The Role of the Church in the Prevention of HIV/AIDS

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Abstract

We sought to identify the role of the church in the prevention of HIV/AIDS among high-risk individuals. Data were collected in 1998-99 from 827 individuals living in Illinois, including men who have sex with men (MSMs), injection drug users (IDUs), sex workers, people living with HIV, heterosexuals at high risk, migrant workers, and perinatal women at high risk. Results indicated that 60% had attended a church service at least once in the past three months, and 78% indicated that religion and spirituality was "somewhat" to "extremely" important to them. Of the total sample, 25% had heard some type of HIV/AIDS prevention message in a church setting. This varied substantially by risk group, with only .06% of the migrant sample indicating the church as a source of HIV prevention compared to 18.4% of the high-risk heterosexuals. Because many people in these high-risk groups attend church on a regular basis and consider spirituality to be an important part of their lives, these data support the role of the church in providing primary prevention programming for high-risk people.

Introduction

The church has historically been involved in the care and treatment of the people it seeks to serve. The church and associated institutions have provided direct care through hospitals for centuries. Moving beyond hospital care, many churches and religious groups provide hospice programs, nursing home and assisted living care, and the emerging parish nurse program, where nursing specialists employed or volunteering through their church provide nursing care to the members of the parish.

Spirituality and taking part in religious practices appears to have a protective effect. Levin et al (1997), in their review of the literature, have found that a number of conditions are improved as a result of religious belief and spirituality, including heart disease, cancer, and stroke. They suggest that "systematic reviews and meta-analyses quantitatively confirm that religious involvement is an epidemiologically protective factor" (Levin et al., 1997, p. 792). Religion and spirituality may be particularly important when dealing with life threatening diseases, such as cancer and HIV/AIDS. In one qualitative study of 10 women with cancer and 5 men living with HIV/AIDS, Fryback and Reinert (1999) found that spirituality was important in terms of health and well being, and that "many of the subjects viewed spirituality as the bridge between hopelessness and meaningfulness in life" (p.13).

One area where some churches provide care and outreach programming is the treatment and support of HIV/AIDS patients. A South Carolina program known as TEAM (The Ecumenical AIDS Ministry) has trained 62 active care teams and about 620 volunteers, to provide practical, emotional, and spiritual support to people living with HIV/AIDS. This support includes transportation to the physician, helping run errands, providing meals, and light housekeeping. In an assessment of the TEAM program, Christensen et al (1999) found that the volunteers who helped with the program did so because it allowed them to express their faith, and because they knew they were helping someone else in need. The AIDS Interfaith Council of Houston sponsors a similar program, where volunteers are recruited and trained to provide non-judgmental care for those afflicted with AIDS, and to provide respite care for the family members or friends who care for the AIDS patient (Shelp et al., 1990).

Given the church's historic role in the treatment of disease, a logical extension is to consider its role in prevention of disease. More specifically, what is the role, if any, of the church regarding HIV/AIDS prevention, especially for those people at highest risk for the disease? How can the church best reach these high-risk people? We sought to address this question with a sample of high-risk individuals who took part in a statewide Illinois HIV/AIDS behavioral surveillance survey.

Method

Participants

Participants included 827 individuals recruited for a statewide surveillance study based on behavioral characteristics placing them at high risk for HIV. An additional 20 respondents were excluded due to incomplete data. Of the 827 respondents, 63.6% identified as male, 34.1% as female, and 1.3% as transgendered. The sample was 38.3% white, 28.8% African American, 27.2% Hispanic, and 1.1% Pacific Islander or Asian. The mean age of the sample was 33.47 (range = 18 to 69), and was distributed such that 38.6% were 18 to 28 years of age, 27.8% were 29 to

38, and 23.1% were 39 to 48. The mean educational level of the sample was 12.46 years. Primary sources of income included full time employment (36.4%), part time employment (18.9%), public aid (14.3%), partner's income (13.2%), selling drugs (11.0%), and sex work (7.5%). In terms of sexual orientation, 18.3% self-identified as homosexual, 9.2% as bisexual, and 69.9% as heterosexual. In addition, 45.6% were single, 12.5% were married, and 24.3% were partnered.

