A Systematic Review of the Roles of Congregations and Faith-Based Organizations in the Care and Support of African Americans Living with HIV/AIDS in the United States

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Congregations and faith-based organizations (FBOs) are uniquely capable and resourceful to provide supportive care to address the disproportional morbidity and mortality of African Americans living with HIV/AIDS. This study utilized the systematic review research design to examine the literature on the roles of congregations and FBOs in providing care and support to African Americans living with HIV/AIDS. Seven electronic databases were used with well-articulated inclusion and exclusion criteria. Out of 1010 publications identified through the database searches, only seven studies met the inclusion criteria in this systematic review. Congregations' and FBOs' characteristics, types of supportive care (tangible and intangible), and the incentives and barriers encountered by congregations and FBOs are synthesized in summary of findings tables. The article concludes with a call for Christian social workers to be more involved in congregation health ministries (CHMs), especially as this relates to addressing the HIV/AIDS health disparities experienced by African Americans.

Religious congregations and faith-based organizations (FBOs) have been identified as uniquely influential and instrumental institutions that proactively respond to the disproportionate burdens faced by African Americans living with HIV/AIDS (Bauer, 2012; Chambré, 2001; Derose et al., 2011; Frenk & Trinitapoli, 2012; Williams, Palar, & Derose, 2011). Even though government funded social service and public health

Social Work & Christianity, Vol. 40, No. 2 (2013), 184–205
Journal of the North American Association of Christians in Social Work

agencies provide treatment and referral services to African Americans living with HIV/AIDS (Emlet, 2006; Marcenko & Samost, 1999; Reilly & Woo, 2004), some congregations and FBOs have the potential to provide more culturally relevant and spiritually appropriate interventions to ameliorate the burdens that weigh on African Americans living with HIV/AIDS (Bluthenthal et al., 2012; Derose et al., 2010).

Congregational and FBOs Response to African Americans Living with HIV/AIDS

The extant literature is replete with several burdens shouldered by people living with HIV/AIDS (PLWHA) irrespective of race, including African Americans living with HIV/AIDS (hereafter referred to as AA LWHA). Some of the well-documented HIV/AIDS burdens that African Americans confront compared to other racial groups in the USA include: stigma within the African American community (Bluthenthal, et al., 2012; Poindexter & Linsk, 1999), homophobia (Lemelle, 2004; Miller, 2007), financial burden of treatment due to economic inequality when compared to other races (Bozzette et al., 2001), discrimination in the health care settings (Schuster et al., 2005), and distrust of the healthcare system (Whetten et al., 2006) .

Other challenges that AA LWHA face are: inequities in available treatment (Gebo et al., 2005; Shapiro et al., 1999), underutilization of mental and substance abuse treatment (Burnam et al., 2001) and overall mortality (Centers for Disease Control and Prevention [CDC], 2011). Despite these burdens, congregations and FBOs have provided a wide range of care and supportive services to their community members living with HIV/AIDS (Bluthenthal, et al., 2012).

Congregational and FBOs Services provided to African Americans Living with HIV/AIDS

The very small number of supportive and care services that congregations and FBOs provide to AA LWHA are reported in various studies dispersed across the current literature. Some of these services include spiritual wellbeing and psychological support (Coleman & Holzemer, 1999; Prado et al., 2004), pastoral care (Brennan, Strauss, & Karpiak, 2010; Derose et al., 2011), mental health care (Brennan, et al., 2010; Cnaan, Boddie, & Kang, 2005), referral services to public health and social services (Derose, et al., 2011), housing (Derose, et al., 2010), food, and long-term care (Chaves & Tsitsos, 2001; Derose, et al., 2011). However, there is a sharp contrast between the priority, resources, and commitment dedicated to prevention interventions among congregations and FBOs when compared to the care and support to AA LWHA.

From the review of the literature, much evidence can be found regarding prevention interventions offered by congregations and FBOs (Ardley

& Sileo, 2009; Francis & Liverpool, 2009; Griffith, Pichon, Campbell, & Allen, 2010; Werber, Derose, Domínguez, & Mata, 2012). The same breadth and depth of evidence cannot be found with respect to the proactive roles taken by congregations and FBOs to serve AA LWHA directly.

Indifference of Congregations and FBOs to Care for and Support AA LWHA

Some reasons for the indifference in resource commitment for AA LWHA have been identified in literature. The primary reasons include, but are not limited to, stigma and discomfort in associating with congregants living with HIV (Bluthenthal, et al., 2012; Brennan, et al., 2010), belief and judgmental attitude that being HIV positive is a punishment for sin (Brennan, et al., 2010; Sutton & Parks, 2011), and denominational or theological orientation and policies about HIV/AIDS (Bluthenthal, et al., 2012; Cunningham, Kerrigan, McNeely, & Ellen, 2011).

