CHURCH-BASED SOCIAL SUPPORT RELATED TO HIV/AIDS IN NORTHERN VIRGINIA

by

Elizabeth A. Grisham
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Committee:

___________________________________________  Director

___________________________________________

___________________________________________  Department Chairperson

___________________________________________  Dean, College of Humanities and Social Sciences

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George Mason University
Fairfax, VA
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DEDICATION

I dedicate this thesis to journalist and author Randy Shilts, who covered HIV/AIDS before most people were paying attention.
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ABSTRACT

CHURCH-BASED SOCIAL SUPPORT RELATED TO HIV/AIDS IN NORTHERN VIRGINIA

Elizabeth A. Grisham, M.A.
George Mason University, 2015
Thesis Director: Dr. Gary L. Kreps

HIV and AIDS are serious health conditions. They are also conditions that can have profound social consequences for both patients and their families. Social support—or the delivery of assistance to those affected by personal hardships, including illnesses—is one way community leaders can aid those individuals (Burleson, Albrecht & Sarason, 1994). This study seeks to answer the research question: How do religious leaders who work with the Fairfax County Health Department utilize social support to facilitate HIV/AIDS education efforts? This study consisted of a series of telephone interviews conducted with nine of the ten pastors who collaborate with health department officials to inform and educate their congregants about HIV and AIDS. It applies the buffering hypothesis (Cohen & Wills, 1985) and the Diffusion of Innovations theory (Rogers, 2003). This study finds that participants in this study offer their congregants and members of the larger community information about HIV/AIDS and emotional aid in the form of support
groups, one-on-one pastoral communication and other compassionate care (Burleson, Albrecht, & Sarason, 1994) to help them understand HIV/AIDS-related risks and manage HIV/AIDS-related hardships. This study differs from previous communication scholarship in that it identifies social support as a communication feature within African American churches that dates back to antebellum America (Battle, 2006; Scandrett, 1994). This connection had been previously identified by historians and social work scholars, but has not been analyzed from a communication perspective (Battle, 2006; Scandrett, 1994). As this study examines only the perspective of the ministers—the senders of social support communication—future research could explore the experiences of those receiving these messages.
CHAPTER ONE, STATEMENT OF PROBLEM


Doctors and researchers have made many advances with regard to HIV and AIDS in recent years (Centers for Disease Control, 2013, http://www.cdc.gov/globalaids/global-hiv-aids-at-cdc/interventions.html). They have identified treatments that can extend the lives of people with HIV and AIDS and improve the quality of those added years (Centers for Disease Control, 2013, http://www.cdc.gov/globalaids/global-hiv-aids-at-cdc/interventions.html). In addition to medical treatments, scholars have also reported that HIV and AIDS patients—as well as those with other health problems—can benefit
from emotional support (Burleson, Albrecht & Sarason, 1994; Gottlieb, 1988; Goldsmith, 2013).

These and other researchers who have written about such support have often done so on a broad scale. This research seeks to take a more narrow view. It aims to apply the Diffusion of Innovations theory (Rogers, 2003) and the buffering hypothesis (Cohen & Wills, 1985). Through the lenses of these theories, this research seeks to examine the ways that religious leaders use social support to help congregants affected by HIV and AIDS. More specifically, the question this research seeks to answer is: How do religious leaders who work with the Fairfax County Health Department utilize social support to facilitate HIV/AIDS education efforts?

**Diffusion of Innovations**

Everett Rogers (2003) is the communication scholar most people associate with Diffusion of Innovations (Littlejohn & Foss, 2011, p. 380). Rogers (2003) writes that: “…diffusion [is] the process by which (1) an innovation (2) is communicated through certain channels (3) over time (4) among the members of a social system” (p. 11). Rogers writes further that five factors determine how slowly or how quickly members of society take up new inventions or ways of doing things (p. 15). He lists these as: “Relative advantage… compatibility… complexity… trialability… and observability” (p. 16). To state it differently, adoption depends on how much better the new item or behavior is and how well it fits into the lives of users (pp. 15-16). It also depends on how simple the item is, whether people can test it before they adopt it and whether people can
discern the difference the new item or action causes (p. 15-16).

Rogers (2004) writes specifically about how the tenets of Diffusion of Innovations were used in anti-HIV/AIDS efforts in San Francisco at the height of the AIDS epidemic (p. 18). He writes that leaders of an initiative called STOP AIDS dispatched HIV sufferers and those close to the homosexual community throughout the city to draw people to informational sessions (Rogers, 2004, p. 18). Homosexual men headed the events and leaders and attendees discussed the steps and behaviors necessary to prevent AIDS from spreading (Rogers, 2004, p. 18). When the sessions were over Rogers and Singhal (2003) write that: “Each small group meeting [then] ended with the individuals raising their hands if they intended to practice safer sex and if they would organize and lead a small group meeting” (as cited in Rogers, 2004, p. 18). Thanks to these steps, Rogers (2004) writes that: “The STOP AIDS intervention was a ‘success’” (Rogers, 2004, p. 18).

Valente and Fosados (2006) write of another instance in which individuals utilized the Diffusion of Innovations Theory (Rogers, 2003) and achieved victory with regard to their goals. The scholars write of their own research, a study in which they examined work by other scholars in order to see “…how diffusion of innovations has applied interpersonal communication to promote STD/HIV preventive health behaviors” (Valente & Fosados, 2006, p. S23). They found that scholars could devise better health-related initiatives by looking at online connections (Valente & Fosados, 2006, p. S23).

Haider and Kreps (2004) also note the importance of Diffusion of Innovations (Rogers, 2003) in health communication efforts in their work. The authors write: “The
DOI model has made significant contributions to the understanding and promotion of behavioral change” (p. 6). They write further that: “Diffusing an innovation in a way that emphasizes its benefits and downplays the negative consequences can considerably enhance the social acceptance and ultimate efficacy of a public health campaign” (p. 6).

**Buffering Hypothesis**

The other theoretical construct this thesis will use to examine social support and church-based HIV/AIDS education in Northern Virginia is the buffering hypothesis (Cohen & McKay, 1984; Cohen & Wills, 1985). This line of thinking holds: “…that support buffers (protects) persons from the potentially pathogenic influence of stressful events” (Cohen & Wills, 1985, p. 310). Cohen and his colleagues are not the only ones who have written about it, either (Cohen & McKay, 1984; Cohen & Wills, 1985).

Blaney, et al., (1991) utilize the buffering hypothesis “…to investigate the relationship of negative life events, hardiness, and social support to psychological distress among 67 asymptomatic HIV-1 seropositive gay males” (p. 297). They report: “Main effects were found for negative life events and social support, but not hardiness (either as commitment or overall hardiness)” (p. 297).

Goldsmith (2013) also writes about the buffering hypothesis. She offers a broad look at the topic of social support, but devotes a segment of her text to the importance of the shielding comfort of “enacted social support (the things people say and do for one another) and how it can buffer individuals from the negative effects of stress by facilitating coping” (Goldsmith, 2013, p. 3). For the purposes of this study, then, this theory will be used to examine how the assistive steps undertaken by the leaders of these
churches facilitate their efforts to impart lessons about HIV/AIDS.

**Background Literature on HIV/AIDS**

On the cover of his book: *The slow plague: A geography of the AIDS pandemic*, Peter Gould (1993) provides readers with a thought-provoking series of four images. All of the images are maps of the United States (Gould, 1993). The maps are colored in various spots with shades of blue, green, yellow, orange, and red, which are used to indicate locations where people are affected by AIDS (Gould, 1993). The first map—dated 1984—has barely any color (Gould, 1993). The maps for subsequent years, meanwhile, contain increasing amounts of brighter hues, which indicate the spread and density of the disease in various locales over time (Gould, 1993). In the final two images—dated 1988 and 1990, respectively—both coasts and half of the country are covered in the various shades of the rainbow (Gould, 1993). Over the period Gould depicts, in other words, more and more Americans contracted and suffered the effects of HIV and AIDS (Gould, 1993).

Shannon and Pyle (1989) provide a different account of the emergence of the disease in their work: *The origin and diffusion of AIDS: A view from medical geography*. Their account is not only less visual in nature, but it identifies a particular social group as the one in which the illness first emerged (p. 1). They write: “When the Acquired Immunodeficiency Syndrome (AIDS) was first recognized in 1981, it appeared to be almost exclusively limited to homosexual men within the United States (p. 1). For them, then, AIDS was less a disease encroaching on the nation via both coasts and more one that was attacking gay individuals and then affecting the rest of the populace from
there (p. 1).

In a fashion more akin to Gould (1993), Palca (1991) offers readers of his articles an image of the whole of North America painted turquoise, a sign that one million residents of the continent had AIDS (p. 372). Palca places the blue-green land in its appropriate geographical position and shows that it was second only to sub-Saharan Africa with regard to number of infections (p. 372). He indicates on a map he includes that, at the time he was writing, more than one percent of American men had AIDS (p. 372).


Russell (1991) puts forward an array of figures of the epidemic, meanwhile. In *AIDS in America*, he presents data gathered as part of a large national survey by researchers at the University of Chicago (p. 1). He reports more than just numbers of people who were living with AIDS or in which regions of the country those people resided, however (Russell, 1991). He writes, more thoroughly, rather, about the level of knowledge Americans had about the disease and whether people in their respective social circle were affected by it (Russell, 1991). He presents a chart, for example, which report
that more than 35 percent of people 18-35 years old had a “friend” who had AIDS (p. 71). He also proffers information about how communities thought those with AIDS should be treated, including whether respondents thought students with AIDS should be permitted in schools (p. 93). More than 60 percent of both White and Black survey participants responded that AIDS patients should be allowed to attend school (p. 93). Via this measurement and many others, Russell allows readers to see, numerically, the widespread impact of AIDS in the United States (Russell, 1991).

Huminer, et al., (1987) cover AIDS from still a different angle and addressed the experience of those who contracted AIDS before doctors and researchers had identified and understood it. They write of a range of individuals with varied lifestyles (p. 1103). Naturally, then, these scholars write less of community health impact and more of the mystery and certain demise that accompanied the disease (Huminer, et al., 1987).

Singer, et al. (2000) write from a somewhat similar angle of the story by outlining about the effects of personal actions (p. 1049). For these authors, the AIDS epidemic is less a matter of a disease affecting a person or group and more a matter (p. 1049). For them, it is more about the people in a given location acting in ways that make transmission all to easy (p. 1049). In particular, these authors write of three phenomena among people who use injectable drugs that contribute to new AIDS cases in a population (p. 1049). They write that these factors include: the ability to obtain sterile materials to inject their drugs, sanitary surroundings in which to conduct their drug use, and societal norms that support sanitary drug use behaviors (as opposed to unsanitary ones) (p. 1049).

O’Cofaigh and Lewthwaite (2013) make a very similar point in their work—
good habits are necessary to control and prevent the spread of HIV and AIDS (p. 411). In their work, however, O’Cofaigh and Lewthwaite write not necessarily about preventative behaviors (p. 411). Rather, they write about awareness of personal levels of HIV/AIDS risk and the steps one must take to stay safe both before and after contracting HIV or AIDS (p. 411). From their perspective, in other words, HIV and AIDS were part of society (p. 411). How severe and widespread the disease became, however, depended on individuals acts, such as an at-risk person getting tested for HIV or seeking treatment in the form of antiretroviral therapy (p. 411).

While these authors show how HIV and AIDS were affecting Americans on a broad scale, however, other authors explain how individuals around the world were enduring their physical and emotional pain in very personal ways (Shilts, 1987; Quimby & Friedman, 1989, p. 403). As journalist and author Randy Shilts writes in his book: *And the band played on: Politics, people, and the AIDS epidemic* (1987), as early as the 1980s, homosexual men were watching their partners fall ill and die from AIDS (Shilts, 1987, p. 29). Doctors working in Africa watched a colleague succumb to the condition (Shilts, 1987, pp. 4). Physicians stateside watched patients—people seriously ill with diseases altogether unrelated to HIV or AIDS—receive blood that was later found to be contaminated with the virus (Shilts, 1987, p. 57). All of these people watched, up-close, while individuals dear to them died from HIV and AIDS, and while they themselves could only watch them pass and mourn their losses (Shilts, 1987, p. 4; p. 29; p. 57).

Some groups were hit harder than others, with African Americans and Latinos
being among those most affected (Quimby & Friedman, 1989, p. 403). Quimby and Friedman write that while some people who belong to these cultural groups might not be at risk, broadly speaking “…blacks and Latinos are disproportionately likely to get AIDS” (p. 403). They write that this elevated risk status applies primarily to those who are homosexual, who use injectable drugs and those who have intimate contact with individuals who have these characteristics (p. 403).

Kshatriya, Bhattacharya, and Gauniyal (2005) then write several years later with an important point: that 25 years into the AIDS epidemic, Americans were still suffering (p. 69). They note this fact in powerful language: “According to the United Nations (2004) report on the state of the global AIDS epidemic, the disease has not yet begun to reduce its grip on the world population even though AIDS does not generally receive the same amount of public attention as it once did” (p. 69). In other words, other things might steal the headlines, but AIDS was still hurting people (p. 69).

Friedman, Cooper, and Osborne (2009) turn the conversation back to one group that was feeling that pain—African Americans. In their article: “Structural and social contexts of HIV risk among African Americans,” the scholars write: “HIV is spreading faster among African Americans than it is among other US populations” (p. 1002). Citing Kottiri, et al. (2002), Halfors, et al. (2007), and Farley (2006), they write: “African Americans are more likely to have HIV-positive injection and sexual partners than are Whites” (p. 1002).

Where have African Americans, then, turned for help? In many cases—at least more recently—they have sought comfort and support from their church communities
(Harris, 2010, pp. 61-62). While some church leaders and congregations did not readily embrace or aid those affected by HIV and AIDS at first (p. 60), as of late, many have become more accepting and supportive (pp. 61-62). As Harris writes: “…Black churches were discovering that the overwhelming effect of AIDS on the Black community was forcing them to look beyond homosexuality, sex, and drug use in order to confront the disease” (p. 62). Harris continues: “The ways in which many religious leaders tend to deal with social problems is through preaching and the development of ministries” (Harris, 2010, p. 62). She then goes on to discuss the ways African American church members and ministers have addressed this challenge over the years (Harris, 2010).

Where does the epidemic—and where do the experiences of Americans with HIV and AIDS—stand today, though? Stine (2014) writes in his book: AIDS update 2014 that homosexual men and those of African American and Latin descent currently comprise major groups coping with HIV and AIDS (p. xii). More importantly, perhaps, Stine writes: “People with HIV/AIDS were/are considered the scourge of society…” (p. xiii).

These authors are not the only ones to examine the issue of HIV/AIDS and its effects on African Americans or church-based efforts to help such individuals. Many other scholars have also explored this matter in articles and books over the years, and they have done so from a number of different angles. To make this body of literature manageable, this literature review will focus on several categories of works that are relevant to this topic. First, it will explore works relating to the strategies people and communities have used to help people who have the disease. From there, it will look at
health-related scholarship on social support, and works about social support and religion that are not HIV/AIDS specific. Next, it will examine social support texts related to religion, trust, and HIV/AIDS. It will then discuss scholarship pertaining to the HIV/AIDS-related stigma and circumstances that might prevent people from seeking or receiving the full benefit of available social support. It will conclude with a look at the most recent scholarship to offer insight into where this field of study—and where HIV/AIDS—are going.

**Secular Social Support**

People concerned about HIV/AIDS and the needs of those affected by it have not just been members or leaders of church communities. Members of secular society have also worked to assist HIV/AIDS patients and those who care about them. These concerned entities have reached out to these affected populations in a variety of ways.

In some cases, researchers or journalists have worked to impart information and assistance to affected groups (Fisher & Fisher, 1992, p. 463). As Fisher and Fisher write: “A number of risk reduction interventions have been directed at the general public” (p. 463). These efforts have included fear-based media crusades as well as awareness endeavors (p. 463). Despite good faith and hard work on the part of the leaders of these campaigns, however, they have frequently met with marginal success (p. 463).

Aggleton, Davies, and Hart (1997) and their contributing authors write, meanwhile, of challenges faced and services provided by numerous officials across the United Kingdom. Feldman and Crowley (1997), for example, write of programs for females having to adapt to serve patients who are surviving longer (as cited in Aggleton,
Davies, & Hart, 1997). They write of the need for babysitting services among working mothers with HIV (p. 129). They write of the nutritional assistance officials in the United Kingdom provide (p. 129) and the need for educational materials among women coping with multiple HIV/AIDS-related needs (p. 136).

In recent years, Australian officials have also provided material support to those who have or who are at risk of contracting HIV/AIDS (Cohen, 2014, pp. 156-158). Wodak writes that officials there give clean needles to users of intravenous drugs in that country in hopes of limiting the spread of disease (p. 157). He writes: “Today, Australia has more than 3,000 sites that distribute some 30 million needles and syringes to drug users each year” (p. 157). He writes, further, that this support has helped quell not just the spread of HIV, but diseases like hepatitis C (p. 158). He writes: “The health department estimates that they prevented more than 100,000 new HCV infections [via the needle-sharing effort]” (p. 158).

**Social Support Defined**

Whereas the officials conducting those information delivery efforts were working to impart facts about HIV/AIDS to those affected by the conditions, other scholars analyze or advocate for other kinds of assistance. Numerous authors have researched and written about this kind of aid—called social support—and these intellectuals have defined this concept in several ways. While some characterize social support as data given to someone as a way to foster a sense of inclusion (Cobb, 1976, p. 300), others describe it as helpful gestures (Goldsmith, 2004, p. 3). Still others have slightly different
Cobb (1976) offers a three-pronged definition of the term. He writes: “For the present discussion, social support is conceived to be information belonging to one or more of the following three classes…” (p. 300). He then elaborates on the makeup of the three categories. He defines the first as “…information leading the subject to believe that he is cared for and loved” (p. 300). He defines the second as: “…information leading the subject to believe he is esteemed and valued” (p. 300). He defines the third, finally, as: “…information leading the subject to believe that he belongs to a network of communication and mutual obligation” (p. 300).

At least one scholar holds that the definition of social support should change, however (Barrera, 1986, p. 413). Writing in American Journal of Community Psychology, Barrera (1986) proffers the idea that the definition lacks adequate specificity (p. 413). He writes that in its place, scholars should proffer multiple descriptions of the particular interactions that comprise the phenomenon (p. 413).

Other scholars on the subject, Albrecht and Adelman (1987) focus especially on the communication aspect of social support (p. 14). This is to say they focus on the interactions and steps involved in social support as much or more than the content of those interactions (p. 14). They write: “Our central thesis in this book is that social support is a process inextricably woven into communication behavior” (p. 14). They write further that often the most beneficial acts of communication are those that aid others as those individuals navigate challenges (p. 14).

Gottlieb (1983, 1988) presents the concept in great detail in two separate works.
In his book: *Social support strategies: Guidelines for mental health practice* (1983), Gottlieb provides comprehensive information outlining specific ways providers can offer social support to their patients (Gottlieb, 1983). He writes of steps physical health care practitioners can aid their patients (Gottlieb, 1983, pp. 146-151) and the value of such assistance in business settings (Gottlieb, 1983, pp. 160-175). In short, he conveys the idea of the broad applicability of social support and the benefits it imparts to those in need (Gottlieb, 1983).

In his later work: *Marshaling social support: Formats, processes, and effects* (1988), Gottlieb offers a lengthier text with more specific information about potential applications. However, he declines to put forward a single, clear definition of his central concept—social support. He writes: “The mandate we were issued was…to define the boundaries of support interventions…” (Gottlieb, 1988, p. 11). He writes, further: “We engaged in a lively and prolonged discussion of the unique features of support interventions, taking turns presenting and rebutting various exemplars of the genuine article” (Gottlieb, 1988, p. 11). Ultimately, though, Gottlieb and his colleagues opted not to proffer a concrete definition of the term (Gottlieb, 1988, p. 12). He writes: “Accordingly, we skirted the definitional morass and proceeded to firmer ground, generating a set of guidelines rather than hard and fast criteria for designing and conducting interventions involving the modification of social support” (Gottlieb, 1988, p. 12).

Sarason, Sarason, and Pierce (1991) also write very clearly and very early in their work that: “…it is important to understand what the term social support means” (Sarason,
Sarason, & Pierce, 1991, p. 9). They write that it is not simply one idea, but a phrase that encompasses a collection of thoughts, actions and behaviors meant to help individuals thrive (Sarason, Sarason, & Pierce, 1991, pp. 9-10). The trio then points to the definition previously set forth by Cobb (1976) and to steps medical workers take to soothe the sick and the steadying hands parents offer children (Sarason et al., 1991, pp. 10-11).

Albrecht, Burleson, and Sarason (1992) add further detail to the definition in the first lines of another article. They write of how imperative it is that individuals receive positive, comforting messages from others (Albrecht, Burleson, & Sarason, 1992, p. 149). Citing Albrecht and Halsey (1992) and Hamburg and Kililea (1979), they write: “…supportive interactions and the presence of supportive relationships in people’s lives have been shown to play a major role in physical health, emotional well-being, and work performance” (Albrecht, Burleson, & Sarason, 1992, p. 149). They write that even when such steps are financially and temporally costly, they are beneficial to the pained party (Albrecht, et al., 1992, p. 149).

Other scholars have offered more expansive examinations of social support (Burleson, Albrecht, & Sarason, 1994). In Communication of social support: Messages, interactions, relationships, and community, Brant R. Burleson, Terrance L. Albrecht, and Irwin G. Sarason and their contributing authors discuss social support communication (Burleson et al., 1994). They also analyze how elements of such communication function within particular scenarios and personal exchanges (Burleson et al., 1994). Perhaps most important among their words—with regard to this present research—are a few specific
statements. For instance, in his chapter: “Comforting messages: Significance, approaches, and effects” (Burleson, 1994) co-editor Burleson writes of the healing powers of certain social encounters (Burleson, 1994). He writes: “Empathy, warmth, and genuineness (often referred to collectively as “the therapeutic conditions”) supposedly bring about improvement because the climate fostered by these conditions maximizes the individual’s self-exploration, self-understanding and development of appropriate plans of action” (Burleson, 1994, p. 11).

Elsewhere in the text, in their chapter: “Everyday communicative contexts for social support” (Barnes and Duck, 1994, p. 175), contributing authors Melanie K. Barnes and Steve Duck note the importance of familiarity (p. 175). They write: “When people experience a crisis…they initially turn to those people with whom they have continuous relationships…” (p. 175). These statements are relevant and important to the present research because they describe conditions that likely exist in many churches and their probable effect (Barnes and Duck, 1994, p. 175; Burleson, 1994, p. 11).

