A Faith-Based Education Program to Reduce Stigma Associated with HIV/AIDS Among the African-Born Population

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Abstract

Background and Review of Literature*:* Faith-based organizations are important institutions with the potential to increase the reach of HIV knowledge and address HIV-related stigma in the African-born population. This population has a high incidence of HIV/AIDS and late diagnosis mainly due to the stigma. Faith based organizations can play an important role in addressing stigma by creating welcoming environments in the church for people living with HIV.

Purpose*:* The purpose of this project was to implement a faith-based education program in an African Church in Washington State to raise awareness, educate, increase early testing and linkage to care and as a result reduce the stigma associated with HIV/AIDS.

Methods and implementation: The HIV/AIDS Knowledge and Stigma Survey was used for the pre and post assessment. After the pre survey was conducted, the pastors of the church were provided with a toolkit that helped them incorporate HIV related messages in the sermons. The participants were provided with HIV/AIDS and stigma fact sheets in form of pockets cards. Lastly, a woman living positively with HIV shared personal experiences with church congregation. This education program was conducted over one month and a post assessment was done after program conclusion.

Results*:* There was a statistically significant increase in knowledge but no statistically significant change in stigma between the pre and post HIV/AIDS Knowledge and Stigma Survey.

Implications/Conclusion*:* Faith based organizations should be considered as avenues that can be used to increase HIV Knowledge to community members and serve an important role in addressing HIV-related stigma. Future research is needed on measuring HIV related stigma beliefs and strategies to address one's stigmatizing beliefs.

Keywords: African-born, Foreign-born, HIV-related stigma, church groups, congregations, faith-based interventions.

A Faith-Based Education Program to Reduce Stigma Associated with HIV/AIDS Among the African-Born Population.

Africa, the world's second largest continent, is very diverse and has much to offer from its rich culture, beautiful landscapes, great food and above all, a friendly and most welcoming population. Sub-Saharan Africa remains the epicenter of the Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) epidemic accounting for 43% of the global total of new HIV infections (UNAIDS, 2017). Over the years, migration has led the African population to different parts of the globe and Washington (WA) stands out as one of the states where many have settled. As of 2016, statistics from the office of Immigrant and Refugee Affairs indicate that the African-born population in WA is at least 60,000 who unfortunately, have become a larger part of Washington's HIV epidemic in recent years (Office of Immigrant and Refugee Affairs, 2018). Stigma is a significant barrier within this population especially in efforts to raise awareness and normalize conversations around HIV/AIDS. The purpose of this project was to pilot implementation a faith-based education program to reduce HIV/AIDS stigma in the African foreign-born population residing in Washington state.

Overview

Background

Between 2009 and 2013, blacks born outside the United States made up nearly half (48%) of all new HIV case in WA (Washington State Department of Health, 2014). In addition, this population does not seek medical care and most foreign-born blacks with HIV are first

diagnosed as middle or older aged adults. About 40% either have AIDS or progress to AIDS within 12 months of a documented HIV diagnosis (Washington State Department of Health, 2014). One reason for the high incidence and late diagnosis of HIV/AIDS is related to lack of education and awareness about HIV, but a significant factor relates to the stigma associated with a diagnosis especially for people living with HIV (PLWH). HIV related stigma leads to isolation and discrimination and as a result, PLWH are deprived off the much needed support and chance to lead a normal life (Stangl & Grossman, 2013). In addition, stigma poses a serious problem for PLWH due to judgement from other community members. This often leaves the infected individuals with questions about the meaning of the infection, personal behavior, as well as how an HIV-positive status relates to family relationships (Pretorius, Greeff, Freeks, & Kruger, 2016). Other consequences of stigma include loss of income, livelihood, hope, reputation; poor care within the health sector; and feelings of worthlessness (Avert International, 2017).

Several factors have contributed to the stigma of HIV/AIDS in this population. The African-born population is often referred to as “foreign-born” and this status in itself is a unique characteristic that impacts HIV related outcomes. Other contributing factors to poor outcomes include immigration status, language barriers, cultural norms, structural barriers and lack of awareness on how to access and navigate the health care system (Kabocho, 2018). Religious beliefs may influence how this population perceives a diagnosis of HIV/AIDS. Some of the beliefs relate to equating a diagnosis as a sin and as result, PLWH have been abandoned by family members and outcasted from churches which has only exacerbated the stigma.

Stakeholders

For this capstone project to be successful, it was important to identify and collaborate with key stakeholders in the community. These stakeholders included religious leaders,

community-based organizations such as the Center for Multicultural Health (CMCH), and Washington State Department of Health (DOH). It was also important to include at least one community member who is an advocate and is positively living with HIV. CMCH is an organization dedicated to providing culturally competent care to the African-born population and is well known in the community. This organization has engaged the African population Washington through health fairs, sponsoring cultural events in the community, and generally being a great resource for this population. The community member living positively with HIV shared a personal journey from diagnosis, to navigating the health care system, facing stigma and becoming an HIV advocate. These stakeholders supported this capstone project in different capacities and offered resources that ensured the success and sustainability of this project.

Problem Statement

Given the different cultural norms, religious beliefs, and barriers incurred while accessing health care services, HIV/AIDS has become more rampant in the African -born population demanding a call for action. Faith-based organizations are a source of refuge for many and it's important to create safe spaces in the churches for PLWH. The clinical question that this project aimed to answer was: *In the African-born population does a faith-based education program reduce stigma associated with HIV/AIDS?*

Purpose Statement

The purpose of this project was to pilot a faith-based education program in an African church to raise awareness, educate, increase early testing and linkage to care and as a result reduce the stigma associated with HIV/AIDS. This faith-based education program was piloted at a church in the Washington State.

Outcomes

The overarching goal of this project was to normalize conversations about HIV/AIDS, increase testing, and early linkage into care within the African-born population. The project outcomes were to:

1) Increase knowledge about HIV/AIDS.
2) Decrease stigmatization for PLWH.

In order to measure whether the faith-based based education program was successful, a pre and post survey was conducted.

Review of the Literature

Search Trail

The search terms used during the literature search were "African-born", "Foreign-born", faith-based education programs, and HIV associated stigma. "African-born" and "Foreign-born" are sometimes used interchangeably. The two main databases that were used for this search were CINAHL Complete and PubMed. The initial search in the two databases with the search terms did not yield many results and for this reason, Google Scholar database was used to identify other related search terms that would be appropriate. The new related terms from Google Scholar included church groups, congregations, and faith-based interventions. The addition of these search terms resulted in quite a number of studies.

The literature search was limited to studies that had been conducted within the last ten years. Studies excluded were those addressing HIV prevention, mixed populations such as African American and Latinos, that did not include the African-born population, and that focused on other factors such as depression in relation to stigma and stigma related to co-infections such as HIV and Tuberculosis. The inclusion criteria were fairly broad in this search and included

studies that were conducted in an African country that used a faith-based intervention to address stigma associated with HIV, studies with highest level of evidence, and studies that specifically addressed stigma.

