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Managing HIV/AIDS Outreach Strategies in the Black Church: A Case Study

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Abstract

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Abstract

The problem under investigation is that there is little research about how church leaders develop and design HIV/AIDS education and support programs in selected counties of New York State. The gap in the literature is that there is little known about how church leaders support the educational process for the HIV/AIDS Black community in New York state. The theory of normative decision making was the primary conceptual framework for this research. The purpose of this qualitative exploratory multi-case study was to discover how church leaders managed their HIV/AIDS outreach program strategies. The overarching question asked what programs and education do church leaders use to support those with HIV/AIDS and how can church leaders within the selected counties, provide preventative education forums within their congregations. Data collection occurred through 6 semi structured face-to-face interviews with church leaders in the counties of New York State. Data analysis resulted in themes that included how managing HIV/AIDS outreach strategies increases participation, promotes understanding, and immobilizes the spread of HIV/AIDS. The themes that emerged suggested that democratic leadership style made for successful program leaders and existing program features built trust between the church and those in the surrounding communities impacted by HIV/AIDS. Recommendations for action include examining the structure of an active outreach ministry, synchronizing programs, and increasing resources to manage Faith-based organization strategies effectively. This study contributes to positive social change by religious leaders serving as peer educators and advocates within their church community for HIV/AIDS prevention education, igniting discussions, removing stigma, and increasing the number of individuals who voluntarily test for HIV/AIDS.

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Dedication

To my children, Lamaar Walker and Paul Walker, Jr., who always believed I could do anything. To my husband, Pastor Emanuel Agustus Bennett, Jr. who provided moral support and encouragement whenever I felt like giving up. To my mother, Marie Antoinette Hicks and father, John Henry Hicks who instilled in me that hard work pays off. Last but certainly not least God, for giving me favor, grace, and mercy to finish this journey.

Acknowledgments

This journey began because a friend died from HIV/AIDS and the entire time I was unaware. My friend looked like a healthy person, talked like a healthy person, worked out every day and ate all of the right foods never disclosing status. Because of that, I began to think about how the church managed their HIV/AIDS outreach strategies giving those who have contracted the disease a sense of belonging and comfortable enough to disclose their status. Exploring that question led me to pursue this degree. I want to use what I have discovered to assist with developing HIV/AIDS outreach program strategies in the Black Church and their communities.

I would also like to thank my committee, including Dr. Joseph Barbeau (Committee Chair) who stuck with me through this entire process, Dr. Karla Phlypo (Committee Member) for her unwavering mentorship and guidance, Dr. Ragu Korrapati (University Research Reviewer) for his expertise in review completion, Dr. Sandy Kolberg (College of Management and Technology Program Director), for ensuring I kept on track, Dr. Freda Turner (College of Management and Technology Dean), for continuous encouragement when obstacles presented themselves and to Dr. William Brent (former Committee Member), for demanding a quality education for the students of Walden University.

Finally, I want to thank Mary. We met at my first residency, and we formed a bond no one will tear down. Without her support and encouragement, I would never have made it to completion. I would also like to honor the memory of our former classmate Anthony. This dissertation is for you, too.

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Chapter 1: Introduction to the Study

The Black community has been devastated by the human immunodeficiency virus (HIV) acquired immunodeficiency syndrome (AIDS) epidemic. According to the U.S. Centers for Disease Control and Prevention (CDC, 2013), AIDS affects nearly seven times more African Americans and three times more Hispanics than Whites. The Black Church as an organization has a history of responding to the needs of the Black community. The Black Church has been silent on the issue of HIV/AIDS. This dissertation will look to discover why is the Black Church silent and how religious leaders (clergy, pastors, ministers) can communicate HIV/AIDS related health information to their parishioners.

Although the focus was not on one specific denomination in this study, the oldest Black denomination organizational context in the United States is described for the purpose of demonstrating the commitment of the Black Church. The problem is not how committed the church is; but, the problem I addressed lies with the leaders of the church and to understand how and what they are doing to support the communities of Brooklyn, Queens, and Nassau Counties.

The African Methodist Episcopal (AME) Church is one of the oldest Black denominations in the United States, organized in 1816. The AME Church from its inception has demonstrated an active commitment to social betterment (Nelsen & Nelsen, 2015). That commitment has not changed (Pariseau, 2015). According to the Doctrine Discipline of the AME Church (Barbour, 2001), the mission and purpose of the AME Church are to minister to the spiritual, intellectual, physical and emotional, and

environmental needs of all people by spreading Christ's liberating gospel through word and deed (p.13).

At every level of the Connection (a structural organizational principle that all AME church congregations are a connected network of unique compatible, interdependent relationship to accomplish the mission and purpose of the church) and in every local church, the AME Church shall engage in carrying out the spirit of the original Free African Society, out of which the AME Church evolved.

> The mission of the AME Church is, to seek out and to save the lost and serve the needy through a continuing program of (a) preaching the gospel; (b) feeding the hungry; (c) clothing the naked; (d) housing the homeless; (e) cheering the fallen; (f) providing jobs for the jobless; (g) administering to the needs of those in prisons, hospitals, nursing homes, asylums and mental institutions, senior citizens' homes; (h) caring for the sick, the shut-in, the mentally and socially disturbed; and (i) encouraging thrift and economic advancement. (Barbour, 2001, p.13)

The AME Church has a membership of over 2.5 million with churches in 32 countries, including South, Central, and West Africa; the Caribbean; England; South America; and the United States of America. One of the hallmarks of the AME Church is the Women's Missionary Society (WMS, 2000), which is involved in health issues for women and children. Lacey (as cited in Quander, 2001), Chair of the Council of Religious AIDS Networks and Director of Michigan State University's AIDS Education

Training Center, stated, “Religious and faith leaders have a trusted, time-honored role in communities; many people look to their churches, synagogues, temples or houses of worship for information and guidance in their lives” (p.1). The AME Church’s organizational structure and its leadership are an effective tool for HIV/AIDS education, care, and prevention. In the geographical areas for this study, there are 22 AME Churches in Queens, Brooklyn, and Nassau Counties, to choose from the other denominations that are present in the selected counties and used for this study.

Background of the Study

In the year 2000, more African Americans were reported with AIDS, and estimated to be living with AIDS, than any other racial or ethnic group in the United States. Although African Americans represent approximately 12% of the U.S. population, they now account for an estimated 54% of new HIV infections and 47% of new AIDS cases (New York Department of Health and the CDC, 2013). According to the National Center for Health Statistics (2000) National Vital Statistics Report, AIDS is now the leading cause of death for African Americans between the ages of 25 and 44.

There is growing evidence that the HIV/AIDS epidemic is increasingly concentrated in low-income communities in which people of color are often disproportionately represented (Kaiser Family Foundation, 2014, p.1). The Kaiser Family Foundation report also pointed out that low-income communities are generally faced with other multiple health and social issues and limited resources with which to respond to the epidemic.

This epidemic is one of the most serious issues that Blacks have faced since slavery. The epidemic has affected several subgroups within the African American community:

1. African American women represent only 13% of the U.S. female population, but they account for almost two-thirds (63%) of AIDS cases reported among women (New York Department of Health and the CDC, 2013).

2. Black teens represent 15% of the teen population, yet comprise 64% of new AIDS cases reported among 13-19-year-olds (CDC, 2013).

3. Black men who have sex with men (MSM), the HIV prevalence for young African Americans men was 14.1% compared to 3.3% for Whites (Kaiser Family Foundation, 2014).

These findings on the effects of HIV/AIDS among Blacks highlight the devastation of this virus within the Black community. The HIV/AIDS epidemic has hit the Black community the hardest.

HIV/AIDS in the Focus Areas

New York City is the epicenter of the HIV/AIDS epidemic in the United States. HIV diagnoses are 30% higher in the Brooklyn communities of East New York and New Lots than the New York City overall rate (New York State HIV/AIDS Surveillance Annual Report, 2015). The rate of people living with HIV/AIDS is 25% higher in these communities than the rate in New York City overall (New York State HIV/AIDS Surveillance Annual Report, 2015). East New York has one of the highest death rates in Brooklyn, New York. At 44.4 per 1000, the age-adjusted death rate in East New York is the second highest in New York City, which averaged 29.8 (New York State HIV/AIDS Surveillance Annual Report, 2015). East New York has more people who diagnosed with AIDS than 18 states including Delaware and Hawaii (New York State HIV/AIDS Surveillance Annual Report, 2015).

In spite of these numbers, there is no permanent supportive housing program in the East New York community for African-American, Latino, and Caribbean seniors or families living with HIV/AIDS. In the report of HIV Prevalence Estimates, New York City, 2002, the New York City Department of Health developed statewide and area-specific HIV prevalence estimates. The data provided by the state's HIV/AIDS reporting system indicated that Brooklyn, Queens, and Nassau Counties have the highest number of persons living with HIV/AIDS in the state of New York (New York Department of Health, 2007). Table 1 will compare the provisional HIV prevalence estimates of Brooklyn, Queens and Nassau Counties to the state of New York estimates. These three

counties are the focus area of this study, where the Black communities are disproportionately affected by HIV/AIDS.

Table 1

*New York State and Counties: Brooklyn, Queens, and Nassau Living HIV and AIDS Cases as of December 2013**

	Population			
	Living HIV/AIDS Cases			
State/County	Number	Column Percent	Prevalence Rate**	Area Population
New York	133,266	100.0	666.9	19,651,127
Brooklyn	28,170	100.0	1137.0	2,592,149
Queens	16,948	100.0	713.6	2,296,175
Nassau	1,798	100.0	354.2	2,481,613

*Note. From "New York State Surveillance Annual Report" by Bureau of HIV/AIDS Epidemiology AIDS Institute New York State Department of Health, 2015. *Cases reported and confirmed through December 2013. **per 100,000 population. Rates for total, gender and race/ethnicity are age-adjusted to the 2010 US Census Population.*

Brooklyn County

Bedford-Stuyvesant and Crown Heights are areas that have a great history, abundant in self-esteem, and high quality in customary beliefs and social forums; but, less than adequate in health. Bedford-Stuyvesant and Crown Heights are comprised of one of the largest inhabitants of African-Americans in the state of New York (New York State HIV/AIDS Surveillance Annual Report, 2015). They are also the areas where most of HIV/AIDS cases exist in all of Brooklyn (New York State HIV/AIDS Surveillance

Annual Report, 2015).

According to NYSDOH BHAE (2015), Bed-Stuy and Crown Heights are the focused areas in Brooklyn due to the high volume of HIV/AIDS cases. The concern is the increase of cases as the average new HIV and AIDS diagnoses throughout all of Brooklyn were 114 cases. Data released in 2004 for Bedford-Stuyvesant including Crown Heights had 351 newly identified HIV cases and 355 newly identified AIDS cases in 2002.

As frightening as these statistics are, they are light in contrast to the distressing demographic development of the newly diagnosed as many of the newly identified HIV patients in the Bedford-Stuyvesant, Crown Heights section of Brooklyn are between the ages of 13 and 19 years old. The other half are over 50, but the common thread between all of these patients is that they are mainly Black women (Sweeney & Martin-Naar, 2005). Sweeney and Martin-Naar (2005) of Interfaith Medical Center believe that cases continue to increase culturally because of denial that operates on many levels. Still today, many people decline the thought that they can indeed catch the virus (Sweeney & Martin-Naar, 2005). If their partner looks good they trust appearance alone (he/she can't possibly be sick they look nice and healthy) rather than their decision of requesting a HIV/AIDS test from the potential partner before engaging in sexual activity or spending far too much time believing they can't or will not die from this disease (Sweeney & Martin-Naar, 2005). According to Sweeney, "There are people who actually distrust the statistics and don't believe things are as bad as people are saying" (p. 15).

Having family discussions between children and parent(s) appears to be a taboo topic; so, parents stay in the dark or deny the sexual activity that their children could possibly be engaging in. “We have to be more honest about what is actually happening and stop thinking that giving people information makes them act irresponsibly” (Sweeney, 2005, p.25). Sex instruction in the home of young people is crucial because they have formulated in their minds a new definition of what represents sex, therefore, increasing their risk and increasing their fate of getting HIV/AIDS. New York City Department of Education (NYDOE) is currently modifying and increasing their set of courses on HIV/AIDS for students in grades K-12; more parents, the general community, and religious organizations provide frequent communication of avoidance.

According to Sweeney, sex instruction is one feature of deterrence but self-esteem or lack of it plays a significant part in the augmentation of HIV diagnoses. There are a number of incidents of young girls being sexually involved with older men for things they could not obtain on their own lose control of their lives (Sweeney & Martin-Naar, 2005). The belief is that this behavior would not be a factor if they were encouraged and reminded of their self-worth (Sweeney, 2005, p.46). Sweeney (2005) asserted that as a community we need to enforce existing laws on statutory rape, instead of ignoring this common problem. It used to be a time where the village (community) would raise a child.

People appear to have the notion that teenagers are the only group that is at risk for contracting HIV/AIDS. That is far from true, cases have shown that Black women between ages 25-32 and older populations 50 and up have become common in Bedford-

Stuyvesant and Crown Heights central sections of Brooklyn (Sweeney & Martin-Naar, 2005). Interfaith Medical Center is located in Central Brooklyn and the AIDS Center doctors stated that approximately 50% of their caseloads at the hospital were from the 50 and over age population (Sweeney & Martin-Naar, 2005). Treating this age group comes with complications because of the other pre-existing conditions they may have such as diabetes, hypertension, and osteoarthritic which makes it difficult to care for (Sweeney & Martin-Naar, 2005). Interfaith Medical Center also has an Infectious Disease Clinic, which is comprised of experts who supply extra care for patients tackling the difficulties of the illness (Sweeney & Martin-Naar, 2005).

The Bedford-Stuyvesant Family Center, located in Central Brooklyn also supplies a diversity of cure and avoidance agendas. The center offers rapid HIV 20-to-40 testing and core attention treatment for HIV patients; it also promotes neighborhood outreach by going into the housing projects in the area and standing on the street corners conveying how important practicing safe sex and being tested is (Sweeney & Martin-Naar, 2005). Interfaith Medical Center staff believes that everyone should be able to get in touch with those they have had sexual contact with as well as having some way to notify them in case they have tested positive (Sweeney & Martin-Naar, 2005)

This is even a greater concern of infected ex-convicts who have re-entered the community; therefore, Interfaith Medical Center will be vigilant in finding out where this population exists and offer immediate care upon their release because treatment lessens the danger of transmitting the disease (Sweeney & Martin-Naar, 2005). Accentuated by

the doctors at Interfaith how important it is for the church to get involved in precautionary techniques because Bedford-Stuyvesant and Crown Heights are very religious communities and would welcome suitable services by the church (Sweeney & Martin-Naar, 2005). Interfaith Medical Center advocates invited by Pastor Johnny Ray Youngblood of St. Paul Community Baptist Church where he permitted them to discuss HIV/AIDS and campaign for safe sex from the pulpit in a church program (Sweeney & Martin-Naar, 2005).