Pierce, Lakey, Sarason, and Sarason (1997) offer an equally expansive view, and they, too, provide some particular takeaways relevant to this research. These scholars, along with their contributors, write about how the essential behavior traits of an individual affect the ways that person responds to and benefits from (or fails to benefit from) aid others offer (Pierce, Lakey, Sarason, & Sarason, 1997). For instance, contributor Neal Krause writes of how individuals in the later stages of life would rather seek help from established groups (Krause, 1997, p. 347). Because the aged often have modest means and a desire to return care in kind, Krause writes that those people turn to
publicly funded and charity groups (Krause, 1997, p. 347). Since churches often provide services at little or no expense to congregants, individuals might be willing to avail themselves of the resources proffered (Krause, 1997, p. 347).

How can providers of social support of that nature know how much good they are doing in such situations, though? Vaux (1988) asks—and offers an answer to—that question in his book: *Social support: Theory, research, and intervention* (p. 297). He writes that while scholars had devised ways to gauge the benefits generated by social support activities, many still had trouble calculating the value of those steps (p. 297).

Other researchers disagree (Cohen, Underwood, & Gottlieb, 2000). Cohen, Underwood, and Gottlieb offer an entire text on how to tally the effectiveness of such exchanges (Cohen, Underwood, & Gottlieb, 2000). These scholars write that one way to assess this kind of interpersonal care is to determine how one feels about the options available for support by looking at various dimensions of aid (Cohen et al., 2000, p. 35). That is not the only means by which they indicate one may decide how successful such endeavors are, though (Cohen, Underwood, & Gottlieb, 2000). They also write of looking at the level of immersion a person has in his or her respective community—in other words, the number of social positions a person holds (Cohen et al., 2000, p. 41). These authors note, however, that further study will be necessary if scholars are to fully comprehend what contributes to whether these kinds of efforts benefit those in need and how (Cohen, et al., 2000, p. 46).

**Social Support and Health**

Whereas some scholars write about social support broadly, others study and report
on how people apply and experience social support in certain situations and contexts, including during health-related situations (Kaplan, Cassel, & Gore, 1977; Brashers & Goldsmith, 2009; Roy, 2011). These authors do not study the function of social support endeavors in relation to a particular condition, but rather in the context of how supportive actions benefit patients in general (Kaplan, Cassel, & Gore, 1977; Brashers & Goldsmith, 2009; Roy, 2011). In relation to this project, this sizeable group of authors describes how social support steps might help those who are suffering (Kaplan, Cassel, & Gore, 1977; Brashers & Goldsmith, 2009; Roy, 2011).

Kaplan, et al. (1977) take that query—how does social support help those who are sick and hurting—as one of their research questions (p. 47). Specifically, they ask what physiological changes happen within the body of someone who is sick and what tools in the environment of that person facilitate that person feeling the aid others proffer (p. 47). What they report is that not only people, but also animals, benefit from having someone of their own kind close to them when they are enduring a stressful experience (p. 50). These scholars go on to recommend that those in the medical field probe patients for information about the people and associations in their life that might help them through an ailment or treatment (p. 56).

Borysenko and Borysenko (1982) report a positive relationship between stress and sickness in their article (p. 59). These scholars write that their examination of information on this topic—information based on animals—shows that emotional trauma increases the likelihood of illness (p. 59). They write, further, that a number of things contributed to the chance of sickness in these animals, but that the elevated risk was clearly present (p.
Scholar Kathleen Ell only adds weight to the point (Ell, 1984). Ell analyzes works related to social support and writes of how those then-contemporary studies linked social isolation with a range of poor health outcomes (as cited in Ell, 1984, p. 133). She writes: “Recent evidence suggests that network characteristics significantly influence individual health-related behavior as well as the nature and extent of social support available to individuals in coping with life stresses” (Ell, 1984, p. 134).

Cohen and Syme (1985) provide an even broader, more complete picture. They write about the value of such aid at particular junctures in life and in particular relationships (Cohen & Syme, 1985). Importantly, they write about ways to properly provide social support to those in need, both in general and in times of sickness (Cohen & Syme, 1985). They use an encompassing meaning for the phrase, writing: “Social support is defined as the resources provided by other persons” (Cohen & Syme, 1985, p. 4). They write that assistance of this nature helps not only the body, but also the mind (Cohen & Syme, 1985, p. 5).

Of particular relevance to this current work is an article on how recipients of these supportive steps feel about the gestures (Zich & Temoshok, 1987). In their study, Zich and Temoshok looked at males who had AIDS and those who had AIDS-related complex (p. 193). The researchers followed these individuals for a period of years and found that people with AIDS experienced more pain when they believed less aid was available to them (p. 193). They found that people with either condition felt less hopeless and less depressed when they thought such aid was accessible to them (p. 193).
Wong-Rieger and David (1992) arrived at similar results in another study. The scholars studied a group of males living with HIV (p. S66). They write: “The problem for many HIV+ persons is gaining access to adequate support” (p. S66). Therefore, the researchers aimed to inspire the people who took part in their research to build connections with others (p. S66). At the same time, they hoped that those in their study would gain emotional strength and skills that would help them withstand personal anguish (p. S66). What the researchers found was that the steps through which they guided the participants achieved many of the aims they had hoped (p. S67). They found that, post-training, the individuals showed greater likelihood of turning to peers from the research participant population for emotional strength and of proffering it to fellow group than they had at the outset of the initiative (pp. S66-S67).

Gant and Ostrow (1995) find that those results might not hold true for different cultural groups, however. The authors analyze the effects of support among African American males and among Caucasian males (p. 215). What they report is that while the white participants felt positive changes as a result of the connections and interactions they experienced, the African American participants did not (p. 215). Instead, “…data from African American men revealed negative relationships” (p. 215). The scholars attribute these differences in how each group reaches out for assistance and the frequency of aid pursuit by each (p. 216).

Another work germane to this study is one by Cawyer and Smith-Dupre (1995). These authors studied support groups designed for people with HIV/AIDS and the many elements that function simultaneously to make the gatherings the comforting, healing
settings that they are (p. 1). Citing Goffman (1967), they write, importantly, however, of the feature of communication control, or the implementation of guidelines that help maintain a peaceful, protective environment for all group members (as cited in Cawyer & Smith-Dupre, p. 5). While they acknowledge the need for people to converse unimpeded, they write that structure helps affords all attendees respect and freedom (pp. 5; 11).

Three other authors note the value of comforting relationships—both for patients and those who care for and about them, meanwhile (Jankowski, Videka-Sherman, & Laquidara-Dickinson 1996, p. 206). Jankowski, Videka-Sherman, and Laquidara-Dickinson (1996) make clear at the outset of their work that: “There is mounting evidence that social support is positively related to good health” (p. 206). They write, further, that: “AIDS has a devastating impact on the social networks of those most closely involved with the person with AIDS (PWA)” (p. 206). When care providers are on the receiving end of comforting gestures, however, they may achieve reduced turmoil in their own lives as well as enhanced mental and physical wellness themselves (p. 206). In such cases, both the patient and the supporter obtain some of the care they need to cope with the medical situation at hand through social support (p. 206).

While supporters might benefit from such comfort, Turner, Pearlin, and Mullan (1998) report that care providers and patients might also receive poor treatment from peers and other members of society (p. 137). Essentially, they write that the patients might be shunned due to their disease and the person supplying comfort to that individual might be exiled from previous relationships simply for connecting with them (Turner,

Also relevant to this research is a text by Gabriel (1996). The author writes of similar, positive physical changes reported in people with HIV/AIDS when they receive social support (pp. 18-19). Writing of research conducted by other scholars, Gabriel reports that participants in that research who received social support experienced improvement in their bodily condition (p. 19). Gabriel follows that statement with a word of cautious optimism. She writes: “While no firm conclusions have been reached, HIV/AIDS professionals need to be mindful of the potential and impact of support on the immune system” (p. 19).

Whereas Gabriel (1996) lacked solid findings, another group of researchers did not (Swindells, et. al, 1999). This latter group of scholars studied the benefits of social support and its effects on patients with HIV (Swindells, et. al, 1999). This group reports that those who have HIV/AIDS can sometimes attain a better quality of life when they receive social support from others (Swindells, et. al, 1999, p. 383). They write: “Social support, coping style, and hopelessness (depression) were found to significantly influence the QOL of HIV-infected patients in our study” (p. 388).

Hall (1999) looks at an array of research related to health and social support as it pertains to men with HIV/AIDS (p. 74). In particular, Hall explores two-dozen studies on social support and homosexual males and discerned three essential categories among them (p.74). Hall identifies these as those that focused on relational partners and friend
groups and those that focused on techniques for managing hardship (p. 74). Hall ultimately reports an important conclusion: “The research literature on social support and health in gay men with HIV/AIDS in gay men remains tentative” (p. 84). Hall did not discuss social support directly related to HIV/AIDS in religious settings, however, so his conclusions are presented here simply as a means of perspective (Hall 1999).

A study that same year by Leserman, et al. (1999) finds that not only is social support beneficial to homosexual men with HIV/AIDS, but that not receiving such care during times of trial is harmful to well-being (p. 397). The scholars write that people who lack such aid could experience hastening in the course of their ailment or HIV/AIDS that advances more rapidly (p. 397). In their study, however, it is important to recognize that African American participants did not develop quickening of the course of their disease, whereas white members of the participant pool did (p. 404). The authors note, however, that other research has not shown such a difference based on the race of the recipient (as cited in Leserman, et al., 1999, p. 404).

Yet another group of scholars who published that year report different results (Lloyd, Faust, San Roque, & Loue, 1999, p. 120). Lloyd, Faust, San Roque, and Loue (1999) conducted a study of Pacific Islander males, and identified “…no association between any of our measure of social support and reported use of risk reduction strategies” (p. 120). They write, further: “Our data indicate moderate to high levels of HIV risk despite high levels of knowledge” (Lloyd, et al., p. 120).

Two authors offer two conclusions from studies on social support and HIV/AIDS (Siegel & Schrimshaw, 2000, 2004). In their earlier work, Siegel and Schrimshaw (2000)
studied women who have HIV/AIDS and whether they identified anything beneficial as a consequence of their disease (p. 1543). They report that a sizable majority—more than 80 percent—did note a beneficial change (p. 1543). They found that these changes included better handling of substance abuse or altering harmful intimacy practices (p. 1547). In their latter work, furthermore, the researchers studied life challenges of women with HIV and AIDS (Siegel & Schrimshaw, 2004, p. 225). They noted that—contrary to their hypothesis—women for whom antiretroviral treatments were available had a higher likelihood of enduring emotional hardship due to their disease (Siegel & Schrimshaw, 2004, p. 225). They also had a higher likelihood of taking steps to deal with that stress that were less than ideal (Siegel & Schrimshaw, 2004, p. 225). The takeaway that they offer to the present research then, is that the existence of social support outlets can be important to those dealing with HIV/AIDS, but such outlets and such support are not guaranteed to help (Siegel & Schrimshaw, 2000; 2004). This could be due, in part, to the sense that medications and treatments can ease pain temporarily, but cannot stave off eventual pain and suffering that could HIV/AIDS.

Citing Mishel (1988) and Neville (1998), Brashers, Neidig, and Goldsmith (2004) add additional weight to that last point while generally writing favorably of the benefits of social support. The latter scholars, citing Albrecht and Adelman (1987) and Albrecht, Burleson, and Goldsmith (1994), write: “…social support is not without costs that can exacerbate stress and uncertainty” (p. 307). They then provide several examples of ineffective or hurtful support attempts (pp. 307-308).

Tate, et al., (2006) proffer benefits of social support, meanwhile. The scholars
looked at a few elements, including: stress management skills, ethnicity and the presence of social support (Tate, et al., 2006, p. 235). They report that when people received gestures of social support those individuals tended to find and exercise beneficial adversity management behaviors (Tate, et al., 2006, p. 235). They write: “Specifically, high support was linked to greater use of seeking support and positive coping and low social support was linked to self-destructive coping” (p. 244).

Peterson (2009) adds even more evidence to support the notion that social support helps foster positive outcomes in people dealing with HIV/AIDS. Peterson writes first about the often-relaxing nature of church itself and the calm that faith frequently brings (p. 301). She writes that this peace is not unlike the feelings people sometimes take from moments of social support (pp. 303-304). Peterson embraces these similarities as a learning opportunity, then, and finds that women who have HIV/AIDS and who come to church and craft relationships with God benefit from that friendship with the higher power (pp. 306-307). She writes that via that relationship women began to see their HIV experience as either a good thing or something they had to face (pp. 306-307). In that sentence, then, Peterson notes that God—and the church—supply HIV-positive women with strength and somewhere to bring their troubles and find relief (pp. 306-307).

Other scholars report that members of the Latino community might have similar experiences as they deal with HIV/AIDS (Martinez, et al., 2012, p. 281). Like the women, these researchers write in large part about fear, isolation and the pain these feelings bring (p. 281). Rather than just engaging in a dialogue or friendship with a higher power, however, the participants in this study, these individuals also found
strength within themselves (p. 286). One should consider, however, that these researchers did touch on the issue of faith (p. 286). Perhaps, then, the religious practices of these participants were more subtle but just as powerfully influential as those of the women in the study by Peterson (Martinez, et al., 2012, p. 286; Peterson 2009).

Another set of authors puts forward similar statements of social support benefits (Heaney & Israel, 2008). In their chapter on “Social networks and social support,” Heaney and Israel write specifically about the aid that an assembly of people dealing with the same issue or problem can afford (p. 201). They write that these associations often represent a novel array of social relationships for people in need (p. 201). They write that many times, people in these arrangements have a shared concern that links them and provides the foundation for their relationships with one another (p. 201).

At the heart of what Heaney and Israel (p. 201) write about, is adjustment and acclimation to the new circumstances of having HIV/AIDS. Another group of social support scholars touch on these ideas, as well (Goldsmith, et al., 2008). Essentially what these scholars note is that the disease—and the state of being sick with an ailment that an individual will have for life—is a new experience (Goldsmith, et al., 2008). With time and some help, however, people find ways to settle into the new ways of life and to find ways to endure (Goldsmith, et al., 2008).

If support is present early enough, it can even help people gather the courage to find out if they are affected by HIV or AIDS (Grosso, 2010, p. 53). Grosso (2010) studied the data gathered by the Centers for Disease Control via “…a nationally representative telephone survey…” of more than 430,000 people (p. 55). In her article, she writes: “In
In this analysis, I use social support as an individual level measure of social capital and examine its influence on a protective behavior, getting tested for HIV” (p. 53). She writes, further, that “…the more often an individual at risk for HIV infection gets the social and emotional support needed, the more likely he or she is to report having been tested for HIV” (p. 59). Grosso writes that beneficial support gestures include: providing communal settings in which people can communicate about their needs and feelings and supplying babysitting or rides to the affected individuals (p. 59).

Yadav (2010) takes a similar tack in his article. He writes of social support efforts by secular entities in Nepal (p. 159). Like Grosso, he writes of making effective use of connections (Yadav, 2010, p. 157; Grosso, 2010, p. 53). Especially important to Yadav, though, are the connections that are with people outside the family. Of these, he writes: “The non-family support network was greater than the family support network” (p. 157). He writes that this extra-familial aid is useful because it can lower the social ostracism that often accompanies HIV/AIDS (p. 159).

Roy (2011) writes, meanwhile, of HIV/AIDS-related social support as being on rather shaky ground (pp. 140-155). While he clearly states that much of the shame that HIV/AIDS patients endured has ceased, he writes that many members of the public still lack information about the conditions (p. 140). What is more, he writes that support from relatives of an HIV/AIDS patient frequently fades over the course of the illness (p. 145). For those reasons, Roy writes that the patients many times relish the chance to interact with people enduring similar circumstances (pp. 144-145).

In a similar tone, another group of scholars addressed the status of research
related to HIV/AIDS among younger Latino men and women (Martinez, et al., 2012). They researchers identified numerous themes in their study of their participants—themes related to the concerns the youths had about HIV/AIDS (p. 283). The scholars noted several: “…including: (1) initial psychosocial responses to HIV diagnosis, (2) disclosure to family and friends, (3) stigma related to receiving an HIV diagnosis, (4) body image and concerns of the physical changes associated with HIV and antiretroviral medications…” (p. 283). The other issues the scholars identified as concerns of their participants included: “(5) taking antiretroviral medications and side effects, (6) the disruption of their future life goals, and (7) reproductive health concerns” (p. 283). At the conclusion of their work, these researchers found that many of the members of the population they examined found more relief from their pain in solitary endeavors, more than in outside support (p. 288). Among the actions that participants viewed as soothing, the authors include amending personal aims and revising the order of importance of those items (p. 285).

McIntosh and Roselli (2012) report similar results from a study involving participants from a different demographic. These scholars studied more than 7,600 women, with a median age of 36 (p. 2144). For these individuals, self-conducted emotional management techniques supplied more comfort and relief than help from other people (p. 2151). The authors write that: “…women who practice cognitive and spiritual reframing of stress report greater levels of perceived control and stress-related growth than those who turn to outside sources for support relief” (p. 2151).

Schlecker and Fleischer (2013) provide, perhaps, the closest view of social
support of any of the authors discussed thus far. The editors crafted a collection of writings—a work they titled: *Ethnographies of social support* (Schlecker & Fleischer, 2013). Via these writings, the editors convey the experiences of people with HIV/AIDS from around the world (Schlecker & Fleischer, 2013). They find this kind of interpersonal aid occurs not as a consequence of disease, but as an ordinary part of human existence (p. 1). They write: “By offering case studies where support unfolds in less straightforward ways, the contributors seek to counterbalance the emphasis on functions by drawing attention to what might be called mutuality” (p. 1). They write, further: “Mutuality acknowledges support as the everyday business of living in a world that one necessarily shares with others, that is, support as a background operation” (p. 1). For the editors, in other words, social assistance is simply a type of exchange that occurs naturally between human beings (pp. 1-2).

Scheid (2015), however, it is much more complex. Scheid makes it clear in her book that social support is an integral part of HIV/AIDS care endeavors (pp. 9-10). She accomplishes this by writing of massive governmental involvement, funding, and research, and of smaller activities, as well (pp. 9-10). For many public entities and community organizations, it seems, providing resources to those with HIV/AIDS-related needs, is simply standard procedure—and a best practice (pp. 9-13).

**Social Support and Religion in History**

Social support has long been more than just a good idea, though; for hundreds of years, it has been an integral part of the African American religious experience and a part that has not been neglected in the scholarship (Battle, 2006). In *The
Battle (2006) writes: “I define spirituality in the African context of Christianity as the formation of self through communal being or relationality” (p. xv). To put it differently, for Battle, church is a place for African Americans to find out who they are both individually and collectively (p. xv). He then outlines how this approach has characterized religion for people of African descent for centuries (p. xvii). This seems a distinctly social and largely secular endeavor.

Scandrett (1994) writes, however, that it is not. He writes that where community aid outlets have fallen short of sufficiently providing for the needs of African Americans, churches have filled that gap (p. 123). Specifically, they write: “Political and social barriers that have deprived Black people of proper health care have been overcome through religious intervention” (p. 123). He writes, further, that: “The church has been and, to a lesser degree, still is the hub of social activity in the black community” (p. 124). He writes that this function has extended to the realm of health matters and familial relationship issues of congregants (p. 124). It seems, further, then, that Battle and Scandrett report what this study present study will reaffirm: that African Americans have found social support in church when they could not find it in secular society (p. xvii).

**Social Support and Religion Today**

Whereas Battle and Scandrett provide the historical background for this phenomenon of church as an outlet of social support, other scholars provide evidence that this trend continues today (Battle, 2006, p. xvii; Taylor, Chatters, & Levin, 2004, p. 84; Aukst-Margetic & Margetic, 2005;). Taylor, Chatters, and Levin write of the fact that
ministers sometimes serve as confidants and counselors to those burdened with emotional concerns (Taylor, Chatters, & Levin, p. 111). They write that congregants who opt to speak to their minister might do so for a number of reasons, including poor financial conditions (lack of money to pay a therapist) and inability to get to a doctor (p. 115). Perhaps more importantly, though, they write that many churchgoers have confidence in their religious official and in his or her ability to provide comfort and care (p. 115). They write: “Further, individuals who seek assistance from clergy generally do so within the context of a meaningful personal relationship with their minister in which there is rapport and trust” (p. 115). Aukst-Margetic and Margetic write, finally, that a sizeable body of scholarship indicates that aid of this variety supports the health of the minds and bodies of those affected by diseases, including HIV/AIDS (p. 365).

Some scholars have explored the functions and effects of social support beyond the issue of HIV/AIDS (Ferraro & Koch, 1994). Ferraro and Koch (1994), for example, write simply about the impact of religious faith on physical wellness (Ferraro & Koch, 1994). Specifically, they write that while African American women are more likely to be religious, they tend to be less healthy (Ferraro & Koch, 1994, p. 362). Even when both African American and Caucasian women receive gestures of social support, then, the African American women are still less healthy than Caucasian women (p. 362). The scholars did identify some benefit for African American women who engage in religious activities, however (p. 371). Regarding this, the scholars write: “…religious practice has a salutary effect on health among black subjects above and beyond the role of social support, but this is not the case for white subjects” (p. 371). For Black worshippers, in
other words, the primary benefit is from the connection with their faith, not their fellow men (p. 371).

Wilkum and MacGeorge (2010) write, furthermore, of how this phenomenon is not limited to African Americans. The scholars studied more than 300 college pupils (p. 723). They instructed the participants to think about losing one of their grandparents (p. 723). The scholars asked the participants to consider “…comforting messages representing different levels of person centeredness and different types of religious content” (p. 723). The researchers found that individuals favored communication in which God is the entity who brings comfort and helps the person in times of trial (p. 723). The authors write: “…support providers who want to comfort the bereaved most effectively should consider not only the person-centeredness of their messages, but also the extent to which God is referenced as intervening or assisting in the coping process” (p. 739).

Taylor and Chatters (1988) take it as their mission, meanwhile, to provide a complete exploration of the comfort church communities provide. The scholars write: “It is our contention that a fuller appreciation of the supportive nature of church congregations in particular can be realized by examining the church within an explicit social support framework” (Taylor & Chatters, 1988, p. 193). From there, they detail how churches rally around those in need and how for African Americans the church has long been one place where they can find help (pp. 193-194). In other words, churches stand as institutions especially suited for this kind of aid to the African American community (pp. 193-194).
Taylor, Ellison, Chatters, Levin, and Lincoln (2000) continue this story in a subsequent article that discusses other, then-current, literature. This time, the scholars and their new co-authors write of church leaders in a rather traditional shepherd role (Taylor, et al., 2000). They write of leaders keeping their members safe from outside evils and of how social support is a natural extension of this care (Taylor, et al., 2000, p. 76).