Using self-reported behavioral data, each participant was classified into risk categories. Due to multiple risk behaviors, individuals could be identified as belonging to more than one risk group (e.g., a gay man who injected drugs and engaged in sex work would be in at least three risk categories: MSM, IDU, and sex worker). Of the total sample, 253 were MSMs, 574 were heterosexuals, 278 were IDUs, 194 were or had recently engaged in sex work, 44 were PLWHIV, 86 were migrant workers, and 40 were perinatal women.

Regarding access to care issues, many of the participants could not afford health and human services in the last three months. For example, over half of the sex workers (54.6%) and migrant farmworkers (51.2%) had been unable to obtain dental health services due to costs. Regarding access to prescription drugs, 41.4% of the IDUs were unable to get prescription medicines in the last three months because they could not afford it, and 61.6% of the migrant farmworkers were not able to get food during some times in the past three months because of lack of money.

The sample was also asked about access to a regular physician, health insurance, and mental health issues. Whereas 61.9% of the gay youth indicated they had health insurance, only 4.7% of the migrant population had health insurance coverage. Less than one in three (30.5%) of the sex workers had a regular physician. A large proportion of the sample had been diagnosed with a substance abuse problem. Not surprisingly, 61.5% of the IDUs indicated they had been previously diagnosed with a substance abuse problem, while only 3.6% of migrants indicated such diagnosis.

Measures

The survey instrument was designed to measure frequency and extent of sex and drug use behaviors among populations at high risk for HIV infection; service penetration of HIV prevention programs among these populations; barriers to service accessibility; and perceptions of risk reduction measure acceptance among survey participants and/or peers. The measures were developed based on the literature and reviewed by a statewide evaluation committee. After the survey was initially developed, modified based on pilot results, and then approved by the evaluation committee, a native Spanish-speaking health care worker translated the survey into Spanish. Several native Spanish-speaking individuals reviewed the Spanish version, and after incorporating their changes, the Spanish-version survey was then back-translated into English. Comparison was made to determine if the two surveys were compatible. Where differences existed, the researchers worked with the Spanish-speaking individuals to resolve such differences.

Sources of Prevention Messages . Sources of prevention messages were measured using 19 items developed from Kalichman et al (1993) and in collaboration with the evaluation committee. For each item, participants indicated whether or not (i.e., yes or no) they had ever *heard* any HIV prevention messages from the specific source (e.g., friend, family, outreach worker, TV, the church, medical provider, etc.). The reliability of the scale, as measured by Cronbach's alpha, was .81.

Interpersonal Communication about HIV. Interpersonal communication about HIV risk and prevention was measured using items developed from Ibrahim (1991) and in collaboration with the evaluation committee. For each item, participants indicated whether or not (i.e., yes or no) they had ever *talked* with someone about the specific topic (e.g., safer injection techniques, using condoms), across 8 different categories of sources of HIV prevention messages (e.g., someone from school, friend, outreach worker, someone from church).

Importance of Religion and Spirituality. The importance of religion and spirituality was measured by three questions. The first question was open-ended, and asked: What is your religion? The second question asked: In the past three months, how many times have you attended a worship service?" The third question asked: How important is your religion/spirituality to you?" Responses for this item ranged from "not at all" to "extremely important."

Data Collection Procedures

The survey was administered in a face-to-face format in 1998 and 1999. A combination of graduate students and individuals working for agencies in the region served as interviewers. An extensive training session was conducted with all data collectors. The training program focused on: 1) the goals of the project 2) populations to be surveyed, 3) ethical guidelines, 4) confidentiality, 5) interview procedures, including recruiting participants, informed consent, and establishing rapport, 6) techniques for conducting the interview, including avoiding interviewer bias and clarification of questions, 7) steps for completing the interview, including guidelines for terminating an interview if needed, and 8) safety. People whose first language was Spanish administered the Spanish version of the survey.