The final number of studies included for the literature review were eight. Six studies were qualitative and based on the hierarchy of evidence, are rated level VI. One study was a report from an expert committee which is rated level VII and one was a randomized control study which is a level II. Themes resulting from the literature search include the role of the church, community-based participatory faith-based interventions, and lessons from around the world. The literature search trail is found in Appendix A.

The Role of the Church

Churches and other faith-based organizations (FBOs) are often seen as places where people seek refuge and have a sense of belonging. Studies show that FBOs play both a supporting and mitigating role when it comes to the care and prevention of HIV/AIDS (Campbell, Skovdal, & Gibbs, 2011). However, FBOs can contribute to stigma if church teachings promote that people with AIDS are sinners and have fallen short of the glory of God. Case studies conducted in Tanzania (Hartwig, Kissioki, & Hartwig, 2006) and Uganda (Otolok-Tanga, Atuyambe, Murphy, Ringheim, & Woldehanna, 2007) aimed to explore the perception of church leaders in regards to the church's role in supporting PLWH and reducing stigma. These two studies found that the church leaders had not created welcoming environments in the churches for PLWH (Hartwig et al., 2006).

In the Tanzania and Uganda studies, the church leaders were educated on HIV and guided on interventions that could be used to promote awareness and advocate for love towards PLWH. These interventions aligned with Bible teachings and resulted in a change of attitude in

the church leaders after the interventions. The pastors were more open about personal HIV status and ended up visiting PLWH in their homes. One pastor from the case study in Tanzania stated, "If God is going to judge us on how we treated people with AIDS, we didn't do very well. May God forgive us"(Hartwig et al., 2006, p. 494). Stigma can be as a result of lack of knowledge about the disease itself and one's perception about PLWH. Faith-based interventions in this case demonstrated that the church is capable of playing a role to reduce stigma.

Community Based Participatory Faith-based Interventions (CBPR)

Project FAITH (Fostering AIDS Interventions That Heal) and the TIPS (Taking it to the Pews) project are examples of how community based participatory research was used to engage the church leaders and the congregation in implementing faith-based education programs in churches to address stigma associated with HIV (Berkley-Patton et al., 2013). Project FAITH was conducted in South Carolina with 22 churches while the TIPS project was conducted in Kansas with 4 churches. Both projects engaged the church leaders as well as the congregation in implementing faith-based interventions to address HIV stigma. The TIPS project implemented an HIV toolkit in churches and found that the churches played an important role in changing HIV stigma beliefs in the church and communities by promoting compassion and providing support for PLWH (Berkley-Patton et al., 2013). Project FAITH had a similar success story where attitudes and perceptions of the pastors and the congregations changed after incorporating HIV related information in sermons, prayer baskets, and youth groups to dispel myths and advocate for compassion for PLWH (Lindley, Coleman, Gaddist, & White, 2010).

Lessons from Around the World

Faith-based interventions to address stigma associated with HIV have been implemented in other parts of the world and studies have shown that FBOs are key influencers in addressing

stigma, but there is room for growth. A report published by the Horizons group evaluated studies completed in ten countries to address HIV stigma and found that common stigma-reduction interventions focused on changing individual knowledge, attitudes and behaviors rather than advocating for broader social and environmental changes (Pulerwitz, Michaelis, Weiss, Brown, & Mahendra, 2010). One study conducted in Zambia focused on training youth members of the "anti-AIDS" clubs in the country on how to provide care and support for PLWH in the community. These youth members visited PLWH in their homes, assisted with activities of daily living, offered companionship, and provided information and resources to family members (Esu-Williams et al., 2006). As a result of these visits, family and community members were more accepting of PLWH, became more involved in care giving, and ended up creating support groups in the community.

Although changing individual behaviors has been successful in reducing stigma, there remains a need for advocating for change from an upstream approach which means involving key stakeholders to join the fight against stigma by advocating for policies to be inclusive of immigrants and emphasizing the role of FBOs in reducing stigma.

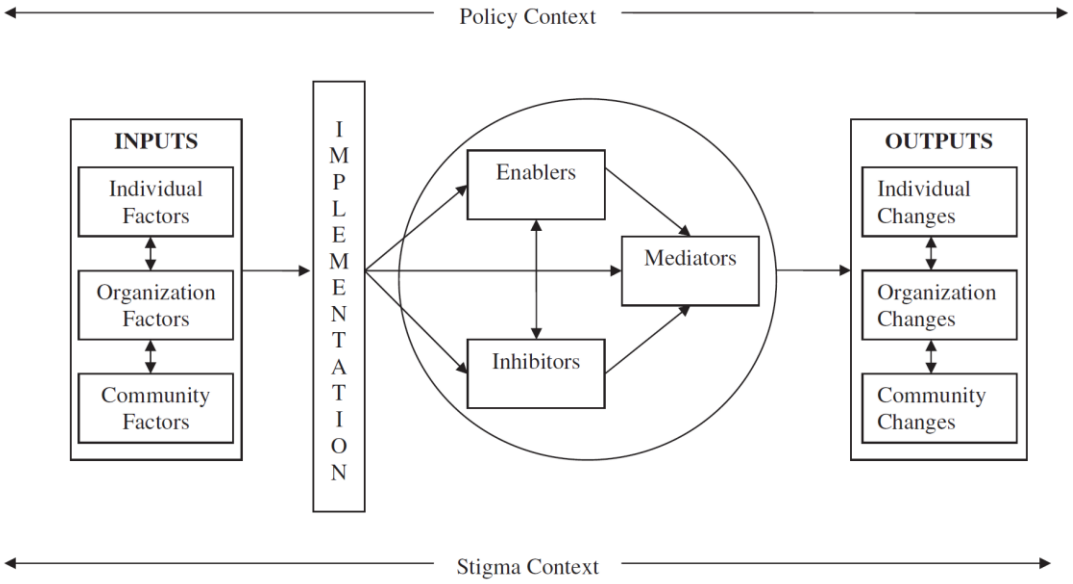
Literature Review Summary

Studies from around the globe have indicated that FBOs play an important role in addressing stigma associated with HIV by creating welcoming environments in churches, showing compassion and modeling the "love thy neighbor" teachings from the Bible especially for PLWH. CBPR should be considered as a way to involve communities to be part of faith-based interventions to address HIV stigma. Studies implementing faith-based interventions have had success but gaps remain in advocating for broader changes and evaluating the interventions from the perspective of PLWH to determine impact (See Appendix B for the Reference Matrix).

Theoretical Framework

The framework that underpinned this project was the Replicating Effective Programs framework (REP). This framework was developed based on principals adapted from an Agency Capacity Model developed by the Center for Disease Control and Prevention (CDC) to facilitate implementation of evidence-based behavioral interventions by community-based organizations related to HIV prevention work (See Figure 1).