There are state and federal funding that goes towards precautionary approaches. The available monies utilized for both treatment and prevention. It is still hopeful to believe that if communities work together it will create more open and truthful conversation about HIV/AIDS whether in church, on the job, in school, at the barber shop or simply at home. The shame attached to the disease has to be removed so that those who already have it feel at ease looking for treatment and begin being truthful with themselves and their partners (Masquillier, Wouters, Mortelmans, & van Wyk, 2015, pp 3264 – 3292).

Queens County

Southeast Queens has the biggest amount of HIV cases in Queens County, with a little more than 2,500 people living with the virus (New York State HIV/AIDS Surveillance Annual Report, 2015). Southeast area of Queens County consists of the following neighborhoods: Jamaica, South Jamaica, Hollis, St. Albans, Rosedale, Laurelton, Springfield Gardens, Brookville, Cambria Heights and Rochdale Village.

Therefore, when referencing Southeast Queens the above-mentioned neighborhoods are considered.

In Queens County, there are approximately 6,177 living with HIV (New York State Surveillance Annual Report, 2015). Since 1981, 10,639 people in Southeast Queens have tested positive and are living with HIV (New York State HIV/AIDS Surveillance Annual Report, 2015). Within the entire including Southeast Queens and all of the remaining sections of the county, 14,791 persons have tested positive and are living with HIV (New York State HIV/AIDS Surveillance Annual Report, 2015). Numbers are going down in the Southeast Queens sections of the county, but they are still the highest in Queens. There could be many explanations around this. Nationwide numbers showed that 57% of persons that test positive with HIV are minorities and Southeast Queens consist largely in minority areas (New York State HIV/AIDS Surveillance Annual Report, 2015). Women Center coordinators at Jamaica Hospital in Jamaica, Queens, has the same opinion that HIV/AIDS impacts minorities more than others. Inadequate economic conditions, low income, low self-esteem, lack of preventative awareness, and lack of community outreach involvement, appears to be some of the reasons minority groups test positive more often than not. (Kennedy &Jenkins, 2011)

According to Lewis et al. (2015), minority areas are faced with poor quality, scarcity, the lack of, deficiency, or shortages that leads to a feeling of desperation and many young people when situations become too stressful or too hard for them to manage they fall into making the wrong decisions and doing things they would not normally do if

their lack of becomes promising. The sections of Southeast Queens do not have the lowest average income, therefore, reducing the probability that low-income is a cause for persons making unintelligent decisions when it comes to promiscuous sex and drug activities (Lewis et al., 2015).

New York State, recognized as the melting pot of the world, is comprised of many different cultures and people who have migrated from many other parts of the world (Bayor, 2016). Different backgrounds view women and their bodies in a different way in the United States, increasing the risk of them contracting HIV/AIDS (Wilson, Critelli, & Rittner, 2015). Women from other parts of the world would travel to the United States, get off the plane and come straight to the hospital to give birth because their only function is to have babies (Gibson & Fair, 2015). These women have become infected because their cultures do not believe in practicing safe sex or using condoms, which will defeat the goal of bringing children into the world if they were to use condoms (Gibson & Fair, 2015).

The men in some cultures mistreat women by diminishing their self-esteem, damaging their self-worth, or eliminating their right to contribute as their partner, so she succumbs to his request of sexual favors, which can or will cost her her life. Cultural values add to the problem of HIV as well as religious presence within minority areas (Zahn et al., 2015).

The coordinators at the Women Center in Jamaica Hospital tend to make presentations in the Black Churches in Southeast Queens because Pastors have a way

with the people and a venue to present to large audiences at one time (Neaigus et al., 2016). Because the pastor has the right to review the information rendered, he/she also has the right to advise what information not appropriate for discussion such as sex or condom presentations. As the pastor censors the appropriateness of the information discussed in a church setting it increases the problem of HIV (Hardy, 2013).

People who need the information are not receiving the entire picture, which may include some topics Pastors do not agree with, but are necessary because an informed person has much more power and authority to make right and rational decisions (Nelsen & Nelsen, 2015). In the Queens, Brooklyn and Nassau county Black Churches where Pastors preach the gospel, the scriptures do not condone bisexuality and homosexuality and congregations are more homophobic therefore for those who do practice those lifestyles are very cautious about sharing their sexual preferences or behaviors (Hays, 2015).

According to Kennedy and Jenkins (2011), if a man is bisexual, he does not tell anybody because it is so looked down upon, and then he ends up spreading the disease because his partner or partners do not know. Women get HIV much easier than men do because of the nature of sexual intercourse. Contracting HIV/AIDS becomes easier when men do not expose themselves to their partners (Kennedy & Jenkins, 2011).

In Southeast Queens, women obtain HIV a great deal more. Since 1981, 9,510 men diagnosed whereas only 1,129 women diagnosed. “It’s because of the homosexual

aspect of HIV. There will always be more men than women as a result." (Kennedy, Jenkins, 2011, p.143)

The number of HIV-diagnosed persons in Southeast Queens was still high in 1994; in 1999, the numbers dropped significantly as well as infection rate amongst New York City IV drug users as per Department of Health statistics. The drop in numbers credited to more community outreach, more government attention, and communities beginning to accept there is a problem and something should be done about it. Religious leaders are seeing the significance of enlightening the members of their congregations. In addition, schools are allowing presentations, which is important. "Teaching children at a young age about the dangers of unsafe sex could stop them from becoming accustomed to such negative behavior. Community groups getting involved with handing out brochures and presenting information is helpful" (Kennedy & Jenkins, 2011, p.145).

Illegal IV drug use is another form of transmitting HIV/AIDS by sharing dirty syringes. As a result, of a new state law that allows drug stores to sell syringes over-the-counter without prescriptions has helped keep needles clean, and has made drug use safer (Kennedy & Jenkins, 2011, p.145). AIDS service centers in the Bronx, Brooklyn, and Manhattan has taken on the same approach from their offices in Rego Park, Jamaica, and Far Rockaway (Cahill et al., 2015). Due to those successes, the AIDS center of Queens has assumed the same approach. In Southeast Queens, Jamaica Hospital has tried to help drug users as well utilizing the same approach as the AIDS centers previously mentioned (Neaigus et al., 2016).

The purpose is not to support drug use, but to help a drug user do it safely because until they are ready to stop doing heroin they will not, so making a way for them to obtain clean needles as well as how to clean a needle properly, will lower the risk of contracting HIV (Kennedy & Jenkins, 2011, p.147). Doctors are attempting to educate themselves more about the treatment and counseling of HIV patients. In New York State there is a chapter named Minority Providers in HIV Care. The chapter has been around for over 9 years and it educates doctors on how to treat the disease and counsel patients.

Not only has Jamaica Hospital assisted with helping drug users, they have also been devoted to improving their women's center and HIV clinic. All pregnant women who come to the women's center have to see an HIV counselor are offered the choice of taking an HIV test, which is highly suggested to do for the protection on their babies. With at least18 new HIV drugs on the market, premature testing for the disease gives babies a 92% chance of being born HIV free. If a mommy gets tested and she is positive, we can save the baby. We can also prolong the life of the mother. So many people are afraid to take the test, but they should, even if just for their peace of mind. (Kennedy & Jenkins, 2011, p.149)

Although abstinence is encouraged to evade the disease, people are still having unprotected sex with several different partners so other avenues such as the use and education of condoms becomes an option. Condoms are the key factor that will give women back the power of thinking about themselves and their health before adhering to the request of engaging in unprotected sex by their partner or partners. Before the thought

of using a condom comes into play, get tested and make sure, partners are tested. “Live a safe life. The world is hard. Avoid promiscuous sex and drugs. It is not always easy. Come to us during the tough times. We are always here to help” (Kennedy & Jenkins, 2011, p.149).

The table below references neighborhoods of Queens and reported AIDS cases by gender. The table shows that HIV/AIDS affects at least twice as many men than women.

Table 2

Department of Health Totals of Reported AIDS Cases in Queens Neighborhoods by Gender

Reported AIDS Cases by Neighborhood		
Neighborhood	Male	Female
Rockaway	506	297
L.I.C. Astoria	1,240	290
West Queens	3,393	631
Flushing	597	162
Bayside Little Neck	149	36
Ridgewood	774	214
Fresh Meadows	200	69
S.W. Queens	1,086	325
Jamaica	2,010	821
S.E. Queens	750	308

Note. Data courtesy of the New York City Dept. of Health, Office of AIDS Surveillance, 2011.

Nassau County

In Nassau County, the first AIDS cases diagnosed in 1981. Between 1981 and 2000, 3127 residents of the county diagnosed with AIDS and 1882 people have died from the disease. Until 1995, AIDS was a rapidly fatal disease. The average time between diagnosis and death was 18 months. In 1995, announced a new family of antiretroviral drugs called protease inhibitors, which prolonged survival for HIV-infected persons. Less than 1 year later, the standard of care for the immuno-compromised HIV-infected patients included a combination of highly active antiretroviral medication (HAART). These rapid adoptions of HAART lead to the decrease in mortality that began in 1995.

As in the rest of the country, the earliest cases were among MSM. MSM remained the most common risk factor as late as 1990. Since that time, the epidemic has shifted; now most of the AIDS cases with known risk factors occur in injection drug users (New York State Surveillance Annual Report, 2015). AIDS does not discriminate based on race, ethnicity, gender, or sexual orientation (New York State Surveillance Annual Report, 2015). However, since early in the epidemic, this disease has disproportionately affected African Americans (New York State Surveillance Annual Report, 2015). Although approximately 10% of Nassau County's population is African-American, 42% of the cumulative AIDS cases have occurred in this group (New York State Surveillance Annual Report, 2015). Over time, African Americans have accounted for an increasing proportion of new AIDS cases. This pattern among new AIDS cases reported in other regions of New York State (New York State Surveillance Annual Report, 2015).

The AIDS epidemic affects every community in Nassau County. People from the richest and poorest areas have died from the disease (New York State Surveillance Annual Report, 2015). Nevertheless, the communities that have shouldered the greatest burden of the disease are Freeport, Hempstead, Inwood, Roosevelt, Uniondale, and Westbury (New York State Surveillance Annual Report, 2015). The residents of these towns also disproportionately suffer from high rates of sexually transmitted disease, teen pregnancy, and poverty. Both incidence and mortality (the rate of new cases and deaths) in all groups has decreased since the peak of the epidemic 1995 (New York State Surveillance Annual Report, 2015). Yet, the proportion of cases among African Americans and Hispanics has increased. Nassau County and nearby regions have demonstrated a decrease in AIDS incidence since 1995 (New York State Surveillance Annual Report, 2015). Comparison of new case rates for Whites and African American shows that the gap between the two groups has narrowed (New York State Surveillance Annual Report, 2015). However, the discrepancy in new case rates remains significant.

AIDS became a reportable disease in 1983; but, HIV infection only became reportable in 2000. Health care providers and laboratories are required to report all newly diagnosed cases of HIV infection, HIV-related illness and AIDS to the New York State Department of Health (NYSDOH). This law provides for early identification of HIV-infected individuals. Knowledge of new HIV infection allows better targeting of resources and earlier treatment. Under the same law, either the health care provider or the newly diagnosed person may request assistance with partner notification. For Nassau County residents, reports for person's possibly needing assistance with partner

notification, conveyed to the Nassau County Department of Health PartNer Assistance Program (PNAP). A Social Health Investigator contacts the medical provider to verify the need for assistance, discuss partners, and assess for risk of domestic violence. If indicated, the infected person contacted and encouraged to provide the names of needle sharing and/or sexual partners. Accordingly, named individuals, notified of their exposure to the HIV virus, offered on-site HIV counseling and testing, and referrals made available as needed.

Preliminary data based on reports to PNAP for 2002 indicated 144 cases possibly needing assistance with partner notification. The disparities in race/ethnicity seen among AIDS cases persist in the HIV infections. Males comprise a higher percentage of cases referred to PNAP than females and the preponderance of cases lies within the 35 to 44 age group. This disease, as in other African American communities around this country, disproportionately affects the Black community In Queens County. The census reported that Blacks in Queens County comprise only 21% of the population; however, they account for the largest percentage of HIV/AIDS cases out of the three counties. The following percentages about HIV/AIDS among Blacks in Brooklyn, Queens, and Nassau Counties reveal how crucial this disease is affecting Blacks in these counties. Blacks account for:

- 54% of people living with AIDS as of 12/31/2013
- 83% of women living with AIDS
- 82% of adolescents living with AIDS for the past two years

- 92% of children living with AIDS
- 57% of people age 50+ with AIDS
- 60% of IV drug users living with AIDS
- 56% of the people diagnosed with AIDS over the past two years
- 67% of HIV cases reported between 7/1/97 – 12/31/09
- 86% of new HIV cases among women
- 85% of new HIV cases among teens
- 47% of all cumulative adult/adolescent AIDS-related deaths
- 65% of adult/adolescent AIDS-related deaths since 1996
- 91% of all pediatric AIDS-related deaths
- 94% of pediatric AIDS-related deaths in the past 17 years

The Black Church has a history of addressing discrimination and injustices that affect the Black community. The issue of HIV/AIDS seems to be one of those issues that have not made it to the forefront as a concern among many others confronted by the Black community in the past. According to Koenig, Weatherford, and Weatherford (2013), “throughout history, the Black Church has helped the community navigate storms of adversity” (p. 2). The obligations of the Black Church a beacon for high-risk groups and a lifeline for those stricken with AIDS (p. 2). Koenig et al. further stated, “we have

buried too many too soon. Saving souls are not enough. We must save lives as well" (p. 2).

According to Quander (2001), "Church leaders will not really act until they see AIDS, like the civil rights movement, as a moral and spiritual fight" (p. 2). Perhaps the problem for the church is that of seeing the issue of HIV/AIDS as a moral and spiritual fight over and against that of a health issue. The church can no longer relegate this issue to that of homosexuals. Church leaders in the Black community cannot conveniently say that HIV/AIDS is a retribution for wrongdoing in the gay community. The research indicates overwhelmingly that HIV/AIDS is everybody's problem and the virus has no respect for ordinary persons.

