM-PrEP. *J Acquir Immune Defic Syndr*. 2014;67(5):555–63.
- Goedel WC, Mayer KH, Mimiaga MJ, Duncan DT. Considerable interest in pre-exposure prophylaxis uptake among men who have sex with men recruited from a popular geosocial-networking smartphone application in London. *Glob Pub Health*. 2019;14(1):112–21.
- Franks J, Hirsch-Moverman Y, Loquere AS, Amico KR, Grant RM, Dye BJ, et al. Sex, PrEP, and stigma: experiences with HIV pre-exposure prophylaxis among New York City MSM participating in the HPTN 067/ADAPT study. *AIDS Behav*. 2018;22(4):1139–49.
- Pérez-Figueroa RE, Kapadia F, Barton SC, Eddy JA, Halkitis PN. Acceptability of PrEP uptake among racially/ethnically diverse young men who have sex with men: The P18 study. *AIDS Educ Prev*. 2015;27(2):112–25.
- Bauermeister JA, Meanley S, Pingel E, Soler JH, Harper GW. PrEP awareness and perceived barriers among single young men who have sex with men in the United States. *Curr HIV Res*. 2013;11(7):520.
- Silverberg MJ, Leyden W, Quesenberry CP Jr, Horberg MA. Race/ethnicity and risk of AIDS and death among HIV-infected patients with access to care. *J Gen Intern Med*. 2009;24(9):1065–72.
- Pence BW, Ostermann J, Kumar V, Whetten K, Thielman N, Mugavero MJ. The influence of psychosocial characteristics and race/ethnicity on the use, duration, and success of antiretroviral therapy. *J Acquir Immune Defic Syndr*. 2008;47(2):194–201.
- Cooperman A, Smith GA, Comibert SS. U.S. public becoming less religious: modest drop in overall rates of belief and practice, but religiously affiliated Americans are as observant as before. 2015. <https://www.pewforum.org/2015/11/03/u-s-public-becoming-less-religious/>
- Brewer LC, Williams DR. We've come this far by faith: the role of the black church in public health. *Am J Public Health*. 2019;109(3):385–6.
- Campbell MK, Hudson MA, Resnicow K, Blakeney N, Paxton A, Baskin M. Church-based health promotion interventions: evidence and lessons learned. *Annu Rev Public Health*. 2007;28:213–34.
- Scandrett A. Health and the black church. *J Relig Health*. 1996;35(3):231–44.

29. Butler-Ajibade P, Booth W, Burwell C. Partnering with the black church: recipe for promoting heart health in the stroke belt. *ABNF J*. 2012;23(2):34–7.
30. Hawes SM, Berkley-Patton JY. Religiosity and risky sexual behaviors among an African American church-based population. *J Relig Health*. 2014;53(2):469–82.
31. Tsevat J, Sherman SN, McElwee JA, Mandell KL, Simbartl LA, Sonnenberg FA, Fowler FJ Jr. The will to live among HIV-infected patients. *Ann Intern Med*. 1999;131(3):194–8. <https://doi.org/10.7326/0003-4819-131-3-199908030-00006>.
32. Berkley-Patton J, Bowe-Thompson C, Bradley-Ewing A, Hawes S, Moore E, Williams E, et al. Taking It to the Pews: a CBPR-guided HIV awareness and screening project with black churches. *AIDS Educ Prev*. 2010;22(3):218–37.
33. Nunn A, Parker S, McCoy K, Monger M, Bender M, Poceta J, et al. African american clergy perspectives about the HIV care continuum: results from a qualitative study in Jackson Mississippi. *Ethn Dis*. 2018;28(2):85–92.
34. Nunn A, Jeffries WL 4th, Foster P, McCoy K, Suttan-Coats C, Willie TC, Ransome J, Lanzi RG, Jackson E, Berkley-Patton J, Keefer M, Coleman JD. Reducing the African American HIV disease burden in the deep south: addressing the role of faith and spirituality. *AIDS Behav*. 2019;23(Suppl 3):319–30. <https://doi.org/10.1007/s10461-019-02631-4>.
35. Payne-Foster P, Bradley ELP, Aduloju-Ajijola N, Yang X, Gaul Z, Parton J, Sutton MY, Gaskins S. Testing our FAITHH: HIV stigma and knowledge after a faith-based HIV stigma reduction intervention in the rural South. *AIDS Care*. 2018;30:232–9.
36. Aholou TM, Cooks E, Murray A, Sutton MY, Gaul Z, Gaskins S, et al. “Wake Up! HIV is at Your Door”: African American faith leaders in the rural South and HIV perceptions: a qualitative analysis. *J Relig Health*. 2016;55(6):1968–79.
37. Pichon LC, Williams Powell T, Williams Stubbs A, Becton-Odum N, Ogg S, Arnold T, et al. An exploration of US Southern faith leaders’ perspectives of HIV prevention, sexuality, and sexual health teachings. *Int J Environ Res Public Health*. 2020;17(16):5734.