Furthermore, inadequate capacity and competing resource allocations (Williams, et al., 2011) also contribute to the relative indifference of congregations and FBOs to provide supportive care to AA LWHA. Despite the aforementioned debilitating factors, scholars unanimously agree that congregations and FBOs are uniquely positioned to provide one of the best supportive cares to people living with HIV/AIDS (PLWHA) overall, and more importantly to AA LWHA (Bauer, 2010; Bazant & Boulay, 2007; Derose, et al., 2010; Frenk & Trinitapoli, 2012; Williams, et al., 2011).

Justification for Current Study

An extensive review of the literature indicated that very few studies exclusively focus on the roles and activities of congregations and FBOs that address the burdens of AA LWHA. Overall, evidence abounds in extant literature about the paucity of research on the relationship between congregations and the role they play in the support and care of PLWHA (Bauer, 2010; Bazant & Boulay, 2007; Derose, et al., 2010; Derose, et al., 2011). Consequently and more specifically, little is understood about the characteristics of the congregations and FBOs that provide supportive care to AA LWHA, the types of supportive services they provide, and the barriers or incentives that these faith organizations encounter in their quest to provide services and ameliorate the burden of AA LWHA.

Research Purpose

Against this backdrop, the purpose of this study was to conduct a systematic review of the literature with a view to identifying, understanding, and appraising the range of existing congregational and faith-based care

and support services that primarily focus on AA LWHA. To this end this research reviewed seven databases over the last 20 years to identify and synthesize the roles that congregations and FBOs (or community-based organizations [CBO]) play in the care and support of AA LWHA.

Research Questions

The following questions guided the current study:

1. What are the characteristics of congregations and FBOs that provide care and support to AA LWHA?
2. What are the types of the supportive care services that these congregations and FBOs provide to AA LWHA?
3. Are there barriers or incentives that hinder or motivate these congregations and FBOs to provide care and support to AA LWHA?

Methodology

Research Design

A systematic review of extant literature was adopted as the research design. Petticrew and Roberts (2006) describes systematic review as an organized and replicable approach to identify, appraise, and synthesize relevant studies to answer a specific research question. Consequently, a systematic review of both quantitative and qualitative studies that investigated the role and activities of congregations and FBOs care and support for AA LWHA was conducted. The research design was guided by specific inclusion and exclusion criteria to limit bias and assure objectivity of selected studies (Cooper, Hedges, & Valentine, 2009).

Databases Searched

Seven electronic databases were systematically searched for relevant literature focused primarily on the role and activities of religious congregations' and FBOs' care and support for AA LWHA. The electronic databases searched were Social Work Abstracts, PsychINFO, CINAHL (Cumulative Index to Nursing and Allied Health Literature), Medline, PubMed, and Google Scholar. To ensure that unpublished dissertations were not overlooked in the eligible studies, the dissertation-based electronic database ProQuest Dissertation and Theses (PQDT) was also searched.

Moreover, HIV/AIDS specific journals such as the *Journal of HIV/AIDS and Social Services, the Journal of AIDS/HIV, AIDS Patient Care & STDs, HIV and AIDS Review*, and *AIDS Care*, for example were thoroughly searched to ensure that all available publications related to congregations' and FBOs' care and support for AA LWHA are included in this systematic review.

These HIV/AIDS specific journals were searched to understand and identify a panoramic view of existing evidence on care and support for AA LWHA based on the "scoping and mapping" (p. 20) methodology suggested by Bronson and Davis (2012).

Inclusion and Exclusion Criteria

According to Bronson and Davis (2012) it is imperative that inclusion and exclusion criteria be stated *a priori* to conducting a systematic review. The inclusion and exclusion criteria serve as benchmarks or objective gauges that independent reviewers can replicate to select the same studies (Bronson and Davis, 2012). To this end the inclusion criteria for eligible studies were: 1) the study focused on AA LWHA as at least 40% of the respondents or congregants; 2) the study must be conducted in the last 20 years, that is, between January 1992 and June 2012; 3) the study was conducted in the USA; 4) it was either a quantitative or qualitative study; and 5) the care and support provided to the AA LWHA must be provided by a congregation or FBO.

Exclusion criteria included: 1) the study focused on prevention of HIV/AIDS among African Americans; 2) the study focused on other races but with less than 40% of AA LWHA; 3) the study focused on caregivers stigma or people living with AIDS stigma; 4) the focus was on non-faith-based or non-congregational care and support services for AA LWHA; 5) the study focused on the role of spirituality or religious beliefs of AA LWHA for treatment adherence or coping mechanism; 6) the study was conducted outside of the USA; and 7) the study focused on AA LWHA and their management of HIV/AIDS stigma.