Problem Statement

African Americans affected disproportionately by HIV/AIDS since the epidemics' beginning 26 years ago (Kaiser Family Foundation, 2014). The statistical comparison of HIV/AIDS among African Americans in New York as of May 2010 with that of the United States in 2010 indicates how devastating this disease is affecting the African American (New York Department of Health and the CDC, 2013).

The Black church and its leaders have a great impact on getting across to people as the church is a place of refuge, peace, and safety. It is also a place where one does not have to be exposed and it lacks promotion of established and successful programs that manages HIV/AIDs outreach strategies; the need to study and understand how or what is being done to support this population by church leaders directly.

Approximately 5.6% of church leaders in the United States provide programs or activities to people living with HIV/AIDS. However, within Black Protestant places of worship only a third offers HIV prevention/awareness programs (Szaflarski et al., 2015). Rapkin (2015) associated shame linked with religious principles and ethical positions as a key obstacle to successful HIV prevention/outreach programs. Churches willing to address HIV/AIDS in their communities' stay away from talking about HIV/AIDS specificities. It continues to be uncertain on how to confront doctrinal perspectives on HIV/AIDS; but, enlistment and involvement straight from church leaders and faith communities in precise local settings are developing as valuable methods (Barber, 2015).

The general problem is that little understanding about how church leadership develops their HIV/AIDS education and support programs. The specific problem is that there is little discussion about how church leaders develop and design HIV/AIDS education and support programs in Queens, Brooklyn, and Nassau counties.

Purpose of the Study

The purpose of this qualitative exploratory multi-case study was to understand how church leaders of the Black Churches in the communities of Brooklyn, Queens, and Nassau Counties manage strategies of their HIV/AIDS outreach programs and providing preventive education for those who would potentially become infected by this disease. The Black churches in Brooklyn, Queens, and Nassau Counties formed the study group for this study. The outcome of the study uncovered strategies for Black Church leadership to use in supporting the HIV population. The recommendations looked for reverends,

ministers, clergy, and pastors to begin contemplating a vision to plan, organize and coordinate HIV/AIDS prevention and awareness to their parishioners, local and surrounding neighborhoods. The findings of this study can also support federal, state, county, and local government agencies in addressing the HIV/AIDS epidemic among Blacks through the Black Church.

Six church leaders interviewed two from the counties of Brooklyn, Queens, and Nassau. The focus was on African Methodist Episcopal, Baptist, Pentecostal, Church of God In Christ, and/or Nondenominational ministries. Each church leader participated in a semistructured interview after receipt of consent. The purpose of the interview and additional criteria explained to the respondent prior to interview taking place.

Research Questions

I examined how the Black Church leaders of Queens, Brooklyn, and Nassau Counties develop their programs to support persons living with HIV/AIDS. The overarching question is: What programs and education do church leaders use to support those with HIV/AIDS?

1. What are the church programs that support HIV/AIDSs in Brooklyn, Queens, and Nassau Counties?

2. How do the church leaders view their responsibility to support HIV/AIDS affected families, friends and/or parishioners?

3. What should the components be for an HIV/AIDS program focus on with respect to improving the life of those with HIV/AIDS?

4. What leadership styles do church leaders' exhibit?

Conceptual Framework

The theory of normative decision is the primary conceptual framework for the study. Vroom and Yetton (1973) created the normative decision process theory to understand how effective leadership depends on comprehending the conditions of a given situation and gaging how much involvement or power sharing is necessary for success and what form that involvement should take. The normative decision leadership theory tells leaders how they ought to act.

This theory built on ethical ideologies or norms providing guidelines for endorsing ethical leader behavior (Minor, 2015). Normative decision leadership theory calls for managers to select a leadership style according to the amount of participation in decision making appropriate for the situation. Leaders use variations of authoritative, consultative, group-based, and delegative styles. These styles lead to different decision-making processes for solving both individual and group problems. To use the theory, the church leader will answer the research question and 4 sub-questions, which addresses the leadership style of the participant. Leadership styles or attributes will be define to provide a clearer understanding to the participant with reference to managing HIV/AIDS program strategies (p. 266).

The purpose of the qualitative exploratory multi-case study was to explore the HIV/AIDS outreach strategies of the Black Church in Brooklyn, Queens, and Nassau counties that showed how the church leaders manage established and successful programs. Many researchers use the normative decision theory with leadership styles such as authoritarian, democratic and laissez-faire in their research on traditional groups and organizations such as Black Churches (Bridbord, & DeLucia-Waack, 2011; Khan, Aslam, & Riaz, 2012; Ruggieri & Abbate, 2013). The Black Church may not only be about ministering to the needs of all people by spreading Christ's liberating gospel through word or deed (Barbour, 2001); researching how the church leaders can manage HIV/AIDS outreach strategies could create peer educators and advocates within the Black Church community. The ability to understand the management of HIV/AIDS outreach strategies may provide insight into how the leaders of the Black Church (i.e. Pastors, Ministers, Elders, Overseers, Bishops, etc.) can have successful HIV/AIDS programs within the organizational structure of their churches.

Nature of the Study

I used a qualitative multi-case study methodology. Qualitative research tends to gather narrative, non-numerical data. In a qualitative approach to research, the objective is to understand the mean of an experience. Morden et al. (2015) suggested,

> In the qualitative approach, the researcher tries to understand the whole in its natural, organic setting. The approach is less concerned with propositional

> knowledge and law-like generalizations and more concerned with understanding and a holistic appreciation for the extension of experience. (pp. 1564-1565).

The qualitative methodology allows researchers to study intricacies in distinctive behaviors from the viewpoint of the partakers regarding an existing incident (Yin, 2013).

Data saturation related to the depth of the sample and the ability to find repetition in the data through interviewing six church leaders of Black Churches in Queens, Brooklyn, and Nassau Counties (Fusch & Ness, 2015). With an exploratory case study design data saturation occurs by structuring interview questions to facilitate asking multiple participants the same questions (Bernard, 2012). The sample for the study, six interviews, allowed for the greatest chance for repetition and significance for the results (Walker, 2012). Additional qualitative research could answer questions about how HIV/AIDS strategies are developed, implemented, and sustained with increased detail (Abara et al, 2015). In comparison, Quick and Hall (2015) stated quantitative research is a statistical approach giving a numerical collection of results providing extra sets of data to examine. Conversely, numerical and statistical approaches do not allow members to give detail accounts about their encounters (Morgan, 2015). For this study, a qualitative method was the best of the options.

Given the nature of the problem, the exploratory case study design is appropriate. A case study focuses on the progress in a group, which results in comprehensive inquiry, and presents an all-inclusive view of issues from diverse data sources (Yin, 2013). Case studies are exploratory, explanatory, or exploratory and involve one organization and

location, or in a comparative case study a number of organizations and locations (Yin, 2013). Other methods such as grounded theory, narrative, content analysis, ethnography, or phenomenology method would not have proved worthwhile and would not have met the objective of the study. Phenomenological and ethnography research did not support the doctoral study because the design concentrates on a cultural group from a single data source, not a process within a group of individuals (Morgan, 2015). Grounded theory would not have allowed for integrating many comprehensive replies from participants within a business (Mellon, 2015). The narrative design is through the author's narratives and the process may miss specifics and topics from the contributors (Wolgemuth, 2014).

According to Merriam (2014), particular study methods alone do not define and characterize the strengths and uniqueness of case study research. Rather, the uniqueness of case study research, found in the types of questions being asked and the relationships to be found between the observed phenomena. The case study design integrates many ways to gather data and the ability to create common dynamics between the data (Meriam, 2014).

Definitions

Connection or connectional: A structural organizational principle that all AME church congregations are a connected network of unique compatible, interdependent relationship to accomplish the mission and purpose of the church (Barbour, 2001, p.13).

Normative Decision Theory: This theory is concerned with identifying the best decision to take assuming an idea decision maker who is fully informed, able to commute with perfect accuracy, and fully rational (Vroom, Yetton & Jago, 2015).

Assumptions

Assumptions are things that are out of the researcher's control; but, if they were not there, the study would be irrelevant (Baranyi et al., 2015). There were some basic assumptions for this study. The first assumption was that the Black Church could make a difference in providing HIV/AIDS programs to their members and surrounding communities. The second assumption was that the presence of the church and its' programs can influence a reduction of the incidence of HIV/AIDS. The final assumption was that the roles of church leaders are to educate people about HIV and to fight its spread to the extent that the Black Church can be the mobilizer in the Black community to address this life-threatening issue.

Scope and Delimitations

The delimitations are features that restrain the scope and describe the limits of the study. The delimitations are in a researcher's control. Delimiting parts contain the option of objectives, the research questions, variables of interest, theoretical views embraced, and the people chosen to study (Simon, 2011).

Since the beginning of the HIV/AIDS epidemic, African Americans have been disproportionately affected; the focus spent on the Black Church and its leaders. How the leaders of the Black Church can participate in promoting prevention and awareness to

their parishioners and surrounding communities in Brooklyn, Queens, and Nassau counties.

The population included participants aged 25 years or older; male or female; pastor, minister, or clergy. The population excluded any male or female under 25 years of age and who was not a delegate chosen by the pastor, minister, or clergy. Interviews were limited to six church leaders and/or their delegates over HIV/AIDS programs to discuss management of HIV/AIDS outreach strategies.

Although related to the study the life cycle, situational, trait, Theory x and y, exchange, attribution, and contemporary theories was not investigated in depth; but, references may be used to identify leadership styles and characteristics. Transferability describes the process of applying the results in research of one situation to other similar situations (Barns et al., 2012, pp 4-5). The process/steps of developing and managing HIV/AIDS outreach strategies in faith-based organizations by Black Church leaders will be applicable to any church leader who may be considering an HIV/AIDS program but do not know where to start.

Limitations

Limitations are possible disadvantages in the study and are out of the control of the researcher. (Depoy & Gitlin, 2015). One of the main limitations in this study was that the data collected came from only three counties Brooklyn, Queens, and Nassau. Two church leaders per county, 25 years of age or older, who manage or desire to manage HIV/AIDS strategies per county were interviewed limiting participants to 6 church

leaders in total. In interview research, the first limitation is susceptible to bias (Lomangino, 2015). Program staff might want to prove that the program is successful. Community members and program participants maybe biased conceivably due to their investment in the program. Every effort made to conduct interviews that will allow minimal bias. The second limitation is that interviews can be a time-intensive evaluation activity because of the time it takes to conduct interviews, transcribe them, and analyze the results (Bernard, 2012). In planning the data collection effort, care taken to include time for transcription and analysis of the detailed data. The interviewer must make the interviewee comfortable and appear interested in answers. The use of effective interview methods, such as, avoiding yes/no and leading questions, using appropriate body language, and keeping personal opinions safeguarded. A final limitation is that when conducting in-depth interviews, inability to create overviews about the results because of the selection of small samples and utilization of random sampling methods. The general rule for sample size for interviews is when the same stories, themes, issues, and topics are surfacing from the interviewees than an adequate sample size has been accomplished (Malterud et al., 2015).

Significance of the Study

Flourishing HIV/AIDS outreach programs may have strategies to share, creating opportunities to improve how to manage programs for other church leaders and their ministries. Church leaders have begun to take more effective role in HIV/AIDS outreach program strategies (Powell et al., 2016). HIV deterrence instruction, intercessions and vetting are welcome by some congregations and possible to put into action in some Black

Churches (Pichon & Powell, 2015). When church leaders have the right strategies to manage a HIV/AIDS outreach program, there is a better chance of increasing prevention endeavors, increasing support and decreasing the stigma attached to HIV/AIDS (Quinn et al., 2016). Positive social change comes from empowering church leaders through the provision of things such as medicine, shelter, jobs, funding, partnerships and establishing a culture where more HIV/AIDS outreach programs are thriving (Phillips, 2015).

The nature of the study went beyond identifying strategies for HIV/AIDS outreach programs. The research could provide training workshops to various churches to produce resources and classes to develop future HIV/AIDS outreach programs managed by church leaders. Additionally, an increase in training for church leaders could increase their knowledge to provide effective leadership and could contribute to the growing African American communities. Increasing training for managing successful HIV/AIDS outreach programs could help enhance the scholastic needs of possible church leaders leading outreach program strategies. Information from the investigation shared with other church leaders and faith based organizations to develop partnerships.

Welcoming the use of training workshops to provide the tools required to manage HIV/AIDS outreach program strategies can help eliminate barriers for church leaders that prevent having an HIV/AIDS ministry/program. Some church leaders experience barriers such as fear, lack of awareness, mindset, and lack of support, requiring different strategies for HIV/AIDS outreach programs. The lack of standardized strategies for some church leaders may lead to less success in their outreach programs, which could affect the

overall implementation and development of HIV/AIDS ministries. Positive social change can come from removing the barriers and emerging skills and proficiencies through creating strategies specific to the needs of church leaders who manage HIV/AIDS outreach programs.

Significance to Practice

Faith-based organization activities play a vital role in the community, and faith-based organizations can learn from each other's successes in developing and managing HIV/AIDS outreach strategies (Abara et al., 2015). Faith-based organizations will be able to establish new associations and alliances with many HIV/AIDS agencies and churches with comparable HIV/AIDS prevention goals (Coleman et al., 2012). Faith-based organizations that create new associations and alliances within the congregation and community will increase HIV/AIDS-related knowledge, attitudes, and changes in HIV/AIDS-related shame. The churches' role in HIV/AIDS prevention intervention can begin open conversations about HIV/AIDS, willingness to get tested for HIV, increase general knowledge about HIV/AIDS, and dismiss the fabrications about its transmission (Coleman et al.,2012).

Highlighting the church HIV/AIDS program strategies that will work in HIV/AIDS prevention intervention can help to demonstrate the success of the church as a go-between in addressing dynamics in HIV/AIDS prevention like HIV/AIDS-related humiliation and normative feelings and understanding about HIV testing and safe sex. The immersion of the church in overseeing HIV/AIDS strategies will be able to assist in

alleviating HIV/AIDS shame. The church leaders will be able to grant the freedom to hold sermons from the pulpit that will focus on the impact of HIV/AIDS within the African-American community (Nunn et al., 2012). The study could affect many church leaders in the Black Church because the findings could contribute to their understanding of how to manage HIV/AIDS outreach strategies to develop maintainable and longstanding approaches that will address elements that may otherwise hinder HIV/AIDS reduction efforts in African American communities.