Coleman and Holzemer (1999) then bring the conversation back to the notion that churches are ideally suited to provide this kind of aid. They report however, that even if this is the case, many African Americans have less than perfect church participation (p. 46). They write: “Throughout history, Black churches have contributed to the quality of life for African American families” (p. 42). The scholars looked at concepts of faith, the physical rigors of HIV/AIDS and individual social standing via a survey of black HIV/AIDS patients (p. 42). They report: “Church attendance was important to a minority of participants” (p. 46) and attribute this to changing health demands (p. 46).

Chatters, et al., (2002) write of different individuals having different needs with regard to support, meanwhile. After reviewing a pre-collected dataset—“the National Survey of Black Americans” (p. 70)—the scholars drew conclusions from the information. They report: “Overall patterns of family and church support indicate that slightly more than half of respondents receive assistance from both family and church networks…” (p. 66). Twenty-five percent of respondents obtain aid just from relatives and just under ten percent get aid only from their religious community, they report (p. 66).

Krause (2001, 2002, 2006) and numerous colleagues also examine this caretaking
in three scholarly articles. In the first, Krause, et al. (2001), write that the aid found in church is not exclusively—or even most importantly—from the leader (p. 637). Rather, people gain the most from faith support from the people seated beside them in the pews (p. 637). What is more, females find more solace in faith settings than men (Krause, Ellison, & Marcum, 2002, p. 21). Finally, though, Krause (2006) alone reports that simply knowing help is near and imminent is enough to make people healthier (p. 125). He writes: “Data from a nationwide longitudinal survey of older adults suggest that anticipated support is associated with more favorable changes in health, whereas enacted support is associated with a slight decline in health over time” (p. 125).

**Social Support, Religion, Trust and HIV/AIDS**

Whereas those scholars addressed topics related broadly to religion and health, others have focused on HIV and AIDS. Seegers (2007) is one such author and she writes that on some occasions, the place where HIV/AIDS patients go to seek comfort becomes uncomfortable due to social judgment (p. 5). She writes that while those with HIV or AIDS were at peace with their health status, if they became aware that others disagreed with their sexual preference, they would, in turn, act differently (p. 5).

Brashers and Goldsmith (2009) write broadly of health communication, but one author who contributed to their work provides the most valuable insights for this paper (Brashers & Goldsmith, 2009; Peterson, 2009, pp. 301-321). Peterson writes about HIV-positive women and religion (Peterson, 2009, pp. 301-321). While the women in question had access to church community-based social support, Peterson reports that more than
half of the women in her study identified God as the entity who provided them comfort (Peterson, 2009, p. 306). She writes: “Those who spoke of spirituality described a strong sense of faith that they would be taken care of no matter what happened to them” (Peterson, 2009, p. 306).

Haddad (2011) also offers insights on HIV/AIDS communication as it relates to religion. Haddad is unique in her perspective in that she writes as a resident of the African continent and as a theologian (book cover). She serves as “director of the Theology and Development Programme and Director of the Collaborative for HIV and AIDS, Religion and Theology at the School of Religion and Theology, University of KwaZulu-Natal, South Africa” (book cover). For her, further, social support—primarily in the forms of interpersonal comfort and data—is an essential part of ministerial duties (pp. 242-244). She writes that this support includes providing information on prophylactics and advice and efforts related to changing exclusionary attitudes and behaviors (pp. 242-244).

Stateside, though, African American churchgoers do not rely solely on the spiritual hands of a higher power to assist them; they accept help human help from people in their place of worship (Baker, 1999). Baker writes: “Historically, the Black church has participated by lending support, providing care, and being actively involved in the health and social welfare of its members” (p. 71). In other words, members and leaders of African American churches have supplied their fellow community members with social support (p. 71).

That kind of assistance is not limited to a single church, either (Agate, et al.,
2005). In another study, researchers found religious leaders offering similar care to their congregants in Broward County, Florida churches (p. 60S). They write that via a church initiative, leaders were taught how to design church-based programs to inform attendees about various aspects of AIDS (p. 61S). The authors write that church leaders examined techniques for imparting delicate data, such as information about prophylactics, drugs, and sexual orientation (p. 60S). They write: “CUSH’s objectives include training faith-based leaders and congregations to develop HIV educational programs, outreach and referral services and support programs for infected individuals and others affected by the epidemic” (p. 61S). The authors then conclude by writing of the influential position of the church in the minds of the congregants—a position which contributes to the receptivity of those congregants to the health message (p. 62S). Finally, they write of the value of church leaders having connections or partnerships with local health officials (p. 62S). They write: “In conclusion, CUSH activities underscore the importance of faith-based organizations in HIV prevention. This innovative program demonstrates how collaborations between public health and faith-based organizations can connect science with communities” (p. 62S).

In a number of studies during the years that followed, other groups of scholars studied various church communities across the country (Derose, et al., 2011; Berkley-Patton, et al., 2012; Frenk & Trinitapoli, 2013). Derose, et al. (2011), for example, examined the nature of HIV/AIDS aid within Los Angeles County churches and found that when church HIV communication efforts complemented church teachings, congregants were more receptive to the information (p. 2). Leaders of those churches,
therefore, conducted classes and provided printed documents about HIV to their members (p. 6).

Berkley-Patton, et al., (2013) looks at the fitness of those religious officials to impart the information needed to help people concerned about HIV/AIDS. They write that: “African American churches may be well-positioned to provide HIV education, screening, and support services, particularly if they are equipped with church-appropriate, easy-to-deliver HIV tools that can be implemented through the naturalistic church environment” (p. 482). In other words, church leaders have a reputation of caring for those in need and keeping people safe, and HIV education is clearly a task that fits well within that realm (p. 482).

Frenk and Trinitapoli (2013) analyze the factors that determine whether religious organizations creates such support services for its members at all. They write: “Using data from a nationally representative sample of U.S. congregations, this study estimates the proportion of congregations that provide programs or activities that serve people living with HIV/AIDS (PLWHA) and examines the effects of congregational characteristics on the likelihood of having them” (p. 1829). They report that a number of features contribute to the creation of such services, including having people in the church community who have HIV/AIDS and studying the congregation to discern its traits (p. 1829). They also report that fewer than six percent of church leaders have these programs in place in their churches (p. 1829).

Aaron, Yates, and Criniti (2011), write, furthermore, about HIV/AIDS initiatives designed to teach people within the church walls. Citing Lincoln (1990) they write:
“Historically, African American churches have had wide-reaching institutional power within their communities and have acted as a locus of community organization for African Americans” (as cited in Aaron, Yates, & Criniti, 2011, p. 151). The authors then write that church officials have utilized their power as leaders to address HIV and AIDS because they see how the diseases are hurting members of their congregations (p. 151). They report that some black church leaders had formed alliances with nursing officials to promote churchgoers to gain a better understanding of health information and their personal health status (p. 154). They report further that in their study, a successful medical and religious alliance was formed, but such initiatives would have to exist on a broad scale in order to affect change for society as a whole (p. 156).

Edwards, Irving, Amutah, and Sydnor (2012) even touch on some of the thornier questions surrounding social support—like children caring for parents (p. 571). They suggest that while social support might be helpful, care providers in a number of settings might not have perfected its application or delivery (Edwards, Irving, Amutah, & Sydnor, 2012).

**Stigma & Other Impediments**

The fact that an individual or group provides social support to someone with HIV/AIDS does not mean that good has been done or pain has been eased. Sometimes, words and actions interfere with the giving or receiving of social support and receivers are unable to reap the benefits of that aid. A number of scholars have written about such challenges (Elwood, 1999; Bennett & Travers, 1999; Bogart & Thorburn, 2005; Smith, Simmons, & Mayer, 2005; Muturi & An, 2010).
Ellwood (1999) writes of the mark of dishonor that HIV/AIDS often emblazons on those who suffer from the conditions (Ellwood, 1999, pp. 3-7). He writes that HIV/AIDS is a disease “…with which few wish to be infected and seemingly everyone wants to be associated” (Ellwood, 1999, p. 3). Clearly, Ellwood is placing patients in the first category in that statement and doctors, caregivers, and those who aim to be do-gooders in the latter category (p. 3). He is writing that people wish to reach out to these individuals, but often only to change or fix them (p. 3).

Sometimes, the social consequences—both positive and negative—of HIV are more extreme, though (Bennett & Travers, 1999, pp. 231-241). As scholars Lydia Bennett and Michele Travers write, some women with HIV/AIDS discover new activities to enjoy in the world and become more accepting of others (p. 231). At the same time, though, these individuals often experience pain and shame (p. 232). They write that this might happen when they discuss their condition with others, as others might see their illness as something brought on by misconduct (p. 232).

Beyond the challenges and mistreatment people with HIV/AIDS may endure from others, at times, they also have to deal with their own complicated ideas about their disease (Bogart & Thorburn, 2005). In some cases, these notions might not be grounded in the truth (Bogart & Thorburn, 2005). Bogart and Thorburn asked questions of African Americans to see how many embraced ideas that government officials created HIV to decrease the black population (p. 213). The researchers report that numerous people did espouse such ideas, including the notion that American leaders deny details about the disease and possible remedies to particular groups of people (p. 216).
Another group of scholars looks at this problem from an angle very similar to that of this present project—by looking at church-based response (Smith, et al., 2005). Smith, Simmons, and Mayer (2005) make note of some key points in their work. They write of how integral religion is to the African American community and how church leaders who serve African American communities might be the best senders for messages pertaining to HIV/AIDS (p. 1682). However, they continue by noting that, the vast majority of religious officials—82 percent—who serve in African American churches have not undertaken the task of conveying such information (p. 1682).

Prachakul, Grant, and Keltner (2007) also address stigma in their work. These scholars write not of religion, but rather of patients in a hospital setting (p. 67). They write of their participants and the emotional hardships that those individuals endured, and they write of how the individuals coped with depression and how that one condition resulted in a number of other negative circumstances (p. 67). They write that these emotional events included greater feelings of isolation and decreased social support (p. 67).

Another group of scholars writes of a similar endeavor in another locale (Griffith, et al., 2010). In this case, the researchers write of an initiative in Michigan (p. 5). They write that it included a dozen groups that primarily help African American community members (Griffith, et al., 2010, p. 4). The scholars offered educational programs to African American church congregants and residents of lower income areas (p. 6). They report that the information led the participants to a new, more accurate understanding of their HIV/AIDS-related risks and necessary protection steps (p. 7). They write: “The
young people in the YBH program seemed to internalize information about HIV transmission and recognize they did not know all there was to know about sex, STIs, HIV transmission and sexual risk” (p. 7). They write further: “Following the training, [the minister] participants demonstrated increased sexual health knowledge, improved facilitation skills, and a greater comfort level with discussing sexual health topics” (p. 8).

Muturi and An (2010) studied another issue more closely related to church. The researchers started with a question: “…whether and to what extent religiosity plays a role in stigma toward HIV/AIDS” (p. 388). They found that the people with the strongest devotion to their religious faith were most likely to view AIDS as an act of a higher being—a form of punishment for immoral behavior (p. 388). They write: “Verbatim responses to an open-ended question also revealed seemingly ingrained prejudice against HIV/AIDS from a religious perspective. The findings point to the important role of faith-based organizations (FBOs) in addressing HIV/AIDS within African American communities” (p. 388).

Aholou, Gale, and Slater (2011) write of another, somewhat different, part clergy have to play as they work to advise their congregants—the role of pre-nuptial educator (p. 330). The researchers studied the thoughts and attitudes of African American religious leaders related to sex, with a particular focus on what those officials would discuss with congregants seeking advice before marriage (p. 334). Following interviews with seven participants, the researchers reported that the found three common ideas among in their interviews, including: “ ‘Disclosure,’ ‘Sexual Communication,’ and ‘Integration of HIV
awareness and prevention strategies,” (p. 337). Aholou, Gale, and Slater report, however, that not all of the participants were fully informed on the issues germane to their discussions with their congregants—including the means of passage of HIV from one person to another (p. 341). They report, further, that only some of the participants had completed an educational session on the disease (p. 341). They write: “This is significant in that these forums typically address how HIV is transmitted as well as strategies to prevent the spread of the HIV virus” (p. 341).

Bluthenthal, et al., (2012), report, finally, that their study of more than fifty religious leaders and lay individuals that feelings about people with HIV/AIDS vary widely in church communities (p. 1520). They write: “We explored congregational and community norms and attitudes regarding HIV, sexuality and drug use through a qualitative case study of 14 diverse religious congregations in Los Angeles County, California between December 2006 and May 2008” (p. 1520). In part, what they report is that low and marked stigma both exist, but that most churchgoers in the studied communities held moderate negative emotions about HIV/AIDS and those affected by the conditions (p. 1524). Of those harboring poor sentiments of those affected, they write: “At the stigmatizing end of the continuum, participants tended to link HIV to sin and condemned people with HIV for having engaged in risk behaviors that are contrary to scripture or doctrine” (p. 1524). Citing Brown, et al., (2003), they write, further: “Reducing stigma within religious congregation is important, as stigmatizing HIV, homosexuality and substance abuse may directly harm at-risk populations” (p. 1529). As for ways to accomplish that, the authors recommend monitoring and guiding
group feelings about the disease, making sure that the solution is designed for the population in need of change (pp. 1529-1530).

**Recent Research on Social Support**

After all of this research, what is the current state of social support scholarship? The authors of some very recent articles offer a few insights (Illangasekare, et al., 2014; Werber, et al., 2012). The first scholars write about some of the emotional issues that can accompany HIV and AIDS (Illangasekare, et al., 2014). They write about how some women of low socioeconomic status risk encountering abuse at the hands of their significant others and drug use in addition to HIV and AIDS (p. 551). They write that while social support tactics might soothe a spectrum of hurt, the pain of the women in these circumstances might be too severe for the steps espoused by the array of social support scholars (pp. 555-556). They write, in other words, that while social support offers a number of benefits for many people, in other cases, people need different solutions (pp. 555-556).

Werber, et al. (2012) write, meanwhile, about HIV/AIDS-related community efforts. They write of the relationships that churches and other social organizations craft to collaborate as they work to help people with HIV/AIDS (p. 777). They write that these affiliations involved those in which: “…1) resources flowed to congregations to external entities 2) resources flowed from congregations to external entities; 3) congregations interacted with external entities” (p. 777). They write further: “These types of relationships were present in roughly equal proportions” (p. 777). In summary, then, 14
church sample examined by these researchers consisted of churches whose leaders and members were not simply looking to solve internal HIV/AIDS issues, but to address larger, community-wide needs (p. 777).

Stewart and Dancy (2012) also write on the matter. They write of the occurrences that motivate ministers to create church-based aid for congregants affected by HIV/AIDS (p. 425). The researchers studied one church and report that a number of phenomena lead to such a decision (p. 425). They write that these traits include: charitable spirit among congregants, a sense of care for others and instruction about HIV/AIDS (p. 419).

Thomas, et al., (1994), meanwhile, reports that for a group of churches in the northern United States, the decision really came down to two things (p. 575). They identify those things as the years of schooling completed by the pastor and the number of people in the pews (p. 575). They reached their conclusions after examining conditions in more than 600 churches and write that their findings are indicative of the conditions in more than 75 percent of the congregations they examined (p. 575).

Two other groups of researchers also find that a key longstanding issue of related to HIV and AIDS continues to cause pain for people with HIV and AIDS (Grodensky, et al., 2014; Wilson, et al., 2011). Grodensky, et al., write that stigma (along with fear of participating in mainstream social activities because doing so could lead others to learn their health secrets) often plagues such individuals (p. 1). Of their female-only participants, they write: “Many women felt isolated and inhibited from seeking social connection due to reluctance to disclose their HIV status, which they viewed as more shameful at their older ages” (p. 1). Even faith-based settings did not relieve all of the
anxiety these women experienced, as even these carried some moral expectations (p. 1).

Wilson, et al., (2011) write, meanwhile, that “…churches play a role in promoting stigma against Black [men who have sex with men] which impedes prevention efforts” (p. S227). The researchers collected their data via focus groups and individual interviews with 81 people affiliated with a number of predominantly African American churches (p. S230). They write that they culled three main ideas from their data, all of which cast an unfavorable light on homosexual men and promoted stigma (p. S231). They identified these notions as: “…love the sinner, hate the sin…Don’t ask, don’t tell…and] ‘Your body is a temple…” (p. S231).

This research, however, is not simply intended to explore situations where social support has fallen short or research that has long since been completed. It is intended to explore situations in which social support is provided in good faith by religious leaders in Northern Virginia. It is intended to answer the question: How do religious leaders who work with the Fairfax County Health Department utilize social support to facilitate HIV/AIDS education efforts? In other words, what steps do the leaders take to provide social support? What aid do they proffer? How do they determine which actions to take? Finally, what goals do they hope to achieve via those actions?

Beyond answering these questions, this research also seeks to accomplish something more. It seeks to connect previous social work and history scholarship—scholarship which shows the centuries-old role of the black church as a venue of social support—to communication scholarship. It seeks to make that connection and to examine the present-day example of this phenomenon through the lens of two communication
theories: the buffering hypothesis (Cohen & Wills, 1985) and Diffusion of Innovations (Rogers, 2003).
CHAPTER TWO, METHOD

Research for this thesis consisted of in-depth personal interviews with religious leaders to ascertain the ways in which they communicate with congregants living with or at risk of contracting HIV/AIDS. This method was selected because it allowed each participant to share thoughts and insights about the HIV/AIDS needs and experiences of their congregants more freely than they might have in a focus group or via a survey.

Participants

Participants for this research were religious leaders who collaborate with Fairfax County Health Department officials to provide HIV/AIDS education and support to their congregants. All participants were male and all were African American. All participants serve as pastors of predominantly African American churches in Northern Virginia. All also serve as members of the Northern Virginia Clergy Council for the Prevention of HIV/AIDS.

The researcher recruited these individuals by submitting research and recruitment materials to a Fairfax County Health Department official via email. Materials submitted included a draft of the participant recruitment email, the informed consent form, the interview protocol and a thesis proposal that had been approved by thesis committee members. This method of recruitment was undertaken at the request of the health department official. The official reviewed these materials and sent them via email to the potential participants. This individual also sent the researcher the contact
information—email addresses and telephone numbers—for the participants. The researcher then sent each religious leader a recruitment email with a copy of the informed consent form. In the recruitment email, the researcher requested that if a minister were willing to participate in an audio-recorded telephone interview that he notify the researcher of this consent via email. The researcher saved and took screenshots of the resulting consent emails and compiled those screenshots in a Dropbox folder as records of participant consent.

Participants were notified on the informed consent form that the researcher would protect participant confidentiality by using pseudonyms to refer to participants in any published work. In addition to taking this step, the researcher has also removed church names from interview transcripts and will refrain from mentioning church names and affiliations in this work.

The interviews for this research were conducted between November 14, 2014 and January 23, 2015.

One religious leader declined to take part in this research.

The participants for this research represent a purposive sample (Frey, Botan, & Kreps, 2000, p. 132). Participants were chosen because they possessed the qualities this researcher was interested in studying, which is to say they are involved in church-based HIV/AIDS education in connection with health officials (Frey, Botan, & Kreps, 2000, p. 132). This kind of sample allows a researcher to examine a particular phenomenon (Frey, Botan, & Kreps, 2000, p. 132). It can, however, undermine generalizability—the ability to claim that research findings for a particular population are representative of
conditions that exist in the larger community. This is due to the fact that individuals not studied may have different experiences.

Another weakness specific to this specific sample is that these participants are all members of a common group. They meet and discuss issues related to their HIV/AIDS education efforts. By virtue of this association, the participants could have incorporated information from those group conversations into their individual interview responses. In other words, they could have provided responses that were not necessarily specific to the conditions and social support within their own church, but rather related to conditions present in congregations of other members of the larger clergy council.

At the time of each interview, the researcher called the respective participant and turned on two recording devices—a microcassette recorder and an Apple laptop equipped with GarageBand. Participants were notified verbally at the time this step was taken. This recording configuration was chosen to avoid the possibility of recording failure. The researcher then asked the approved interview questions and—in some cases—relevant follow-up questions one at a time and afforded participants the opportunity to respond.

The approved interview protocol consisted of seven questions. (See Appendix A for the Interview Guide used in this study.) The questions included inquiries about the name of the participant, the name of his particular church and number of congregants in that church. These questions were asked to allow the researcher to understand the contexts in which the religious leaders were working, communicating and providing social support.

Other questions pertained to the steps each participant takes to communicate with
his congregants about HIV/AIDS, the goals of those steps and successes and challenges each leader had experienced and foresaw. The researcher also asked participants if there were any additional details they felt were essential to their HIV/AIDS communication efforts and that should be considered as part of this study.

During some interviews, the researcher also asked follow-up questions of participants. These questions included inquiries as to how respective participants became involved with the clergy council and reactions of congregants to HIV/AIDS education content. Some participants were also asked about the age ranges of their congregants and their responses to challenges related to communicating about HIV/AIDS.

Participants were free to decline to answer any question(s) they wished. Each was also free to stop his/her interview at any time and for any reason, without penalty. No participants elected to terminate their interviews early. One participant did, however, opt not to directly answer one question, citing concerns about clergy-congregant confidentiality.

At the end of each interview, the researcher ended the interview in question by hanging up the telephone and then turning off the two recording devices. While still in the interview setting, the researcher next took a few moments to write down notes and observations about the interview just completed and possible connections and commonalities with other interviews.

As the interviews were completed, the researcher transcribed each interview. During transcription, the researcher removed participant names and names of churches to preserve participant confidentiality. The researcher replaced participant names with the
word participant and a letter (i.e., Participant A, Participant B, etc.).

From there, the researcher printed each transcript and uploaded each to a Dropbox folder for this project. The researcher then read the printed copies of each transcript and made notes related to the themes present in each. After some of the interviews had been completed, the researcher also uploaded the completed transcripts to an analysis website called Dedoose, which is designed to assist researchers in conducting qualitative analyses. Subsequent transcripts were printed and uploaded to both Dropbox and Dedoose after those interviews were completed.

The researcher looked to a number of communication research and analysis texts for help during data processing and examination. The first is: *Constructing grounded theory* (2014) by Kathy Charmaz. Charmaz writes: “Stated simply, grounded theory methods consist of systematic, yet flexible guidelines for collecting and analyzing qualitative data to construct theories from the data themselves” (p. 1).

The second data analysis book consulted for this research was: *Qualitative data analysis: A methods sourcebook* (Miles, Huberman, & Saldaña, 2014). Saldaña writes: “This book offers its readers practical guidance in recommended methods for assembling and analyzing primarily text-based data” (p. xvii).