Figure 1
Replicating Effecting Programs framework



(Coleman, Lindley, Annang, Saunders, & Gaddist, 2012, p. 4)

This framework uses five main categories to guide work. These categories include inputs, enablers, inhibitors, mediators and outputs (Coleman et al., 2012). The five categories in relation to this project are discussed.

Inputs

These are the elements that are present within the church before the implementation of the education program either at an individual level or at the organizational level (Coleman et al., 2012) which include:

- Perception of the leaders towards HIV as a disease and towards PLWH
- How ready is the church to implement the program? This will be helpful in determining the level of buy in from the church.

Enablers

These are the factors that will facilitate the continued success of the intervention (Coleman et al., 2012). These include:

- The role of church as an organization as it relates to reducing stigma
- The support from the leaders for this project
- Acceptance of this program by the congregation

Inhibitors

These are the factors that could prevent the successful implementation of this project (Coleman et al., 2012) such as:

- Lack of commitment from the churches
- Resistance from the leaders and congregation
- Lack of resources

Mediators

These are factors that could influence the delivery and success of the program (Coleman et al., 2012) which include:

- Making sure that the message to be delivered remains in a faith-based context

- Having church leaders display support for PLWH in the church

Outputs

These are the factors that describe the benefits to the church. These will include tangible and intangible changes in the church (Coleman et al., 2012) such as:

- Increase in knowledge about HIV
- Decreased stigma
- Increase in HIV testing and linkage to care
- An overall supportive and welcoming environment for PLWH

The REP framework was successfully used in project FAITH (Coleman et al., 2012) and provides evidence that using the right framework especially for community-based interventions is key in influencing behavior changes. For this project to be successful, it will be important to use the five categories described to guide the work and account for all the factors associated with each category.

Organizational Assessment

The project was implemented at one church in Washington State. The leaders at this church have been actively involved in the community through partnerships with health care systems to bring mobile medical vans and health fairs to the church so that the congregation can have access to health care services. This church aims to serve the community not only in faith related matters, but in every aspect of life. A letter of support was received from the church council.

Methodology

The capstone project aimed to implement a faith-based education program at to raise awareness about the current state of HIV/AIDS in the Kenyan population and reduce HIV

stigma. This education program was a practice change intervention as the pastors talked about HIV/AIDS in a faith-based context which is a practice that is out of the norm. During the project, quantitative methods were used to collect data. During the implementation of the faith-based education program, the pastors and church leaders were provided with a tool kit that guided means to address HIV/AIDS during church services. Providing the toolkit helped reduce barriers to practice change for church leaders.

In addition, the congregation was provided with information on ways church members can get involved to reduce HIV stigma. Information utilized specific quotes from the Bible that related to teachings of loving your neighbor and the church welcoming all people. Fact sheets and pocket cards were created and distributed to the congregation upon entering the church. These pocket cards included information about HIV/AIDS, stigma, and resources available in the community for testing and treatment services (See Appendix C).

Lastly, a Kenyan woman who is positively living with HIV shared a personal story from diagnosis, to stigma experienced, and personal advocacy for those with HIV/AIDS. This woman works at CMCH as a community health navigator and has been a panel member at the Association of Nurses in AIDS Care annual conference and hosts a circle of women of color monthly.

Setting

The church is centrally located in a major city in Washington State and has a congregation of about 150 members. Most of the church members live in neighborhoods close to the church and the farthest member has about a 30-minute drive to the church.

Sampling

The congregation at the church was composed of Kenyans from different backgrounds. The members work in various professions, but the majority work in the health care field. Since congregation members vary in age, the inclusion criteria included participants who were 19-years and older without any restriction on gender. Participants 18-years and younger were excluded from participating in the survey.

Implementation Procedures

In order to effectively implement this project, the project coordinator worked closely with the church leadership to identify the best Sundays to provide information and outline the steps of the project to the congregation. Identifying specific Sundays was crucial in order to be respectful of the church's time and schedule. The pre survey, intervention, and post-survey occurred over a 6week period.

Measurement Instrument(s)

In order to measure the outcomes of this project, a modified version of the HIV Knowledge and Stigma Survey was used (Lindley et al., 2010). The questions in the survey were originally adapted from the National Health Interview Survey of AIDS Knowledge and Attitudes and the AIDS Attitude Scale and were used in project FAITH. The survey used in project FAITH had forty questions but for the purpose of this project, the survey was customized to fit this population and was reduced to fifteen questions (See Appendix D). Written permission to use and adapt the survey was granted from the author (See Appendix E). As reported by the researchers in project FAITH, Cronbach's alpha test was used to measure reliability of the survey. The Cronbach's alpha was 0.789, indicating high reliability of the scale. The survey accurately measures stigma through a point system where the range was 0-12. A high score

indicated high stigma and low score indicated less stigma which demonstrated the validity of the survey (Lindley et al., 2010). Reliability and validity were not determined on the adapted tool.

Data Collection Procedures

Pre-intervention

The pre-intervention phase was two weeks in length and included recruiting the congregation as participants in the project and administering the pre-intervention survey. Recruitment involved going to one Sunday service and providing information about the upcoming project. The steps involved in planning and pre-intervention phase included:

1) Meeting the church leaders and providing details of the project.
2) Providing the toolkit to the pastors and church leadership.
3) Addressing concerns and questions.
4) Preparing the congregation for the upcoming project; discussing inclusion and exclusion criteria (Week 1).
5) Administering the pre-intervention survey to the congregation on the Sunday after project introduction (Week 2).

The aim of this pre-intervention survey was to collect demographics and have a baseline of the congregation's HIV knowledge and perceptions on stigma.

Intervention

During the intervention phase, the pastors included information on HIV/AIDS and stigma in sermons with guidance from different Bible readings to ensure that this information remained in a faith-based context. The steps involved in this phase included:

1) The HIV related sermons were conducted for a total of two consecutive Sundays on Weeks 3 & 4.

2) Inserts were included in the church bulletin with information on HIV/AIDS and stigma (what it is, what it looks like and how to address it). The education materials were provided in Weeks 2, 3, & 4.

3) A Kenyan living positively with HIV shared a personal story on Sunday of Week 5.

Post-Intervention

In Week 6, members were asked to complete a post-intervention survey asking the same questions as the pre-intervention survey. The steps in this phase included:

1) Conducting the post-intervention survey once during service (Week 6).
2) Analyzing and comparing pre and post intervention results.
3) Meeting with the church leadership to plan on best way to present results.
4) Presenting the results to the congregation and an executive summary of the project to the church leadership.
5) Providing information to the church on implications for the future based on the results.

Ethical Considerations/Protection of Human Subjects

Institutional Review Board (IRB) approval was obtained prior to initiating this project. The project coordinator did not have any conflicts of interest to declare related to this project. In addition, no member of the church was ostracized due to non-participation in the survey. There were no names or any other personal identifying data used on the survey. Data collected was reported in aggregate values.