HIV/AIDS outreach strategies within Black Churches exist the least as oppose to other outreach strategies managed by church leaders, but for reasons that may not be fully understood (Pichon et al., 2015). Future research may help provide strategies specific to HIV/AIDS outreach for the church leaders of the Black Church.

HIV/AIDS epidemic is disproportionately affecting the black communities of Queens, Brooklyn, and Nassau counties, thus successfully developing and managing HIV/AIDS outreach strategies by way of church leaders can be vital to individuals and nearby communities for addressing the racial and ethnic disproportion that is associated with this virus (Stewart & Thompson, 2015). Communicating how to manage successful and established HIV/AIDS outreach strategies may increase the chances that other church leaders will provide preventative education forums, support and resources to increase the number of programs within Queens, Brooklyn, and Nassau county areas (Pichon & Powell, 2015). This study can contribute to business practice by providing knowledge to

church leaders about how to manage and develop HIV/AIDS outreach strategies to increase effectiveness of the church.

Significance to Theory

The normative decision leadership theory tells leaders how they ought to act. This theory built on ethical ideologies or norms provide guidelines for endorsing ethical leader behavior (Minor, 2015). Normative decision leadership theory calls for managers to select a leadership style according to the amount of participation in decision making appropriate for the situation. Leaders use variations of authoritative, consultative, group-based, and delegative styles. These styles lead to different decision-making processes for solving both individual and group problems. The purpose of this qualitative exploratory multi-case study is to explore the HIV/AIDS outreach strategies of the Black Church in Brooklyn, Queens, and Nassau counties that will show how the church leaders manage established and successful programs.

Normative decision leadership theory and the church built on moral principles. This management theory contributes to developing pastors and church leaders by their use of various leadership styles such as authoritative, democratic, consultative, delegative, and group based. Church leaders display various leadership styles that results in different decision-making processes when managing HIV/AIDS outreach program strategies. Pastors and/or church leaders make choices, formulate visions, set objectives, lay routes to reach the objective, and make all attempts with congregation and others who follow in accomplishing it.

Significance to Social Change

HIV/AIDS is a health crisis of pandemic proportions affecting the Black community. The Black Church has a unique role within the Black community and pastoral leadership is the key to making a significant impact on the HIV/AIDs infected church going community. People seek safety in the church and trust in pastors, therefore the influence within communities alone can assist in a venue to increase awareness of HIV/AIDS prevention, care and treatment within the Black community. Strengthening church organizations to address the HIV/AIDS epidemic in Black communities can decrease stigma and misperception and increase the engagement of Black communities in HIV/AIDs prevention and treatment services.

Summary and Transition

Chapter 1 was a description of the effects of HIV/AIDS on the Black community. It includes the organizational context of the A.M.E. church, as it is one of the oldest denominations in the United States. Chapter 1 included the background and discussion of percentages of African Americans living with HIV/AIDS within Queens, Brooklyn, and Nassau counties. Chapter 2 will provide an in-depth literature review. Information provided in Chapter 2 will define the impact the leaders of the Black Church have on the HIV/AIDS epidemic within the communities of Queens, Brooklyn, and Nassau counties, conducted in the counties of Queens, Brooklyn, and Nassau to demonstrate the importance of the issues involved. Information offered to the reader regarding the History and Epidemiology of HIV/AIDS. The history and epidemiology of HIV/AIDS will include the first time hearing of HIV/AIDS, how HIV causes AIDS, the first discovery of

HIV, and the use of current drug therapies for the epidemic. The impact of the Black Church described in terms of the role the leaders play in health promotion and disease prevention in the black community. Chapter 3 will detail the methodology and procedures used in this study. Through data collection and interview responses, a set of recommendations to leaders of the Black Church produced as the final product, to employ the Black Church as one of the major mobilizing institutions in addressing the HIV/AIDS epidemic among Blacks. Chapter 4 will present the results of this study that will benefit all Black Churches because the findings would shed new light on the knowledge of the congregants and pastors as it relates to the seriousness of this disease. Chapter 5 will conclude with interpretation of findings, limitations of the study, recommendations, implications, and conclusions.

Chapter 2: Literature Review

African Americans affected disproportionately by HIV/AIDS since the epidemics' beginning 26 years ago (Kaiser Family Foundation, 2014). The statistical comparison of HIV/AIDS among African Americans in New York as of May 2010 with that of the United States in 2010 indicated how devastating this disease is affecting the African American (New York Department of Health and the CDC, 2013).

The purpose of this qualitative exploratory multi-case study was to understand how church leaders of the Black Churches in the communities of Brooklyn, Queens, and Nassau Counties manage strategies of their HIV/AIDS outreach programs and providing preventive education for those who would potentially become infected by this disease. I analyzed current literature related to the following three concepts: (a) roles of Black Churches in HIV/AIDS prevention, (b) addressing HIV/AIDS in the African America communities, and (c) families caring for persons with HIV/AIDS.

Literature Search Strategy

Inquiries conducted based on peer-reviewed journals, data from the Centers for Disease Control and Prevention, books, data from church leaders, and personal communication. The databases used included MEDLINE with Full Text, CINAHL Plus with Full Text, SocINDEX with Full Text, Academic Search Complete and Business Source Complete. Keywords and phrases used as search terms included *HIV/AIDS, family, public policy, family health, HIV prevention, African American, substance abuse, coalition, mobile testing, faith-based HIV prevention,* and *HIV/AIDS outreach programs.*

Those of which presented sound science and persuasive arguments on the topic of managing HIV/AIDS faith-based outreach program strategies determined the articles selected for review. The data presented in this review were analyzed by using a literature matrix that outlined each article's research question, methodology and research design, sample, analysis and findings, and recommendations for future research.

Conceptual Framework

The theory of normative decision is the primary conceptual framework for the study. The normative decision theory calls for managers to select a leadership style according to the amount of participation in decision making appropriate for the situation. Leaders use variations of authoritative, consultative, group-based, and delegative styles. These styles lead to different decision-making processes for solving both individual and group problems.

Figure 1. A Continuum of leadership styles. Adapted from "The Bass handbook of Leadership: Theory, Research, and Managerial Applications," by B.M. Bass and R. Bass, p. 896. Copyright 2009 by the New York: Free Press. Adapted with permission.

Leaders should consider numerous factors in analyzing the situation. The eight questions leaders use in the decision tree to determine the most effective leadership style in a specific situation are listed below:(Covey, 2004, p.198-204)

1. Is there a quality requirement such that one solution is likely to be more rational than another is?
2. Do I have sufficient information to make a high-quality decision?
3. Is the problem structured?
4. Is acceptance of decision by subordinates critical to effective implementation?
5. If I were to make the decision by myself, is it reasonably certain that my subordinates would accept it?
6. Do subordinates share the organizational goals attained in solving this problem?
7. Is conflict among subordinates likely in preferred solutions? (This question is irrelevant to individual problems.)
8. Do subordinates have sufficient information to make a high-quality decision?

Answers to these questions lead the manager down the appropriate branch of decision tree, identifying one or more decision-making processes appropriate for the situation.

The normative decision theory is a decision-making theory that defines how ideal people should make decisions, based on logic and reason that people often cannot understand e.g. starting HIV/AIDS ministries in the church (McFall, 2015). There are five levels of secondary participation in the decision-making process. In the first autocratic level, the manager makes the decisions himself. The second autocratic level, advice might be ask, but in the end, the manager makes the decision. In the first level of the counseling segment, the manager asks persons in the group for their contribution, and then makes a decision. Their view has more bearing on his decision in this level. The next level of the counseling segment is to have a group meeting, and then the manager makes the decision. The final level, the group ultimately makes the decision (Randles & Laasch, 2015).

The manager has to assess how much he/she knows about an issue to determine which level of involvement to use in the decision-making process. A good manager/leader has to know which level to use for the best quality decision. Time also considered when determining which level of participation to use in making a decision. Finally, employee satisfaction is something leaders need to think about when making a decision. Always choosing autocratic approaches will make employees feel helpless. A good balance is required in order to uphold quick, valuable decisions and happy, invested employees (Vroom, Yetton, & Jago, 2015).

The majority of the studies used for this investigation were qualitative case studies and a few quantitative studies. This exploratory qualitative case study filled the

gap of understanding how the Black Church manages HIV/AIDS outreach strategies because we know they exist but the church is still reluctant in communicating its existence.

The purpose of the qualitative exploratory multi-case study was to explore the HIV/AIDS outreach strategies of the Black Church in Brooklyn, Queens, and Nassau counties that will show how church leaders manage established and successful programs. Many researchers use the normative decision theory with leadership styles such as authoritarian, democratic and laissez-faire in their research on traditional groups and organizations such as Black Churches (Bridbord, & DeLucia-Waack, 2011; Khan, Aslam, & Riaz, 2012; Ruggieri & Abbate, 2013). The Black Church may not only be about ministering to the needs of all people by spreading Christ's liberating gospel through word or deed (Barbour, 2001); so, researching how the church leaders can manage HIV/AIDS outreach strategies could create peer educators and advocates within the Black Church community. The ability to understand how to manage HIV/AIDS outreach strategies may provide insight into how the leaders of the Black Church (i.e. Pastors, Ministers, and Elders) can have successful HIV/AIDS programs within the organizational structure of their churches.

Table 3

Leadership Characteristics

Trait	Definition
Empathy	Creating a legitimate rapport with your staff makes it less likely that personal issues and resentment can creep in and derail the group. When your team knows that you are empathetic to their concerns, they will be more likely to work with you and share in your vision, rather than foster negative feelings.
Consistency	Being a consistent leader will gain you respect and credibility, which is essential to getting buy-in from the group. By setting an example of fairness and credibility, the team will want to act the same way.
Honesty	Another characteristic of leadership that lends itself to credibility. Those who are honest, especially about concerns, make it far more likely that obstacles will be addressed rather than avoided. Honesty also allows for better assessment and growth.
Direction	Having the vision to break out of the norm and aim for great things –then the wherewithal to set the steps necessary to get there—is an essential characteristic of good leadership. By seeing what can be and managing the goals on how to get there, a good leader can create impressive change.
Communication	Effective communication helps keep the team working on the right projects with the right attitude. If you communicate effectively about expectations, issues, and advice, your staff will be more likely to react and meet your goals.
Flexibility	Not every problem demands the same solution. By being flexible to new ideas and open-minded enough to consider them, you increase the likelihood that you will find the best possible answer. You will set a good example for your team and reward good ideas.

Alternative methodologies not selected discussed in Chapter 3 in the Research Method section on page 104.

History and Epidemiology of HIV/AIDS

AIDS was first reported in the United States in 1981 (National Institute of Allergy and Infectious Diseases [NIAID], 2012, when clinicians in New York, Los Angeles, and San Francisco began to see young, homosexual men with Peneunocystis carinii pneumonia and Kaposi's sarcoma. During the early stages of the disease, HIV/AIDS, identified as gay-related immunodeficiency syndrome (Greenberg, 2015). Since the inception of AIDS, the disease has become a major worldwide epidemic.

HIV causes AIDS by killing or impairing cells of the immune system, HIV progressively destroys the body's ability to fight infections and certain cancers. Individuals diagnosed with AIDS are susceptible to life-threatening diseases called opportunistic infections, caused by microbes that usually do not cause illness in healthy people (NIAID, 2012).

According to the NIAID (2012), HIV identified first in 1983; studies of previously stored blood samples indicate that the virus entered the United States population sometime in the late 1970s. In the United States (US), more than one million people living with HIV reported to the CDC as of 2013. One in five people, which equates to approximately 21%, are living with HIV and are ignorant of their infection. In spite of increases of people living with HIV in the US in current times, the yearly figure of new HIV illnesses has stayed comparatively steady. However, new HIV illnesses carry

on at far too high a level, with a predictable 56,300 American tainted with HIV each year. More than 18,000 persons with AIDS even now die every year in the US. Gay, bisexual, and other men who have sex with men (MSM) are fervently exaggerated and stand for the majority of persons who have died. All the way through 2013, over 846,726 persons with AIDS in the US have expired since the outbreak started.

By Most Affected Population

Gay, Bisexual, and Other Men Who Have Sex With Men (MSM)

Gay, Bisexual and Men who have sex with other men of all ethnicities still remain the group most harshly exaggerated by HIV.

- MSM comprise of 53% of all new HIV infections in the United States every year, as well as 48% of people living with HIV.
- While CDC calculates approximately that MSM account for just 4% of the United States male inhabitants aged 13 years and older, the speed of new HIV findings among MSM in the United States is more than 44 times that of other men and more than 40 times that of women.
- White MSM account for the major amount of yearly new HIV diseases of any group in the United States, trailed strongly by Black MSM.
- MSM is the only risk group in the United States in which new HIV diseases have been escalating since the early 1990s.

Heterosexuals and Injection Drug Users

Heterosexuals and injection drug users also remain distressed by HIV.

- Persons impure because of heterosexual acquaintance account for thirty-one percent of fresh HIV illnesses yearly and twenty-eight percent of the populace alive with HIV.
- Women account for twenty-seven percent of fresh HIV illnesses yearly and twenty-five percent of folks alive with HIV.
- Inoculation drug addicts stand for twelve percent of fresh HIV illnesses yearly and nineteen percent of persons living with HIV.

By Race/Ethnicity

African Americans. Amongst cultural classifications, African Americans mainly faced with the unsympathetic problem of HIV in the United States.

- As African Americans stand for about 12% of the United States residents, African Americans account for more or less, 46%, of people living with HIV in the United States, as well as nearly half, 45%, of fresh illnesses annually. HIV diseases amid Blacks in general have been just about steady since the early 1990s.
- Sometime in their existence, just about one in 16 Black men will be detected with HIV, as will one in 30 Black women.

- The pace of fresh HIV illnesses for Black men is about six times as high as that of White men, just about three times that of Hispanic/Latino men, and more than doubles that of black women.
- The HIV occurrence rate for Black women is virtually 15 times as high as that of White women, and just about four times that of Hispanic/Latino women. Hispanics/Latinos: Hispanics/Latinos are also unreasonably impacted.
- Hispanics/Latinos stand for fifteen percent of the people but account for approximately 17% of the population living with HIV and 17% of fresh illnesses. HIV illnesses amid Hispanics/Latinos in general have been more or less steady since the early 1990s.
- The pace of latest HIV illnesses with Hispanic/Latino men is more than twice that of White men and the pace with Hispanic/Latino women is almost four times that of White men.