The third analysis text consulted was: *Thinking qualitatively: Methods of mind* (2015) by Johnny Saldaña. The author writes: “The purpose of this book is to profile and activate multiple ways to think for qualitative inquiry and data analysis” (p. xiii). He writes, further: “Each person reading this book will get something completely different out of it and construct his or her own opinion about its utility and value” (p. xiv).
The researcher consulted these texts as a way to ensure that the analysis that went into this process was effective and well formulated. In other words, these texts were used to ensure that proper themes were identified to analyze the data obtained from participants. The researcher worked alone to develop the coding scheme and to select the codes used in this research.
CHAPTER THREE, RESULTS

This research sought to answer a single research question. That question was: How do religious leaders who work with the Fairfax County Health Department utilize social support to facilitate HIV/AIDS education efforts? It finds that participants primarily utilize informational and emotional support (Burleson, Albrecht, & Sarason, 1994) as they work to deliver this information to their congregants and members of the wider community (Participants A-I, communication with author). These participants spoke of such efforts more frequently than they did other types of support (Participants A-I, communication with author). Education, in the form of sermons, support groups, printed informational materials and a video produced by the Fairfax County Health Department all serve as parts of the social support provided by the participants (Participants A-I, communication with author).

Eighteen codes were used to analyze the interviews. These codes were: awareness, discussion, emotional support, festival, information, meeting (leaders), ministry, motivation, outreach, preaching, pulpit, video, sharing, speaking/talk, stigma, survey, teaching/education/knowledge and trust. These codes were selected because they represent phenomena or concepts mentioned by participants either specifically (verbatim) or as broad themes.

Each of these codes needs a clear definition for effective analysis and explanation.
Awareness was applied to comments in which the participants mentioned efforts to make congregants and community members cognizant of issues related to HIV/AIDS. Discussion was applied to two-way dialogues between religious leaders and congregants related to HIV/AIDS issues. Emotional support was the code applied to efforts to help congregants and community members feel better and cope better with their HIV/AIDS-related life struggles. Information was a code broadly applied to efforts to impart facts about HIV whether the participants were doing so in writing, via electronic or online means. Preaching and pulpit were the codes applied to comments in which participants spoke of incorporating HIV/AIDS messages into their sermons. Though these codes seem quite similar both here in this analysis and in the larger context of the individual transcripts, they are listed separately because the participants mentioned them separately. Speaking/talk was the code, meanwhile, applied to verbal messages that were delivered outside of religious sermons.

Each of the eleven other codes also represented particular events or ideas noted by participants. For example, motivation is the code used to signify the reasons the leaders cited for undertaking HIV/AIDS communication with their congregants. Meeting (leaders) is the code used to represent a gathering the ministers themselves attended to discuss the disease and their responses to it. Outreach is the code used to note steps that the religious leaders took to communicate HIV/AIDS information to people who are not members of their respective churches. Information, is used, finally, to describe printed materials containing HIV/AIDS data which the religious leaders make available to their congregants.
For the sake of clarity, these codes, analyses and explanations will be categorized under two main subheadings based on the type of support the participants were providing: informational support and emotional support.

Figure 1: Research code word cloud

Informational Support

Of the eighteen codes identified for this research, fourteen of those related to
informational support that the participants provide to their congregants and to members of the larger community. Those relevant codes are: motivation, awareness, stigma, discussion, festival, information, meeting (leaders), ministry, outreach, preaching, pulpit, video, sharing, teaching/education/knowledge. These codes represent a number of different circumstances and endeavors—all of which help to impart HIV/AIDS facts and information to the receivers of the various communication efforts.

Motivation is the code used to signify the reasons the leaders cited for undertaking HIV/AIDS communication with their congregants. While the members of the council convene to discuss and address the HIV/AIDS concerns and circumstances of their congregations today, they did not all join the council at the same time (Participants A-I, communication with author). They also did not all join for precisely the same reasons (Participants A-I, communication with author).

Participant D spoke of how he came to the council prior to its inception (Participant D, communication with author). He said: “I became involved with being invited by one or two other pastors in the local area” (Participant D, communication with author). The purpose would be: “…to explore the possibility of setting up a group of churches that would focus on this whole HIV challenges that we’re having in the community” he said (Participant D, communication with author). “So, I was invited by another pastor to meet with others who were expressing an interest in how we could build a collaborative together of our congregations in Northern Virginia” (Participant D, communication with author). Their initial aim was “…to see how we could reach out to other churches and invite them to be a part of it” (Participant D, communication with
Participant A spoke of a similar set of circumstances that led him to the group (communication with author). “Well, it began when I was working with the Northern Virginia Baptist Association and I was with, speaking to x. He spoke to me about being on that council,” he said (Participant A, communication with author).

Participant I was also part of the Northern Virginia Baptist Association (Participant I, communication with author). Regarding the steps that led to him joining the clergy council, he said: “Well, the clergy council came to the Northern Virginia Baptist Association” (Participant I, communication with author).

“That’s probably about seven, eight years ago they came to the, to the association, and they were trying to make, I think Fairfax County Health Department was trying to make inroads into the black community…” he said. He added, “…and the most likely place is to go through the black church” (Participant I, communication with author).

Now that the ministers are engaged in HIV/AIDS communication efforts, one of their goals is to make people aware of the conditions (Participants B; Participant H; Participant G, communication with author).

"We talk about the fact that we're here to raise the awareness of and deal with people who are infected and affected by HIV/AIDS," Participant B said of discussions that take place among members of the Northern Virginia Clergy Council (communication with author).

Participant H said he works to raise awareness, as well (Participant H, communication with author). More specifically, he said he works "…to bring
awareness to the fact that the high rate of infection within the African American community and ways we can prevent it…” (Participant H, communication with author).

Participant G said that he hopes to do more than enlighten people as to the continuing presence of HIV/AIDS in the African American community or society in general (Participant G, communication with author). He said his aim was: "…to raise awareness about the stigma surrounding persons effected and affected by HIV/AIDS as well as STDs” (Participant G, communication with author).

He was not the only participant concerned about stigma, either (Participants A-I, communication with author). Every participant interviewed for this project spoke of stigma existing either in their church or in the larger community in which their respective church is situated (Participants A-I, communication with author.) One participant said the stigma associated with HIV/AIDS sometimes altogether stops communication about the conditions (Participant A, communication with author).

He said, “One of the things that has prevented us, within the African American community in talking about it has been stigma” (Participant A, communication with author). He said, further: “So we feel that if we can break that stigma barrier, and we as African American people begin to talk about it, then we can prayerfully lower the rate of HIV/AIDS within the African American community, particularly in Northern Virginia” (Participant A, communication with author).

Part of the way the participants indicated that they work to do this is by gathering and talking as a group (Participant A; Participant I, communication with author) and by fostering discussions among their congregants (Participant C; communication with
In the words of Participant I, “We have sat down and talked to leadership at our church concerning the necessity for us to be involved in some way when it comes to eradicating this,” (communication with author).

Congregants have been included in other communication efforts, including dialogues related to a video about HIV/AIDS (Participant C, communication with author). In the words of Participant C: “The first thing I did was, we as a church, we did a viewing of a video that was produced by the Fairfax County Health Department called ‘Break the Silence,’…” (Participant C, communication with author). Participant C describes the film as one designed to increase knowledge about HIV/AIDS (Participant C, communication with author). “So, we did a viewing of that, and we had a question and answer session” (Participant C, communication with author).

Congregants have not just received HIV/AIDS information from these forms, however; they have also had access to social support information via the pulpit and the words of their own pastor (Participants A; B; F; I, communication with author). Participants A and I both said they had spoken about HIV/AIDS from the pulpit (communication with author). Participant A said he has taken this step more than once (communication with author). Participant I said he takes this step on days dedicated to HIV/AIDS awareness (communication with author).

Several of the ministers have also incorporated the information into their sermons (Participants A; B; C; H, communication with author). For Participant B, this was a first step (communication with author). For the other ministers, on the other hand, it was simply one of the efforts they undertook to disseminate HIV/AIDS information
In addition to incorporating this material into their weekly teachings before their respective congregations, some of the participants have created special ministries to tend to the needs of those affected by HIV/AIDS (Participant I; Participant D, communication with author). In the words of Participant D, “…when we first started our HIV/AIDS ministry, it was a matter of educating our congregation about what HIV/AIDS, HIV and AIDS are…” (communication with author). The words and efforts of Participant I are somewhat different, though (Participant I, communication with author).

Participant I provides his congregants with a ministry that is not solely focused on the issue of HIV/AIDS (Participant I, communication with author). “We do have a health and wellness ministry that we established to deal with HIV and AIDS, but not only that, but some other health issues that plague our community” (Participant I, communication with author). Both ministries regardless of how wholly they focus on HIV and AIDS provide information to congregants (Participant D; I; communication with author).

The efforts of these ministers do not just affect the people within the walls of each church, though; outreach efforts also take HIV/AIDS information and assistance to people in the larger community (Participants E; G; H; I, communication with author). Participant E, for example, said: “One of the things that we do annually—well, we did for several years, we didn’t do it this year—is have kind of a community day…” (communication with author). At the event, “…we actually set up in the parking lot and have various agencies come in and we have a lot of fun for the kids and we cook out and that sort of thing” (Participant E, communication with author).
Participant I said missionaries tend to outreach efforts in his community (communication with author). “We have a missionary,” he said (Participant I, communication with author). “We have missionaries that deal with outreach. Those are the people that normally deal with our members in hospitals and some of the other things” (Participant I, communication with author).

In other instances, however, this external dissemination of HIV/AIDS information by individuals associated with Participant I’s church, takes place at a festival (Participant I, communication with author). He said: “…we do have those that have engaged folks during the African American festival that goes on” (Participant I, communication with author). He said: “I believe they do it in June every year in Manassas, and they pass our pamphlets at a booth there” (Participant I, communication with author).

Three more information-related themes are identifiable in this research, as well: information, teaching/education/knowledge and sharing. Information was a theme discussed by many of the participants, who discussed the delivery of facts and data to congregants on a number of topics (Participants B; C; D; F; H; I, communication with author). Information, for the purposes of this research, consists of published materials and facts conveyed to congregants and members of the community. For example, Participant B indicated that he provides his congregation with a newsletter (Participant B, communication with author).

Finally, the ministers offer aid to their congregants and community members in the form of lessons, which are here listed as teaching/education/knowledge (Participants D; G). In the words of Participant D: “And then we incorporate it into our workshops and
training sessions that we do both individually as a local church as well as in collaboration with other churches in our Northern Virginia area” (communication with author).

Participant G spoke, meanwhile of the effect of HIV/AIDS educational information on adolescents in his youth group (communication with author). He said: “Well, the youth liked it. They were shocked…it enhanced their knowledge” (Participant G, communication with author). He said, further: “It gave them a lot to think about, to walk away. It allowed them to discuss their endeavors and their false beliefs as well as what they already do” (Participant G, communication with author).

**Emotional Support**

The participants did not simply seek to educate via informational aid, however; they also utilized emotional support (Burleson, Albrecht, & Sarason, 1994). For example, Participant I said missionaries tend to outreach efforts in his community (communication with author). “We have a missionary,” he said (Participant I, communication with author). “We have missionaries that deal with outreach. Those are the people that normally deal with our members in hospitals and some of the other things” (Participant I, communication with author).

To alleviate the negative attitudes toward HIV/AIDS and those who have the conditions within the church, Participant B said he took certain steps (communication with author). He said: “And so, what we tried to do is say from the pulpit that we’re not here to talk about how people got in the…ditch, we’re saying they’re in a ditch and we need to get them out of the ditch” (Participant B, communication with author). He said: “We hold the notion that Jesus loves people where they are” (Participant B,
Participants also spoke of their own, individual-level efforts to love and comfort members of their congregations and for members of their surrounding communities (Participants B, D, G, H, communication with author). These efforts take many forms, from being physically present for someone affected by HIV/AIDS in order to combat loneliness (Participant D, communication with author), to providing an informal outlet for people to talk and to have someone to listen (Participant B, communication with author).

In some cases, this kind of support is provided one-on-one between a religious leader and a congregant or individual (Participant G, communication with author). Participant G said he experienced such a situation (communication with author). He said: “I had one person which was affected with the virus and we talked. This person is no longer around the church, but feels healthy” (communication with author).

Beyond interacting with that one individual, Participant G said he also engaged in broader emotional and informational support (communication with author). “I continue just to make sure that they are aware, and that I still become a light to the community, and therefore they do have someone in the church they can turn to so they have an avenue to help” he said (Participant G, communication with author).

While the members of the council convene to discuss and address the HIV/AIDS concerns and circumstances of their congregations today, they did not all join the council at the same time (Participants A-I, communication with author). They also did not all join for precisely the same reasons (Participants A-I, communication with author).
Participant D spoke of how he came to the council prior to its inception (Participant D, communication with author). He said: “I became involved with being invited by one or two other pastors in the local area” (Participant D, communication with author). The purpose would be: “…to explore the possibility of setting up a group of churches that would focus on this whole HIV challenges that we’re having in the community” he said (Participant D, communication with author). “So, I was invited by another pastor to meet with others who were expressing an interest in how we could build a collaborative together of our congregations in Northern Virginia” (Participant D, communication with author). Their initial aim was “…to see how we could reach out to other churches and invite them to be a part of it” (Participant D, communication with author).

Participant A spoke of a similar set of circumstances that led him to the group (communication with author). “Well, it began when I was working with the Northern Virginia Baptist Association and I was with, speaking to x. He spoke to me about being on that council,” he said (Participant A, communication with author).

Participant I was part of another organization, for example—the Northern Virginia Baptist Association (Participant I, communication with author). Regarding the steps that led to him joining the clergy council, he said: “Well, the clergy council came to the Northern Virginia Baptist Association” (Participant I, communication with author).

“That’s probably about seven, eight years ago they came to the association, and they were trying to make, I think Fairfax County Health Department was trying to make inroads into the black community…” he said. He added, “…and the most likely
place is to go through the black church” (Participant I, communication with author).

Now that the group is together, what are they working to do?

"We talk about the fact that we're here to raise the awareness of and deal with people who are infected and affected by HIV/AIDS," Participant B said of discussions that take place among members of the Northern Virginia Clergy Council (communication with author).

Awareness is also something Participant H said he works to achieve (Participant H, communication with author). More specifically, he said he works "…to bring awareness to the fact that the high rate of infection within the African American community and ways we can prevent it…” (Participant H, communication with author).

Participant G said that he hopes to do more than enlighten people as to the continuing presence of HIV/AIDS in the African American community or society in general (Participant G, communication with author). He said his aim was: "…to raise awareness about the stigma surrounding persons effected and affected by HIV/AIDS as well as STDs" (Participant G, communication with author).

He was not the only participant concerned about stigma, either (Participants A-I, communication with author). Every participant interviewed for this project spoke of stigma existing either in their church or in the larger community in which their church is situated (Participants A-I, communication with author). One participant said that the stigma attached to HIV/AIDS sometimes altogether stops communications about the condition (Participant A, communication with author).

He said: “One of the things that has prevented us, within the African American
community in talking about it has been stigma,” (Participant A, communication with author). He said, further: “So, we feel that if we can break that stigma barrier, and we, as African American people, begin to talk about it, then we can prayerfully lower the rate of HIV/AIDS within the African American community, particularly in Northern Virginia” (Participant A, communication with author).

Participant B spoke of a similar situation (communication with author). He said: “And in our community, for some reason, it was sort of taboo to talk about HIV/AIDS because of the stigma attached to it, and the behavior kind of thing that were attached to it” (Participant B, communication with author). He said, “Normally, it was either somebody who was homosexual, doing drugs, or someone who their lifestyle was deviant, kind of” (Participant B, communication with author).

The participants said that when that help is provided as information it can take many forms (Participants B; C; D; F; I, communication with author). In some cases, religious leaders provide information in the form of a video on HIV/AIDS (Participants A; C, communication with author). In other instances, the leaders supply their members and local citizens with information on electronic signs and via printed bulletins (Participant C, communication with author). On still other occasions, Participant A said a fellow religious leader and health official would address members of his church (communication with author).

Other participants said efforts to provide information take place via outreach endeavors (Participants E; G; H; I, communication with author). Participant E, for example, said: “One of the things that we do annually—well, we did for several years, we
didn’t do it this year—is have kind of a community day…” (communication with author). At the event, “…we actually set up in the parking lot and have various agencies come in and we have a lot of fun for the kids and we cook out and that sort of thing” (Participant E, communication with author).

Participant I also mentioned a local festival (communication with author). He said: “…we do have those that have engaged folks during the African American festival that goes on” (Participant I, communication with author). He said: “I believe they do it in June every year in Manassas, and they pass our pamphlets at a booth there” (Participant I, communication with author).

How did these leaders decide to take these steps, or any steps at all, though? Clerical leaders gathered and explored the issue and opted to take steps (Participants A; I, communication with author). In the words of Participant I, “We have sat down and talked to leadership at our church concerning the necessity for us to be involved in some way when it comes to eradicating this,” (communication with author).

Also, as part of his efforts, one participant studied his own congregants by having them take a survey (Participant A, communication with author). He said, “…the first thing we did was to have a survey done…to see if people really know about it, also how people feel about it” (Participant A, communication with author).

From there, Participant A turned to talking with his congregants, while other participants took this step—minus the survey—on their own (Participants A, E, G, communication with author). He said, “And really, the main goal now is education, and first and foremost, just to begin to have a conversation about it,” (Participant A,
communication with author).

In a similar fashion, Participant E said that he spoke to the young men in his congregation and had a female health care official speak to the women in the church (communication with author). Participant G, meanwhile, made a similar presentation to the young members of his church (communication with author).

Some of the HIV/AIDS communication efforts occur as part of more traditional church activities, including preaching and speaking from the pulpit (Participant F, communication with author). Participant F said, for example that his “[e]fforts would have been, first of all, talking points from the pulpit…” (communication with author). In a similar manner, Participant I said, “During the year, if it’s a day that’s designated to HIV/AIDS, we make mention of that in pulpit,” (Participant I, communication with author).

Beyond that, Participant I said members and leaders of his church provide support by creating a ministry, but not one solely devoted to HIV/AIDS (Participant I, communication with author). “It’s not the only issue the African American church or the African American or any community has to deal with, so we have to address it along with other areas we address, as well” (Participant I, communication with author).

Participant I also offered thoughts on why he thinks the efforts of the church to provide HIV/AIDS-related support and information work (communication with author). He said that the way the issue is shown to the church members helps, as does the trust that African Americans have for the church both contributed (Participant I, communication with author).
CHAPTER FOUR, DISCUSSION

Via interviews with nine of the ten ministers who work with the Fairfax County Health Department, this research sought to examine assistance available to people living with or affected by HIV/AIDS. More specifically, it sought to explore the social support that these pastors provide to their congregants. This research was guided by the question: How do religious leaders who work with the Fairfax County Health Department utilize social support to facilitate HIV/AIDS education efforts? It found that the church leader participants provide their congregants and members of the larger community with social support by imparting facts and providing emotional support (Burleson, Albrecht, & Sarason, 1994). It also found that stigma is one of the main challenges faced both by those affected by HIV/AIDS and the participants who work to provide social support (Participant A; Participant C; Participant D; Participant, E; Participant F; Participant G; Participant H).

This study differs from previous communication research related to social support in that it identifies social support as a longstanding phenomenon within the Black church. Earlier communication research has primarily examined social support in particular geographic settings or in relation to particular health conditions. This study, like previous history and social work scholarship, meanwhile, recognizes social support proffered by ministers who work with the Fairfax County Health Department as an extension of
longstanding efforts by African American ministers and congregants (Baker, 1999; Taylor, Chatters, & Levin, 2004; Battle, 2006). As the role of the church in the Black community as an outlet of community assistance and community strength shows no signs of changing, it seems unlikely that efforts such as the ones of these ministers will change. As long as African Americans look primarily to the church for such aid, furthermore, one could assert that entirely secular services are unlikely to emerge. This phenomenon, unfortunately, could contribute to the perpetuation of stigma by prompting individuals affected by HIV/AIDS to feel overlooked by society and required to seek church-based help.

The connection of the public health entity—the health department—to the church could, however, inspire congregants to trust public health officials. If congregants see that their religious leaders trust the public health officials, those churchgoers might begin to trust the health department representatives, too.

As noted earlier in this paper, Fairfax County church leaders and health department officials are not alone in their effort to collaborate to help inform citizens. Agate, et al., (2005) discussed an effort by Broward County, Florida leaders that was very similar in nature to those of the Fairfax County Health Department and the Northern Virginia Clergy Council for the Prevention of HIV & AIDS. The Florida effort, while somewhat similar in the helpful information (Burleson, Albrecht & Sarason, 1994) they offer, differs from the steps taken by Northern Virginia ministers in one key way: the Florida endeavor includes more than 100 churches (Agate, et al, 2005).

The individuals in Northern Virginia also exist in a particular social and economic
environment. Sixty percent of Fairfax County residents have a college degree and nearly 90 percent have health insurance (U.S. Census Bureau, 2013, American Community Survey, as cited in http://www.fairfaxcounty.gov/demogrph/gendemo.htm#educ). Only about 30 percent of Broward County, Florida residents, meanwhile, have a college degree (U.S. Census Bureau, 2013, quickfacts.census.gov/qfd/states/12/12011.html).

There are four limitations of this research. First, it examines only the senders of social support communication. While these participants can offer a complete account of the social support that they proffer, they might not be able to offer as accurate an account of the impact or effects of that support. Second, the participants for this research are all members of a common committee that convenes periodically to discuss their social support endeavors and the state of HIV/AIDS within their churches. It is possible, then, that the answers that any given participant provided was not indicative of the conditions or responses related to their own congregants.

The other two limitations to this research are researcher-related. First, this study represents the first major communication research project this researcher has undertaken. Thus, even though this researcher had the guidance of the experienced communication scholars who served on the thesis committee, this researcher likely made choices and mistakes that more advanced scholars would not have made. Second, this researcher conducted the interviews for this study via telephone, and thus, was unable to gauge facial expressions and to proffer follow-up questions as effectively as would have been possible had the interviewer and interviewees been in the same location.

This research could have a number of implications not only for participants, but
for their congregants and for providers of secular social support, as well. For participants and other religious leaders, this research could point to effective or ineffective aspects of their social support. For congregants, this research could raise awareness of the efforts of religious leaders to provide social support and the types of support available. For providers of secular support, this research could raise awareness of stigma and its effects on those affected by HIV/AIDS, which could lead to the development of additional secular resources.

As this research examines only one side of social support communication with regard to this phenomenon, the most obvious recommendation for future research is to study the congregants in the churches of the present participants—the recipients of the social support. Are those congregants aware that HIV/AIDS social support is available to them? Are they happy with the level and types of support that their religious leaders provide? Are they affected by stigma, and if so, to what degree? Do they feel that the stigma is coming from fellow congregants or from members of secular society? These are questions that only support recipients can answer, and their answers are essential to an effective examination of church-based social support related to HIV/AIDS. The existence of this collaboration, however, demonstrates that the role of the Black church continues to be one of multidimensional care—spiritual, emotional, educational and corporal. As Participant A put it: “…it has to start with the church” (Participant A, communication with author).
APPENDIX A

COMM 798 Research Interview Questions

Elizabeth A. Grisham
George Mason University

1-Please state your name, your title, and the name of your religious organization. Please also provide an estimate of the size (in number of members) of your organization.