Staff from the Illinois Department of Public Health provided a list of subcontracting agencies that assisted in the data collection procedures. These subcontractors worked throughout the state of Illinois, which ensured a geographically diverse and representative sample. Subcontractors were asked to serve as a liaison to the targeted populations by matching interviewers with outreach workers who knew the population and could facilitate the interviewer in approaching individuals to participate.

Interviews were conducted in many different locations, ranging from health departments and social service agencies, to STD clinics, bars, parks, shelters, and needle exchanges. The university's Human Subjects Committee approved all data collection procedures. When necessary, approval was also secured at the local level from individual agencies that required internal review.

Results

Religious Experiences of Sample

The majority of these high-risk people felt that religion and spirituality was important in their lives. Figure 1 shows that 75% of the sample indicated that religion and spirituality was "somewhat" to "extremely" important to them.

Importance varied somewhat by risk group (Table 1). For example, 48.8% of the migrant sample indicated that religion and spirituality was at least "somewhat" important to them, compared to 34.8% of the MSMs. Over 1/3 (34.9%) of the IDUs felt that religion was "very" important to them. Regarding church-going behavior, 60% had attended a church service at least once in the past three months.

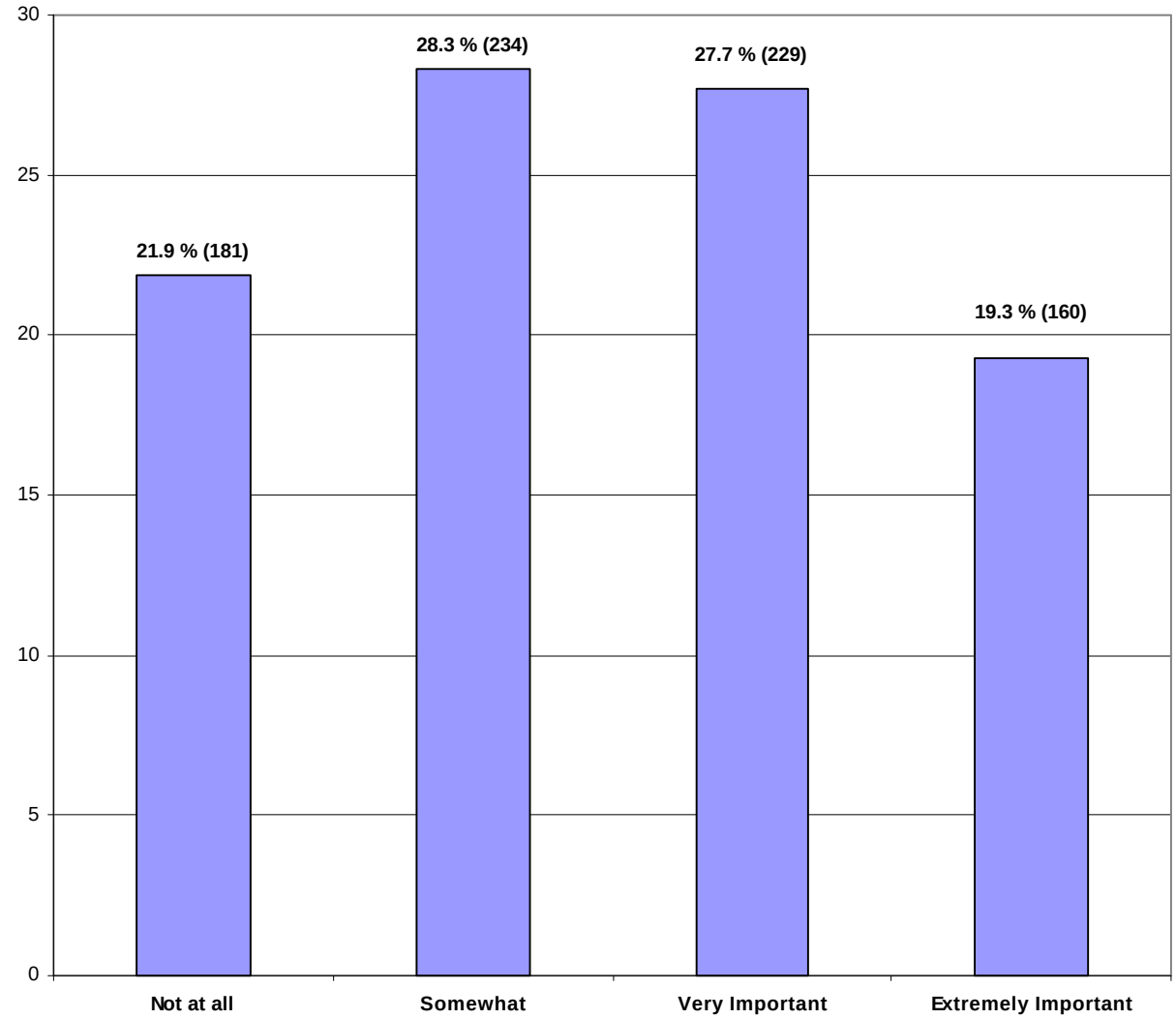

Figure 1. Importance of Religion and Spirituality for Total Sample (N= 827)

Of those who answered the question "What is your religion?" (N = 449), the majority of the sample indicated affiliation with either the protestant or Catholic church. In rank order, 15% were Baptists or Catholics, 8.2% indicated "Christian", 2.3% Lutheran, 2.2% Methodist and 1.9% "Protestant."

These data clearly suggest that a large proportion of these high-risk people are involved in some kind of church-related activity, and that religion and spirituality is important to them.

Interpersonal Communication Concerning HIV