The impact of HIV on the immune system described in this manner: In a healthy immune system, all components work together to protect the body against invasion by microorganisms. Lymphocytes, important components of the immune system, divided into two distinct types, B-cells and T-cells (CDC, 2015). The bone marrow creates stem cells that can later mature into B-cells. The B-cells divide and generate antibodies are known as humoral immunity. Cellular immunity is a major defense against infections caused by viruses, bacteria or fungi. T-lymphocytes are an integral component of cellular

immunity. Four different varieties of T-cells identified. In adults with healthy immune systems, the CD4 cell count ranges from 800-1,200 cells/mm3 (CDC, 2016).

The transmission of HIV has been isolated to a variety of tissues and body fluids such as blood, semen, cerebrospinal fluid, tears, saliva, breast milk, vaginal or cervical secretions, and urine (Sengupta et al., 2011). There are three major documented routes of HIV infection: (a) Intimate sexual contact that includes exposure to blood, semen or vaginal/cervical secretions of an infected partner, (b) Blood-to-blood contact with infected blood or blood products via transfusion or by sharing drug equipment such as needles, syringes and filters, and (c) Passage of the virus from mother to infant in utero, during labor and delivery or through breast feeding. (Sengupta et al., 2011). The use of zidovudine, or more commonly AZT (Azidothimidine) and other drug therapies, has slowed AIDS incidence and mortality rates dramatically; however, the HIV/AIDS problem among African Americans is far from over (CDC, 2013, p.7).

HIV/AIDS and African Americans

The literature review consistently affirmed that African Americans been excessively exaggerated by the HIV/AIDS epidemic (Sankar et al., 2011). The epidemiology of HIV/AIDS in communities of color continues to be a severe and ongoing crisis that remains virtually unchecked, especially among African Americans and Hispanics (Gray et al., 2015). The burden of HIV/AIDS on racial and ethnic minorities exacerbated by drug use and remains an ongoing crisis that requires both

immediate measures and long-term sustained commitment to overcome (Linton et al., 2015).

According to the Kaiser Family Foundation (2014), attitudes toward and knowledge of HIV/AIDS vary by age, gender, income, and education within the African American community. Younger African Americans, African American women, parents, and those with less education and lower incomes are particularly concerned about the risk and potential impact of HIV/AIDS. African Americans with less education (high school education or less) and lower incomes (under $20,000 per year) are significantly more likely to say that AIDS is a "very serious" problem for people they know (50% of each group), compared to those who have at least some college education (27%). Those with less education express higher levels of personal concern than those with at least some college education (44% compared to 29% say they are "very" personally concerned; Kaiser Family Foundation, 2014.

African Americans view AIDS as the number one health problem facing the nation and the world. The AIDS issue hits close to home. The Kaiser Family Foundation (2013) research revealed that 5in 10 (50%) African Americans say that AIDS is a more urgent problem for their local community today than it was a few years ago. The research also pointed out that a majority of African Americans (56%) says they know someone who has HIV/AIDS or has died of AIDS.

The demographics of the virus have drastically shifted since its inception within the Black community. A systematic review of the HIV prevention intervention literature

for African Americans in the United States commissioned by the Surgeon Generals' Leadership Campaign on AIDS and completed in collaboration with the University of California. Their research identified four major behavior risk groups in the African American community: (a) Men having sex with men (MSM), (b) injection drug users (IDUs), (c) heterosexuals, and (d) youth and adolescents (Billings et al., 2015).

In every aspect of the virus, Blacks are disproportionately affected. The AIDS Patient Care and STDs (Sankar et al., 2011) published an article on Cultural Rationales Guiding Medication Adherence among African American with HIV/AIDS that concluded there are important reasons to be concerned about disparities among minority groups of patients with HIV in terms of enrollment in medication trials and expanded-access programs.

The Sankar et al. (2011) article pointed out that fewer than half as many Black patients as White patients attempt to obtain experimental HIV medications, suggesting that there is less awareness and a more widespread negative attitude about treatment in minority communities. This author agreed that the negative attitude among Blacks relates to our suspicion that goes back to the past injustices with the Tuskegee Syphilis Study, which the article referenced.

The CDC (2013) estimated that approximately 47,352 people per year in the United States infected with HIV, a number that has remained relatively stable but unacceptably high for much of the past decade. Although the use of new drug

combinations known as protease inhibitors to treat HIV infection has taken place, there is still a lack of prevention, treatment, and care within the Black community.

Indeed, there is evidence to suggest that African Americans often not given this new drug combination as often as other groups. One reason advanced for this is that African Americans are poor at complying with medications that have high toxicity (i.e., liver damage). The AIDS Patient Care and STDs (Sankar et al., 2011) publication supported outreach programs and efforts by providers to educate patients about research and investigational treatment, which could improve trust in researchers and boost enrollment. The following statement suggests that there are some barriers for Blacks infected by HIV/AIDS:

> However, such programs may not eliminate disparities in access to experimental drugs, since certain groups, such as blacks, were less likely to receive experimental treatments for HIV infection even when they tried, and they had higher rates of withdrawal from studies after they had enrolled. In our study, characteristics of the practice providing the patient's HIV care, such as a higher number of patients with HIV treated on site and close proximity to an NIH-Funded HIV trial center were independently associated with enrollment in research and use of experimental medications. This finding suggest that we must examine critically such structural barriers as the entry criteria for trials, enrollment and tracking procedures, and the practical details of study-center operation, as well as the attitudes and practices of clinical researches.

> New, innovative therapies for HIV have been successful in part because of impressive participation in the well-designed clinical research studies that have guided treatment and in expanded-access programs for persons with few other options. Nevertheless, as the demographic features of the epidemic have shifted toward patients with fewer resources, the disproportionately small number of disadvantaged patients who enrolled in treatment trials or have early access to experimental therapies is of particular concern. (p. 549)

The Research again pointed to the disparities among Blacks who are infected with HIV in participation in research trials and access to experimental treatment.

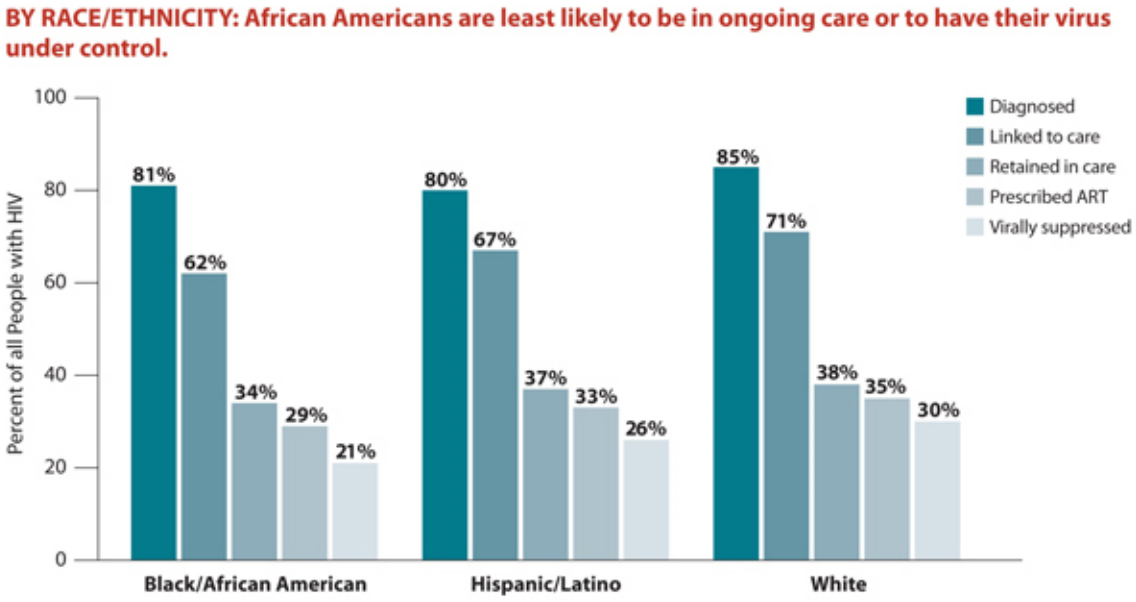

Figure 2. HIV in the United States: The Stages of care. Adapted from "CDC Fact sheet," by U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. Copyright 2012 by CDC.gov. Adapted with permission.

An Environmental Method

An article in the Journal of Urban Health ("The organization of HIV and other health activities within urban religious congregations", 2013) explained the configuration of a neighborhood-based alliance and emphasizes three proposals it has taken on in the topics of movable HIV checking, HIV instruction, and confidence-support effort to enhance HIV assistance for African Americans. The HIV/AIDS outbreak has overwhelmed the U.S. for the past two and a half decades and remains to be an important community wellbeing dispute. The brunt of this dispute experienced most intensely in the midst of minority neighborhoods. Predominately those of Black lineage, descent or persuasion, who have been strangely exaggerated by HIV since the commencement of the outbreak, accounting for forty-nine percent of HIV illnesses that were reported and forty percent of reported AIDS cases (Centers for Disease Control and Prevention [CDC], 2013). The constant, uneven influence of HIV/AIDS on African Americans is a consequence of the multifaceted communication between person, communal, and ecological issues (Gray et al., 2015). Conclusions of HIV, conversely, frequently looked at from an individual viewpoint, concentrating more often than not on behavioral elements of transmission (Sherman et al., 2006, pp 1-11). In the argument of African Americans, for instance, intimate acquaintance with a man is the primary reason of HIV illness (CDC, 2013; Wilson et al.,2015), with the rate of recurrence of HIV transmission via male-to-male intimate relationship highest among African Americans (CDC, 2015; Brito et al., 2015). For African American females, while man and woman intimacy

dissemination speed is alike across racial/ethnic groups, they are twenty times more probable tainted with HIV/AIDS than their White corresponding persons (CDC, 2013).

Substance use is one more entity, behavioral issue that puts African Americans at severe risk for HIV contagion. Conclusions from a current examination of racial/ethnic inoculation drug use differences exposed African Americans expected to infuse drugs than Whites (Linton et al., 2015). Additionally, study has time after time recognized an affirmative association between substance use and excessive dangerous sexual practices such as having sex without condoms, many sex associates and bartering sex for drugs and/or cash, predominantly among African Americans (Brooks et al., 2015).

In reply to this focus on entity-level dangerous conduct, HIV interferences have concentrated on impacting intrapersonal issues such as information, health viewpoints, approaches, and proficiencies to influence conduct and diminish the spread of HIV (Sherman et al.,2006; pp 1-11). Intrusion techniques normally engaged to attain optimistic behavioral results include HIV edification and information on lessening the threat of HIV, interpersonal and specialized proficiency preparation, and the terms of support help (Crepaz et al., 2015; Whiteside, 2015; Lacefield et al., 2015). Generally, these behavioral interferences have diminished excessive dangerous behaviors among men who have sex with men (Crepaz et al., 2015; Wilson et al., 2015), people living with HIV (Crepaz et al., 2015; Wilson et al., 2015), addicts (Schackman et al., 2015; Safren et al., 2015), and women (Fogel et al., 2015). Results, however, are not clear.

A recent systematic review of 206 condom-related intrusions found these intrusions did not amplify or lessen the number of penetrative intercourse incidents or sexual cohorts, but did show a small, but important decline in sexual action status (Smoak et al., 2006). Another behavioral intercession besieged to men who have sex with men illustrated an unpretentious, inconsequential fall in HIV acquisition among the intercessory group (Friedman et al., 2015; Hidalgo et al., 2015). Although entity-level dangerous issues play an important position in the spread of HIV and behavioral interferences, they are essential parts of a complete HIV prevention plan, this focal point does not think about the wider deciding aspects that effect the spread of HIV (Houston et al., 2015; Sherman et al., 2006; Johnston, Deane, & Rizzo, 2015). As noted by Houston, et al. (2015), "the continuing uneven spread of HIV illness within racial and ethnic marginal neighborhoods signifies the flowing together of many threatening factors" (p. 898). These numerous danger aspects consist of communal and ecological factors such as scarcity, racial discrimination, imprisonment rates, low sex rations, unfair right of entry to healthcare, and inadequate communication and ability, all which help make easy the spread of HIV among African Americans (Andrasik, Clad et. al., 2015; Houston et al., 2015; Gray et al., 2015; Johnston, Deane, & Rizzo, 2015).

Given the many factors engrossed in HIV transmission, environmental methods that acknowledge the lively interaction amid persons, their surroundings, and health results have materialized to tackle both the person and broader factors of HIV illness, and also develop neighborhood means to help guarantee the long-term existence and support of these ideas (Auerbach & Smith, 2015). The methods engaged in these intercessions

consist of neighborhood recruitment, intercession completion across numerous neighborhood locations, consumption of individual and ecological intervention approaches, expansion of neighborhood connections, improving community ability, and influencing new society surroundings to assist difficult to attain residents (Auerbach & Smith, 2015).

While not a cure-all for tackling HIV, cost effective involvements have revealed encouraging consequences (Finitsis, Stall, & Friedman, 2014). For instance, the CDC's AIDS Community Demonstration Projects made use of a neighborhood-echelon intrusion to influence condom and bleach use in five U.S. cities. Specially, intrusions improved the accessibility of condoms, bleach kits, and gathered together persons in the neighborhoods to hand out HIV deterrence communication, supplies, and example stories telling how persons in target neighborhoods were altering their HIV dangerous activities (Enhanced Comprehensive HIV Prevention Planning (ECHPP), 2016). Community-level results demonstrated better condom carrying in neighborhoods that took part, as well as a change in the direction of steady condom use and augmented condom carrying (Enhanced Comprehensive HIV Prevention Planning (ECHPP), 2016). The Jewelry Education for Women Empowering their Lives (JEWEL) is another cost effective grounded venture that made available HIV preclusion instruction, but also trained target women how to create, promote, and persuade somebody to buy beaded trinkets, charms, ornaments or gems (Sherman et al., 2006).