Search Terms

To identify articles focusing on congregations or FBOs that provide care and support to AA LWHA, the following MESH and Boolean search terms were used to identify eligible studies: African Americans OR Blacks living with HIV/AIDS AND Congregation OR Churches OR Faith-based AND People living with HIV/AIDS (PLWH*) OR PLWHA. Another search combination was: African Americans OR Blacks living with HIV/AIDS AND Congregational Churches OR Faith-based. Moreover, the search term (church congregation) AND (blacks or African Americans) AND PLWHA AND faith-based was used. In addition, the following combination of search algorithms was also utilized: *PLWHA * and African Americans OR Blacks and Congregation care *, HIV/AIDS and African Americans, and Faith-based organization or Congregation support* PLWHA* and African Americans and Congregation care OR Support* and HIV/AIDS* and African Americans, and Faith-based care OR Support**.

Results

Study Population and Sample

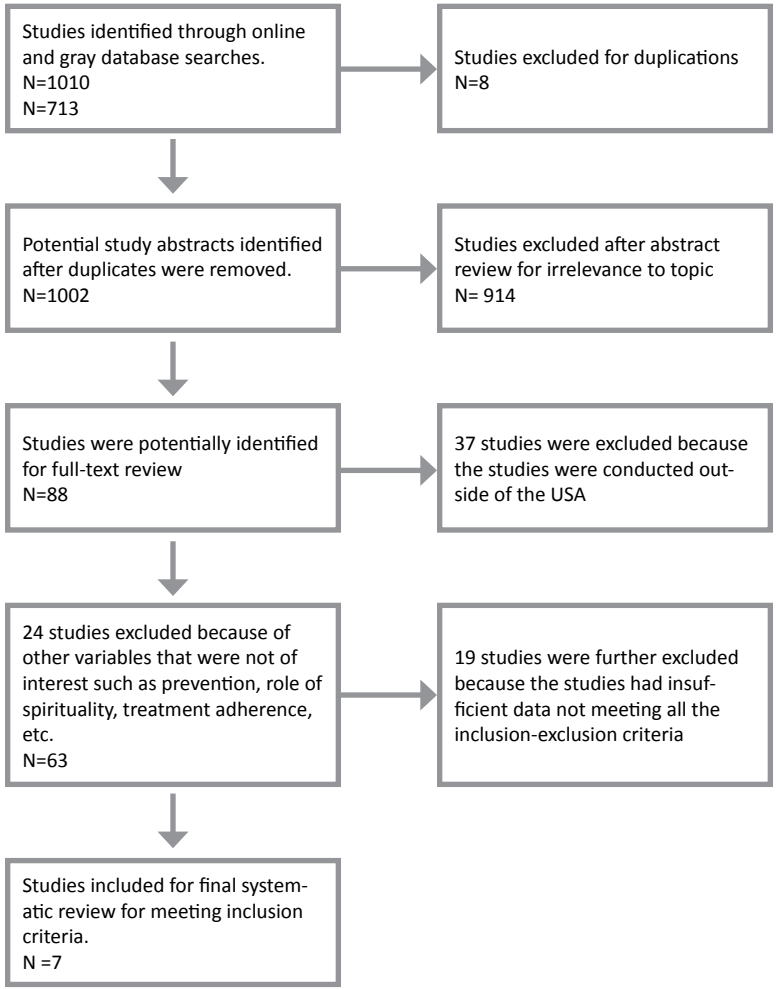
Based on the inclusion-exclusion criteria and the search terms, the initial and gray databases searches resulted in 1010 potential studies. Thereafter, a three-step iterative process based on the Preferred Reporting Items for Systematic Reviews and Meta-analyses (PRISMA) protocol for screening studies was adopted (Littell, Corcoran, & Pillai, 2008; Moher, Liberati, Tetzlaff, & Altman, 2009) First, after an initial review of the titles and abstracts of the 1010 potential studies, eight duplicated studies were removed. Second, the remaining 1002 studies were further reviewed and reexamined for study relevance and this resulted in the removal of 914 studies.