The survey was placed in envelopes and each participant was asked to put the completed or non-completed survey into the same envelope for the protection of privacy. The participants were asked to pass the envelopes to the end of the pew, where the envelopes were collected and

placed in a box by the project coordinator. The survey responses were transferred to an excel workbook that was password protected on the project coordinator's computer which is also password protected. The hard copies of the survey were kept in a locked cupboard and will be shredded after dissemination. Electronic data records will be deleted at that time as well. Appropriate Collaborative Institutional Training Initiative (CITI) training was completed.

Data Analysis

Demographic data was analyzed using descriptive reporting. The results from the pre and post survey were analyzed using independent two samples t-tests. Means were computed to describe pre and post HIV knowledge and stigma items.

Results

Overall, 160 surveys; 75 pre and 85 post, were completed. Demographic data of pre and post survey takers indicated the groups to be homogenous based on high p-values in terms of age, gender, and marital status as shown in Table 1.

Table 1
Participant Characteristics

Participant Characteristics					
		Pre		Post	P value
Age					0.68
		N	**Percent**	**N**	**Percent**
	19-24	7	9%	11	13%
	25-34	1	1%	8	9%
	35-44	24	32%	21	25%
	45-54	18	24%	16	19%
	55-64	15	20%	18	21%
	>65	10	13%	11	13%
Gender					0.71
	Male	34	45%	33	39%
	Female	41	55%	52	61%
Marital Status					0.88
	Married	48	64%	48	56%
	Single	18	24%	21	25%
	Widowed	2	3%	1	1%
	Separated	0	0%	1	1%
	Divorced	0	0%	1	1%
	Not Answered	7	9%	13	15%

The pre and post survey had a total of fifteen questions. Questions 1-9 measured HIV/AIDS knowledge while Questions 10-15 measured stigma. The overall averages for the HIV/AIDS knowledge and stigma scores during the pre and post survey were calculated and are shown in Table 2. The p value calculated is based on question type (knowledge or stigma) rather than each question. A low p value in both the knowledge and stigma questions was desirable as this would indicate increase in knowledge and decreased stigma. Statistical significance was defined as a p value ≤ 0.05.

Table 2
Independent Sample t-tests

Combined Pre & Post Means			
	Pre	Post	p value
Knowledge	7.83	8.19	0.033
Stigma	5.55	5.72	0.176

There was a statistically significant increase in knowledge, but no statistically significant change in stigma, between the pre and post survey. These results indicate that the first outcome for this project, to increase knowledge about HIV/AIDS, was met. There was an upward trend in mean stigma scores, however it was not statistically significant, thus the second outcome was not met.

The HIV/AIDS knowledge and stigma means were further broken down by age groups and comparisons made between pre and post survey. The p-values between the age groups were not calculated. These pre and post survey differences based on age group are shown in the Figures 2 and 3.

Figure 2
Mean Knowledge Scores Based on Age

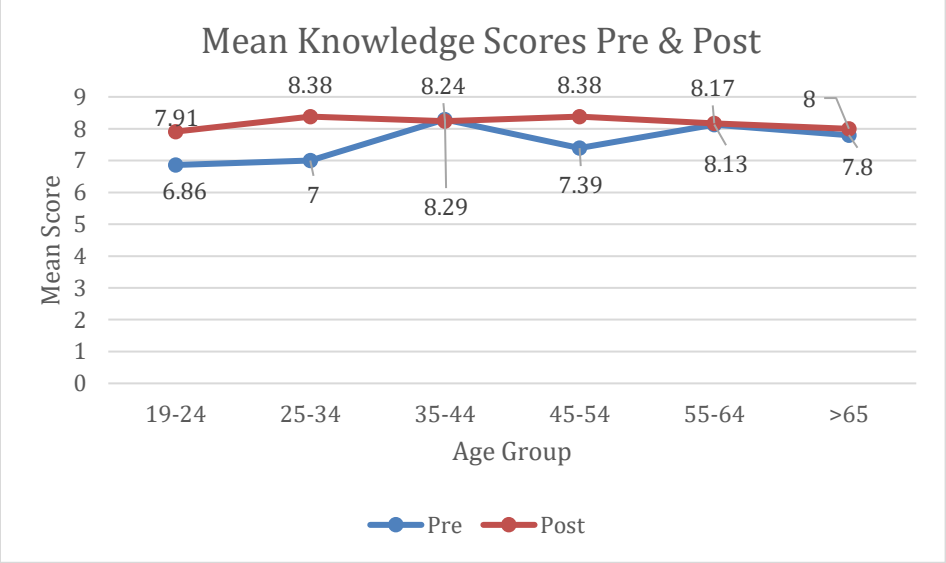
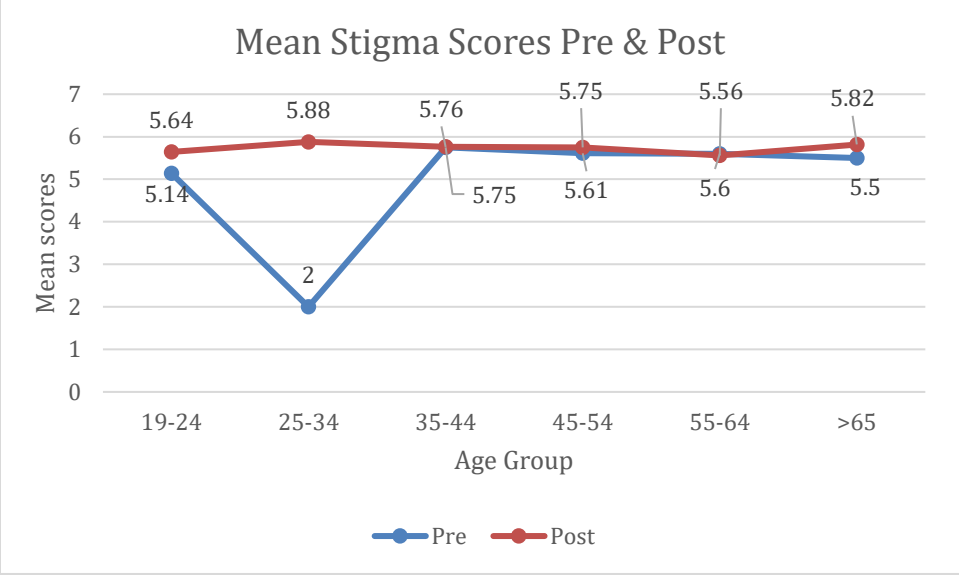


Figure 3
Mean Stigma Scores Based on Age



Figures 2 and 3 indicate that the 19-24 and 25-34 age groups had the biggest change in mean scores between the pre and post surveys in both the knowledge and stigma-based questions.