Joint companies are another cost effective method utilized to modify the surroundings in which health performances occur by gathering together communities and connecting them at numerous stages and in numerous locations (Naimoli et al., 2015; pp 3-5). Innovative or customized agendas, strategies, and practices are all ways joint companies' labor in the direction of attain these objectives (Naimoli et al., 2015). Partnerships are a specific kind of joint company that been exploited for HIV deterrence attempts (Rhodes et al., 2015; pp 312-332). While merger objectives differ and incorporate such things as building capacity, improving risk factor consciousness, making better access to health benefits, and influencing neighborhood power (Rhodes et al., 2015, p 316), associations play a serious position in recognizing the wants of a neighborhood, scheming answers, and assembling neighborhood assistance for these endeavors (Bumbarger, 2015). For example, an alliance of community health experts in Broward County, Florida tackled cultural and national differences in HIV (Carey et al., 2015). The association's neighborhood evaluation enlightened the expansion and completion of an action plan that integrated outreach, planned messages, competence developing, and communications growth (Carey et al., 2015). Assessment of alliance participation attempts demonstrated considerable boosts in HIV testing and HIV/AIDS crisis acknowledgement, as well as amplified involvement in neighborhood HIV-avoidance attempts (Carey et al., 2015, pp 584-593). The Metro Boston REACH 2010 HIV Coalition is one more illustration of a neighborhood affiliation intended to connect local stakeholders in the recognition and decision of disparities in HIV prevention and aid for the Haitian population (Allen al., 2015). Partnership achievements comprised the

formation of an HIV/AIDS preclusion set of courses, HIV media movement, recruitment of neighborhood means, and the growth of long-term, joint associations to speak to HIV and other community health matters (Allen al., 2015).

Given the difficulty of HIV transmission, complete methods are required in societies to tackle the rising disproportion of HIV illness among African Americans (Houston et al., 2015). The article illustrates the attempts one neighborhood had taken to undertake the many problems enclosing HIV in the African American society. Particularly, the Brothers-to-Brothers/Sisters-to-Sisters Coalition (BB/SS), a Substance Abuse and Mental Health Services Administration/Center for Substance Abuse Treatment-funded (SAMHSA/CSAT), Targeted Capacity Expansion HIV grant, took on an environmental outline for dealing with minority differences in HIV/AIDS in Montgomery County, Ohio. This piece of writing gave a short impression of the alliance's progress and explained three precise plans the alliance had agreed to tackle HIV/AIDS in the African American community, movable HIV examination, HIV instruction with substance addicts, and labor with the faith community.

Family Resiliency, Doubt, Hopefulness, and the Value of Existence

The Joe (2015) article sought out to add to the discerning of excellence of existence, practiced by a community-based, non-clinical example of persons with HIV/AIDS. Using the idea that alters their concentration from the loss of control and chaos credited to exposure to nerve-racking situations, to the person moral fiber and social practices linked with either usual, or without warning optimistic psychosocial

growth and conscious intellectual activity assessment ideas (thinking, reasoning, remembering, imagining, or learning words) of doubt and hopefulness. Through Web-based examination, 125 persons with HIV/AIDS finished an online opinion poll. Illness succession, as deliberated by CD4 count, not found connected to value of existence. When measured independently, mutually the family resiliency variables and the cognitive appraisal variables found to forecast value of life. The overall forecast example, collected of the three sets of forecaster variables – cognitive appraisal, family resiliency, and illness successions – found to give reasons for over 60% of the discrepancy in quality of life of persons with HIV/AIDS.

With the arrival of pharmacological involvement, HIV/AIDS no longer treated as an incurable disease; rather, now regarded as a chronic disease (Sidibe et al., 2015). For this reason, health care investigators are paying less attention in quantifying health care results by morbidity and death rates or by living expectation. As an alternative, investigators are more worried with the consequences that health care therapy has on a person's routine in everyday behaviors with family, friends, neighbors, colleagues at work, and in his or her neighborhood. In other words, the basic intention of health care is preserving or going back to normalcy those rudiments of health-related caliber of existence. Consequently, caliber of existence turns out to be a significant current area of health care and rehabilitation investigation (e.g., Centers for Disease Control and Prevention, 2011).

HIV/AIDS has occupational, mental, and communal inferences (Sullivan, Messer, & Quinlivan, 2015). The interaction between occupational change and psychosocial change efficiently recognized in the professional and therapy psychology prose (Garcia et al., 2015). However, employment results are frequently the main concentration of change in treatment studies (e.g., Razzano, 2015). Acknowledging the limit of using employment results as the only sign of program efficiency, many treatment investigators have been pressing for the use of wide-ranging, multidimensional constructs, such as caliber of existence, to assess occupational treatment results (e.g. Persenius et al., 2015). The use of quality of life as a final dimension in treatment is reliable with the existing tendencies in health care (Nahas et al., 2015), and as a more complete concept for evaluating the full scope of other possible advantages of professional treatment; assistance may be particularly suitable for persons with HIV/AIDS.

Caliber of existence can also be referred to as Quality of Life is defined by the World Health Organization as “individuals’ perceptions of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards, and concerns” (Lifson et al., 2015, pp 88-96). Quality of Life may be conceptualized as a concept that (a) is multidimensional and prejudiced by individual and ecological issues and their connections; (b) has both biased and unbiased mechanisms; and (c) is improved by empowerment, supplies, intention in life, and a feeling of fitting in (Cummins, 2016). There is no one cohesive hypothesis of Quality of Life. Cummins warned that the description and dimension of variables in Quality of Life examples could be predisposed largely by the distinctive views of individual examiners.

To improve the condition of Quality of Life study on persons that are immobilized, it may be productive to look at Quality of Life from a scheme viewpoint putting together the micro (single person or family unit), the meso (business and assistance relief arrangements), and macro systems (humanity and customs) in which persons and family units live (Cummins, 2016).

This study examined the importance of means of a family in assisting a person helping attain his or her aspirations in Quality of Life areas. The study intended to observe the cognitive assessment dynamics of doubt and hopefulness in relation to Quality of Life. Knowledge concerning one's illness and the instillation of cheerfulness and hope are also parts mentioned as requiring compassion for persons identified with recurring illness and immobilization (Earnshaw et al., 2015; Ghafari et al., 2015). The study serves as an information base for experts in recognizing desired involvements and assistance relief alternatives and may make possible the growth of practical measure to assist persons to become accustomed productively to HIV/AIDS. The authors were engrossed in probing the responsibility of disease development, family buoyancy, and cognitive assessment dynamics as interpreters of Quality of Life in people with HIV/AIDS. Additionally, they looked at the inter-correlations between the measures to check the exclusivity of the variables on Quality of Life.

Relatives Concerned for People with HIV/AIDS

Persons living with chronic illness face many challenges in their everyday lives such as ache, weariness, and complex medicine routines. Their family units must

frequently become skilled at managing these challenges as well. The degree to which family affiliates are eager and capable to lend a hand with every day events and give emotional support can significantly have an effect on the quality of life for people with chronic sickness. In the situation of HIV/AIDS, the problems of warning sign managing and medicine augmented by social shame. This disgrace produces emotional pressure and thoughts of separation that may, in turn, hold back physical health. Because of the complex array of social and emotional questions that go together with an analysis of HIV/AIDS, the Functional-Age Model of Family Treatment is particularly helpful in putting together a variety of features of evaluation and attention. Cook (Perspectives of linkage to care among people diagnosed with HIV, 2015) presented a synopsis of the bodily, mental, communal, and religious concerns linked with HIV/AIDS along with methods to evaluation and therapy that are consistent with the Functional-Age Model.

The functional age model supports the practitioner to arrange evaluation and involvement by conceptualizing the family unit as a structure in which affiliates have mutual responsibilities. The person looked at within the context of bio-psychosocial performance. By means of the model, the practitioner works to comprehend a person's functional age by reviewing natural, mental, communal, and religious characteristics of functioning. The practitioner also reviews the performance and growth of the family unit structure and neighboring community support set-up. As HIV influences the health of the person, it also alters family operation by shifting family responsibilities and adding an immense amount of constant worry to family members' everyday lives.

An appraisal of persons with HIV/AIDS and their families should contain information about bodily and mental functioning, neighboring support, and religion. Because HIV/AIDS spread coupled with dangerous sexual relation and habitual usage of drugs, those with HIV/AIDS feel disgraced and embarrassed of the finding. Consequently, HIV positive persons are frequently unwilling to reveal the nature of their condition to acquaintances and even family affiliates. In administering an evaluation, it is vital that the practitioner be conscious of who knows about the HIV/AIDS.

According to the Functional Age Model, natural age inferred as a mixture of things that alter bodily performance eventually. This is important for those living with HIV, because the ailment has an effect on the bodily system that protects the body from foreign substances, cells, and tissues by producing the immune response and augments vulnerability to opportunistic viruses. The natural age of those with HIV differs because they may experience phases of wellbeing followed by phases of excruciating illness (Cook et al., 2015).

Enhancements in medicine throughout the past ten years such as the presentation of antiretroviral treatment (ART) have expanded the average length of life and made better the caliber of life for many persons existing with HIV/AIDS. Bodily performance may differ extensively based on reaction to medicine routines, diet, bodily movement, and other dynamics coupled with a healthy way of life. Significant to incorporate an evaluation of bodily performance, conscious of the influence that HIV/AIDS may have and life expectancy, also have disturbing consequences. ARTs may cause vomiting,

headaches, inflammation, and lose bowels (Kumar, Rao, Earla, & Kumar, 2015, pp 343-355). For those living with HIV/AIDS, it is often hard to differentiate between indications of the disease and by-products from the medications. A physical assessment should include questions about medicinal substances because the consequences can change caliber of life and can cause persons to discontinue taking their medicines at all. Abiding by the rules with taking medicines is serious because many investigators approximate that the prescribed medicines lose potency when not taken properly at least 95% of the time (Gordon et al., 2015).

Exhaustion usually linked with HIV along with high temperature, lacerations in the mouth, inflammation, and loose bowels. Exhaustion may cause persons to lessen their activity level, which can lead to even greater powerlessness and low energy amalgamated by extra troubles such as depression (Wu et al., 2015). In order to comprehend an individual's bodily performance, it is imperative for a practitioner to evaluate parts pertinent to a healthy way of life. HIV positive individuals who continue a healthy way of life together with good diet and regular physical activity are likely to improve their sleep, have enhanced endurance and less exhaustion, and less sadness warning signs (Grace, Semple, & Combrink, 2015).

An appraisal of the family unit's reply to transformations in bodily performance can assist the practitioner decide how well the family is handling and how much provision they are giving to the individual with HIV. Families, relatives, kinfolk may be weighed down by health difficulties that slow down the capability to carry out normal

actions and thus cause a change in family positions. A mother with HIV, for instance, may have to depend on other family associates for childcare household tasks when her health vacillates. The value of family backing can greatly influence worth of life and health.

Mental age, according to the Functional Age Model, is worried with a person accustomed to transformations. In the case of HIV/AIDS, mental age in part decided by a person's capacity to deal with anxieties and whether indications of despair and nervousness are there. A finding of HIV may cause those and their relatives to deal with the passing away of a family member before they would have anticipated. Such stressors can make it difficult for families to adapt in the face of an HIV verdict (Cook et al., 2015).

As with other recurring illnesses, the mental consequences of HIV/AIDS intimately link with the bodily results. Those existing with HIV/AIDS frequently experience exhaustion and insomnia, which can intensify bodily indicators of HIV/AIDS (Lifson et al., 2015). Hopelessness is connected with poor adherence to medicine for adolescence and grown-ups tainted with HIV (Feldman, Arakaki, & Raker, 2015; Saberi et al., 2015; Fair, Goldstein, & Dizney, R., 2015). Among women, despair related to indicators that are more brutal and rises in AIDS associated fatalities (Dale et al., 2015). Existing with the disease brings on an enormous amount of worry for both the person and their families or friends. Studies point out that mothers, fathers or guardians with HIV who go through drops in nervousness and despair over periods after their status revealed

stay alive longer than those who do not go through such reductions (Fair, Goldstein, & Dizney pp 684-690).

A persons' social age described as the capability to perform social responsibilities and contribute as part of a social system. Finding out the power and dimension of social systems is significant when a family is dealing with HIV/AIDS. Family principles, background, age, earnings, and schooling aid to mold a persons' social age. The shame linked with HIV frequently serves as an obstacle to making healthy communal systems and can influence nearly every feature of every day existence, together with employment, companionships, and family interactions (Cook et al., 2015).

Including areas of religion in an evaluation of people alive with HIV is serious because studies point out that they are more probable to take part in sacred and devout customs than comparable persons who are not HIV positive (Grodensky et al., 2015). Grodensky et al. (2015) found that a lot of people living with HIV put significance on appeals to God, belief in eternal life once passed on, faith in wonders, faith that they are watched over for by a supreme being and faith that HIV/AIDS is not a sentence. In the same research, those who said they placed greater value on formal religion as an asset and reported more frequent prayer and a higher level of spirituality used adaptive dealing with tactics more frequently and obtained more backing from family affiliates.

Religion fervently joined to mental, communal, and even bodily performance for families dealing with a verdict of HIV/AIDS. It can add to thoughts of health and happiness, along with giving a feeling of significance to one's life amongst those alive

with unrelieved disease including HIV/AIDS (Meisenhelder, D'Ambra, & Jabaley, 2016). These advantages can also improve bodily health (Pandey & Shrivastava, 2015). Religion also connected with enhanced value of life, social backing, and managing, as well as reduced perceived stress, depression and psychological distress (Burdette, Hill, & Myers, 2015, pp 349-370). Persons living with HIV/AIDS frequently look for other treatments that contain a religious part (Nlooto, 2015). For numerous women with HIV, prayer and belief play a vital position in every day existence (Iles et al., 2016). Possessing a religious viewpoint, assist women with HIV/AIDS deal with constant worry (Fang et al., 2015, pp 1015-1021) Commonly HIV positive persons may sense that their religious values provide emotional support that they cannot locate somewhere else. If they are scared to reveal the finding to friends and family, their religious values may work as their main support method.

Individuals living with HIV are normally unwilling to unveil their HIV status due to doubts of negative response and desertion. It is imperative to identify whether the HIV status has been divulged and to whom. Exposure of HIV status is often imperative in supplying a stronger support network (Zang, He, & Liu, 2015, pp 72-80). It is also important to reveal HIV status to possible sexual associates in order to stop the spread of the virus. Individuals who would be inclined to reveal their status to those they have had sexual contact with or relatives may need help and support from their physician (O'Connell, Reed, & Serovich, 2015). A feeling of self-worth is an essential emotional trait in making the choice to unveil their HIV status. Since self-worth is often hard to judge, it may be useful to make use of a scale to find out whether individuals believe they

are capable of divulging their HIV status. Lightfoot and associates (2015) have developed dependable and applicable levels to gauge self-worth for exposure that can be utilized for this reason.

The functional-age model of family treatment is particularly helpful for doctors who are supporting families attending to a relative with HIV/AIDS because the disease affects families on multiple ecological levels. The interrelationships between bodily, mental, societal, and religious performance mean that shortfalls in one part are likely to have a negative consequence on others. A person who is going through acute symptoms of HIV is likely to turn out to be more publicly secluded and miserable which can, in turn, worsen the bodily symptoms. It is so critical that the practitioner is able to empower the family to acknowledge and build on their strong points in order to enhance performance in all of these areas.