Third, 88 studies were potentially identified for full-text review and possible inclusion in the systematic review based on the predetermined inclusion-exclusion criteria. However, these 88 studies were further reduced for the following reasons:

1. Thirty-seven (37) studies were excluded because the studies were conducted outside the United States of America on respondents in African countries and other "blacks" who were living with HIV/AIDS.
2. Twenty-four (24) studies had other variables that were not of interest such as prevention, role of spirituality for PLWHA, treatment adherence among PLWHA, role of social support for PLWHA, other congregational social welfare activity but not directly related to PLWHA to mention a few.
3. Nineteen (19) studies were further excluded because the studies had insufficient data and did not fully meet all the inclusion-exclusion criteria for the current study.
4. One (1) study was excluded because it was a systematic review of congregation-based programs to address HIV/AIDS among all races and not specifically focused on African Americans (Williams, et al., 2011). Therefore, it was impractical to isolate studies and specific demographics of AA LWHA from other races in this study.

Consequently, seven primary studies out of the 88 (or 8%) eligible study population qualified as the study sample that met the *a priori* inclusion-exclusion criteria. The PRISMA flowchart (Littell, et al., 2008; Moher, et al., 2009) which is a four-phase flow diagram that outlines the studies' selection and screening processes is presented as Figure 1.

Figure 1: PRISMA Flow Diagram for Studies Screening and Inclusion-Exclusion Process



Data Extraction and Article Coding

To answer the research questions for this systematic review, relevant data were extracted and coded for the seven studies that met the inclusion criteria. For the data extraction, a modified version of the data abstraction form utilized in a study on efficacy of computer technology-based HIV-intervention (Noar, Black, & Pierce, 2009) was utilized. The seven articles were coded on four major dimensions of the study's interest such

as: Descriptive information of the article (author, year, source and title); Congregation/FBO characteristics (denomination, location, racial composition, etc.); Types of the care and supportive services provided to AA LWHA (including the various HIV/AIDS activities of the congregation or FBO); Demographic characteristics of the AA LWHA in each of the included studies; and the barriers and incentives that are encountered by congregations and FBOs that provide care and support to AA LWHA.

Characteristics of Congregations and FBOs that Support AA LWHA

With respect to the first research question for this study a modified version of the *summary of findings table* (used to display findings from a systematic review) as recommended by the Cochrane Collaboration (Schünemann, et al., 2008) was utilized to display the characteristics of African American congregations and FBOs that provide care and support to AA LWHA (See Table 1). From the summary of findings table it is observable that six congregations (71%) provided supportive care for AA LWHA compared to one FBO (14%), and one community-based organization (CBO) (14%) respectively in this study. The only FBO (Derose, Domínguez, Plimpton, & Kanouse, 2010) included in this review is affiliated with a congregation, while the only CBO (Brennan, et al., 2010) in this study collaborated with congregations in providing supportive services to AA LWHA. This evidence underscores the strategic importance of congregations in collaborating and working with both FBOs and CBOs in providing care and support to AA LWHA.

Denominational Orientation of Congregations

The summary of findings table also indicates that congregations that provide care and support to AA LWHA vary in their denominational orientations. Table 1 indicates that conservative denominations such as the Church of Christ (Koch & Beckley, 2006), a liberal non-denominational congregation as the Unity fellowship church (Leong, 2006), and a combination of denominations (Derose, et al., 2011; Frenk & Trinitapoli, 2012) with varying denominational orientations (Black protestants, Catholics, White mainline protestant, Jewish, and White conservative protestant) have been proactive and successful at meeting the needs of AA LWHA.

In addition, the summary of findings table reveals that congregations in the urban areas and with a sizeable number of African Americans who have HIV or who others who identify themselves as LGBT are more likely to provide supportive care to AA LHWA compared to rural congregations with AA LHWA or those who self-identify as LGBT. These observations are consistent with similar findings of Frenk & Trinitapoli (2012) and

Williams, Palar and Derose (2011). However, more studies are needed to understand the needs and congregational/FBO service provision to AA LWHA who live in rural areas, and for AA LWHA whose membership in their congregation is in the minority.

Table 1: Summary of Findings on the Characteristics of Congregations/FBOs

Author (Year)	Denomination/ Organization (Location)	Demographic Characteristics of Congregation/ FBO or Organization	Denomination Affiliation	Type of Organization*
Koch & Beckley (2006)	Church of Christ (South Western USA)	Established in 1994 and located in a metropolitan low-income, drug and crime prone single family rental apartments neighborhood. Membership is 150 with even distribution of Whites, African Americans, and Hispanics.	Conservative/ Fundamentalist	Cong
Leong (2006)	Unity Fellowship Church (Non-Denominational) (Los Angeles)	Founded in 1982 by an openly gay pastor, this predominantly African American congregation is located in an economically depressed area. The membership is between 150-200 and majority of the members are openly confessing GLBT averaging in their late 30s. Between 20-50% of the congregation are PLWH.	Liberation	Cong
Brennan, Strauss, & Karpiak (2010)	AIDS Community Research Initiative of America (ACRIA) (New York)	ACRIA is a community-based HIV research and education organization that conducted a Research on Older Adults with HIV (ROAH). The sample consisted of 914 HIV positive respondents with a mean age was 55.5 years. Half were African Americans, a third were Latinos, and 13% White. Three-quarters had high school degree and majority was unemployed.	Not Applicable	CBO