2-Have you communicated about HIV and AIDS with your congregants? If yes, probe with: How and when did your efforts to communicate about HIV and AIDS with your congregants begin? Was there a particular event or circumstance that prompted you to undertake these efforts? If so, please describe that event or circumstance. (If no, skip to question 8.)

3-What do your efforts to communicate about HIV and AIDS with your congregants entail? If the efforts have evolved since they began, please describe the initial efforts and the changes that have been made over time.

4-Describe the goals you hope to achieve with this communication. How did you determine which goals to pursue?

5-Tell me about a success that you have achieved as part of your efforts to communicate with people about HIV and AIDS. Has there been one moment where you have felt that you were achieving the goals that you wanted to achieve by telling members of your community about HIV and AIDS? If so, describe that moment.

6-Are there any challenges that you see on the horizon in communicating with members of your community about HIV and AIDS? If so, what are they? How could you address these challenges?

7-Is there anything that I have not asked about related to your HIV/AIDS communication efforts that you would like to share? Is there anything else you think it is important for me to know about your community or what you try to communicate about HIV/AIDS?
APPENDIX B

Participant A Transcript

EG: Okay, recorders are going. Could you please start by telling me the name of your, the name, your title, and the name of your religious organization. Please also provide an estimate, in size, I’m looking for number of members, of your organization.

A: My name is A. I’m the pastor at x. I, it’s a typical African-American Baptist church, approximately about 145, 155 members.

EG: All right. Question two. Have communicated about HIV and AIDS with your congregants?

A: Yes, I have by mention from the pulpit several times. I’ve also had an opportunity to preach on it, and had some, about to have some teaching on it. And we actually also had a leadership meeting concerning the HIV/AIDS epidemic in the Northern Virginia community.

EG: Okay. As a, as a part of that question, was there a particular event or circumstance that prompted you to take these actions?

A: Yes. I work for the Northern Virginia Clergy Council on HIV/AIDS Awareness. I am on that council and that council thought it was very necessary for us to work with the department of, Fairfax County Department of Health to get the word out in the African American community and one of the things that we want to do is work with the churches in our Northern Virginia Baptist Association so that we can begin to discuss HIV/AIDS within our community. One of the things that has prevented us, within the African American community in talking about it has been stigma. So we feel that if we can break that stigma barrier and we, as African American people, begin to talk about it, then we can prayerfully lower the rate of HIV/AIDS within the African American community, particularly in Northern Virginia.

EG: Okay. Could you tell me how and when your efforts to communicate about HIV began?

A: Yes. Well, it began when I was working with the Northern Virginia Baptist Association and I was with, speaking to x. He spoke to me about being on that council.
So, as I got on the council, they expressed the need in talking about HIV/AIDS awareness within the Northern Virginia community and how it is essentially within our African American community the black church has a very strong voice. So, our hope is to work with the department, Fairfax County, excuse me, Fairfax County Health Department to lower that rate. I did have a particular family member, but I do know that it’s very prominent within the community.

EG: Okay. What do your efforts to communicate about HIV and AIDS entail. If your efforts have evolved since they began, please describe, you know, the initial efforts and the changes that have been made over time.

A: One of the initial efforts is education—getting us to understand, first of all, what HIV is, what AIDS is. A lot of people don’t know, they’ve just heard some things in the, within the media, but right now, concerning my church, education, and also to really discuss how we can again, lower that rate. Also, understanding that within all the other races, it seems as though, the HIV/AIDS has gone down as far as cases are concerned, but in the African American community it has gone up. So, again, the biggest part is stigma and discussing how we can really understand what it’s all about and protection, to understand transmission, to also understand who is at risk the most, concerning our community.

EG: And describe for me your goals that you hope to achieve with this communication. How do you determine what goals to pursue?

A: With working with the clergy council, one of our goals is to, again, get all of the, within our particular association, within our community of Northern Virginia, the African American churches, to get, at least, a representative from those churches, to speak to their congregation about HIV/AIDS and just make us aware and begin to talk about it. If we can talk about it within the church, and it is typically the black church, the African American church that really has been a voice in the African American community. We can see that with the civil rights movement and dealing with segregation. If we can, if it starts with the church, then we can reach a lot of people, within, again, the black community. So, again, initially, it has to start with the church.

EG: Tell me about a success that you’ve had that you’ve achieved as part of your efforts to communicate about HIV and AIDS. Is there a moment where you’ve felt you were achieving the goals you wanted to achieve by telling your members, the members of your community about HIV and AIDS? If so, describe that moment.

A: Okay. Well, one of the things we just began to do that within my congregation, the first thing we did was to have a survey done, to see exactly what we as x understands about HIV/AIDS, to see if people really know about it, also how people feel about it. I’m very happy to know that they don’t think it’s an act of God in punishment of a race of people or a certain kind of people. But the first thing we did was a survey. The second
thing that we’re doing, which, this Sunday, the second thing we did was work with our
leadership. So, we had Dr. Gloria Addo-Ayensu to come, as well as x, to come and speak
to our congregation, well, not the congregation, but the leadership for teaching session
on Wednesday night bible study. But the next step was to speak to the entire congregation
about it. And on this Sunday, coming, x as well as Dr. Gloria Ayensu, they’re going to
come, and once again, speak to the entire congregation on a Sunday morning. And it’s
particularly our youth Sunday, as well. So, the youth will be there. Parents will be there
and one group of parents, one group of people that’s very important, which is stress, is
making sure the grandparents are there. So that is a major step as far as getting us to
discuss and talk about HIV/AIDS within the congregation. The other thing that we’re
doing, we’re watching the Breaking the Silence video, which was created by the Northern
Virginia Clergy Council for HIV/AIDS. So, that is a major step within a traditional black
Baptist church, to discuss HIV/AIDS on a, in a Sunday morning service. So, the next step
would be to reach out to the other churches, the other sister churches within our
community to see if we can do that again. And really, the main goal now is education and
first and foremost just to begin to have a conversation about it, because that’s part of the
problem. Within our churches, sometimes, it is almost taboo to talk about anything
related to drugs or anything of that nature.

EG: Okay. Are there any challenges on the horizon you see in communicating with
members of your community about HIV and AIDS? If so, what are they and how can you
address these challenges?

A: Not within my congregation. My congregation is very open. The only challenge that I
would see would be the stigma part or the ignorance in regards to that. There are still
some people who are, I guess, embarrassed to talk about it. I don’t know exactly why, but
it’s breaking past that stigma that there’s something wrong with you because you have
HIV/AIDS, and not necessarily in regards to health, but almost, I’d have to say,
something spiritually, wrong. But I think the main thing is fear because they don’t
understand. I think that’s a big challenge—overcoming fear, overcoming stigma,
overcoming ignorance.

EG: And my last question for you is: Is there anything that I have not asked about, related
to your HIV/AIDS communication efforts that you would like to share, that you think is
important for me to know as I conduct my research?

A: No, not particularly. I think you’ve pretty much covered the bases. I think it’s very
important, again, particularly in the African American community that we discuss, that
we have a conversation because a lot of our other brother and sisters, you know, outside
of that particular African American culture, they’re not afraid to talk about it. I realize
that there are some cases, you know, some people are, but that’s one of the barriers that
we really have to just begin to do is to have a conversation and destroy the stigma where
there’s an embarrassment to talk about it—to discuss it, to understand it, to, to really
reach out to the younger people at a very early age as well as the grandparents, who, you
know, not just the parents, but as well as the grandparents, who have a big influence on our children and in our culture. Again, it just starts, and I really believe it has to start with the church in order to reach out into the African American community, successfully.

EG: All right. Well, let me—I’m going to continue with my research and I believe that I had, I’ve asked all the questions that I had. Do you have any, is there any other information that you, that I can provide with regard to where my research is going or of that nature?

A: Not that I know of. I guess the other research part, would be just to see exactly how many churches have HIV/AIDS ministry. And, what churches can do to provide for that. I mean, there’s the communication part, which is good, but then there’s what are we doing about it, besides just information. How does it affect the churches even in regard to understanding, biblically, our understanding of it, what’s going on. But I hope your research does very well and that it’s able to make a difference within our community as far as just getting the word out.

EG: Again, thank you so much for your time.

A: No, thank you. Appreciate it.

EG: All right, have a good day.


---END OF INTERVIEW---

Participant B Transcript

EG: I appreciate you taking the time to talk with me, sir.

B: Okay.

EG: Let me get to the first question. If you could, please tell me your name, your title, the name of your religious organization. Please also provide an estimate in number of members of your organization.

B: My name is B. I served as pastor of the x. Had about 1400 members. Also served as president of the Northern Virginia Clergy Council. We had about 9 churches, 8 or 9 churches that are part of that council, probably representing somewhere around 7-8,000 members.

EG: Can you tell me how long you’ve been leader of that group?
B: I think about 6, 7 years.

EG: Okay. All right, my next question is have you communicated about HIV and AIDS with your congregants?

B: Yes.

EG: Okay. How and when did your efforts to communicate about HIV and AIDS with your congregants begin?

B: Well, as pastor, I buried some members, and I believe, I’m confident they died from HIV/AIDS, from AIDS, and the families did not make that known, and I believe they suffered in silence. And because of that, I start preaching about it and teaching about it, to remove the stigma so that we might bring this dreaded disease from the shadows into the light so that people would not feel like they were outcast because they had been effected or affected by HIV/AIDS.

EG: Okay. Could you possibly gauge the level of success that you think you’ve had?

B: Well, I think that as far as I know, once we start talking about it, I don’t remember having another person in our community at that time die from HIV/AIDS, and we also witnessed people willing to talk about it, openly, in the congregation.

EG: All right. Tell me about what your efforts to communicate about HIV and AIDS with your congregants entail? If they’ve evolved, if these efforts have evolved since they began, tell me about the initial efforts and the changes that have occurred over time.

B: Well, we did first of all through sermons and through we have a newsletter, things that we wrote in the newsletter. And then we had a support group that we established for individuals who wanted to come and talk about HIV/AIDS and how do you contact it, how disease is transferred and that kind of thing. And we believe by raising the issue in particular from the pastor that we open up dialogue and people were able to talk one with the other about it.

EG: Okay. So, it sounds, tell me the support that’s HIV/AIDS-based in your community is it, is it mainly coming from the pulpit or did it start at the pulpit and now it’s a part of the congregation?

B: Well, in our community, I think it for the black community, most of social issues and things like that go through the church, go through the black church, if it doesn’t, it usually doesn’t get out in a effective way. And in our community, for some reason, for a long time, it was sort of taboo to talk about HIV/AIDS because of the stigma attached to it and the behavior kind of thing that were attached to it. Normally it was either somebody who was homosexual, doing drugs, or someone who their lifestyle was
deviant, kind of. And, so, what we tried to do is try to say from the pulpit that we’re not here to talk about how people got in the hole, we’re here to say, I mean in the ditch, we’re saying they’re in a ditch and we need to get them out of the ditch. And then once we get them out of the ditch, we can talk about trying to prevent them from going into the ditch again. We hold the notion that Jesus loves people where they are.

EG: Okay. You’ve kind of touched on this already. Tell me about some of the goals that you hope to achieve. How did you determine which goals to pursue?

B: Well, what we’re trying to do is to suggest that HIV/AIDS, this disease is a disease and let’s treat it like a disease as would someone who had any other kind of disease and let’s lovingly support them through the process and that we don’t have to outcast people and not love them because they have this particular disease. We can still love them, and then let’s move from there to talk about—once we show them that we love them—then we can talk about helping them maybe change their lifestyle or at least a lifestyle that’s more safer, that this does not happen again in their life.

EG: Okay. Does the social support extend at all to the family members who might have someone in their family who has AIDS, even if they personally don’t have the disease?

B: Yes, because we try to get them to come to the support system to talk about it and how do you deal with people, what are the ramifications, what are the long-range process, I mean, prognosis of someone with HIV/AIDS? I mean, what’s going to happen before with someone got AIDS and they died. But now, people can get HIV, be affected by HIV and live long healthy lives if they go to the doctor, come out, talk about it, get all the good information and get health, you know, go to the hospital and do all the kind of things they need to do. But our concern was making sure that people didn’t have to suffer alone, that they, you know that they’re lovingly shepherded through the process, in particular getting educated, the right kinds of medicine and all those kinds of things.

EG: Okay and I touched on this next question before, but I’m going it to you again and you can answer however you see fit. Has there been a success, a specific moment where you’ve achieved a level of success related to your efforts to communicate with people about HIV and AIDS? Has there been a moment where you felt like you were achieving the goals that you wanted to achieve?

B: Yeah. I think particularly with the Northern Virginia Baptist, I mean Northern Virginia Clergy Council, I think the fact that we’ve got at least nine black preachers that are willing to sit down and talk about it and what we do at the council, make sure we keep the main thing the main thing. In other words, we don’t talk about homosexuality. We don’t talk about whether or not someone is same-sex marriage or transgender. We don’t talk about those kind of things. We talk about the fact that we’re here to raise the awareness of and deal with people who are infected and affected by HIV/AIDS. And what we discover is when we first came to the council, ministers were not willing to openly discuss it and talk about it and give instances within their own churches where
they felt that they had buried someone with HIV/AIDS or whether or not they knew members in their church were struggling with this dreaded disease and we believe at this point in time, we now have at least nine ministers who openly talk about it, who openly share it with their congregations and have now been educated because we have the health department who come and talk about statistics and tell us about those the growing population, I think the last we heard was black young women was the fastest-growing population being affected and infected with HIV. And so, we’re able to talk about that within the council and we believe by being openly able to talk about it within the council, now these ministers go back and share with the larger, their particular congregations in a more open kind of way.

EG: Okay, now moving toward the other side of the issue is, are there any challenges that you see on the horizon in communicating with members of your community about HIV and AIDS?

B: Yeah, because we still believe that there, unlike what, unlike what many people believe, the black congregation, black religious people are extremely conservative and they are not real comfortable talking about condoms, they’re not talk—because we preach abstinence. But what we have now concluded within the council is that while we that will be our main focus is abstinence, however, we also need to share that if you can’t get there, then you need to practice safe sex. You need to make sure you use condoms. And we talk about that in an open kind of way. And we believe that it’s making a difference. But it took us a while to get there because we don’t like to talk about any other lifestyle other that the one that, you know, the bible seems to call us to, one of holy living and whatever. But we know that while we raise it up as the place where we call our people to, there’s still people who are not there yet. And what do we do for them until they get there? And one of the things is be willing to share about safe sex and doing the right kinds of things and with needles and all these other kinds of things that would cause one to be exposed to HIV.

EG: All right, this has been a very brief, very informative interview for me. Is there anything in particular, that I have not asked about that you think that I need to know about your efforts to communicate with your community about HIV and AIDS?

B: Well, we still see this as an uphill battle, because, again, like I say, I know in our church when we first started this process and we had someone come over and a couple people started talking about whether or not we talked to our teenage girls and boys about condoms and the use of condoms. There was an outcry about that and that’s still something that does not go down very well in our community, because we, for the majority, they would rather just hear you talk about abstinence, period, and nothing else. But what we’ve had to try to move the community to a different level in saying, while that is our main focus, that is what we would hope all of our youngsters and adults as well, those unmarried, would be, however, we need to meet people where they are and look around and look at statistics, and if we are going to be agents of change, we also
have to make sure that we provide other information for people and that is, how do one protect themselves and how do one, if you’re not going to exercise abstinence, what, what, we need to share information with them how to be safe in the midst of not being abstinent, not practicing abstinence. So, we’ve got an uphill battle we believe, but we believe we see some movement. It’s not major shifts, but we do see some movement and we’re hoping to broaden our clergy council. We’re hoping to move that very soon to not just nine churches to including, ‘cause right now, as far as we know, we have at least 120 Baptist churches, black Baptist churches in Northern Virginia and we’re hoping to one day have this same kind of level of communication and openness with these nine churches that we would have with all 120 of these churches that’s part of the Northern Virginia Baptist Association.

EG: If I may, you made me think of something. Tell me about the role of the generations within the church, with related, in relation to talking about HIV and AIDS. Is there, do the older generations work to influence the younger generations?

B: Well, the younger generation already know about condoms, already know about HIV/AIDS, already know about all of these kind of things and they’re much more acceptance of individuals who are homosexuals or lesbians or whatever. That’s not an issue for them. But they won’t, they don’t talk about it openly because they know for the older people, that is not something they’re very comfortable talking about or willing to share about. So, it’s a kind of process of how do, how do we move the older generation a little bit closer to the younger generation and the younger generation a little bit closer to the older generation in terms of acceptance whether you agree with where they are, at least respect where they are. And the other from the older side, whether you agree with where they are, at least respect it and maybe you can learn something. And that’s a challenge of bringing these two groups together.

EG: Okay.

B: Because the younger generation, it’s just not an issue for them and things that we’re thinking we’re trying to teach them, they already know. But they just won’t share it, because they know that we have been, you know, adamant abstinence, abstinence, abstinence. As if we don’t know people are having sex outside of marriage and many a large group of teenagers to whom we’re preaching to and teaching to on Sunday morning, they’ve already had sex before they got there or had sex during the week. And so, that’s not an issue for them, but for the older people, you know, that’s not the world they lived in, and not the world they’re comfortable talking about those kinds of things, even though, I’m sure you know and I know that they did that themselves, but it wasn’t as openly talked about. It wasn’t as openly dealt with and it was not something that your parents would say, “Okay, young girl, I’m going to put you on birth control,” or: “I want you to learn that if you’re going to have sex, have it, make sure the man have a condom.” I mean, that’s not something that this older group said to their children, but this is what their children are doing.
EG: Okay. Thank you so much for your time. Is there any information that you need from me?

B: No. I’m good.

EG: All right.

B: I hope that it works out well and we’re hoping that whatever you’re doing is going to help us move forward.

EG: I hope so. I’ll be happy to share my information when I finish my research.

B: Okay.

EG: Thank you again.

B: All right. Have a good day.

EG: Bye-bye.

B: Bye.

---END OF INTERVIEW---

Participant C Transcript

EG: Okay. We are recording. I appreciate you taking time to talk with me this morning.

C: Oh, I appreciate it. I appreciate the opportunity to share with you.

EG: Okay, the first question is more for informational purposes.

C: Okay.

EG: I need you to please state your name, your title, the name of your religious organization. Please also provide an estimate in the size, number of members of your organization.

C: Okay. My name is C. I am the pastor of x. My denomination of faith is Baptist. I presently pastor a membership of about 70 members and I also x.

EG: All right. Moving on to question two. Have you communicated about HIV and AIDS with your congregants?
C: Yes, I have.

EG: Okay. How and when did your efforts to communicate about HIV and AIDS with your congregants begin? Was there a particular event or circumstance that prompted you to undertake these efforts?—

C: [indiscernible]

EG: If so, please describe the event or circumstance.

C: Okay. Well, for me, I have actually been working in the field of HIV for 10+ years. And so, I’ve been the pastor of x for approximately seven years. So, when I came to the church, HIV was already something that was very important to me, especially in the manner in which it affects the African American community. So, it’s something I actually incorporated into the fabric of the church upon becoming the pastor. Also, because of my affiliation with HIV and being a member of the Northern Virginia Clergy Council for the Prevention of HIV and AIDS, The first that I did was, we as a church, we did a viewing of a video that was produced by Fairfax County Health Department, called “Break the Silence,” which is an awareness video that helps people understand the effects of HIV in the African American community as well as talk about the main issues that continue to cause our infection rates to be what they are. So, we did a viewing of that and we had a question and answer session. And since then, we have routinely done educational opportunities within church, whether that’s on Sundays, during what we call pastoral emphasis, where I lift up important events that are happening in the world, what are happening in our community, talk about the importance of knowing your status, how HIV is transmitted, the importance of getting tested and just having the regular conversations that we need to have as empowering our congregations to then go and teach their families, teach their children, grandchildren, nieces, nephews, you name it. We also put things on, in our bulletin. We have a Facebook page that at times, for instance, we’re coming up on World AIDS Day, so we’ll have some factoids about HIV, so that people can constantly be aware.

EG: You’ve touched on this a little bit, but could you—the next question is: What do your efforts to communicate about HIV and AIDS with your congregants entail? If they have evolved, if these efforts have evolved since they began, please describe the initial efforts and the changes that have been made over time.

C: Okay, well as I said, our initial effort was a viewing of Break the Silence video, [indiscernible/121] open forum discussion in regards to that. Since then, we regularly do, like I said, pastoral emphasis, to where I talk about HIV, give them the facts, simple HIV 101, talk with them about the importance of getting tested, knowing where they can go to get tested. Also, and that’s kind of how things have evolved. We also do, have partnered
with one of our other churches to do a, a workshop discussion as well. We’re looking to start implementing a faith-based curriculum. Also, another thing that I do, like during World AIDS Day, National HIV Testing Day and National Black HIV/AIDS Awareness Day is preach sermons that deals with the issue of HIV, as well, and it’s been well-received by the congregation.

EG: Tell me about, describe your goals that you hope to achieve with this communication. How did you determine which goals to pursue?

C: Well, actually the goals that we pursue actually go online with the strategic focus of the Northern Virginia Clergy Council for the Prevention of HIV, which is we are working to make new HIV infections rare in Northern Virginia. And we do that through educating individuals about personal responsibility, making sure that people are HIV aware, that we have a focus on stigma reduction and the importance of people going and getting routine testing. So, that’s really the focus of everything that we do.

EG: Okay. Tell me about a success that you’ve achieved as part of your efforts to communicate with people about HIV and AIDS. Has there been a moment where you felt like you were achieving the goals you wanted to achieve by telling your members about HIV and AIDS? If so—

C: Well, the main thing, the main thing you look for is people’s knowledge base to increase and as their knowledge base increases, then what happens is you actually start to see a behavioral change. And so, one thing that we do in partnership with the Fairfax County Health Department is they have a Knowledge Base Assessment which has probably like 100 questions that we offer to the congregation every now and then to see where they are in their knowledge base in regards to HIV, their knowledge of testing and also there’s some questions in there that help to really assess where a person’s stigma is. And what we’ve seen is the knowledge base of individuals has gone up, and that though there is still stigma, the stigma is not as high as it was when we initially did it.