We asked the target sample if they had ever talked with anyone about a series of HIV-related topics. These questions implied that an interpersonal conversation had taken place on any one of a variety of issues, ranging from sharing a needle that someone else has used to safe sex methods without condoms. Regarding IDU issues, friends and outreach workers were cited most frequently as people who had talked with the subjects related to injection drug use. Friends and outreach workers were also cited most frequently in areas related to condom use and other latex barriers.

Table 1: Percent Distribution of Risk Groups by Importance of Religion/Spirituality

	Total (N=827)	MSM (N=207)	Gay Youth (N=43)	IDU (N=278)	Sex Workers (N=205)	Trans-genders (N=12)	PLW-HIV (N=44)	Hetero-sexuals (N=578)	Migrant (N=86)	Peri-natal (N=41)
Not At All	21.9 (181)	22.7 (47)	27.9 (12)	26.3 (73))	33.2 (68)	41.7 (5)	22.7 (10)	21.5 (124)	27.9 (24)	26.8 (11)
Somewhat	28.3 (234)	34.8 (72)	39.5 (17)	21.6 (60)	26.8 (55)	250 (3)	25.0 (11)	24.0 (139)	48.8 (42)	22.0 (9)
Very	27.7 (229)	22.7 (47)	11.6 (5)	34.9 (97)	22.9 (47)	8.3 (1)	22.7 (10)	30.8 (178)	19.8 (17)	31.7 (13)
Extremely	19.3 (160)	17.9 (37)	16.3 (7)	14.0 (39)	14.1 (29)	16.7 (2)	27.3 (12)	0.9 (121)	2.3 (2)	14.6 (6)

Note: Respondents may belong in more than one risk group.

1. MSM: includes homosexuals & bisexuals who self-identified their orientations as such; men who received anal sex from men; and men who gave oral sex to men.
2. GAY YOUTH: includes homosexuals and bisexuals of age group 18-21; youths who received anal sex; and youths who gave oral sex.
3. IDU: includes respondents who ever used needle for drug, tattooing, piercing; used methamphetamine; powder cocaine; heroin; steroids in past 3 months.
4. SEX WORKERS: includes respondents who had sex to get money, drug, shelter in past 3 months; and those as identified by interviewers.
5. TRANSGENDERS: includes respondents who self-identified their orientation as such.
6. PLWHIV: includes respondents who identified themselves as HIV positive.
7. HETEROSEXUALS: includes respondents who self-identified their orientation as such.
8. MIGRANT: includes respondents as identified by the interviewers.
9. PERINATAL: includes respondents as identified by the interviewers.