Discussion

This project aimed to increase knowledge and reduce stigma associated with HIV/AIDS among the African-born population by implementing a faith-based education program. The participants had some knowledge on HIV/AIDS and stigma based on the average scores of the pre survey. The HIV knowledge questions most often answered incorrectly were Question 3 which asked if someone can have HIV and not have AIDS; and Question 4 which asked whether there was medication available to prevent mother to baby transmission. For Question 3, 35% of the participants answered incorrectly in the pre survey with 12% in the post survey. In Question 4, 22% answered it incorrectly in the pre survey and 20% in the post survey.

Two questions from the stigma items that are worth highlighting are Question 10 which asked if HIV/AIDS was a punishment from God; and Question 11 asked if people who have HIV/AIDS only have themselves to blame. On Question 10, 10% answered that HIV/AIDS was a punishment in the pre survey and 8% in the post survey. For Question 11, 14% of the participants answered that people with HIV/AIDS only have themselves to blame in the pre survey and 17% in the post survey answered the same way. Some factors that may contribute to this would be personal beliefs that one should be responsible for their own health, which is true, but ignores the fact there are different modes of transmission and in some cases an individual may not be able to prevent exposure and transmission. Another possible factor is that more time is needed between pre survey, implementation, and post-survey to measure stigma in order to see actual change.

The project coordinator received feedback from the participants that the personal story from the woman living positively with HIV was impactful. One of the participants spoke about having never met someone with HIV before and seeing someone from the community made it real. As a result, this person expressed increased understanding that HIV could affect anybody, the need for compassion and for the reduction of stigma around HIV so that people are empowered to share personal stories and feel welcome even in churches.

The results of this project were shared with the pastors and the entire congregation. Church members expressed gratitude for increasing awareness of the role the church in reducing stigma for PLWH. Pastors and congregation members stated the need for continued education sessions in the future relating to HIV/AIDS and other issues affecting the community. By doing this, members hope to influence other churches to participate in this program with the goal of creating a stigma free environment for all and loving unconditionally just as the Bible teaches.

There is still more to learn about mobilizing churches to address HIV stigma by utilizing the various ministries in the church to increase HIV stigma reduction strategies. These church ministries could use strategies such as: (a) creating support groups and prayer circles for those affected by and living with HIV; (b) ministry led group discussions on HIV stigma; and (c) self-assessments on personal HIV stigma beliefs and strategies to address one's stigmatizing beliefs.

Limitations

One of the limitations in this project was not being able to match the pre and post surveys due to anonymity of the surveys and as a result, the people who took the pre-survey may not necessarily be the same who took the post survey. In addition, there were more post surveys than pre-surveys.

Another potential limitation of this project is question clarity for participants. After participation in the post-survey, some participants discussed question interpretation. This was particularly true for Question 4, which asked if there was a medication to prevent mother-baby transmission; and Question 8, which asked about transmission through breast-feeding. These interactions with participants post-survey allowed for additional education to occur.

In addition, the stigma questions may not have been answered truthfully due to participants' personal HIV beliefs that may not fully coincide with the teachings of the church. Even though the surveys were anonymous, individuals may have felt compelled to answer a certain way, despite their true feelings.

Lastly, this project was conducted with the Kenyan community and for this reason, the data and results cannot be generalized to the entire African-born population.

Sustainability and Nursing Implications

This faith-based education model led to increased knowledge about HIV/AIDS and with continued efforts in the church, conversations about HIV/AIDS and stigma associated with HIV may normalized. These ongoing conversations create an open environment that the church is not only committed to address spiritual needs, but also addresses issues that affect the human being as a whole. This model can also be adapted to address other issues facing this population such as mental health and it will be extended to other African churches in Washington State. Lastly, this model is an example of a practice change implementation program outside the clinical environment by using a faith-based organization to address health from a population-based perspective. This model is important to the field of nursing as it is a tool that can be used to create a better subject experience by meeting the people where they are and using faith-based organizations as avenues to advocate for practice changes especially when working with vulnerable populations.

Conclusion

HIV stigma may affect people and communities in different ways but the consequences of stigma such as isolation, hopelessness and being out casted from society are common around the world. Faith-based organizations are key aspects of the community especially in the African-born population which brings about the need to involve them in the fight against stigma. This initiative to reduce stigma through a faith-based education program will set the pace for other churches to be involved and with continued interventions, conversations around HIV will be normalized and PLWH will no longer be stigmatized.

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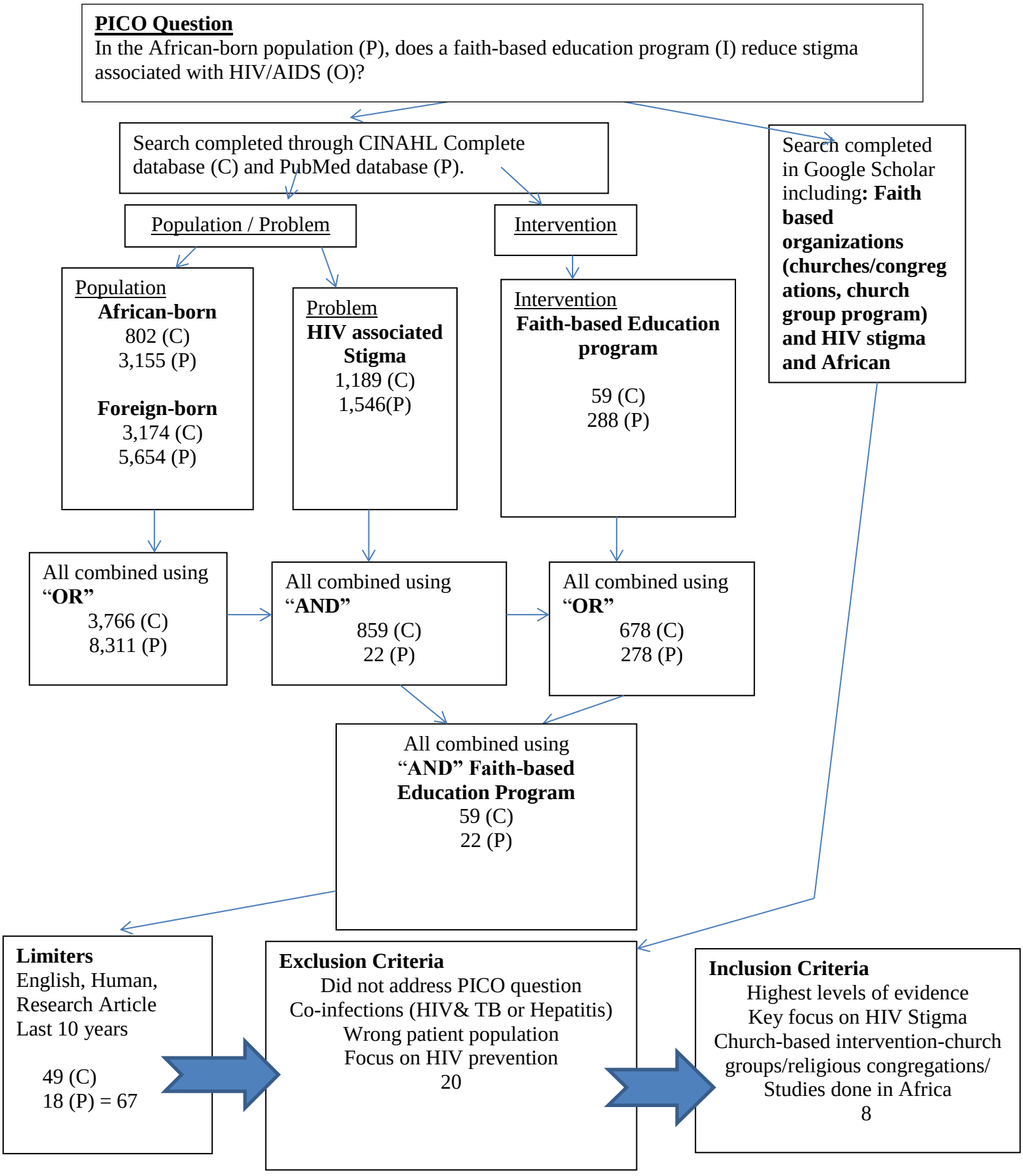
Appendix A