Exposé of Affirmative HIV Serostatus by Men having Sex with Men to Relatives and Acquaintances Eventually

Researchers have time after time established that friends receive HIV diagnosis information from gay and bisexual men more often and at larger degrees than relatives do (Lee, et al., 2015; Henry et al., 2015; Cook, Valera, &Wilson, 2015). This inclination does not seem to change by friend distinctiveness such as sexual category (Ybarra et al., 2016), sexual orientation (Cook, Valera, &Wilson, 2015; Fields et al., 2015), or attribute of the revealer such as cultural association, (Beck-Sagué et al., 2015).

While proof for special friend confession is compelling, this body of text experienced numerous procedural challenges. First, most studies have been cross-

sectional approximations of proportions of family and friends aware of the finding (HIV status) at any given point in time (Lee et al., 2015; Ybarra et al., 2016; Beck-Sagué et al., 2015). Detail occurrence examinations are significant as they give a brief summary of disclosure examples at distinct times. Such studies, however, are restricted because outcomes would probably change by participants' exposure duration and in what year the research took place. For instance, it is possible that studies performed in the late 1980s would generate diverse conclusions from those in the late 1990s, because of modifications in medical care and overall community reaction concerning those with HIV.

Additionally, because people are living long with HIV, understood that studies performed a short time ago integrated individuals who have been identified longer and therefore have additional chances for admission. Lastly, because customary family and friendship groups naturally develop and grow in different ways, detail occurrence studies cannot capture these variations. An inquiry in due course, whether retrospective or prospective, offers a more convincing and influential perception of how admission happens to family and friends.

Further than detail occurrence studies, the second most frequently utilized method to examining disclosure are intended to monitor recently diagnosed men for limited time periods such as 3 months (Barskey et al., 2016), 6 months (Wiew et al., 2015) or 12 months (Cook, Valera, &Wilson, 2015) and review to whom participants had revealed for the duration of these isolated periods. These studies supplied necessary HIV/AIDS status

data to instantly post-diagnosis but their restricted time perspective does not give an understanding of admission over the life path.

Third, many studies (Lee et al., 2015; Ybarra et al., 2016; Beck-Sagué et al., 2015; Brown et al., 2015) have made use of prepared or closed consultations to assess confession. These techniques requested participants to specify if they had confessed to precise targets (i.e., mother, father, sister, brother, current sexual partner, and friend). Confession calculated this way presented information that showed the rates of confession were higher for friends than relatives. For example, Beck-Sagué and coworkers (2015) investigated 398 men and found that seventy-five percent of female acquaintances exposed while only thirty-nine percent of mothers, twenty-two percent of fathers, thirty-seven percent of sisters, and thirty-six percent of brothers told of an HIV finding. Comparable outcomes were reported in another study (Ybarra et al., 2016) of 101 men, where fifty-eight percent of male associates and forty-three percent of female acquaintances were revealed to while only twenty-four percent of mothers, eight percent of fathers, thirty-one percent of brothers, and thirty-four percent of sisters were told of an HIV finding. Contrasting friend and family confession by these methods, but, may be excessively prejudiced by the evident fact that partaker's were permitted to choose the associated of their choice to be incorporated in the collective set of contacts. Lee and colleagues (2015) mentioned that these approaches instituted a selection partiality whereby participants individually choose a subset of acquaintances, yet family is prohibited and as a result not agreeable to selection.

As a minimum, one exemption to these methods was an examination carried out by Henry and equals (2015). For this research, participants petitioned to name the ten most important persons in their lives and acknowledge which individuals knew of their HIV diagnosis. From these facts, rates of disclosure measured and established that disclosure rates to family and friends amplified over the first 4 years and then leveled off. The main complexity was the narrow range of the network evaluated and the fact that this network consisted of the "most significant" individuals considered by the respondent and not the wider community network. As a result, inferences drawn are only to some extent useful. One effort to remedy this partiality was described by Lee et al. (2015) in an exploration of men (n = 233) and women (n = 98). By means of an unguarded dialogue method, these investigator asked contributors to make a wide-ranging list of persons in their lives. With this line of attack, rates of exposé, confession or admission to family and friends more intimately looked like one another. In fact, partakers reported revealing to eighty-six percent of associates and/or acquaintances, seventy-nine percent of mothers, sixty-five percent of fathers, seventy-eight percent of sisters, and sixty-eight percent of brothers.

In a preceding investigation (Camacho-Gonzalez et al., 2015) it was established that ultimately mothers are the family member to be told in greatest proportion, yet the rate at which family members are told at all points in time usually does not drastically differ from each other when accounting for attributes of partakers and relatives. A healthy, fair contrast of rates of men's HIV confession to family and friends over a 15-

year duration given in this examination of specific effects of societal system and participant characteristics on rates of discovery, confession or admission.

Possible Responsibilities of Black Houses of worship in HIV/AIDS Avoidance

Stewart (2015) examined the responsibility of Black places of worship in AIDS/HIV avoidance. The initial survey research plan dispensed to 11 places of worship exemplified by 11 preachers and 1 place of worship affiliate. The examination was both qualitative and quantitative. The consequences demonstrated that the majority of the preachers had verbally communicated with their parishioners on HIV/AIDS. A small number of clergies had formerly funded or taken part in HIV/AIDS seminars and circulated HIV/AIDS instructive information in the African American neighborhood. Not any of the places of worship had a recognized HIV/AIDS prevention curriculum. The majority of the reverends were open to putting into practice an HIV/AIDS preclusion course, provided it did not go against the church set of guidelines or principles. The results in this research suggested that Black Churches stand for a significant possible source for HIV/AIDS preclusion. For achievement, the preliminary approach should have involved the minister in the primitive preparation phase. Future investigation will concentrate on increasing the scope of Stewart (2015) research and developing communication between the place of worship, neighborhood-based associations, and health experts.

The literature provided a substantial amount of information to propose that church-based prevention plans can be successful. Sattin et al. (2016) reported that a

church-based intervention was successful in dropping weight among inner-city African-American women at danger for diabetes. Church-based deterrence plans shown to lessen hypertension and diminished weight in African-Americans (Arriola et al., 2016; Martino Pegg & Frates, 2015). In addition, church-based deterrence plans have been successfully engaged to step up breast cancer screening among rural African-American women (Highfield et al., 2015). As well, they have worked to instruct African-American adults in cardiopulmonary resuscitation (King et al., 2015).

Black places of worship have also been engaged in executing national HIV prevention plans. Some of these HIV prevention plans consist of enlisting unpaid helpers from the church, preparing volunteers to explain AIDS education, and supplying therapy to HIV-pretentious patients (Hardy, 2015). There is a national organization called 'The Balm in Gilead (2015), that authorizes Black Churches in taking an active place against HIV/AIDS in the Black neighborhood, anticipated that 10,000 Black Churches would have participated in The Black Church Week of Prayer for the Healing of AIDS (The Balm in Gilead Incorporate, 2015).

Although the hard work by Black houses of worship was hopeful, there is a need to, methodically comprehend the powers of Black Churches. The distinctiveness of possible target groups for the prevention of HIV/AIDS in the African-American community could result. In the south, mainly country, where places of worship are vital to every day existence of so many occupants, this was a specific test. By carrying out an

investigation on the possible responsibility of Black Churches in HIV/AIDS prevention, a better perceptive acquired.

The intention of this study was to look at the possible input that Black Churches could give in the preclusion of HIV/AIDS. The method included (a) questioning African American clergy and getting their viewpoints on the responsibility of their churches in HIV/AIDS preclusion, and, (b) recognizing houses of worship with documented HIV/AIDS prevention curriculums or HIV/AIDS connected activities to question their respective ministers and health-care workers associated with the activities.

This pilot examination proposed that houses of worship in black communities could be a possible resource for HIV/AIDS deterrence in Black neighborhoods. The ministers were open to carrying out HIV/AIDS curriculums in their places of worship as long as the curriculums stayed in agreement with the church principle. As such, the HIV deterrence agenda would need emphasis toward self-restraint. Even though a large amount of religious leaders preferred that a member of their church facilitate the program, they were eager to work with community-based groups in applying such courses. The bulk of ministers had talked to their parishioners about HIV/AIDS and had circulated HIV/AIDS material. Some of the churches subsidized HIV/AIDS activities including seminars and colloquiums, and participated in the Week of Prayer for the Healing of HIV/AIDS.

An obvious drawback of this study was the little sample size, but it was an intentionally calculated pilot study. The participants were chosen based on their

preceding support to work collaboratively with researchers and strangers from other programs. In addition, dynamics such as denomination and location (e.g. country versus city), may be significant thoughts that were not capable of being dealt with in this study. Consequently, these outcomes cannot be widespread to all churches in the Black community. It symbolizes latest information, but to the literature in that, there have been incomplete past studies speaking to these topics.

The strong point of this study was few studies looked at HIV programs among Black houses of worship. Black priest and HIV/AIDS prevention was an understudied section. The research plan integrated the mixture of facts illustrated in a survey and a qualitative evaluation that required a person-to-person meeting with the ministers or church delegates. As well, this study tackled a thought-provoking dilemma, that is, the recognition of possible responsibilities of Black Churches and ministers in the endorsement of HIV/AIDS prevention endeavors. It acknowledged issues that affected HIV prevention attempts among Black preachers.

Incomplete information was accessible and still is amongst the Black populace on HIV deterrence. The data from this research used to plan impending HIV prevention approaches for the Black community, given the ministers' community impact. The data collected from this research also implied that the Black Church could be a useful source in HIV/AIDS prevention, deterrence, or preclusion. The curriculums, however, might need customization. HIV/AIDS involvement and prevention curriculums in Black houses

of worship must stay in agreement with the church policy and beliefs in order for ministers to put such courses in to action.

As a final point, more exploration in this topic will teach examiners on Black priests' viewpoints on HIV/AIDS in the Black neighborhood, as well as how they have selected to deal with the matter of HIV/AIDS in the African-American neighborhood. I hope that this study acted as a means for more exploration in this domain.

The Black cathedral, its preachers and parishioners are vital neighborhood sources for health endorsement pursuits. The plan by which Black places of worship and neighborhood health organizations and programs may exchange ideas to improve HIV prevention will need joint teamwork from all participants. A better study is required to look further at the position of the Black Church in HIV avoidance. Yet, based on the outcomes of Stewart (2015) study, the subsequent proposals made are:

1. Endorse interaction between Black places of worship and community-based organizations. There is a propensity for church leaders not to have faith in community-based organizations. By endorsing interaction, the level of disbelief might diminish.

2. Endorse interaction between the Black Church and medical experts. The church can serve as a catalyst for medical professionals in understanding different beliefs Americans of black African descent might have and how to better serve.

3. To make available continuous HIV/AIDS training and workshops for Black religious leaders. Continuous training is necessary to teach clergies about HIV/AIDS. It will also help them in talking about this issue more openly with their congregations.

4. Offer federal funds to Black Churches to assist them in implementing collaborative efforts to enhance their ability to learn, explore and discover innovative ways by which they may potentially play a vital role in HIV/AIDS prevention.

Religious Congregations' Involvement in HIV

Derose et al. (2011) scrutinized programmatic information from a centrally subsidized faith-based rapid HIV testing proposal. In 2012, Recovery Consultants of Atlanta, Inc. (RCA, Inc.) began making available rapid HIV testing in partnership with six Atlanta-based African-American places of worship. Of the 1,947 persons tested from January 2007 to July 2010, 96.1% (1,872) were African-American, 64% (1,247) were male, and 82.8% (1,612) were between the age of 26 and 56. Eighty-five HIV-tainted persons acknowledged and 72 acknowledged as earlier undetected instances (proved positive rate of 3.7%). They highlighted and promoted rapid HIV testing offered in partnership with African American churches as a tactic for increasing HIV consciousness among inner-city substance addicts.

Research showed that even in 2012 African Americans bore an uneven problem of American's HIV/AIDS outbreak. Of the projected 1,000,000 Americans living with

HIV, 50% were of Black ethnicity (Centers for Disease Control and Prevention [CDC], 2012). Substance use related HIV-infection rates among African Americans were just as alarming. Injection Drug Use (IDU) was the next most important reason of HIV illness among both African American men and women (CDC, 2012). Sharing contaminated needles were not the only HIV hazard associated to substance use. An assessment of danger factors described by persons checked for HIV by Derose et al. (2011) demonstrated that a bulk of those who revealed a history of informal or constant substance use also describe many high-risk actions that integrated at risk sex with an Injection Drug User. People living in inner-city neighborhoods with high occurrence of substance use may be in extreme danger for HIV-virus precisely through Injection Drug Users, or through sex with Injection Drug Users, or sex with those who have sex with Injection Drug Users. Fulton and DeKalb Counties, host regions to the city of Atlanta, accounted for the most HIV/AIDS occurrences in Georgia (Georgia Department of Public Health [GDPH], 2013). At one Fulton County drug healing treatment center, the HIV occurrence among minority customers were 18% to 19% (GDPH, 2013).

As an organization, the Black Church has recognized itself as a chief contributor of community support benefits within the African American community (Pichon et al., 2015). According to one source, upwards of 90% of all Black Churches supplied some technique of community, monetary, religious, and/or instructive backing in their own communities (Oliver, Robinson & Koebel, 2015). Reacting to a broad collection of community disapproval, the Black Church has improved its commitment in tackling the HIV plague from a prevention, concerned, and religious outlook (Pivnick, 2015). This

disapproval promoted in part by a community opinion that the Black Church either rejected or was slow to react to the HIV/AIDS calamity in the African American community. A groundbreaking HIV avoidance plan connecting the African American church incorporated setting up affiliations with community-based organizations (CBOs) and executing rapid HIV testing programs intended to improve knowledge among African Americans.

This technique flattered President Bush's proposal, made during his February 2, 2006 State of the Union Address, which called for the execution of rapid testing plans in collaboration with African American churches as an approach for improving HIV knowledge inside the African American community. Some investigators, however, assumed that in order to settle on the efficiency of these types of faith –based methodologies, joint involvement of this kind must resign your-self to meticulous arithmetical examination and assessments, corroborating their aptitude for duplication in next African American communities (Kim, & Menzie, 2015).