Table 2: Church as Source of Information regarding HIV Safety Behaviors/ Percent Distribution for Risk Groups

	MSM (N=207)	GAY YOUTH (N=43)	IDU (N=278)	SEX WOR-KERS (N=205)	TRANS-GEN-DERS (N=12)	PLW-HIV (N=44)	HETER OSEXU ALS (N=578)	MIG-RANT (N=86)	PERI-NATAL (N=41)
Using syringe someone else has used	11.6 (24)	9.3 (4)	15.5 (43)	16.1 (33)	16.7 (2)	9.1 (4)	12.3 (71)	1.2 (1)	4.9 (2)
Safer injection techniques	6.8 (14)	4.7 (2)	8.3 (23)	10.7 (22)	16.7 (2)	2.3 (1)	6.4 (37)	0 (0)	2.4 (1)
Cleaning syringes with bleach	6.8 (14)	4.7 (2)	9.4 (26)	11.7 (24)	8.3 (1)	2.3 (1)	6.6 (38)	0 (0)	2.4 (1)
Condoms for sex	16.4 (34)	14.0 (6)	12.9 (36)	16.1 (33)	16.7 (2)	13.6 (6)	14.4 (83)	1.2 (1)	14.6 (6)
Other latex barriers	9.7 (20)	11.6 (5)	12.6 (35)	13.7 (28)	8.3 (1)	4.5 (2)	10.7 (62)	2.3 (2)	4.9 (2)
Safer sex methods without condoms	10.6 (22)	9.3 (4)	9.4 (26)	11.7 (24)	8.3 (1)	9.1 (4)	9.0 (52)	11.6 (10)	4.9 (2)
Drug/Alcohol-at HIV risk	14.0 (29)	11.6 (5)	16.2 (45)	16.1 (33)	16.7 (2)	4.5 (2)	14.2 (82)	4.7 (4)	14.6 (6)
HIV positive - risk of reinfection	9.2 (19)	7.0 (3)	11.2 (31)	11.7 (24)	16.7 (2)	4.5 (2)	9.9 (57)	0 (0)	7.3 (3)
Going to drug treatment/ rehab	9.2 (19)	7.0 (3)	14.7 (41)	17.1 (35)	16.7 (2)	6.8 (3)	11.9 (69)	1.2 (1)	2.4 (1)
Using needle exchange	6.8 (14)	7.0 (3)	8.3 (23)	10.2 (21)	16.7 (2)	2.3 (1)	7.6 (44)	0 (0)	2.4 (1)
Going to STD clinics	10.1 (21)	9.3 (4)	16.2 (45)	12.7 (26)	8.3 (1)	6.8 (3)	14.0 (81)	2.3 (2)	4.9 (2)
About gay/lesbians etc programs	11.6 (24)	7.0 (3)	5.0 (14)	6.3 (13)	16.7 (2)	11.4 (5)	4.8 (28)	2.3 (2)	2.4 (1)

One of the eight possible responses related to talking with someone about HIV-related topics was "someone from church." Table 2 shows the data by risk group, showing that a modest level of interpersonal communication is taking place in churches related to HIV prevention. The topics of conversation vary by risk group. For example, 16.4% of the MSMs had some kind of conversation with someone from church related to condom use and 16.2% of the IDU population had talked with someone from church about drugs and alcohol as they relate to risk of HIV; 17.1% of the sex workers had talked with someone from church about going to a drug treatment or rehabilitation program. These data suggest that

when conversations are taking place with someone from church, they appear to be focusing on risk behaviors directly related to the risk group.