38. Gross TT, Story CR, Harvey IS, Allsopp M, Whitt-Glover M. “As a Community, We Need to be More Health Conscious”: Pastors’ perceptions on the health status of the Black Church and African-American Communities. *J Racial Ethn Health Disparities*. 2018;5(3):570–9.
39. Haynes T, Turner J, Smith J, Curran G, Kramer T, Harris K, et al. Reducing depressive symptoms through behavioral activation in churches: a hybrid-2 randomized effectiveness-implementation design. *Contemp Clin Trials*. 2018;64:22–9.
40. Nunn A, Cornwall A, Chute N, Sanders J, Thomas G, James G, et al. Keeping the faith: African American faith leaders’ perspectives and recommendations for reducing racial disparities in HIV/AIDS infection. *PLoS ONE*. 2012;7(5):36172.
41. Kamaara E, Oketch D, Chesire I, Coats CS, Thomas G, Ransome Y, et al. Faith and healthcare providers’ perspectives about enhancing HIV biomedical interventions in Western Kenya. *Glob Public Health*. 2019;14:1–13.
42. Smith J, Simmons E, Mayer KH. HIV/AIDS and the Black Church: what are the barriers to prevention services? *J Natl Med Assoc*. 2005;97(12):1682–5.
43. Paschen-Wolff MM, Campbell ANC, Tross S, Castro M, Berg H, Braunstein S, et al. HIV treatment knowledge in the context of “treatment as prevention” (TasP). *AIDS Behav*. 2020;24(10):2984–94.
44. Eisinger RW, Dieffenbach CW, Fauci AS. HIV viral load and transmissibility of HIV infection: undetectable equals untransmittable. *JAMA*. 2019;321(5):451–2. <https://doi.org/10.1001/jama.2018.21167>.
45. Calabrese SK, Mayer KH. Stigma impedes HIV prevention by stifling patient-provider communication about U = U. *J Int AIDS Soc*. 2020;23(7):e25559.
46. Hennink MM, Kaiser BN, Weber MB. What influences saturation? Estimating sample sizes in focus group research. *Qual Health Res*. 2019;29(10):1483–96.
47. Thomas DR. A general inductive approach for analyzing qualitative evaluation data. *Am J Eval*. 2006;27(2):237–46.
48. Juliet Corbin AS. Basics of qualitative research. Thousand Oaks: Sage; 2008.
49. Levin JS. The role of the black church in community medicine. *J Natl Med Assoc*. 1984;76(5):477–83.
50. Rendina HJ, Talan AJ, Cienfuegos-Szalay J, Carter JA, Shalhav O. Treatment is more than prevention: perceived personal and social benefits of undetectable = untransmittable messaging among sexual minority men living with HIV. *AIDS Pat Care STDS*. 2020;34(10):444–51.
51. Okoli C, Van de Velde N, Richman B, Allan B, Castellanos E, Young B, Brough G, Eremin A, Corbelli GM, Mc Britton M, Hardy WD, de Los Rios P. Undetectable equals untransmittable (U = U): awareness and associations with health outcomes among people living with HIV in 25 countries. *Sex Transm Infect*. 2021;97(1):18–26. <https://doi.org/10.1136/sextrans-2020-054551>.
52. Calvert WJ, Isaac-Savage EP. Motivators and barriers to participating in health promotion behaviors in Black men. *West J Nurs Res*. 2013;35(7):829–48.
53. Brooks RA, Nieto O, Landrian A, Fehrenbacher A, Cabral A. Experiences of pre-exposure prophylaxis (PrEP)-related stigma among Black MSM PrEP users in Los Angeles. *J Urban Health*. 2020;97(5):679–91.
54. Quinn K, Dickson-Gomez J, Kelly JA. The role of the Black Church in the lives of young Black men who have sex with men. *Cult Health Sex*. 2016;18(5):524–37.
55. Turner-Musa J, Ajayi O, Kemp L. Examining social determinants of health, stigma, and COVID-19 disparities. *Healthcare (Basel, Switzerland)*. 2020;8(2):168.
56. Rowland ML, Isaac-Savage EP. As i see it: a study of African American pastors’ views on health and health education in the Black Church. *J Relig Health*. 2014;53(4):1091–101.
57. Levin J. Faith-based partnerships for population health: challenges, initiatives, and prospects. *Public Health Rep*. 2014;129(2):127–31.
58. Weiser J, Beer L, Frazier EL, Patel R, Dempsey A, Hauck H, et al. Service delivery and patient outcomes in Ryan White HIV/AIDS Program-funded and-nonfunded health care facilities in the United States. *JAMA Intern Med*. 2015;175(10):1650–9.
59. Bradley H, Viall AH, Wortley PM, Dempsey A, Hauck H, Skarbinski J. Ryan White HIV/AIDS program assistance and HIV treatment outcomes. *Clin Infect Dis*. 2015;62(1):90–8.
60. Diepstra KL, Rhodes AG, Bono RS, Patel S, Yerkes LE, Kimmel AD. Comprehensive Ryan White assistance and human immunodeficiency virus clinical outcomes: retention in care and viral suppression in a Medicaid nonexpansion state. *Clin Infect Dis*. 2017;65(4):619–25.

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