Derose et al (2010)	Project New Hope (PNH) Affiliated with the Episcopal Church (Los Angeles)	Through a needs assessment of PLWH, PNH is a bi-lingual FBO established in 1990. Eligibility include PLWH earning below 200% of federal poverty level, and PLWH at risk of been homeless. Residents are made of up of Latinos, African Americans, and Whites. Majority of residents are single parents and a third of each family's income is adequate for rent at the PNH.	Undisclosed	FBO
Bauer (2010)	No specific denomination or organization disclosed (Champaign and Urbana & Chicago)	21 church leaders with outreach ministries to PLWHA in the Champaign and Urbana & Chicago areas were interviewed. No specific congregational demographics were disclosed. The PLWHA respondents showed that 71% and 29% were African American and Whites respectively.	Undisclosed	Cong
Derose et al (2011)	14 various congregations involved in HIV activities (Los Angeles)	The demographic features vary because of the purposive sampling of the congregations. Membership of these 14 congregations range from 150 to thousands. Majority have health ministries for congregants with specific emphasis on PLWHA care and support.	Jewish reform, Catholic, Evangelical, and Protestant	Cong
Frenk & Trinitapoli (2012)	No specific congregation is highlighted in this national sample of 1449 congregations	The study is a nationally represented sample of 1449 congregations. The congregations represent a wide range of sizes, resources, racial composition and activities specifically focused on PLWHA.	Black protestants, Catholics, White mainline protestant, non-Christian (Jewish and Muslim congregations) and White conservative protestant	Cong

**Note*: Congregation: Cong; Community-Based Organization: CBO.

Types of Supportive Care that Congregations and FBOs Provide to AA LWHA

The second question of this research synthesis seeks to identify the different types of care and supportive services that congregations and FBOs provide to AA LWHA. To fully comprehend and understand these supportive care services, Tables 2 and 3 highlight the evidence extracted from the seven studies in this review. The summary of findings reveals that congregations are more proactive than FBOs in responding to the burden of HIV among African American congregants through the establishment of culturally appropriate and spiritually sensitive AIDS ministries, outreaches, messaging, pastoral care, and counseling services.

Tangible and Intangible Supportive Care Provision to AA LWHA

More specifically, the types of supportive care programs and activities that congregations and FBOs provide to AA LWHA can be broadly classified as tangible and intangible. For this study, tangible programs and activities are defined as material support, while intangible programs are spiritual and professional services. This study revealed that in the last 20 years congregations and FBOs have provided more intangible programs compared to tangible programs to AA LWHA. Examples of intangible programs include, but not limited to, pastoral care, addiction and substance abuse counseling, referral services to medical and social services, job placement, and employment workshops. Other types of intangible services found in this study include HIV-testing, T-cell count, spiritually affirming and culturally sensitive sermons, advocacy, and health information programs. Conversely, previous studies identified more tangible supportive care programs and activities to PLWHA generally (Bazant & Boulay, 2007; Werber, et al., 2012) and for AA LWAH specifically (Frenk & Trinitapoli, 2012). Examples of tangible programs include food and clothing support, financial donations, housing, and medication supply.

Despite a slighter higher provision of intangible supportive care to AA LWHA, the tangible supportive care that congregations and FBOs provide to AA LWHA indicates an assortment of such support (See Table 2). Primary among the tangible supportive care that congregations and FBOs provide to AA LWHA include but are not limited to: food, financial assistance, clothing, housing, hospice facility, condoms, transportation to medical appointments and bleach kits. For older adults who are AA LWHA, Brennan, Strauss & Karpiak (2010) reported religious congregations provide meals as a form of tangible supportive care.