PICO Question
In the African-born population (P), does a faith-based education program (I) reduce stigma associated with HIV/AIDS (O)?
Search completed through CINAHL Complete database (C) and PubMed database (P).
Search completed in Google Scholar including: Faith based organizations (churches/congregations, church group program) and HIV stigma and African
Population / Problem
Intervention
Population
African-born
802 (C)
3,155 (P)
Foreign-born
3,174 (C)
5,654 (P)
Problem
HIV associated Stigma
1,189 (C)
1,546(P)
Intervention
Faith-based Education program
59 (C)
288 (P)
All combined using "OR"
3,766 (C)
8,311 (P)
All combined using "AND"
859 (C)
22 (P)
All combined using "OR"
678 (C)
278 (P)
All combined using "AND" Faith-based Education Program
59 (C)
22 (P)
Limiters
English, Human, Research Article
Last 10 years
49 (C)
18 (P) = 67
Exclusion Criteria
Did not address PICO question
Co-infections (HIV& TB or Hepatitis)
Wrong patient population
Focus on HIV prevention
20
Inclusion Criteria
Highest levels of evidence
Key focus on HIV Stigma
Church-based intervention-church groups/religious congregations/
Studies done in Africa
8

Appendix B

PICOT
In the African-born population (P), does a faith-based education program (I) reduce stigma associated with HIV/AIDS (O)?

Citation/Level of Evidence	Participants/ Setting/ Sample Size	Purpose/ Background	Methods/Design & Limitations	Findings/ Summary Strengths/ Weaknesses	Applicability to Capstone
Berkley-Patton, J. Y., Moore, E., Berman, M., Simon, S. D., Thompson, C. B., Schleicher, T., & Hawes, S. M. (2013). Assessment of HIV-related stigma in a US faith-based HIV education and testing intervention. *Journal of the International AIDS Society*, *16*(3 Suppl 2), 18644. https://doi.org/10.7448/IAS.16.3.18644	4 churches in Kansas recruited for this study. 2 churches randomly assigned to intervention group and 2 churches assigned to comparison group. Total participants at baseline =543. 235 intervention, 308 comparison. At the end of the study 93 in intervention,178 in comparison group	The primary aim of this study was to pilot test feasibility of the Taking It to the Pews (TIPS) project (an HIV education and testing intervention in AA churches) and assess HIV stigma beliefs	CBPR approach used to mobilize AA churches to address HIV prevention through education and testing and reducing HIV stigma through the Taking it to the Pews toolkit (TIPS). Inclusion criteria clearly outlined in the study. Study conducted over a 12-month period, church liaisons delivered the TIPS HIV Tool Kit materials/activities through various church activities (e.g., community outreach, church	No significant differences were found between intervention and comparison groups for the individual HIV questions or composite scores assessed at baseline, 6-month and 12-month assessments. Also, subgroup analysis found no significant effects on HIV stigma score outcomes based on hypothesized factors. Participants were highly satisfied with the TIPS	This article supports my research because it involves a CBPR study among churches to address HIV and the stigma associated with it. Although this study is not specific to the African-born population who are the focus of my study it was done in African American churches and gives a framework that I can adopt for my own study and customize it to my population. African

Level II (evidence from RCTs)			services, ministry groups, interpersonal interactions). Limitations: loss of participants during the study	intervention and some of the TIPS materials/activities such as sermons, printed and video testimonials, brochures/church bulletins that were delivered in church services and group ministries, were significantly related to lower HIV stigma beliefs. Future studies need to include more interventions aimed at reducing HIV stigma for better and significant results	American and Africans share the same struggles with HIV and stigma and so this article is applicable to my own work that intends to do.
Bogart, L. M., Cowgill, B. O., Kennedy, D., Ryan, G., Murphy, D. A., Elijah, J., & Schuster, M. A. (2008). HIV-Related Stigma among People with HIV and their Families: A Qualitative	33 families (33 parents with HIV, 27 children under age 18, 19 adult children, and 15 caregivers). Parents were drawn from the HIV Cost and Services Utilization Study.	The purpose of this study was to explore the interconnectedness of stigma experiences in families living with HIV, from the perspective of multiple family members.	The study was conducted between March 2004 and March 2005. semi structured interviews were used. Parents interviewed first and consented for	Result on Stigma reported themes based on the 5 types of stigma that came up during the interviews: felt, enacted, courtesy and any type of stigma.	This study relates to my work as it identifies the different types of stigma and illustrates who is affected by stigma. It also includes recommendations for

Analysis. *AIDS and Behavior*, *12*(2), 244–254. **https://doi.org/10.1007/s10461-007-9231-x** **Level VI (Evidence from qualitative studies)**			the children to be interviewed if they knew about the parent's HIV status. Open- ended questions used. Interviews lasted 1hr with the children and 1.5hrs for parents and caregivers. Very detailed and thorough inclusion and exclusion criteria discussed in the study	Felt stigma emerged as the most common stigma-related theme in families living with HIV. Current stigma scales need to be refined to include items that will measure different types of stigma experiences. Stigma does not only affect people living with HIV and this study showed how different family members and caregivers experience stigma. Interventions to reduce stigma should include all the affected people. Sample size was relatively small. Study may not be generalizable to other populations.	interventions to reduce stigma which should be tailored not only to the people living with HIV but also to family members. It may not be specific to faith-based organizations but it has a lot of information on stigma in general that will be applicable in my work.