Sources of Prevention Messages

Respondents were also asked: Have you ever heard any HIV prevention messages from any of the following? Respondents were given a list of 19 possible response options. The top sources (listed by more than 50% of the respondents) for prevention messages included, listed in rank order, were as follows:

- TV
- Friend
- written material
- outreach workers
- medical providers
- radio
- health department
- volunteer
- family

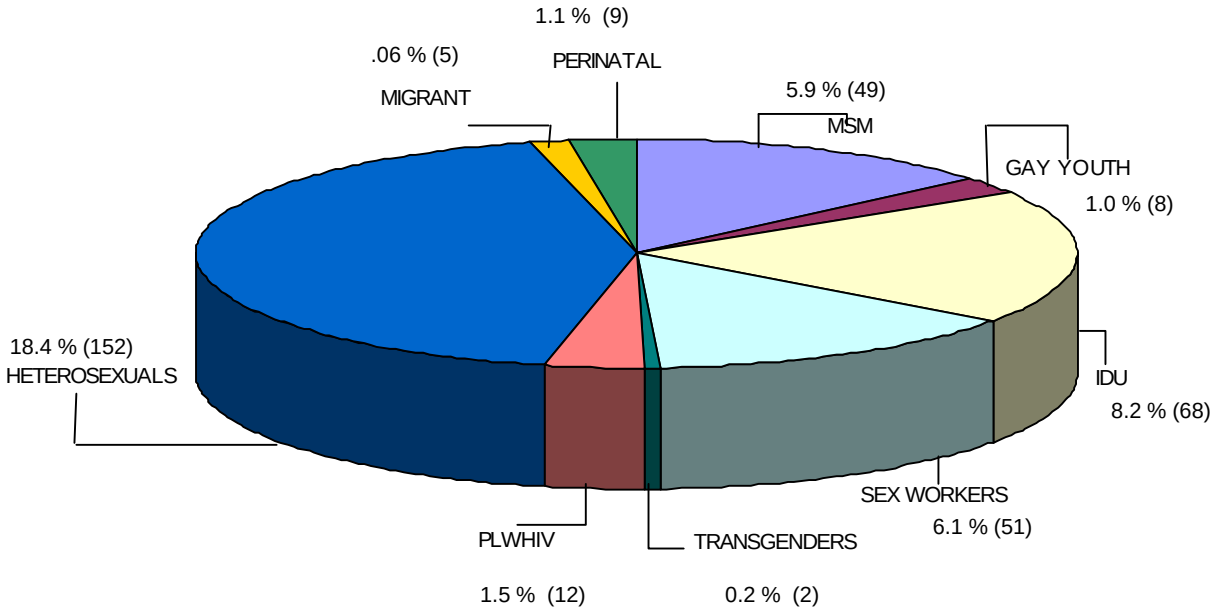

Figure 2. Church as a Source of Information About HIV Prevention Messages [N=827]

About 25% of the sample indicated that they had received some sort of HIV prevention message from the church. The proportion varied by risk group. Whereas less than 1% of the migrant farmworker population indicated that the church was a source for HIV prevention messages, 6.1% of sex workers had heard some form of HIV prevention message through the church (Figure 2).

Conclusions

The results of this survey have provided us with many ideas related to the importance of religion and spirituality in this high-risk population. Among our conclusions:

- Religion and spirituality is important to this high-risk population
- A majority of the people attend church at least occasionally.
- A modest proportion of the sample indicated that people from churches are having conversations with them regarding risk behaviors and treatment options.
- Some churches are also providing public information regarding HIV prevention for this population
- A church-sponsored outreach worker and peer-based program might be one of the most effective ways the church can meet the interpersonal HIV prevention needs of these high-risk people
- Church-sponsored TV, and radio programs might be viable approaches for providing mass media prevention messages for these high-risk people.

Our data suggest that the church does indeed have a major role in the prevention of HIV/AIDS. Major issues remain for a program to be fully implemented. Some denominations will clearly have an easier time providing prevention programs than others. Despite differences in theology, there appears to be a place according to these data for HIV prevention programming in the church. Church leaders should adjust their programs so they carefully match the theological beliefs of their church, and, meet the needs of their people. If churches are already providing support for those afflicted with the HIV/AIDS, why not work on the prevention of the disease as well?

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