Table 2: Summary of Supportive Care Programs for AA LWHA

Author (Year)	Tangible	Intangible
Koch & Beckley (2006)	Food, clothing, the congregation also distributes bleach-kits to disinfect needles, and procures condoms for AA LWHA	Transitional living assistance, bible study, addiction counseling services, free confidential testing and HIV/STD prevention education.
Leong (2006)	Not Stated	Culturally-sensitive and affirming spiritual counseling, therapy, and improved self-image. HIV-testing, open conversations "testimonies" about T-cell count, HIV-status, diet, and weight loss etc.
Brennan, Strauss, & Karpiak (2010)	Provision of meals to older adults who are HIV positive	Offers counseling and spiritual support.
Derose et al (2010)	The Episcopal diocese through PNH exclusively provides single-site housing and hospice facility for PLWHA. Financial support, volunteers provide assistance in food and clothing collection. Transportation to healthcare appointments for residents of PNH.	Parish level and pastoral care network and workshops to decrease the stigma of HIV/AIDS. Other intangibles are: job placement and employment workshops, vocational services, mental health and substance abuse counseling.
Bauer (2010)	Not Stated	Development of congregational health and AIDS ministry within congregations; and partnerships with AIDS social services organizations.
Derose et al (2011)	Distribution of condoms to PLWHA	HIV testing, advocacy, hospice care, substance abuse treatment and mental health services
Frenk & Trinitapoli (2012)	Not Stated	Needs assessment provided for community needs of PLWHA

Incentives and Barriers Congregations/FBOs Confront in Providing Supportive Care

The third research question focused on identifying the incentives and barriers faced by congregations and FBOs in providing supportive care to AA LWHA. The reason for seeking an answer to this question is to understand the experiential challenges and encouragements that congregations and FBOs encounter in their quest to provide supportive care to AA LWHA.

Evidence from the summary of findings indicates that congregations and FBOs enjoy numerous incentives, as well as face diverse barriers to provide supportive care to AA LWHA. The next section will enumerate these incentives and barriers respectively as extracted from the seven studies included in this systematic review.

Table 3: Summary of Findings on Incentives and Barriers in Providing Supportive Care to AA LWHA

Author (Year)	Incentives	Barriers
Koch & Beckley (2006)	Community-based volunteers and program sponsors; Collaboration with local congregations of Church of Christ irrespective of divergent theological slant.	Controversy and debate with institutional or mainline theological beliefs about PLWHA; Stigma of being HIV+ and being LGBT still persists; HIV perceived as a punishment from God; Financial limitations.
Leong (2006)	Congregants living with HIV identified the non-judgmental messages and attitudes of other members of the church as significant. Open embrace and acceptance of AA LWHA and who identify as LGBT	Challenged by enduring taboos on HIV, stigma, shame, and being ostracized in the African American community
Brennan, Strauss, & Karpiak (2010)	HIV positive older adults reported connectedness and engagement with their congregations; and noted availability of complementary community-based supportive services.	Stigma, comorbid conditions associated with older adults with HIV e.g. depression. Absence of functional support, inadequate social support and small social network to complement congregations.
Derose et al (2010)	The Episcopal diocese provides financial support, facilitates parish level and pastoral care network and workshops to decrease the stigma of HIV/AIDS. Volunteers also provide assistance in food and cloth collection and transportation to healthcare appointments for residents of PNH.	Community resistance to the housing location of PNH based on property value in the neighborhood. Stigma of HIV; limited funds to expand the housing programs; waitlist of PLWHA who needs PNH housing, and concerns about long-term sustainability of the program.
Bauer (2010)	Development of congregational health and AIDS ministry within congregations; and partnerships with AIDS social services organizations;	Stigma, discrimination, and intolerance of some members of the congregations towards PLWHA; blame-the-victim attitude; theological debates about HIV/AIDS.

Derose et al (2011)	External collaboration with other congregations, FBOs, faith-leaders, coalitions to provide additional supportive care such as: HIV testing, advocacy, hospice care, substance abuse treatment and mental health services.	Competing priority with prevention programs instead of care of PLWHA. Controversy and debate on denominational orientation towards LGBT and PLWHA, use and distribution of condoms, misinformation and ignorance about transmission of HIV.
Frenk & Trinitapoli (2012)	Congregants who are HIV positive incentivize PLWHA programs; openness and welcoming attitude of congregation to LGBT and PLWHA. Needs assessment analysis motivates programs for PLWHA.	Inadequate resources, limited volunteers, stigma, doctrinal difference, debates and controversies on PLWHA and LGBT.

Congregational and FBOs Incentives to Provide Supportive Care to AA LWHA

From the data extracted from the seven studies for this review, three major incentivizing factors were identified as being important for congregations and FBOs in providing supportive care to AA LWHA. The three major incentives are:

1. The clergy leadership and prioritization towards the needs and welfare of AA LWHA.
2. The financial and voluntary support of congregants.
3. The availability of collaboration between congregations, FBOs and other organizations or agencies like social services agencies.

The identification of these incentives in this review is similar to the findings of other studies previously conducted on the roles of congregations and FBOs in the provision of social services (Chaves & Tsitsos, 2001; Cnaan & Boddie, 2002; Cnaan, et al., 2005; Frenk & Chaves, 2010).