EG: Are there challenges that you see on the horizon in communicating with members of your community about HIV and AIDS? If so, what are they? How could you—

C: Well, the main challenge is the challenge that it’s been for the past 30 years, which is stigma. Stigma creates such a fear within individuals because of things like—to talk about HIV, you have to talk about sex practices and risk behaviors, talk about drug usage and then of course there’s the issue of homophobia that individuals have, which can be buried, if you are afraid to confront it. One thing is, as I said, because I’ve been working in this field for 10+ years, I really don’t have a problem talking about sex practices, talking about drug usage, and talking about sexual orientation and talking about other sex practices that individuals have. So that’s one advantage that we have as a church, that that really is not a barrier within the church, because it’s not a barrier for the pastor.
EG: Okay. Those cover my main questions. Is there anything that I have not asked about, related to HIV and AIDS communication and your efforts that you would like to share? Is there anything that you think is important for me to know about your community—

C: Well, I think, and I wouldn’t just say that it’s my, my community, but I think this is just the church community at large is that we have to not be afraid to address the hard issues and HIV brings some hard issues to the table. You know, because, because of the way the virus infiltrates the body, you have to deal with some very personal conversations and most individuals are not comfortable talking about sex and sex practices. Most individuals are not comfortable, you know, talking about drug usage. Most individuals are not comfortable talking about sexual orientation and how all of that goes. I mean, even one of the key things that even the church talks about is abstinence, but abstinence is so much more than just refraining from an activity, but it’s really looking at my self-worth and my value and understanding that. The importance of negotiation skills. How does the church really begin to talk, how do you negotiate your relationship with another individual what you’re willing to do and what you’re not willing to do and how do we really equip individuals. And I think those are the kind of things that really we are trying to do as a clergy council of concerned clergy as it pertains to HIV and the Fairfax County Health Department is really helping us and empowering us to be able to do it in a factual way, so that when people leave they’re really empowered.

EG: All right. That concludes my question list. Is there any other information that you need from me?

C: No.

EG: All right, well, I appreciate your time and I hope you have a great day.

C: Okay. You, too.

EG: Thank you.

C: All right. Bye-bye.

---END OF INTERVIEW---

Participant D Transcript

EG: Okay. We are recording. And my…

D.: Okay.
EG: Let’s see. My first question: Could you state your name, your title, and the name of your religious organization. Please also provide an estimate in size, the number of members, of your organization.

D.: Okay. The name is D. I am associate minister with x, and I’m also x. I serve as x. And I also serve on the x. The local congregation that I serve with is approximate size of around 6,000 members—

EG: Okay.

D.: --based in x. The national organization is somewhere in the vicinity of well, actually, I should say in terms of our churches, it’s about 300 African American churches and the international organization is, that I serve with, roughly, we work in 9 countries in the continent of Africa, and I don’t know, in terms of individual numbers of members, but we also serve there about 200, 200 churches in west Africa and the other countries is about another 7 or 800 churches throughout the continent.

EG: Okay. Now, your work with these other churches, does all of this pertain to HIV and AIDS information?

D.: The bulk of it does. The organization—the international organization is all HIV/AIDS, and now more recently, Ebola. The local congregation, I serve as director of our HIV/AIDS ministry.

EG: Okay.

D.: So, I, that’s one of the things that I do with the church, but also some of the others, too. Could you, could I ask you to hold for just one quick moment?

EG: Absolutely.

D.: Okay. [Long pause]. Okay. I’m sorry. I’m back. So, my primary activity in the HIV/AIDS-related area is director of the AIDS ministry for x. So, much of my work is in HIV/AIDS, but there are other areas, too, that I’m involved in.

EG: Can you tell a little bit about the age breakdown of the people in your church? Do you have a certain number of younger people and then younger people and then older congregants?

D.: It’s, it’s primarily, much of the 6,000 members are in that 20-to-40-something range. The, I don’t know off hand the percentage of those under 20, but I know that we have at least, there’s a good 3 or 400 who are regularly active in our weekly activities as far as under 20. I’m sure it’s more than that, but at least 3-400 that we see on a regular weekly basis there. The active participation in the church it’s about, 80 percent of it is 20- to 40-
something age ranges there, and our seniors make up the balance of the other, from that roughly 15-20 percent a portion of that. So, the predominant age range is in the 20 to 40-something, so.

EG: If I had to ask you to gauge, is there a certain group, within those age groups that is most receptive to what comes from the pulpit?

D.: I don’t know if I can say if there’s a certain group that’s most receptive, because we’ve found that in terms of the messages from the pulpit, that much of the time, the younger and older members are quite receptive, so I’m not sure I can identify which, which may be showing more receptivity than the others. Engagement is usually pretty, pretty full for both segments, the younger and older members of the congregation.

EG: Okay, then. Moving into the most directly related to HIV and AIDS communication, the first question is: Have you communicated with your congregants about HIV and AIDS?

D.: You say have we communicated with the congregation about HIV and AIDS?

EG: Yes, sir.

D.: Yes, we have. We regularly communicate with them through print, verbal and programmatic information that’s disseminated to our congregation and the communities that we serve.

EG: Okay, when you say print, can you tell me more about that.

D.: Yes. We share fliers about and pamphlets about HIV/AIDS ministries that post and make available at our distribution points in the church so people can pick them up and read them at their leisure. So, we keep those available with our weekly materials that are available for people to pick up as they come through the church. And we also provide brochures and fliers when we have HIV/AIDS programs at the church. And we also provide electronic information on HIV/AIDS through our website resource of the church there to those who are both part of our congregation as well as the general public who may be utilizing our website for informational purposes.

EG: Do you keep track of the hits on your website?

D.: Do we keep track of what? I didn’t hear.

EG: Of the number of visitors to the website.

D.: Yes we do. We have a social media team that monitors our usage on our website and hits on it there.
EG: Have your efforts to communicate about HIV and AIDS changed over time. If so, tell me a little bit about what happened at the beginning and how things have evolved.

D.: Well, initially, back in 2000, when we first started our HIV/AIDS ministry, it was a matter of educating our congregation about what HIV/AIDS, HIV and AIDS are to help them to be more familiar with the pandemic itself and what the virus and to be familiar as to why it’s important for members of the congregation to know their status and to be able to discuss it in settings, at home and at work and in educational settings. So, we spent a lot of time in our programmatic effort in developing ways to inform the congregation to directly, through training, and also through briefing our leadership of the church, and also reaching out to our community around us in a way that church members would understand how important it is as a congregation to open our doors to receiving those with HIV, you know living with HIV or caring for those with HIV in a way that demonstrated the church’s love and concern and support for them. So, we spent a good deal of time, initially, with just the educational aspect and highlighting the ways that individuals as well as the church itself could engage in responding to the global HIV/AIDS pandemic. Over the time of the first five to seven years, it was also opening up the attitudes and the response of the congregation to the obstacle of stigma and how to rethink their understanding of how HIV is spread and how it is to be viewed from the perspective of the faith that we teach at the church and how to help others to understand ways to respond to HIV and AIDS. And after the first five to seven years then roughly a number of congregation members and leaders who became more familiar with this began to engage with the practice of counseling and testing for themselves and also encouraging others to get counseled and tested. And they also were ones that helped to begin to suggest ideas that the church could begin to use to be brought to our ministry as well as to our leadership--ideas and thoughts and suggestions and opportunities to, both inform the congregation more as well as to actively engage in HIV. And we were also, I should point out become active in projects in our local community outside the church. Members from our local congregation got involved with providing assistance to people who were living with HIV and their families. In the latter part of the time after those five to seven years from then until now, it has been mostly leveraging our populations that are coming into the church and introducing them to the HIV/AIDS information that we’ve been sharing and also helping to heighten and sensitize their awareness of the spread of HIV and the urgency of our faith community being able to help them educating and responding to the critical impact that it’s having on our local community and our region and our country and our globe. And also their opportunity as members, the members who come into the church, where they can find opportunities to participate in supporting HIV/AIDS programs in ways that they would feel most comfortable for themselves to do so. And the more recently, the last three, four, five years have been emphasis on the stigma aspect itself of HIV, how both the church and the community needs to continue to address the barrier of stigma and responding to the devastation HIV is causing in our community.
EG: Okay. You’ve touched on this a little bit. Do you have any larger, broader, overarching goals that you haven’t touched on via your work and how do you determine which of, which goals to pursue—maybe which order to pursue them?

D.: Maybe our goals we’ve had in terms of—the basic goals that we’ve been doing throughout have been one both as a ministry and as a church, educating our congregation and community about what HIV 101 is—knowing what it is first. And then, two, taking action personally and collectively to help reduce the spread of and work toward elimination of HIV. Those have been the two primary goals we’ve been doing. Within those goals, the steps of how to engage the education process within our church and our local community and the specific steps or projects or actions or programs that we take have varied from year to year. The ones that I may not have touched on so far in our congregation today have been for example, among the seniors in our community, the spread of HIV has been rising. And so, one of the more recent goals has been making sure that we do provide for our annual planning to include targeted messages to our senior population within our congregation itself as well as communities that we go out to and serve and ministry at around our local area, to have the discussions and conversations with those groups that represent senior members of the community. So, those have been kinds of things that we have expanded. We’ve also spoken to our incarceration communities that we work with as a faith community to address HIV/AIDS in different ways there, both verbally as well as our program planning. And then we also incorporate it in our workshops and training sessions that we do both individually as a local church as well as in collaboration with other churches in our Northern Virginia area. We’re also part of a group of churches in the Northern Virginia area that collaborate around HIV and AIDS and meet monthly to develop and design programs and training and testing opportunities to prevent the spread of it. So, we do present ideas and programmatic efforts through the collaboration of our Northern Virginia community and finally, we also incorporate HIV/AIDS training in some of our youth programs, the annual programs of the church that go on. We look at ways that we can continually refine and include messages about HIV and AIDS in those programs that are part of the traditional activity of the church.

EG: Tell me about how you became involved with the clergy council.

D.: I became involved with being invited by one or two other pastors in the local area to explore the possibility of setting up a group of churches that would focus on this whole HIV challenge that we’re having in the community. So, I was invited by another pastor to meet with others who were expressing an interest in how we could build a collaborative together of our congregations in Northern Virginia and see how we could reach out to other churches and invite them to be part of it. So, my engagement became directly through the invitation of one of the pastors in the local area who was interested in looking at how we could develop the idea and I agreed to do so on behalf of our congregation, since I was also involved in our initial HIV/AIDS ministry for our local congregation and have been involved since its inception.
EG: Tell me about a success that you’ve achieved as part of your efforts to talk about HIV and AIDS with your congregants. Has there been a moment where you felt like you were achieving the goals you had set out to achieve?

D.: We have seen some good strong indicators of it. The success from the time we started to now, we’ve seen a wider awareness of our members of our congregation in talking about HIV and bringing questions about HIV to our ministry members more readily. We get them directly, personally when we’re after services on the weekends. We’ll have people walk up and approach us about questions they have with HIV unsolicited, which they didn’t used to do. And we also have those referrals to us of people who have members of their family living with HIV that they will come and ask us about resources that may be available to help with certain aspects of [indiscernible/623] which we didn’t have as much before. We have increased frequency of that. We also now have a monthly program in our church, which we started maybe five years ago, roughly, in connection with one of our worship services where we regularly do counseling and testing as a part of that worship service experience. Before we begin a worship service, there’s a fellowship activity that takes place and what our ministry does is we arrange, in connection with partnerships that we’ve formed in our community of HIV/AIDS counseling and testing services that are funded through the federal and state resources. We’ve arranged through those partnerships for them to come in and do the counseling and testing on-site, in the church, as part of the monthly activity. So, that has been a big positive influence in our congregation and one seeing that it has readily been supported by our pastoral leadership both former and current pastors as well as our senior leadership of the church as far as deacons and trustees and officers of the church that they actively both participate and encourage members to get tested. And we also make an announcement to the congregation inviting them to go get tested before they go into services as well as afterward if they are interested. So, that’s been a very positive part. And also our church’s funding of HIV/AIDS ministry has increased over the years, too. So, our resources for outreaching through the community have been significant as compared with our, really our first five years or so of activities. So that has been a blessing to be in a position to reach more people, to see the numbers of those who regularly get counseled and tested have grown, have increased in major ways. What we used to, what we normally would have one or two persons who might com out and get tested, we now have 15, 20, 25 people each time coming out to be tested. That’s a rare occasion we find from [indiscernible/705] churches in this local area.

EG: Can you tell me, you’ve touched on this a little bit. Can you tell me anything about maybe the response of the peers within the community—the church community, when these people do step forward and say, “You know what, I might be at risk. I’d like to be tested.”

D.: You mean for those who specifically thinking they might be at risk versus those who just want to make sure they are in general okay?
EG: I think the question, rather, if this is a situation where someone is stepping forward and might be putting themselves at risk of being judged or being exposed to stigma. You know, they’re just coming forward because they think they’ve had an experience or where they may have been exposed. How do the other congregants maybe react to that?

D.: Well, we have in our arrangement for the counseling and testing at the church, the way we’ve arranged it is that persons who have a concern about being exposed, we do have a confidential setup so that they can go to a certain area of the church that is specifically kept private. So, for example, if I want to be tested, I can come to the AIDS ministry and say, “I’d like to get counseled and tested, but I’d like to do so in a private way, so it’s not clear that that’s what I’m going for.” So we’ll have a room that’s non-designated to the general public. Our ministry would tell that person where they can show up at and a counselor and tester will be there and it’ll be conducted in that room without anyone else in the church being aware that that’s what’s being done. And then we also have the general rooms that persons who do not have that concern or are not as expressive of their concern, they can come and line up with the others who are waiting to be counseled and tested. And so they are, people are walking by can see that this group of people are waiting for HIV counseling and testing, but they don’t express that concern.

So, we tell people they have either option available. And the third option, of course, is if they don’t want to be counseled and tested within the church environment, we also have provided to them direct counseling and testing centers in the community that they can go to and get tested with complete anonymity to the church not being in the vicinity of the church when they get it done, as well, we advise them that they can get it done by their own general physician as a part of their annual check-up. So, we present all those options to persons who are thinking about getting counseled and tested and allow them to proceed with the one that is most comfortable with them. As far as other people in the church, attitudes, things that are expressed about people who are getting counseled and tested for HIV/AIDS as far as our ministry has observed, because of our strong emphasis by our church leadership that we encourage everyone to get counseled and tested who is of age from the teenage through the adult ages, that’s a part of our stewardship as a member of the congregation, we ask everybody to exercise that, so we try to counter any perceptions of persons going to get tested is doing so because they may well very well may be susceptible to having it. There’s more that they’re doing what the church leadership has asked everyone to do and that’s the way it’s being, has been and continues to be presented to our congregation.

EG: All right. Are there any challenges that you see on the horizon in communicating with your community?

D.: There’s still the challenge, that we still continue to have a challenge in the stigma area of those who refuse to take an opportunity to: one learn more about HIV and still carry notions that it is somehow affiliated with something bad that someone has done. They make the automatic assumption. We still come up against those attitudes because of
persons who have not chosen to either come to a training session or to take time and read about it or to hear others about it. So we have those challenges. We still have among our community there’s still people who are substance abusers or substance users that because of their susceptibility to being compromised by that activity are still put themselves at risk of HIV by continuing to engage in those kinds of activities. So we still have the challenges of working with the persons who [indiscernible/889] making themselves vulnerable to the spread of HIV. And we still have challenges on the part of some of our leadership who—a very few—who may, who have not embraced HIV as something that they should be particularly concerned with helping others to address. They don’t see it as part of their own responsibility. So we do have, maybe a handful or less that just have chosen not to be involved in expressing or participating in helping others to learn more about HIV and to actively try and assist in clarifying the misconceptions and the attitudes that have been expressed earlier. So we still have those challenges before us there and we still work on ways as to how we can address them.

EG: Okay. We’ve reached the last question. Is there anything that I haven’t asked about that your think it’s important for me to know about what you do, the efforts that you undertake to talk to your community members about HIV and AIDS?

D.: I don’t know if there’s anything you haven’t asked—well, I do have, I do say it’s important to know we are, we are finding that the response to by the community in general in terms of roles of persons taking on personal accountability within their own households and communities or educating themselves and others within their circles of influence about HIV, we’re finding that that is slowly improving in some sectors of our community where the church and the faith community has been engaging in and I’m thinking about nursing homes, educational institutions, non-profit organizations that work with our churches—those kinds of entities—that we’re finding that there is slowly more discussions about HIV that’s occurring, but it’s also not as at an optimum rate as we would hope it would be by this time in 2014. I still get those who will walk up to me time to time and ask me: “Rev. Nixon is HIV still a major issue in our community?” because of the misconception that with the advance of medicines and treatments, you know, the kinds of progress that has been made by our health and science sectors in treating HIV that the attitudes of some have been the misconception of it no longer being an issue has been between that kind of conception that it’s been dealt with by the health community as well as the not as much popular advertisement of HIV as was done in say the late 90s and early 2000s. That is still something that is a misconception from time to time that’s still a reality among people in our community there—that AIDS is not as big a problem as it has been in the past as far as numbers and severity of impact on the community.

EG: All right. Well, I thank you so much for your time. As you requested, when I get home this evening—I’m at school right now—when I get home tonight, I will make you a digital copy of this recording and I will send that to you via email.
D.: Okay. I do appreciate that very much. And I was going to as now, too, when you do have any findings, or things that you make available to the public, will there be a point that we’ll be aware of those, those who have been participating in the interviews? That somehow we’ll know the results of your research and work when it’s completed?

EG: Yes, sir. I will be most happy to share that with you. I’m not quite sure how that will take place yet, but that is the plan. I will share the data with you.

D.: Okay. I appreciate that much and thank you for the opportunity to participate and I’m glad to hear that someone is still making some inroads into looking at the topic from the faith community’s perspective.

EG: Happy Thanksgiving, sir.

D.: All right. Happy Thanksgiving to you now. Blessings to you.

EG: Yes, sir. Thank you.

D.: All right. Take care.

---END OF INTERVIEW---

Participant E

EG: All right. We are recording. Question one. Just for my records, please state your name, your title, and the name of your religious organization. Please also provide an estimate in the size, number of members, of your organization.

[low volume—indiscernible]

EG: Now we’re having a different kind of technology problem. I’m trying to get my speakerphone set up so that I can get you recorded. Let’s see here. Let’s try that. Oh, shit. [indiscernible/35] 978 [indiscernible/40]. [Sigh.]

[Dialing—extended silence]

EG: I’m here. I’m so sorry. All right. Let’s try that.

PARTICIPANT E: Fine.

EG: Okay. Yes. I can hear you. So, back to the first question. Um, let’s see. Could you please state your name, your title, and the name of your religious organization? Please also provide a number, estimate in size, number of members of your organization.
PARTICIPANT E: I’m Participant E, director of the X and associate pastor for missions and outreach. We have a little over 2,000 members.

EG: Okay. Have you communicated about HIV and AIDS with your congregants?

PARTICIPANT E: Yes.

EG: Okay. How and when did your efforts to communicate about HIV and AIDS with your congregants begin? Was there a particular event that prompted you, a particular event or circumstance that prompted you to undertake these efforts?

PARTICIPANT E: Yes. We probably started about seven years ago. And the event would have been, we had a student that was in seminary who actually had this as a project. And once we began, I just kept the ministry going. We formed a full HIV/AIDS prevention ministry.

EG: Has the student stayed involved?

PARTICIPANT E: No.

EG: Okay. Could you tell me about what the, what your efforts to communicate about HIV and AIDS in your congregation entail? If they’ve changed over time, tell me about how the events started, how the communication started and how it’s changed over time.

PARTICIPANT E: Well, I guess our first effort was just a presentation by me to the men of the church. Just a slide and presentation and that sort of thing. And then we had a full HIV/AIDS prevention day which involved I invited folk from the health department who came in—we actually had three services. We have three services each Sunday morning and we preached a message at each service called “Sounding the Alarm.” We had breakout sessions with various age groups hosted by members of the health department and that was our first sessions. Since that time, we’ve done, continued to do presentations as often as circumstances would permit with the women’s and men’s ministry. We’re working now with the youth ministry—our young people’s ministry. They seem very engaged. They seem very curious about the presentations. We’ve not done it with them yet. Pardon me. We’ve not done it with the full youth department. However, we had a anti-stigma conference just a few months ago, like three, four months ago, and we had a lot of young people that attended in that. They have subsequently expressed great interest in having events not only here in Fairfax County but in Prince William County. So, and we have bulletins that run each Sunday and we have different blurbs or statistics in the bulletin. When there are national days, for instance, last Sunday we had one run because December 1st was National Black HIV/AIDS Prevention Day. So we had a big in our church bulletin. And you know we had posters around and that sort of thing. So our principal mode of communication has been at various forums and through printed media.
EG: Now you said that your efforts to communicate started with the male part of your congregation. Was there a particular reason for that?

PARTICIPANT E: Probably just the availability. And the main reason was because I was anxious to get the men involved and we tried to have men speak to men and women speak to women, simply because some of the questions and the interests among the groups is peculiar to men or to women. So, the very first presentation I made to the men was simply because I’m a man and that was the first available forum. And subsequently I invited someone else in from the health department to present to the women. And that was well received, it was well presented. However, one of the concerns was we have a multicultural congregation, but the principal, the largest group among our various cultures, of course, is African American. So, we wanted to get someone in that looked like some of those women. It was not a big issue, but it was mentioned, so I just wanted to share that.

EG: And how do people react or take to the communication that you engage in with the younger members of the congregation?

PARTICIPANT E: They seem very curious. Depending upon the age group, the biggest hurdle is getting over the parents, because when you say HIV, the first thing that comes to mind is sex, and many parents don’t want to have that conversation. One of the things I, when I present to the men, that I share with them is the fact that that conversation about sex, they hesitate to have it simply because they think their kids are going to ask them about their own sexual history. So, I sort of hit the men between the eye with that fact that they’re doing a disservice to their young people, but the young people themselves seem to be anxious to hear. Now, whether that’s because they know the prevalence or the you know what they’re facing on a day-to-day basis, I don’t know if that’s the principal driver, but they do, they seem quite curious.

EG: Okay. Tell me about your goals with regard to your HIV/AIDS communication in your church. What do you hope to accomplish and how did you decide what goals to reach for?

PARTICIPANT E: I’m a member of the Northern Virginia Clergy Council for the Prevention of HIV and AIDS and our stated goal is to make HIV and AIDS rare in Northern Virginia and our goal of HIV x HIV/AIDS ministry mirrors exactly that. Our goal is to make it rare by making our people as informed as possible and having it leave the church. We want to permeate the families and educate the families. The image I always use is that of a rock and water and the ripples that go out from it. So, Our goal is to impact our church and through the church our community and make HIV/AIDS rare.