Otolok-Tanga, E., Atuyambe, L., Murphy, C. K., Ringheim, K. E., & Woldehanna, S. (2007). Examining the actions of faith-based organizations and their influence on HIV/AIDS-related stigma: a case study of Uganda. *African Health Sciences*, *7*(1), 55–60. **https://doi.org/10.5555/afhs.2007.7.1.55** **Level VI (Evidence from case studies)**	Faith Based Organizations (FBO) contributions were analyzed in relation to priorities established in *the Global Strategy Framework on HIV/AIDS*, a consensus based strategy developed by United Nations Member States. 30 expert key informants from 11 different sectors. Participants recruited through the snow balling technique	The purpose of this study was to explore perceptions of Uganda-based key decision-makers about the past, present and optimal future roles of Faith Based Organizations (FBOs) in HIV/AIDS work, including actions to promote or dissuade stigma and discrimination.	Semi-structured, face-to-face interviews were conducted from September to December 2003. Lasting on average 60 minutes, interviews examined key informants' perceptions of the extent of FBO leadership, collaboration and contribution to strategies to reduce risk, decrease vulnerability, and mitigate the impact of HIV/AIDS. Interviews were conducted in the preferred language of the interviewee. Small sample size. Inclusion and exclusion criteria not clearly defined	The findings are presented in two sections; the first relating to FBO actions perceived as promoting stigma, the second focusing on actions taken by FBOs to challenge stigmatizing behavior. The study found that participants attributed actions that promoted stigma to inadequate knowledge and misconceptions about HIV/AIDS transmission and fear relating to socially-sensitive issues including sexuality, disease and death. Interventions relating to increasing knowledge and	This study is very specific to my population as it was done in Uganda which is an African country and it involved faith-based organizations. The results indicate that the FBOs play a big role in efforts to reduce HIV stigma.

				understanding about HIV/AIDS led to actions that challenged stigmatizing behavior. Increased openness about one's HIV status among both clergy and congregation members, and the involvement of PLWHAs in prevention, care and advocacy efforts led to changing attitudes relating to stigmatization and discrimination.	
Campbell, C., Skovdal, M., & Gibbs, A. (2011). Creating Social Spaces to Tackle AIDS-Related Stigma: Reviewing the Role of Church Groups in Sub-Saharan Africa. *AIDS and Behavior*, *15*(6), 1204–1219. https://doi.org/10.1007/s10461-010-9766-0	Systematic literature review Peer reviewed articles only that presented empirical evidence. A total of 36 articles included in this systematic review	This literature review aimed to answer the following questions: 1. What role do the churches currently play in contributing to HIV/AIDS-	Electronic databases used include (Medline, PubMed, Popline, PsychInfo, African Journals Online (AJOL), Google Scholar and Web of Knowledge/Sci	The findings are presented in form of 5 key questions that were based on emerging themes from reviewing the articles. The questions below indicate the 5 themes	This literature review will be helpful in my work as it shows what other churches have done to address HIV related stigma and what else can the churches do to provide support for

Level of evidence: Level V; Evidence from systematic reviews of descriptive or qualitative studies.		related Stigma? 2. What role do the churches currently play in tackling HIV/AIDS-related stigma?	ence). The Cartography of HIV and AIDS, Religion and Theology a bibliography was also reviewed key words 'AIDS','HIV', 'treatment', 'care', prevention', 'stigma', 'church', 'faith groups', 'religion', 'sub-Saharan Africa' and 'Africa'	identified in the study 1. What representations held within church groups hinder their responses to AIDS and contribute to stigma? 2. How does the linking of AIDS and Sin relate to representations of gender in ways that intensify AIDS-related stigma? 3. What is the impact of churches' role in forms of social control that facilitate HIV prevention? 4. In what ways can church groups	people living with HIV. This review is very relevant and specific to my population of interest.

				and faith provide support to people living with AIDS? 5. How can church groups create 'supportive social spaces'? Overall the results indicate a lot of churches are involved in addressing HIV/Aids-stigma but there is room for more specific interventions	
Lindley, L. L., Coleman, J. D., Gaddist, B. W., & White, J. (2010). Informing faith-based HIV/AIDS interventions: HIV-related knowledge and stigmatizing attitudes at Project F.A.I.T.H. churches in South Carolina.	A total of 1,445 parishioners, 61 pastors/ministers, and 109 care team members (all aged 18 years or older) from 20 Project F.A.I.T.H. churches Setting: Project F.A.I.T.H. (Fostering AIDS Initiatives that Heal) was established in January 2006 in South Carolina	Project F.A.I.T.H was established to reduce the stigma (HIV) among African American faith-based organizations.	Surveys were conducted to assess HIV-related knowledge and stigmatizing attitudes. Survey was divided into 4 sections: Section 1 demographics, section 2 (12 items) assessed knowledge of HIV transmission. Section 3 (20 items) assessed	Among parishioners, significant differences were reported in mean total HIV knowledge and stigma scores based on gender and age. Females had a significantly greater mean total HIV knowledge score and a significantly lower mean	This article provides a great background on how knowledgeable pastors and other members of the church are as it relates to HIV/AIDS and stigma. This article applies to my work as I hope to adapt some of the survey

Public Health Reports (Washington, D.C. : 1974), *125 Suppl 1*(Suppl 1), 12–20. https://doi.org/10.1177/00333549101250S103 **Level of evidence:** Level VI; Evidence from qualitative studies			participants' basic HIV/AIDS knowledge and lastly section 4 six items) assessed whether participants held stigmatizing attitudes toward people living with or at risk for HIV/AIDS. Inclusion/exclusion criteria is well defined Limitations: Convenient sample	stigma score than males. Parishioners aged 25–34 years had the highest mean total HIV knowledge score, while parishioners aged 65 years and older had the lowest. Moreover, parishioners aged 65 years had a significantly lower mean total HIV knowledge score than parishioners aged 18–24), 25–34 and 35–44 years. Parishioners, in particular, were less knowledgeable about ways in which HIV could *not* be transmitted. Overall, HIV-related stigma was low among parishioners, pastors, and care team members at	instruments in my work.

				Project F.A.I.T.H. churches. Nearly one out of every four parishioners in Project F.A.I.T.H. churches had "little sympathy for people who get HIV from sexual promiscuity," believed that "AIDS was a punishment from God for sin," and believed that "most people with HIV only had themselves to blame.	
Hartwig, K. A., Kissioki, S., & Hartwig, C. D. (2006). Church leaders confront HIV/AIDS and stigma: a case study from Tanzania. *Journal of Community & Applied Social Psychology*, *16*(6), 492–497. **https://doi.org/10.1002/casp.897**	The case study took place in Tanzania. 15 church leaders participated (8 women, 7 men)	The purpose of this study to assess HIV health promoting activities of Tanzanian based church leaders following a series of HIV/AIDS and reproductive health training sessions.	This evaluation workshop was done in 2 days. The design for this case study included large group sessions, interactive exercises and single sex focus groups. Limitations: Small sample size Study cannot be generalized	The church leaders were able to identify barriers to HIV prevention and could recognize stigmatizing behavior that they had been part of prior to the trainings. The leaders agreed that the church is a	This article relates to my project as it directly relates to my population and it also shows that education programs to address HIV stigma in churches are successful in changing attitudes and beliefs to reduce stigma.