With respect to FBOs that provide supportive care to AA LWHA, there is a heavy reliance on the clergy or denominational leadership, in addition to the financial commitment of congregants (Derose, et al., 2010). It was also observed in at least four of the seven studies (Bauer, 2010; Brennan, et al., 2010; Frenk & Trinitapoli, 2012; Leong, 2006) in this review that the presence of congregants who are HIV positive, the open embrace and acceptance of AA LWHA and those who identify as LGBT, and the availability of congregational health or AIDS ministries all provide incentives for congregations to provide supportive care to AA LWHA. Another incentive includes the capability of congregations and FBOs to conduct needs assessment of AA LWHA (Derose, et al., 2010; Frenk & Trinitapoli, 2012). Despite these incentives, barriers still persist.

Barriers Congregations and FBOs Encounter in the Supportive Care of AA LWHA

The range of supportive services that congregations and FBOs are willing to provide to AA LWHA is constrained by a number of barriers as highlighted in Table 3. Some the barriers are common while others were newly identified in this systematic review. The most persistently identified common barriers include controversy and debates on providing supportive care to AA LWHA based on denominational or theological beliefs, stigma and discrimination towards AA LWHA, and financial constraints. In addition, typical barriers also found in this systematic review are congregational intolerance toward AA LWHA, blame-the-victim attitude among congregants, and low priority accorded to the supportive care and needs of AA LWHA by the leadership and membership of congregations.

Furthermore, identified barriers found in the current study are related to the challenges that FBOs and CBOs face in the provision of social network support for AA LWHA. For instance, in the study conducted by Brennan, Strauss, & Karpiak (2010), a major barrier that religious congregations reported in supporting older adults who are HIV positive is inadequate or small social network of friends or relatives to complement the supportive care provided by congregations.

In addition, Derose et al., (2010) reported that Project New Hope (PNH) (a FBO program that exclusively provides housing to PLWHA) experienced community resistance to the location of the housing project in a neighborhood because of concerns that locating PNH nearby would significantly reduce the value of other properties in the neighborhood. Derose et al., (2010) also identified waitlist of PLWHA seeking housing at PNH, and the worries of the program's sustainability in the long-run as potential barriers that FBOs may encounter in the provision of supportive care for AA LWHA.

Discussion

This systematic review contributes additional knowledge to the few studies available on the activities and programs that congregations and FBOs provide to AA LWHA. Currently, there are limited systematic reviews for understanding the best evidence about congregational and FBO supportive care for AA LWHA. However, there is convincing scholarship that indicates that congregations and FBOs significantly provide supportive care to PLWHA in general and AA LWHA in particular (Bauer, 2010; Derose, et al., 2010; Frenk & Trinitapoli, 2012; Williams, et al., 2011). This study therefore provides additional information regarding the untapped or underutilized capabilities of congregations and FBOs towards providing supportive care to AA LWHA.

This study showed that a major incentive across the seven studies was that congregations collaborated with one another, and other community-based organizations in providing supportive care to AA LWHA. In addition, the study illuminated a finding that congregations are becoming less judgmental, more compassionate, and more likely to be facilitators of workshops and enlightenment programs to decrease the stigma associated with HIV/AIDS among African Africans. Furthermore, pastoral care network, volunteer support, and the emergence of AIDS ministry specifically targeted at AA LWHA are additional incentives noted in this systematic review. On the other hand, a major barrier is the controversy associated with theological or doctrinal beliefs about PLWHA. Like the congregations and FBOs of other races, this study showed that African American congregations and FBOs also confront profound barriers of stigma, shame, and inadequate social support towards AA LWHA.

Identifying the characteristics of congregations and FBOs that provide supportive care to AA LWHA is a useful contribution of this systematic review. This study highlighted that it is not unusual for congregations not to provide supportive care for AA LWHA based on doctrinal beliefs or denominational affiliation. However, this review found that conservative or fundamentalist denominations as well as liberal denominations have embraced AIDS ministries based on compassion, evidence of congregants who are HIV positive, clergy efforts through sermons to reduce stigma of HIV, and needs assessment of AA LWHA.

Moreover, the types of supportive care that congregations and FBOs provide to AA LWHA can assist the faith community in identifying the best and most effective allocation of their resources and manpower to either the provision of tangible or intangible supportive care services to the needs of AA LWHA. This study indicated that congregations and FBOs invested their resources in tangible supportive care such as food, housing, financial support, and transportation. For intangible supportive care, it was observed that congregations and FBOs focused more on culturally and spiritually sensitive sermons, education, and workshops to improve supportive care, and reduce the stigma AA LWHA faced. In addition, this study showed that congregations and FBOs are well-suited to provide free confidential HIV testing, HIV prevention education, mental health services, and needs assessment for AA LWHA. The summary of findings tables provide a summarized reference of the spectrum of supportive care services that are available to congregations and FBOs in their intention to support AA LWHA.