EG: Okay. Tell me about a success that you’ve had as part of your efforts to communicate about HIV and AIDS. Has there been a moment when you felt like you were achieving those goals that you just talked about?
PARTICIPANT E: That’s a tough question to answer, simply because there are no quantifiable stats that would tell us, you know, our impact, our thing is to be a part of a greater whole. So, the, that’s very difficult to—I think that in terms of the reception to our presentations, there have been times that I’ve felt we’ve had more impact than other times. But I could not tell you, you know, give you a demographic that would quantify exactly the results of our imp—our impact on the community. One of the things that we do annually, well, we did for several years. We didn’t do it this year. Is have a, kind of a community day, where we actually set up in the parking lot and have various agencies come in and we have a lot of fun for the kids and we cook out and that sort of thing. And we invite the surrounding communities. And we make presentations there. And over the two or three years that we’ve had it, the first year, people sort of avoided the table that we had information on about AIDS. And then the next year, they sort of passed by and lingered and asked few questions. And last year, we had folks that actually came up and were very curious about it. We had quite a number that came up. So, we went from zero to let’s say 50 or maybe 50 folk that came by. One of the things that we’re most concerned about, not concerned about, the clergy council wanted to provide testing, but we’re very conscious of staying in our lane. And so, we didn’t want to bring testing to the church. What we wanted to do was make the church aware of the available facilities and agencies for testing. And so, we don’t know who has been tested. We don’t count numbers there, but I do know that some people have been tested.

EG: Okay. Are there any challenges that you see on the horizon in communicating with the people in your community about HIV and AIDS? If so, how do you plan to address these challenges?

PARTICIPANT E: I really don’t know. I know that there are challenges, but in terms of how you address them—I suppose our major challenge is still dealing with the cultural, not only the cultural differences, but there in the African American community, there are certain nuances, taboos, if you will. And so the biggest hurdle is discussing HIV/AIDS in the church without having the conversation dwindle to sexual practices, because folk get very nervous when you start talking about sex from the pulpit. But the idea of, so that’s a major hurdle of how do you sound the alarm, if you will, of the, what the ravages of this disease and what it’s doing to our community, without addressing some of the cultural practices that make it—One of the things we’re most concerned about is among other racial demographics, the stats seem to be going down, while in the African American community, they still continue to climb. And we want to—I’m very concerned about that. But again, the biggest challenge is addressing it in the faith community without having folks sort of draw back because when you say HIV/AIDS, they make it synonymous with sex.

EG: I’m just looking over the questions here.

PARTICIPANT E: Okay.
EG: Is there anything that I have not asked about thus far that’s related to your HIV/AIDS communication efforts that you think it’s important for me to know as I continue my research?

PARTICIPANT E: Well, you’ve probably thought about it, but as I’m sure there’s a line that runs through most of my responses that tell you that there are cultural differences and how this is handled and it’s difficult to fully understand the grasp and the depth of the taboos in the African American community, especially as it relates to the faith community. So, I’m not sure how germane that is to your research, but I do know that one size does not fit all. As you look at this, I’m, part of my doctoral thesis was ministering to African Americans among their, pardon me, ministering to African Americans amid their mistrust of the health community. And the idea is that same fear is magnified when it comes to HIV/AIDS. People in the African American community have been lied to and they feel that they’ve been mistreated in the healthcare system. So, just the basic hesitancy to engage the healthcare community is greatly magnified when it comes to something. If you, if we had a door, and it said on the other side of this door was a cure for HIV/AIDS, we have people who would not go through that door because they do not want to be seen at that door and have others know that they have anything to do with HIV/AIDS. So, I think that one size fits all, Elizabeth. I think that concerns me, because many of the things, many of the tools that have been made available, just don’t, they’re not effective in our community. So, we are grappling for a response.

EG: Is there anything that you need from me? Any information that I could provide you with as I continue my research? Any questions I can answer for you?

PARTICIPANT E: If there are any commonalities that you’ve run into, I’d be interested to know. It’s always good to know that you’re not swimming alone, so if there are others that are having similar problems or similar issues to those that I’ve expressed, if they come up with any solutions or approaches, I’d be interested, I’d be interested to know what those approaches are.

EG: Okay. Well, I appreciate your time so very much.

PARTICIPANT E: Thank you. I hope we’ve been helpful.

EG: Thank you. Have a good afternoon.

PARTICIPANT E: Same to you. Be blessed.

---END OF INTERVIEW---

Participant F interview
EG: I believe this process should take maybe half an hour.

PARTICIPANT F: Okay.

EG: Let me pull up my question list.

PARTICIPANT F: I don’t have your question list in front of me. I remember reading it, but then I [indiscernible] it away.

EG: Okay. First of all, could you please state your name, your title, and the name of your religious organization? Please also provide an estimate in size, number of members, of your organization.

PARTICIPANT F: I’m [Participant F], pastor of x in x. As I identified, Baptist denomination, comprising membership of nearly 2,000.

EG: Okay. Tell me. Have you communicated about HIV and AIDS with your congregants?

PARTICIPANT F: Yes.

EG: Okay.

PARTICIPANT F: We have. We shared with them on prevention, stigma, and also testing.

EG: Was there a particular event or circumstance that prompted you to undertake these efforts, and, about how and when did your efforts to communicate begin?

PARTICIPANT F: Early efforts dates back to over, I would say 15 years ago. And it was a peer-to-peer youth program where youth came in and they were addressing HIV/AIDS to the youth of our congregation. That was the very first effort that we had begun. And more recently, as we have begun approximately six years with the clergy council for the prevention of HIV/AIDS to move with initiatives with that council and providing emphasis on prevention in our churches as part of a collaborative effort.

EG: Can you tell me how you became involved with the clergy council?

PARTICIPANT F: I was moderator of the Northern Virginia Baptist Association, which comprised 120 churches and as such was engaged by one of my colleagues in ministry, also by the Fairfax County Health Department to come in and to join in discussions of how prevention and the message of prevention and stigma can be addressed in the church. That’s how I got involved.
EG: How would you gauge the stigma within your congregation?

PARTICIPANT F: There is stigma. Studies [indiscernible/38] show that it exists. I think as it was when we tested, it had an indication of it, but I believe that information that we’ve shared has reduced the stigma some, but I would, I would conclude there’s probably still work to be done with regard to the full removal of stigma.

EG: Could you at all gauge the level of stigma in the younger part of your congregation versus the older? Is there a difference?

PARTICIPANT F: I think there is. I think there’s [indiscernible/59] stigma in the older segment of the church congregation than there is in the younger. Speaking younger, in the very young, teenagers or youth side, it may show itself, but not as readily as it does with the older adults.

EG: Is there any reticence on the part of any member, any age group within the congregation regarding having the AIDS education or information present in the church?

PARTICIPANT F: No. It seems to—what I’ve seen it as understanding what is a crisis in our community in our state and in the nation. I think there was more of a receptivity. I think one was introduced more recently. There might have been some general conversations, but not necessarily were there any pushback or very negative sentiments that was as a result of a parent identifying that we did have a urgency and a crisis which was in our local community with regards to the increased spread of HIV infections.

Hmm-hmm.

[long pause]

EG: Could you give me an overall picture of what your efforts to communicate about HIV and AIDS within your congregation entail? If they’ve changed over time, could you give me an idea of what, how they started and how they developed over time?

PARTICIPANT F: Okay. Efforts would have been first of all, talking points from the pulpit, statements made by myself, directly to the congregation with regards to identifying and making them familiar with the effort that is being undertaken to remove stigma, having them informed on the statistics relative to new cases of HIV/AIDS, most especially in African American community. Moved from there to showing a DVD prepared by the clergy council for the prevention of HIV/AIDS and that introducing and sharing information progression, we moved forward to written information that was passed out in what we call bulletins that’s shared weekly at services including posters that’s displayed prominently at various locations in passages where congregants would ingress or egress in the church or come and leave. On our electronic display in the sanctuary that shows graphics and also textual information that relates to prevention. Also hearing and sharing in the various aspects of the ministries where individuals were
given pamphlets and also shared with them information relative to stigma. Knowing your status through being tested and also information on testing sites. That’s what the progression as it rolled out completely across the church.

EG: Okay. Now, the DVD you’re talking about, is that the Breaking the Silence video?

PARTICIPANT F: Yes. That is the Breaking the Silence video.

EG: Okay. Does any discussion come out of the congregation once they’ve seen that?

PARTICIPANT F: I think more so was conversation was that came, I would say from one on one, but not a predisposed opportunity where groups could discuss general comments relative to understanding the statistics that was an attention draw, and I think the DVD itself brought a consciousness to individuals to be aware of what we have in our various communities, nothing that demonstrated, if you will, any comments that showed negative sentiments, but much more of being received as individuals being informed and through these efforts, more individuals feel free to talk about those they knew who have been infected as well as affected by HIV/AIDS.

EG: Okay. Now tell me about your goals, the goals that you hope to achieve via this communication. How did you determine which goals to pursue?

PARTICIPANT F: Okay. First of all, it was to inform. And that’s why I identify what’s called the three A’s, for me are very important. One is awareness. The goal is make individuals aware. Give them, provide them sufficient information to educate and be informed as it relates to the pandemic and as it relates to its impact in our community. So, that was an awareness level so that individuals become advocates and their advocacy would be for removing stigma and also prevention, so that those individuals’ voices could be heard not only in their communities and families but shared along their views and how they, too, are aware and moving with what they could do to help share information and become advocates for prevention. And third goal was to bring individuals to action, that is build them as advocates, but then go into action, giving them tools to go out and to share and I use the word go out that’s beyond the venue or the location or the service that they’re hearing, but go out and share information in families in actions, if you’re an advocate to also share it across communities and also with others in various other venues, employment. And so, that was the goal. Make them aware, build advocates, then move people to action. And also the action included individuals finding out what their own status was. Go be tested. So that was the goal as it went out to what we call the population of the church itself.

EG: Okay. Now how much of what you just mentioned comes from the clergy council and how much is you tailoring your program specifically to the people within your church walls?
PARTICIPANT F: It has to be tailored, because the clergy council sets a framework for informational resources, goals as well as general strategies—

EG: Okay.

PARTICIPANT F: --but the implementation as to how it is carried out or rolled out within the congregation is somewhat dependent upon the congregation itself. So mine’s had to relate to what works best in the x, but yet the outcome or results of those are the same. It’s how it’s been provided and also implemented in the congregation. So, clergy council is a resource for information and a great help as it contributed to what we were doing and also the outcome of what we had hoped to reasonably achieve.

EG: Speaking of achievement, can you tell me about a, maybe a goal or a milestone that you’ve reached with your efforts?

PARTICIPANT F: If I go back to the awareness, just a milestone there is first make sure that individuals are educated. And the goal for that was to make sure that various age groups—the most senior to our teens—and make it systemic—in essence, not just localized to a particular ministry, but have it more dispersed throughout. And so, the goal of sharing was achieved in that all of the segments, agewise, of the congregation were informed. That was a goal. For the advocacy, that was [indiscernible/336] of individuals who are now themselves being informed but talking about prevention. That was to draw that and saw that accomplished by the very fact that there were opportunities where individuals were sharing in a more vocal way, meaning, talking about their experiences and also how they themselves are able to share with others where otherwise they had not shared before. And then on the action side, it [indiscernible/352] goes to more individuals becoming let’s just say more attuned to doing something for themselves, testing, and also sharing. So, those goals were set, we’re seeing them come forward and the idea is as ideas go out, then there’s an understanding that we’re working toward preventing he rate of new infections, that’s in our community.

EG: Do you see any challenges as you’ve undertaken this work and as you continue to work to communicate with members of your community about HIV and AIDS?

PARTICIPANT F: Challenges, of course. First of all, there’s culture. Secondly was the delivery system. Thirdly was the nomenclature or words, culture, meaning the church as a religious entity. And we start addressing a culture that’s more social, although religious context has a social connotation. But you’re introducing a concern into the community of faith, was not an overwhelming challenge, but it was the first move from a disposition where self is and to move into what needed to be done to be more effective. In other words, reconditioning minds so that this become a subject of discussion rather than a subject of reading. Next was the challenge that could have been identified was understanding that the subject matter is dealing with subject that most consider to be a
more private context. Looking at the individual’s sexual behavior practices, practices now discussed in the church about what are ways of contracting HIV. Nomenclature words then abstinence. Then the preaching context. But how then to identify not compromise yet identify that there is a need to be more aware of one’s physical exposure when abstinence fails. So, the challenge may not be for the full masses, the challenge for the whole aspect of removing stigma and also the aspect of speaking to the consciousness of the congregation so that they will become prevention aware. And so that was, that was the type of challenges that I saw. Not so much on the receptivity or receiving those who are to hear and also to receive the information.

EG: Okay. Can you speak to any instances of, of physical social support that you’ve seen within your community?

PARTICIPANT F: When you say physical social support—

EG: Meaning like there are a couple of different kinds of social support. Emotional—

PARTICIPANT F: [indiscernible/456]

EG: support. There’s material support. There’s just a feeling, you mentioned inclusivity. Feeling not so isolated from what’s going on—

PARTICIPANT F: Hmm-hmm.

EG: --around you. Can you point to any of those instances—

PARTICIPANT F: Yeah.

EG: --that you’ve seen.

PARTICIPANT F: Yeah. Yeah. Let’s go back. Let’s use physical support [indiscernible/466]. First of all, let’s just say person to person. And in this case, individuals who are more apt to sit and talk with each other. Yes. We see that. Had we seen that before this? No. Before we started sharing? No way. Individuals who would relate more through social or discussions, organizations, when I look at social organization, who have come alongside and supported the [indiscernible/484] community. And how did they interact with the faith community? Yes, we’ve seen that as well. So that there is a consciousness and an effort undertaken toward prevention of the spread of HIV and AIDS. Hmm-hmm.

EG: Okay. What are the most important things that you think I need to know about what the social support that takes place within your community that maybe I haven’t asked about?
Are there aspects of your HIV/AIDS outreach communication that you think are essential to what you’re doing?

PARTICIPANT F: I think what’s probably as probably not spoken, something that’s endemic or more or less connected with the faith community, that says we look at social, we look at other physical, tangible resources, but there’s a question how has what we considered the more [indiscernible/517] God-centered discussion as related to the understanding of this pandemic and here there is a, a part—how can I explain it—that says individuals of faith recognize that in crisis situation there is a reaction of hope because that’s one of the tenets of faith. There is a reaction of belief and then there is a reaction of prayer. These are the tenets of the faith of the community. Then, the part is how has the impact of HIV/AIDS worked into the normal tenets of what we believe the core of the church our faith community, which meant prior to there may not have been the expressive nature in the related sense in the spiritual response, but now there is, so that the expression of hope translates over into inclusivity of prayer that says now the pendulum that had faith tied into it, that had prayer related to various elements of healing now is directed specifically to HIV/AIDS. The hope that may have been identified that’s somewhat faith-centered is looking now individuals thinking that there is hope that there’s a cure, that there is eradication so that’s tied within the tenets of individuals’ faith. That side, I think would be one that you had not addressed, but that’s what, seeing in this community, as we look at this community of faith as we look at the church, as we look at believers, as we look at those who have what’s called a religious stance, that’s also is a prominent act that’s occurring, that has occurred.

EG: Okay. Could you—

PARTICIPANT F: Now did you capture what I’m saying when I explain to you that’s working within the core personal religious expressions.

EG: Yes.

PARTICIPANT F: Hmm-hmm.

EG: Could you tell me, are there people within your community who are maybe, when they have an experience related to HIV and AIDS, are there people within your community who maybe feel more drawn to God on a personal level and maybe drawn away from the rest of the congregation and if so, then how does that work?

PARTICIPANT F: Well, that’s, that question makes it a little bit difficult, because there’s several sides to it. First, one drawn more to God, less to individuals, because of their experience with HIV/AIDS. It’s hard to tie into that unless one has what’s called the interaction with individuals from what’s called the level of confidentiality.

EG: Right.
PARTICIPANT F: So that means that as one grows closer to God, one might go closer to their spiritual leader. Which means closer to their spiritual leader means closer to God. As it comes closer to that spiritual representative, they may be less inclined to go out and be more closer to those who are in the population. That one may be more expressive than just a sheer statement “closer to God” and not to the people because then that may be more subjective in analyzing [indiscernible/635], but when they come closer and more relative to myself, then I think there is a God-centeredness on the mind of the individual and they may be less inclined to talk about what they are experiencing should that be the case. But then on the other hand, I would say, I’ve not so much seen that that has occurred, maybe some instances where individuals have shared about relations with regard to infections around their family, but there are indicators, I don’t think there are indicators people are swinging because if they become more informed they’ve become more—to me that that’s a line that question ties closer to the stigma side. I will become more with God. I don’t want to talk to people because there’s a stigma here. I don’t, I can’t say I could put my hand on it and say, “Yeah, that’s what’s exactly occurring.” I can’t say that. But I can say that there is a closeness to God overall in reaching to Him by those who have been affected. They’ve either had loved ones who have died from AIDS, they either have friends who died from AIDS, or they have someone they know who died from it. So, they are seeking God as it relates to divine intervention, but not so much as seeking God as opposed to seeking or going to those in the general populace.

EG: Could I get you to give me a basic demographic breakdown of the people within your church? How many young people do you have and how many--?

PARTICIPANT F: Well, that’s, that number’s [indiscernible/696] even grasp. To identify, I would say we have several hundred young people of the composition, percentage-wise. When I look at it, you say young people. You mean teens? You mean children? Which groups are you referring to?

EG: The 18 and under crowd.

PARTICIPANT F: 18 and under, gosh. Two or three hundred.

EG: And what about, say, the 19 to 40?

PARTICIPANT F: Gosh. It would be very difficult. I couldn’t venture—

EG: Okay.

PARTICIPANT F: --to try to put those in groups. I can venture, like when you say, how many, the word many, mean to number, I can give you more representative, if you will. Representative we don’t have as many of what we call the older seniors. We have seniors that would be in the age group 60 to 70s. Not as many in the 80 standpoint. The core
membership would be somewhere between 50 to 35. 35-55 is the core membership of the church.

EG: Okay. Could you give me an idea of how those, if you had to ascribe or assign a viewpoint regarding AIDS to each of these groups, you’ve identified here, the older, 70, 80 generation and the 35-50 year olds.

PARTICIPANT F: Repeat that. Could you describe what now? Repeat that question.

EG: Could you tell me—

PARTICIPANT F: How would I do what?

EG: How you think these two age groups that you’ve identified here—the 80-something crowd, 70-80 crowd and the 35-50, if you had to give a general idea of how each of these groups feel about maybe the current conditions related to HIV and AIDS in the African American church setting.

PARTICIPANT F: I think they believe that it’s a problem, meaning that the pandemic is problematic in society. They will acknowledge it. I think they’re response would be they’re becoming more informed because of the information sharing that they’ve received. How are they receiving it? I would say, they’re receiving it with a receptor that says, in my community, in my, in my attention, in my neighborhood, in my concern, and so, those type responses, I would say, would be pretty much indicative of those age groups. And so, they become more aware by sharing in those segments of age groups because of being exposed to informational support and so on. There might be some in those groups who might still be not as informed either because of somewhere between the process of sharing they have missed something. But I would say that would may typifying where they are.

EG: Okay. Last question. How do you see your work with the clergy council and maybe with health department education efforts in your community? How do you see that changing as we move forward?

PARTICIPANT F: I think it’s been a very, very strong impact from the resources, information, individuals as resources to provide assistance. I think it has brought more of the core, synergistic response because then there’s, we come to understand common goals, strategies to move forward with, and I think the clergy council has been a strong contributor to helping getting us where we see we are. I think the introduction of the clergy council, the health department as they’ve stood along us, conversely we’ve stood alongside them, have garnished what I believe a outcome that are positive. We look at information sharing that we hope yields outcome of stigma reduction or removal, an outcome of testing. I think we may not have been as far as we are now if we had not had that dialogue and that interaction. So I think they’ve been a tremendous help. Has it
changed what changes are brought? I think, I think the message that’s going out has been more of a message that has been toned or if you will, vocalized, as a result of the clergy council and the work along with it.

EG: Okay. Those are my questions for you. Is there any information that you need from me?

PARTICIPANT F: How do you internalize the information with regard to common patterns? Are you looking at the information that is to identify more each, each church, each community in and of themselves, in and of itself? How are you utilizing it?

EG: Right now, I am looking at this from a qualitative standpoint, looking at the interviews as a compilation. I’m assembling all of the interviews together and looking at themes and patterns and what have you.

PARTICIPANT F: Okay. I think there’s a question [indiscernible/876] to another one you asked. How is the rollout of HIV/AIDS in the church? Mainly, how was it ministry? How was the information sharing? Most of the conversation and questions, you focus on how did they receive? What was the information? How was this? How was that? But then how has the church now prepared itself for what called the, not only the immediacy, but what’s, how does it move future, you look at achieving and reaching its goals as it’s tied in the clergy council? And I think that’s where you’re going to see some differences there. For, from the x congregation, I believe in being systemic, which is each ministry has a voice, talking about prevention as opposed to building and establishing a single ministry that does use what’s in place. And I think that’s important as to what works well in a congregation. I think that’s also by presence, by leaders, those of us who are clergy and what we’re deciding how it is discharged in our community itself, if you make, itself, as you make reference to. I think that’s the part there that lends itself to say, “Well, that’s how this church is implementing, and what’s its model of this one, and what’s its model?” Because I think we may be working with the same outcome, but we might use a different model for accomplishing it. And that too become, I think, an assessment, too.

EG: All right. Well, I appreciate your time.

PARTICIPANT F: Well, bless you.
EG: Thank you.

PARTICIPANT F: Good talking to you. Take care.

EG: Bye-bye.


EG: [writing sounds]
---END OF INTERVIEW---

Participant G

EG: Okay. Let’s get started.

Participant G: Okay.

EG: The first question is: Could you please state your name, your title, and the name of your religious organization? Please also provide an estimate in number of members of your organization.

Participant G: Okay. [Participant G]. [x]. x. We are church of 3,000 members—

EG: All right. Question two—

Participant G: --and my title is Youth and Young Adult Pastor.

EG: Well that brings a follow-up question. How many ministers are there, in total, in your church?

Participant G: How many members?

EG: How many ministers?

Participant G: Ministers. Okay, so we have around 40 associate ministers.

EG: Okay. [long pause] And you are the only one who is charged with facilitating HIV/AIDS communication?

Participant G: Yes.

EG: Okay. All right. Question two. Have you communicated about HIV and AIDS with your congregants?

Participant G: Yes.

EG: All right. Um, how and when did your efforts to communicate about HIV and AIDS with your congregants begin? Was there a particular event or circumstance that prompted you to undertake these efforts? If so, please describe that event or experience?

Participant G: Well we, because I’m a youth and young adult, I had a conference where I included HIV/AIDS presentation, as well as a workshop with the, with the participants. And the conference was around 300 persons who attended.
EG: Okay. What was the community response to that conference?

Participant G: Well, the youth liked it. They were shocked, they was very educated. It enhanced their knowledge. It gave them a lot think about, to walk away, allowed them to discuss their endeavors and their false beliefs as well as what they already do.