Level of evidence: Level VI; Evidence from case studies.		The intent of this evaluation was to learn how or if they had used any of the information shared during the earlier trainings and to provide additional skills and tools for HIV prevention and care.	to other populations.	place of love and should be welcoming to all but they hadn't been doing that before the trainings. A change in attitude and beliefs was noted among the group. 10 out of the 15 leaders had implemented activities to address HIV and stigma in their churches including home visits to people living with HIV.	
Pulerwitz, J., Michaelis, A., Weiss, E., Brown, L., & Mahendra, V. (2010). Reducing HIV-Related Stigma: Lessons Learned from Horizons Research and Programs. *Public Health Reports*, *125*(2), 272–281. **https://doi.org/10.1177/003335491012500218** **Level of evidence:** Level VII; Report of expert committees	An analysis of 10 studies in Asia, Africa, and Latin America—conducted from 1997 through 2007 by the Horizons program	Horizons program was created to provide information and tools on HIV stigma, it effects and interventions to reduce it. The purpose of this report was to highlight findings from Horizons intervention studies that tested a range of innovative stigma-reduction strategies at the	Not clearly defined but a table in the report summarizes the studies that Horizons analyzed on interventions for stigma and discrimination. The table lists characteristics of each study.	Successful interventions from the countries studied included: ❖ Involving people with HIV in service Delivery ❖ Using the power of the media to advocate for and empower people living with HIV rather than	This report shows different intervention activities that have been successful in reducing stigma in different parts of the world. It doesn't necessarily address faith-based education programs but it has a wealth of information that would be helpful in my work

		institutional and community levels to achieve individual, social, and environmental change.		stigmatize them. ❖ Engaging the community as a whole while implementing interventions ❖ HIV stigma comes in different form and is measurable. Different strategies can be implemented to reduce stigma based on the population	
Coleman, J. D., Lindley, L. L., Annang, L., Saunders, R. P., & Gaddist, B. (2012). Development of a Framework for HIV/AIDS Prevention Programs in African American Churches. *AIDS Patient Care and STDs, 26*(2),	Setting: Conducted in South Carolina Participants: 8 pastors, 2 project champions, 2 faith based technical assistance providers and 6 care team providers. Total 18	The purpose of this study was to develop a framework to guide the development and implementation of HIV/AIDS prevention programs in African American churches. A qualitative study of Project FAITH guided the development of the	The researchers used semi-structured in-depth interviews and focus groups with persons who were directly involved with Project FAITH. Focus groups were conducted with a stratified sample of care teams and faith-based technical assistance providers. In-	Participants reported that stigma not only created barriers to or challenges for faith-based HIV/AIDS prevention programs, it was associated with community members' denial that HIV/AIDS existed in their communities.	This study provides a framework on implementing programs related to HIV prevention and stigma reduction in churches. This is a framework that I could adapt for my work. The article is

116–124. https://doi.org/10.1089/apc.2011.0163 **Level of evidence:** Level VI; qualitative studies		framework and a grounded theory approach was used to define inputs, enablers and inhibitors, mediators, and outputs in a faith-based context.	depth interviews were conducted with a stratified sample of pastors and project champions. Inclusion/exclusion criteria clearly defined Limitations: Churches self-selected to participate in this study and also in project F.A.I.T.H. Churches were specifically African-American, Christian and had to protestants.	Churches must create a welcoming and understanding environment for all members of the community regardless of sexual preferences in order to reduce stigma. Messages from the pulpit dispelling myths, acknowledging HIV in the community, effects of stigma and providing pamphlets are some of the interventions that can help reduce stigma in faith-based settings. The framework calls for the identification of individuals (members of the congregation and church leadership) who are passionate about and devoted to addressing HIV/AIDS in order for the interventions to be successful.	relevant to my work as the target population for the interventions were faith-based organizations.

Appendix C

HIV Tool Kit

Category	Outline of Materials
Pocket Cards:	▪ Definition HIV/AIDS ▪ Basic Information about HIV ▪ Myths and Realities ▪ What is Stigma ▪ How to address stigma ▪ Testing and linkage to care resources
Pastoral Materials/Sermon Guidance:	Love your neighbor as Yourself
Readings:	▪ Luke 10:25-37 ▪ Psalms 72:12-14
Testimonial:	Kenyan Woman positively living with HIV
Video:	What people of faith need to know about HIV (https://www.youtube.com/watch?v=Y3YdlPMps8w

Appendix D

My name is Besh Gichuhi and I am a Doctorate of Nursing Practice student at Nebraska Methodist College. I am conducting a project at your church related to HIV/AIDS stigma. I am asking you to complete this survey. It is voluntary. By completing this survey, you are giving me permission to use data for the sole purpose of this project only. All data collected will be reported as a whole without any mention of the church or individuals so no names should be placed on the survey. It will take you less than 5 minutes to complete this survey.

The Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) Knowledge and Stigma Survey.

Demographics

1) What is your gender? *Mark only one oval.*

- ◯ Female
- ◯ Male

2) How old are you (Age in Years) *Mark only one oval.*

- ◯ 19-24
- ◯ 25-34
- ◯ 35-44
- ◯ 45-54
- ◯ 55-64
- ◯ >65

3) What is your marital status?

Please answer with "True" or "False" for each of the questions

1) Most people with HIV look sick
2) There is no cure for HIV/AIDS at present

3) A person can be infected with HIV and not have AIDS.
4) There is medicine available to prevent a pregnant woman infected with HIV from passing it to her baby
5) HIV can be gotten through casual contact, such as shaking hands, hugging, or sharing a drink with someone who has HIV.
6) HIV can be gotten from blood transfusions
7) HIV can be spread through having unprotected sex with an infected person
8) If a mother has HIV, the baby can get it by drinking breast milk
9) HIV can be spread through sharing a seat with an infected person in church
10) AIDS is a punishment from God
11) Most people with HIV/AIDS only have themselves to blame
12) People with HIV should not be welcomed to the church as they live a life of sin
13) I have compassion for people with HIV
14) I would like to do something to make life easier for people with AIDS.
15) I believe that the church should be supportive of people with AIDS

Thank you for completing this survey.

Appendix E

SCHOOL OF HEALTH AND KINESIOLOGY

October 1, 2018

Nebraska Methodist College
School of Nursing
720 N 87th St
Omaha, NE 68114

To whom it may concern:

I grant Besh Gichuhi permission to use her modified version of the *HIV Knowledge and Stigma Survey* in her capstone project. I compiled the original survey and have used it in my previous research.

Sincerely,

Jason D. Coleman, PhD MSPH
Director
School of Health and Kinesiology
jdcoleman@unomaha.edu