Furthermore, this systematic review underscores the persistence of barriers previously identified in literature that challenge congregations and FBOs in their quest to support PLWA. With respect to AA LWHA, similar attitudes of stigma, social ostracization, and denominational controversies and debates about being HIV positive were observed. However, this study suggests that the incentives or motivation that congregations and FBOs

derive to do "good deeds" to AA LWHA far outweigh the barriers or challenges that may confront congregations and FBOs in their quest to provide supportive care to AA LWHA.

The findings of this systematic review serve as a reference point for possible interventions for congregations and FBOs that are interested in providing supportive care to AA LWHA. For example, this study highlighted some promising and novel interventions such as single site housing and hospice facility exclusively for AA LWHA, culturally sensitive spiritual counseling, and the development of congregation health and AIDS ministry. Prior to this review, there was no systematic review focusing on the roles of congregations and FBOs in the care of AA LWHA, despite the fact that African Americans have the highest morbidity and mortality rates of HIV among different races in the United States of America. Consequently, this study contributes to the dissemination of the growing evidence and knowledge base of possible interventions of supportive care for AA LWHA. It also illuminates the literature gap identified in extant literature on congregational and FBOs care and support for AA LWHA.

Study Limitations

The limitations of this systematic literature review study are related to search strategies and the supportive care provided to only African Americans, this study's population of interest. Moreover, the search terms used for this systematic review could pose a limitation. The search terms and algorithms used in this study may not have captured all other studies that could have been potentially considered for inclusion in this study.

In addition, the seven electronic databases used for this study could pose another limitation. This is so because other databases may have relevant other studies that are not in the seven databases utilized for this study. Furthermore, despite the fact that great effort was made to include both published and unpublished studies, there may be studies that were presented at conferences or seminars but not published or studies not published or posted online because of insignificant findings. Consequently, the seven studies included in this systematic review are just the documented literature, and therefore cannot be considered to exhaustively document the full extent of the supportive care congregations and FBOs provide to AA LWHA.

Implications

Two major implications for social work education, practice, and research are connected to addressing HIV/AIDS health disparities among African Americans, and the emerging role of congregations and FBOs in the provision of social services. This study confirms the previously identi-

fied roles and capabilities documented by scholars that congregations and FBOs uniquely provide to AA LWHA (Bauer, 2012; Derose, et al., 2011; Frenk & Trinitapoli, 2012; Williams, et al., 2011).

Moreover, the findings of this research synthesis have implications for social work practice values. The social work value of commitment to social justice for minority groups can be advanced through congregations and FBOs. Christian social workers can advocate for AA LWHA, create awareness, and assist congregations and FBOs in the provision of supportive services that will reduce the burden of HIV/AIDS that African Americans disproportionately face.

Furthermore, Christian social workers can work with other healthcare professionals as part of the congregational health and AIDS ministries by competently providing social work interventions to AA LWHA. Studies have shown that congregational health ministries (CHMs) and faith-based health program are effective and vital in the provision of spiritually sensitive and culturally appropriate healthcare to African Americans (Campbell et al., 2007; Carter-Edwards et al., 2012; Catanzaro, Meador, Koenig, Kuchibhatla, & Clipp, 2007; DeHaven, Hunter, Wilder, Walton, & Berry, 2004). Consequently this study affirms that Christian social workers have a significant role to play with other healthcare professionals such as nurses, physicians, health educators and professional counselors in congregational health ministries (CHMs) and faith-based health programs.

Conclusion

Despite the findings of this systematic review, many research questions still remain unanswered. For instance, it is important to understand the types of supportive care that rural congregations provide to AA LWHA in the rural community. Additional investigation is required to assess the curriculum content of social work programs to know if the curriculum infuses spiritual and culturally sensitive interventions for social workers who may work in congregational settings. Moreover, social workers have been identified as competent educators (Cagle & Kovacs, 2009); however, little is known about how this competency can be utilized and maximized in congregational settings or in congregational health ministries (CMHs) or even in FBOs.

Overall this study has demonstrated that while the needs of AA LWHA have not been fully addressed, there are examples of commendable efforts on the part of congregations and FBOs in providing supportive care despite barriers such as doctrinal dogmas, and stigma associated with being HIV positive. However, compassion, the presence of HIV positive congregants, and, most importantly, clergy leadership, are turning points that have incentivized congregations to supporting AA LWHA in particular and PLWHA in general. ❖

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Key Words: African Americans living with HIV/AIDS, supportive care, congregations, faith-based organizations, systematic review