EG: Did any of the parents express any concern about the youths attending this conference?

Participant G: No.

EG: Okay. Okay, so the conference that you mentioned, is that your only, your only effort thus far to communicate about HIV and AIDS?

Participant G: Yes. I had it twice at our conferences.

EG: Okay.

Participant G: And we also had a health fair in which we added HIV/AIDS testing and talked about STDs.

EG: Okay. Tell me about your goals. Describe the goals that you hope to achieve with this communication. How did you decide which goals to pursue?

Participant G: Well, the goal was to really educate and to also erase stigma associated with HIV/AIDS and also with STDs. And so my goal was to really educate and also to raise awareness about the stigma surrounding persons affected and affected by HIV/AIDS as well as STDs.

EG: Tell me about a success that you’ve achieved as part of your efforts to communicate with your, with people about HIV and AIDS. Has there been a moment where you felt like you were achieving the goals you set out to pursue?

Participant G: You know, yes. I think that being able to hear the students use the statistics and talk about it as well as communicating with others how the workshop helped and how they wanted it to continue.

[long pause]

EG: All right, now, kind of turning the coin to the other side. Are there any challenges that you perceive on the horizon I communicating with your members about HIV and AIDS? If so—
Participant G: Yes. One, well, one of the main challenges is people still don’t believe that HIV/AIDS is rapidly killing the way that it is. People are not dying because the advancements of medicine. And so, you’re always met with the belief that medicine has brought about almost a cure or that has tempered [indiscernible/156] of HIV and AIDS, but it’s not and you still are fighting the stigma that only certain people get it and not others.

EG: Um, are there any steps that you’ve taken to address that challenge?

Participant G: We try to. We try to bring a lot of statistics, point them to the website, continue just to bring awareness about it. Really and truly that is one of the main fights that we are still fighting.

EG: All right. I know that the health department produced an HIV/AIDS education video, the Breaking the Silence video. Do you share that with—

Participant G: Yes.

EG: --with your congregants, as well?

Participant G: Yes. We did.

EG: Okay. Can you tell me about the response that, that people may have had to that?

Participant G: Um, they were challenged. The response was they already knew. So, it’s almost like they know, but there’s still disbelief.

[long pause]

EG: I think that brings me to the end of my question list, which leads me to this: Is there anything that I haven’t asked about, related to your HIV/AIDS communication that you would like to share—anything that you think that’s important for people to know about your steps that you’re engaging in to educate your community, your congregants about HIV and AIDS?

Participant G: No. I continue to support HIV/AIDS board that I’ve been on. I continue just to make sure that they are aware and that I still become a light to the community and therefore they do have someone in the church they can turn and talk with so they still have an avenue to help.

EG: Has anyone taken advantage of that relationship with you to, to kind of seek your help with their challenges related to HIV?
Participant G: I had one person which was affected with the virus and we talked. That person is no longer around at the church, but feels healthy.

EG: All right. Well, I appreciate your time. Is there any information that you need from me?

Participant G: No. Thank you so much. I wish you well on, you know, your dissertation. Is this your master’s or your Ph.D.?

EG: This is my master’s thesis for my master’s degree.

Participant G: Your master’s thesis. Well, I wish you much best. And thank you so much. I’m humbled that you even want to hear my voice.

EG: Thank you for your time. Have a, have a great day.

Participant G: Be blessed.

---END OF INTERVIEW---

Participant H

EG: Okay. I just started my recorders and I have you on speakerphone.

Participant H: Okay.

EG: All right. The first question is: Please state your name, your title, and the name of your religious organization. Please also provide an estimate in size in number of members, of your organization.

Participant H: Okay. Name is Participant H, pastor of x. And the size of our congregation is 800 members.

EG: Okay. Question two: Have you communicated about HIV and AIDS with your congregants?

Participant H: Hello?

EG: I’m still here.

Participant H: Yes. What’s your second question again?

EG: Have you communicated about HIV and AIDS with your congregants?
Participant H: Yes. We have.

EG: If so, how and when did your efforts to communicate about HIV and AIDS with your congregants begin? Was there a particular event or circumstance that prompted you to undertake these efforts? If so, please describe that event or circumstance.

Participant H: Well, I had to counsel a couple of my members who were infected with HIV and AIDS and I saw the need to start a ministry to meet need of those persons who are infected as well as those family members and friends who are affected by the, by the dreaded, that deadly disease. So, that was the need to start the ministry in my, in our congregation.

EG: Did your efforts to communicate about HIV and AIDS come before or after you joined the, the Northern Virginia Clergy Council?

Participant H: Oh, it came before.

EG: Okay. And how did your, your joining the council come about?

Participant H: I had, it was a flyer sent to our church that there were having a summit and then, in reference to HIV and AIDS, so I went to check it out.

EG: Can you tell me about the age breakdown of your congregants? How many people in different age groups do you have?

Participant H: We have, let me see. I would say, we have 30 percent youth, another 30 percent young adults and the rest adults.

[long pause]

EG: Okay. Tell me about what your efforts to communicate about HIV and AIDS with your congregants entail. If these efforts have changed since you began communicating, please describe the initial efforts and the changes that have been made over time.

Participant H: Efforts that have been made. Well, we first of all, thought to educate and bring awareness to the, the fact that the high rate of infection in our African American community and ways that can prevent it was the first step. Actually, before that was to try to attempt to remove the stigma that’s associated with either having the disease or knowing someone that had the disease. So, that was our first effort, and then we did some seminars and classes, and the ministry that we’ve developed is very instrumental in keeping it in front of the congregation and keeping the congregation engaged on a monthly fellowship where persons can come and share if they so desire.
EG: Now, you mentioned stigma. Do you, do you see the stigma more affecting the African American community outside the walls of your church or do you see it working between different members of your congregation?

Participant H: I think it’s both. I feel it’s both, but more so in the church because, because the Christian religion and the black church have taken pride in holiness and righteousness, which is good, but my message to them is we still live in the real world and different things do happen, and it does not necessarily mean that one has committed unholy acts or immoral acts to be contracted by that disease. So, we need to be open, to allow persons to really come and share that they’re affected by it so they can get the support that they need—moral, spiritual, and as well as clinical support that they need.

EG: Okay. You had talked about education. So, your education efforts, are those coming primarily from the pulpit or are there other things in addition to the monthly meeting you mentioned?

Participant H: [long pause] Sermons on HIV and AIDS. We have an annual Sunday that’s set aside just for HIV and AIDS, and then the monthly meeting is designed specifically to educate and also to give a forum, a platform where persons can come and share freely, as I said. And also, the clergy council has developed a curriculum that we plan to implement here in our congregation real soon.

EG: Can you tell me about the response that your congregants have expressed as a result of having this available to them, this communication about HIV and AIDS?

Participant H: Yeah. It’s slow, but it’s coming along. We have more people now, participating in it than we did before, but it’s still not at a rate where I would like to see it, but at least it’s available and persons feel free to come and share.

EG: And tell me about your goals. Describe the goals you hope to achieve with this communication and how did you determine which goals to pursue?

Participant H: The goals I’m hoping to achieve is that persons who are affected with the disease will feel accepted and a part of the congregation and our membership and feel and that they’re not made to be feel, they’re not made to be feel, made to feel like they have a disease that would ostracize them. That is my goal, that we would embrace them, love them, and make them feel like they’re part of us, so that’s the goal that I’m pushing to achieve and we’re almost there. The stigma is almost lifted, but it’s not completely lifted.

EG: Okay. All right. Tell me about a success that you’ve achieved as part of your efforts to communicate with, with people about HIV and AIDS. Has there been a moment, a specific moment where you’ve felt like you were achieving the goals you were hoping to achieve by telling your members, the members of your community about HIV and AIDS?
Participant H: Well, we’ve had some testimonials as to how our ministry has impacted not only the church but the community, because members of our HIV/AIDS ministry go out every Monday and distribute lunch and meals to those who cannot leave their homes. And we’ve received letters and thank yous from those persons. And from within the church, we’ve received, to me personally, persons have mentioned to me that they, they’re being made to feel like they’re people, and not just persons who are diseased and to be avoided. So, those things have encouraged my heart.

EG: Are there any challenges you see on the horizon in communicating with people in your community about HIV and AIDS? If so, what are they, and how could you address these challenges?

Participant H: Challenges in communicating. Huh. Challenges in communicating. Well, I’ve, because of the social media and other means of getting information out. I think the platform is ready for us to be able to distribute information and if there would be one thing I would put a finger on, it would be, again, persons feeling free enough, for the lack of a better term, and confident is to what I’m, to come to us after getting the information out. I’ve seen persons still hesitant seeking help. But that would be the biggest challenge. And also, we have annually, annually we have what we call a tent revival, where we go out in the community and we invite medical personnel to come and be out doing testing and it was actually, we had one at a shopping center the other, last month. And we were able to have 50 people tested. So, but, we’re trying to be intentional. We’re trying to be intentional in going out and making ourselves available and making testing and education and awareness available.

[long pause]

EG: Is there anything that I have not asked about related to your HIV/AIDS communication that I have not asked about that you would like to share? Is there anything you think is important for me to know about your community and what you try to communicate about HIV and AIDS as I continue my research?

Participant H: Hmm. Well, I, I am very concerned about the alarming rate in the African American community that’s being infected by HIV and AIDS and the young, young adults or teenagers between the ages of 13 and 24. When I see those statistics, it concerns me and I’m concerned that not enough of our leaders, church leaders, politicians, are out sounding the alarm. That would be one of my main, biggest concerns.

EG: All right. That concludes my question list. Is there any information that you need from me about my research?

Participant H: Oh. No. I think the letter that accompanied your email explained the purpose and how it would be used and all of that. So, I’m, I’m fine with that.
EG: All right. Well, I thank you very much for your time and I appreciate your help with my research.

Participant H: Oh, not a problem.

EG: Have a great afternoon, sir.

Participant H: Same. Bye-bye now.

---END OF INTERVIEW---

Participant I

EG: All right, sir, recorders are going.

I: Okay.

EG: My first question is: Could you please state your name, your title, and the name of your religious organization. Please also provide an estimate in size, in the number of members, of your organization.

I: Okay. My name is x. I’m the pastor of x in x, and we have probably 230 or about church folk.

EG: You said 230?

I: Yes.

EG: Okay. Tell me about a typical day for you.

I: A typical day for me?

EG: Yes.

I: Well, a typical day for me it changes each day because I am retired from the federal government, but at the same time I pastor church. So, that changes depending on what I need to do with, for the members of the church. If it’s to go up to visit, if it’s to take care of other duties as a minister in the area—so it changes. It changes, depending on if there are meetings that I need to go to because of the particular committee or councils that I’m on, as well. So there’s never a day that’s the same.

EG: Okay. Tell me how you became involved with the, with the clergy council.
I: Well, the clergy council came to the Northern Virginia Baptist Association. That’s probably about 7, 8 years ago they came to the, to the association, and they were trying to make, I think Fairfax County Health Department was trying to make inroads into the Black community, and the most likely place is to go through the Black church. And so, they came in, we established the council. I wasn’t initially there when they first started, but I think the second year that they were established, I was part of the council. I think at that time, I was the president of our ministers’ conference, and I came in and, until recently, I served as moderator for our churches in Northern Virginia. That was last year, and I was on the council. I’m still on the council now.

EG: Okay. Next question is: Have you communicated about HIV and AIDS with your congregants?

I: Yes.

EG: Okay. How and when did your efforts to communicate about HIV and AIDS with your congregants begin?

I: Well, I tell you what. I do like I do everything else. Initially, information that’s provided by the council or I should say, Fairfax Health Department, what we do is make sure that is distributed amongst our members. During the year, if it’s a day that’s designated to HIV and AIDS, we make mention of that in pulpit. We have sat down and talked to leadership at our church concerning the necessity for us to be involved in some way when it comes to eradicating this. We do have health and wellness ministry that we established to deal with HIV and AIDS, but not only that, but some other health issues that plague our community, so there are a number of ways that we try to engage them, even from the perspective, we have an African-American festival that a number of the members of our leadership, they do it in Manassas each year. And I think the last two or three years, we’ve had a table there and we pass out information concerning HIV AIDS.

EG: Okay. Now, you mentioned a couple of efforts that you’re involved with. How have your efforts evolved over the years?

I: With HIV and AIDS?

EG: Specifically with regard to HIV/AIDS communication.

I: Oh, okay. Well, at the time I, initially, we didn’t have anything going on in our church dealing with HIV and AIDS. We did not have a health and wellness ministry. This is something that we created, which is still a work in process that we’re working on now. I think from the perspective, our efforts have changed the thinking of some of our members, probably most of our members, concerning stigma, concerning cause, concerning prevention, concerning lifestyle and some other things. So, I think I’ve grown in my knowledge of this particular issue, just like the members of my church.
EG: Okay. Here’s a question. When you talk about stigma, do you see stigma affecting the members of your church from outside, meaning members of the external community have certain opinions about HIV and AIDS that affect your members, or do you see it also being, affecting members within your church, meaning certain members of your church have negative opinions of people who are affected?

I: Well, let me say this. I see it on both sides. I tell you I worked for the federal government for over thirty years, so I see it there in the conversation, but I see it in our church, as well. One of the things I think that I should state is African American churches are more conservative than folks believe they are. They’re not liberal, they’re conservative. So, you have the traditional way of looking at things. It’s always right or wrong. There’s not too much gray that’s involved in that. And then in some aspects, in some of our churches, and mine was one, that you have ignorance, sometimes, of individuals who have been affected by HIV and AIDS, and I would say that for this reason, when you explain to them, a wife that comes home and finds out that she has it, her husband had it for a number of years and did not share that with her or he did not know at all, and now she has it. She hasn’t done anything wrong, but she has HIV and AIDS, or a child or so many other things that go on. I think the what was said years ago, I think you had to get past that thinking that it was just a homosexual, gay, lesbian type of disease, and if they would just change the way they are, we wouldn’t have it. And so that, that’s one of the things I think you have in the church, but you have it outside the church, as well.

EG: Okay. Tell me about your goals. When you talk with your comm-, your community, your congregants about HIV and AIDS, what goals do you hope to achieve and how do you—

I: Well, well, my goals, for our church, is for us to be informed, but also to be engaged with the community, not just with their family, but the community as well. HIV is important. It’s not the only issue the African American church or the African American or any community has to deal with, so we have to address it along with the other areas we address, as well. That’s why we have a health and wellness ministry. I didn’t establish just an HIV/AIDS ministry, even though we have those that are working on that. We established a wellness ministry. So, from my perspective, whatever we can do to make a difference in our community from the perspective, physical, let’s put it this way, from a holistic perspective, when we’re looking from a spiritual, physical, mental, emotional, psychological perspective will make a difference. That’s what we’re looking at. So, we are looking from the perspective of informing, we are looking from the perspective of prevention, and we are looking from the perspective of being able to go out and engage the community when it deals with this particular issue and some of the other health concerns we have, as well.
EG: Okay. What is your, what is the response that you see from, when you do the health fairs say, that you mentioned, what is the response you receive from the people who attend those, who may not necessarily be members of your church, but who receive that information from you?

I: Well, to tell you the truth, I normally make sure when pass out information it’s passed out when we do have visitors. My church is up in x. You may not even know where that area is, but it’s up near x—very small town. Some of the churches that are there, they may have one or two services a month. Some may have three serv--We happen to have five each month. Each Sunday we have a service. So, there’s always those that come to visit our church. I try to make sure that when the members of our church and then the members of those that attend other churches but come to visit us, that’s when we’re passing out the information. I’ve never seen anyone be shocked by that, for the most part, but I’ve, I’ve had individuals say, “Thank you for presenting that information.” I’m not naïve to believe that some of the funerals I have performed and some that my colleagues have, that when members would say things that their family members died of cancer, some of them didn’t die of cancer. So, they may be ashamed of that, but the bottom line is I, the, my congregation has embraced it because I’ve tried to be careful on how I present the information to a church group or church congregation.

EG: [softly] Okay. All right. Tell me about a success you’ve achieved as part of your efforts to communicate with people about HIV and AIDS. Has there been a moment where you felt like you were achieving the goals that you hoped to achieve by telling your members about HIV and AIDS?

I: Well, to tell you the truth, I don’t, I don’t particularly see anything that I would say there was a moment. What I see in the church is that you see people’s attitudes. You see people’s way of thinking about a particular issue or topic. When you see those particular things happening, that’s a tremendous change. When it comes to church I, like I said before, if it was an issue that the majority of the church was against, they would have voiced that concern from our leadership on down. That would not have been an issue. When it comes to this, I think the way we presented it initially, as a concern in our community, as something as Christians that we had to deal with because it not only affected non-Christians but Christians as well, and disproportionately in the African American community that we had to do something, we had buy-in from the very beginning, and then all I had to do is to drive the bus. And because I have the trust of the people, they expect me to be able to understand our culture and how that information should be presented in our church.

EG: Okay. Is there any different between the way that you present HIV/AIDS communication and information to different age groups within the church? Are there efforts that you engage to communicate with the younger population, and if so, how do they, how do the parents and the grandparents and the older people in the church receive that information or feel about that?
I: Well, to tell you the truth, that’s something I would like to address in the church. One of the things, most of our younger, let’s say 20 to 30, 35 they are with us, and they may come back, but when they either graduate from college, they move here closer to Washington, D.C. where the jobs are—[indiscernible/422]. They move in this area to work, so they’re not really engaged, but I don’t have any problems. Most of the, most of our children are young. We have not engaged them from the perspective of surveying them or teaching them about HIV and AIDS, but I don’t know how familiar you are with the Family Life or the teaching that goes on in our public school system. Both of my kids are in that 30, you know late 20 age bracket, and most of what we’re teaching, they learned when they were in middle school. So, this is not new information to, for them. It’s new information for our older members. Our older members, I don’t think they have a problem with us engaging their children, it’s the way that we would do it and the terminology that we would use when we’re engaging our youth. Again we’re talking about older members who are more traditional, and especially, to give you an example, especially at a church culture where these are the same ones if young ladies come in, and their skirt, from their perspective are too short, hopefully they don’t do it anymore, but one time they may have said: “Hey, your shirt, your skirt’s too short.” Or for someone who comes in without a tie, they say: “You know, you ought to have a tie on with that kind of shirt.” So, we’re talking about an older generation with a mindset of how think things should be done. So, they’re more traditional. So you’ve that balance of the church, of those the more traditional, those the more progressive when it comes to dealing with these issues. And I think the terminology and how you deal with it makes a difference when it comes to the congregation.

EG: Okay. Do you have any impression as to how many people take what you, the instruction that you provide related to HIV and AIDS and carry that into what they teach their children at home.

I: No. I sure don’t. But I tell you, one of the things that my church is good at, because of the information that we are able to, to present to them, I see it in everything we do at the church. Normally, it filters down to other churches as well. I get calls all the time saying, “Pastor, I got this information, may be HIV or something else. Do you mind if I share it with so and so church. They could use that.” And I say “Yeah, whatever we have there.” So I know they’re sharing it with friends and family who happen to be members of other churches. I, and I suspect that some aspects when it’s appropriate, they’re sharing it with their children, as well.

EG: Is there any community outreach effort that goes on among, you mentioned a ministry for health and wellness. Do you have a ministry that deals with outreach?

I: We have a missionary. We have missionaries that deal with outreach. Those are the people that normally deal with our members in hospitals and some of the other things, but I think, again, we do have those that have engaged folks during the African American
festival that goes on. I believe they do it in June every year in Manassas and they pass our pamphlets at a booth there. So, we have a booth that the information is passed out and now that we’re about to have training for those who will be facilitators or teaching it, they can probably more engage them, when people ask questions about HIV and AIDS.

EG: Are there any challenges you foresee on the horizon in talking with your members about—or members of the community—about HIV and AIDS? If so, what are they, and how do you think you can address those challenges?

I: No. I don’t think there are any challenges. I think that the congregation is completely behind we need to do something. How that’s done is something that we design it, we agree on to move forward. This is a process that we are attempting to make work in our church, but this is not one that’s finished. It’s one that we’re continuing to tweak and make changes to be effective where we are. And like I said again. If we are informing folks, not only about HIV and AIDS, but testing sites and ways to protect themselves and engaging the community, because like I said before, whatever goes on in the church, it goes out of our church. If we give them information, that information leaves and goes other places, as well. I’ve seen that. I’ve been here 15 years and I’ve seen that that whole period of time. So I don’t see any, any, any challenges from the perspective of dealing with HIV and AIDS and engaging our community.

EG: I guess that brings me to my last question. Is there anything that I have not asked about that you believe that I need to know or understand about your efforts to communicate about HIV and AIDS?

I: Well, I think that if it’s anything, I know that when it comes to dealing with any type of health issue, you have, our medical field, health department, who are the experts on these particular things and the best way for dealing with it. But on the other side, you have a culture that says, “Well,” that has its own principles, its own core values, its own, that you have to be able to blend these two things together. I think if you—go back to that word challenge. If there was a challenge, that’s the challenge there, is to blend these two things together. I’ll share this with you: Years ago, I was a member of the Alexandria ministers conference, I mean years ago. Then the city of Alexandria because of the same issue, same issue, and some others as well—health issues as well. They had proposed the health department to give out needles, clean needles, in Alexandria. Well, we opposed that. But this was years, maybe 25, or maybe 30 years ago. So, we opposed it, and said, “No, we don’t think,” they didn’t have our support when it came to this particular thing, that we would give out clean needles. Now, if you look around, that’s not even an issue anymore in most of major cities in our country, if the government or the health department can afford to do it. You don’t have too many people fighting about it. But back in that time, that was a big issue. You don’t need to be giving out, you’re promoting—and I think when we’re looking at some of the things that are proposed by the health department. They may be able to get the job done, but sometimes to sell what the health department wants to do, sometimes you’ve got to be wise as Solomon. I’ll just
say it that way to make that work and to make it work in the church. So, if there was any tension or whatever, that would be it. Hopefully, I’ve answered your questions.

EG: I think so. I’m very grateful for your time. Is there any information that you need from me about my research.

I: No. I talked to x and he had shared it with me, I guess, when you finish, that we would get a copy of everything and so, I’ll be looking forward to see that.

EG: Yes, sir. I’ll be happy to share it with you.

I: Okay. All right, then. Well, God bless you, and you have a good weekend. All right?

EG: Thank you, sir. You, too.

I: All right. Goodbye.

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Elizabeth A. Grisham graduated from Seton Home Study School in 1997. She received her Bachelor of Arts in History from George Mason University in 2002. She also holds a Master of Arts degree in Pre-Doctoral American History (2012) from Mason and a Bachelor of Arts degree in Communication (2013) from Mason. She currently works in Mason’s English department, communication department and Office of Research.