Rapid HIV tests such as OraQuick ADVANCE, a moderately new HIV testing approach, can create HIV test results in 20 minutes. Because HIV test results need laboratory verification, institutions using rapid testing techniques demanded to stick to the rules of the Clinical Laboratory Improvement Amendments (CLIA) law of 1988. This decree, referred to as the "CLIA waiver," permits an group to act as a laboratory for the sake of performing the rapid HIV test. This waiver and the fact that rapid HIV test kits kept at room temperature present neighborhood and faith-based groups opportunities to

execute a science-based intervention outside of customary experimental or medical surroundings.

Derose et al. (2011) described how a centralized supported peer-led habit recuperation and HIV preclusion program collaborated with a neighboring alliance of African-American places of worship to make available rapid testing to a high-risk populace. The objectives were to: (a) augment the amount of high-risk people who know their HIV status by offering rapid testing in mainly African-American neighborhoods with high ratios of substance use (b) look at the practicality of associating with churches, neighboring industries, and neighborhood groups to offer rapid testing to a high-risk minority populace (c) gain sensible programmatic understanding from improving this model and (d) decide if this model could be duplicated throughout America's African American societies.

Demographics: Queens, Brooklyn & Nassau Counties

HIV/AIDS in the State of New York

The New York Department of Health (2013) estimated that approximately 202,341 persons, or 10-11% of the national total, are currently living with HIV infection in New York. New York has the third highest number of cumulative AIDS cases of all states and the second highest numbers of pediatric cases. AIDS in New York State provided a wide range of statistical information on the HIV/AIDS epidemic in New York State based largely on data collected by the New York State Department of Health. It highlighted findings from epidemiologic studies, surveillance and program evaluations. It

also served as a valuable resource for those concerned with monitoring and addressing the epidemic.

The trend in reduction in the number of deaths from AIDS seen over the past few years in New York and across the nation continues. Many people living with HIV and AIDS continue to benefit from new pharmaceuticals and treatments, living longer, healthier lives. The decrease in HIV infection in women of childbearing age and newborns also continues. That is the good news.

The decline in AIDS cases and deaths attributed in part to the wide range of innovative health care and supportive services for people living with HIV, put into place in New York over the past twenty-eight years. Those services developed through the creative use of state, local, federal and private funding and with a unique collaboration among government, health and community providers, and affected communities.

In 1998, legislation passed requiring a system of HIV/AIDS surveillance, this system implemented on June 1, 2000. With the availability of HIV surveillance data, the epidemiological focus would shift from AIDS to HIV, which provided a much more current profile of the HIV epidemic in New York State.

Although we have made great progress, there is still much work to do. The HIV/AIDS epidemic in New York State continues to affect communities of color disproportionately, particularly African Americans and Latinos. Young adults continue diagnosed with AIDS in their twenties continue, indicating probable infection during their teen years. In some populations, young women have higher infection than men do.

All those who work in and affected by HIV/AIDS and public health will want to keep informed about these and other trends in the epidemic. AIDS in New York State is a key resource for all people interested in monitoring the epidemic.

Table 4

Fact Sheet: HIV/AIDS Among African Americans in New York

New York statistics	United States statistics*
In 2013, an estimated 3,800 adults and adolescents were diagnosed with HIV in New York. New York ranked 4th among the 50 states in the number of HIV diagnoses in 2013.	In 2014, 44% (19,540) of estimated new HIV diagnoses in the United States were among African Americans, who comprise 12% of the US population.
In 2013, 39.1% (1,541) of African American adults and adolescents diagnosed with HIV.	Among all African Americans diagnosed with HIV in 2014, an estimated 73% (14,305) were men and 26% (5,128) were women.
In 2013, Blacks accounted for 73.9% (1,713) of AIDS cases in men and 26.2% (607) of those in women.	Among all African Americans diagnosed with HIV in 2014, an estimated 57% (11,201) were gay or bisexual men. Of those gay and bisexual men, 39% (4,321) were young men aged 13 to 24.
Blacks constitute 47.7 percent of reported cases in NYC; Hispanics 30.9 percent; Whites 18.3 percent; Asian/Pacific Islanders 2.7 percent; and Multiracial/Unknown 0.3 percent.	From 2005 to 2014, the number of new HIV diagnoses among young African American gay and bisexual men (aged 13 to 24) increased 87%. But that trend has leveled off recently, with the number declining 2% since 2010.
HIV/AIDS is the leading cause of death for both male and female Blacks aged 25 to 44 years.	In 2014, an estimated 48% (10,045) of those diagnosed with AIDS in the United States were African Americans. By the end of 2014, 42% (504,354) of those ever diagnosed with AIDS were African Americans.
Among childbearing women in New York, Blacks are at least 10 times more likely than Whites to be HIV infected.	
Three quarters (75%) of Blacks, ages 18-64, report ever having been tested for HIV. 1 in 6 (17%) Blacks living with HIV do not know they are infected.	

Note. From "HIV/AIDS among African Americans in New York: Fact Sheet," by New York Department of Health and the Centers for Disease Control and Prevention, 2016, HIV/AIDS Surveillance Report.

Racial and ethnic disparities continue to be of great concern and require extraordinary counter-measures. Table 4 provides facts about HIV/AIDS among African Americans in New York. The data suggested there are three interrelated issues that play a role in continued health disparities between economic classes. These challenges relate to (1) controlling substance abuse, (b) the intersection of substance abuse with the epidemic

of HIV, and (c) other sexually transmitted diseases. The racial and ethnic disparities point to the fact that Blacks "represent only 45.6% of New York's population in the 2015 census, account for the majority of the recently reported HIV cases, AIDS cases, and HIV/AIDS deaths" (New York City HIV/AIDS Annual Surveillance Statistics , 2013, p.2).

According to the State of New York 2013 HIV/AIDS Annual Surveillance Statistics (2013), the Black population in particular, underserved and over represented in the current AIDS epidemic. The report stated that failure among Blacks to access early testing and treatment are the two important indicators that contribute to these data. Blacks diagnosed with HIV infection within a month of developing AIDS, and they die within months of an AIDS diagnosis.

In 2013, Blacks in New York accounted for 75.6% of newly reported AIDS cases among men, and 24.4% of cases among women. These statistics are very alarming to the extent that IDU or sexual contact with a male IDU accounts for 43% of AIDS cases (reported through 2013) in Black women. Black women with heterosexually acquired HIV are the fastest growing group with AIDS. Cumulatively, 64.9% of the AIDS cases reported among Black women acquired heterosexually. Heterosexual AIDS cases link closely to the epidemic among IDUs and infants.

The research indicated that the New York City Department of Health and Mental Hygiene had redoubled its commitment and mobilized its resources to address the disproportionate influence of the HIV/AIDS outbreak on minority neighborhoods in the

state of New York (Frieden, 2002). Their efforts included development of a minority media campaign, establishment of The Regional Resource Network Project, deployment of eight regional minority AIDS coordinators, funding of a minority AIDS initiative and a Closing the Gap initiative, and contracts with community-based outreach, early intervention, and linkage into care (Frieden, 2002).

In 1999, the state legislature created the Minority HIV/AIDS Task Force. The task force charged with the responsibility of providing recommendations to the governor, the legislature and, the Department of Health regarding strategies to strengthen HIV/AIDS prevention, early intervention and treatment effort in New York's Minority communities (Frieden, 2002).

HIV/AIDS in Queens County

Area Profile for Queens, New York City: 2013 HIV/AIDS data is as of June 2014. Case numbers for 2013 could have increased due to delayed reporting. Unless individuals known to be deceased from the NYS or NYC Vital Records or the National Death Index, presumed to be living. HIV/AIDS case data reported here include (a) all CDC confirmed cases (for which race/ethnicity must be included) and (b) all observed cases for which race/ethnicity is unknown.

As of 2013 persons living with HIV in Queens were 7,214 and persons living with AIDS were 10,182. Ten neighborhoods within the Queens area underwent surveillance, which were Long Island City – Astoria, West Queens, Flushing-Clearview, Bayside – Little Neck, Ridgewood – Forest Hills, Fresh Meadows, Southeast Queens, Jamaica,

Rockaway and Unknown. Cumulatively 17,280 AIDS cases include those living with HIV and those living with AIDS of all neighborhoods within the Queens area. All NYC data includes prisoners, as they are not differentiated (NYC HIV/AIDS Annual Surveillance Statistics, 2015, pp 25-26).

Persons ages 13 and older living with HIV/AIDS in Queens County totaled to 17,496. There were 12,726 males and 4,770 females within different age groups ranging from 13-24 years of age, 25-49 years of age and 50 and older. There were *N*=62 (0.5%) from age 13-19, *N*=1,118 (8.8%) from age 20-29, *N*=2,071 (16.3%) from age 30-39, *N*=3,718 (29.2%) from age 40-49, *N*=3,918 (30.8%) from age 50-59, and *N*=1,824 (14.3%) from age 60 and older within the male population, resulting in twice as many cases as females in Queens County. The age groups represented by female population are *N*=56 (1.2%) from age 13-19, *N*=293 (6.1%) from age 20-29, *N*=648 (13.6%) from age 30-39, *N*=1,464 (30.7%) from age 40-49, *N*=1,578 (33.1%) from age 50-59, and *N*=721 (15.1%) from age 60 and older within the female population. The top two risks found within male population were (a) Men who have sex with men (MSM) and (b) Injection drug use history (IDU). The top two risks found within female population were (a) Heterosexual and (b) Injection drug use history (IDU).

Males living with HIV/AIDS surveyed in Queens County by race/ethnicity and risk. The race/ethnic groups represented by the male population of Queens County are White *N*=2,370 (18.6%), Black *N*=4,416 (34.7%), Hispanic *N*=5,252 (41.3%), Asian/Pacific Islander *N*=598 (4.7%), Native American *N*=44 (0.3%), Multiracial *N*=17

(0.1%), and Unknown *N*=29 (0.2%). African American and Hispanic men in Queens are the top two ethnic groups living with HIV/AIDS in the county.

Females living with HIV/AIDS also surveyed in Queens County by race/ethnicity and risk. The race/ethic groups represented by the female population are of the same as the males, however, population size more than 50% less. White *N*=444 (9.3%), Black *N*=2,781 (58.3%), Hispanic *N*=1,353 (28.4%), Asian/Pacific Islander *N*=153 (3.2%), Native American *N*=13 (0.3%), Multiracial *N*=10 (0.2%) and Unknown *N*=16 (0.3%). African American and Hispanic females in Queens were also the top two ethnic groups living with HIV/AIDS in the county.

HIV/AIDS in Brooklyn County

Area Profile for Brooklyn, New York City: 2013 HIV/AIDS data is as of June 2014. Case numbers for 2013 could have increased due to delayed reporting. Individuals presumed to be living unless individuals identified as deceased from the NYS or NYC Vital Records or the National Death Index. HIV/AIDS case data reported here include (a) all CDC confirmed cases (for which race/ethnicity must be included) and (b) all surveilled cases for which race/ethnicity is unknown.

As of 2013, persons living with HIV in Brooklyn were 11,603 and persons living with AIDS were 17,257. Eleven neighborhoods within the Brooklyn area underwent surveillance, which were Greenpoint, Downtown-Heights Park Slope, Bedford Stuyvesant – Crown Heights, East New York, Sunset Park, Borough Park, East Flatbush – Flatbush, Canarsie – Flatlands, Bensonhurst – Bay Ridge, Coney Island – Sheepshead

Bay, and Williamsburg – Bushwick. Cumulatively 28,860 AIDS cases include those living with HIV and those living with AIDS of all neighborhoods within the Brooklyn area. All NYC data includes prisoners, as they are not differentiated (NYC HIV/AIDS Annual Surveillance Statistics, 2015, pp 21-22).

Persons ages 13 and older living with HIV/AIDS in Brooklyn County totaled to 28,814. There were 19,051 males and 9,763 females within different age groups ranging from 13-19 years of age, 20-29 years of age, 30-39 years of age, 40-49 years of age, 50-59 years of age and 60 and older. There were *N*=152 (0.8%) from age 13-19, *N*=2,025 (10.6%) from age 20-29, *N*=3,060 (16.0%) from age 30-39, *N*=5,095 (26.7%) from age 40-49, *N*=5,583 (29.3%) from age 50-59 and *N*=3,136 (16.4%) from age 60 and older within the male population, resulting 50% more cases as females in Brooklyn County. The age groups represented by female population are *N*=134 (1.4%) from age 13-19, *N*=631 (6.4%) from age 20-29, *N*=1,392 (14.2%) from age 30-39, *N*=2,806 (28.7%) from age 40-49, *N*=3,241 (33.1%) from age 50-59 and *N*=1,559 (15.9%) from age 60 and older. The top two risks found within male population were (a) Men who have sex with men (MSM) and (b) Injection drug use history (IDU). The top two risks found within female population were (a) Injection drug use history (IDU) and (b) Heterosexual.

Males living with HIV/AIDS in Brooklyn County surveyed by race/ethnicity and risk, totaled sampled were 19,071. The race/ethnic groups represented by the male population of Brooklyn County are White N=2,983 (15.6%), Black N=10,955 (57.4%), Hispanic N=4,720 (24.7%), Asian/Pacific Islander N=314 1.6%), Native American N=43

(0.2%), Multiracial N=22 (0.1%), and Unknown N=34 (0.2%). African American and White men in Brooklyn are the top two ethnic groups living with HIV/AIDS in the county.

Females living with HIV/AIDS in Brooklyn County also surveyed by race/ethnicity and risk, totaled sampled were 9,789. The race/ethic groups represented by the female population are of the same as the males, however, population size almost 50% less. White *N*=527 (5.4%), Black *N*=6,870 (70.2%), Hispanic *N*=2,244 (22.9%), Asian/Pacific Islander *N*=86 (0.9%), Native American *N*=28 (0.3%), Multiracial *N*=9 (0.1%) and Unknown *N*=25 (0.3%). African American and Hispanic females in Queens were also the top two ethnic groups living with HIV/AIDS in the county. (NYC HIV/AIDS Annual Surveillance Statistics, 2015, pp 21-22).

HIV/AIDS in Nassau County

Area Profile for Nassau, New York State: 2013 HIV/AIDS data is as of April 2015. Case numbers for 2013 could have increased due to delayed reporting. Individuals presumed to be living unless individuals known to be deceased from the NYS or NYC Vital Records or the National Death Index. HIV/AIDS case data reported here include (a) all CDC confirmed cases (for which race/ethnicity must be included) and (b) all surveilled cases for which race/ethnicity is unknown.

As of 2013 persons living with HIV in Nassau County were 1,239 and persons living with AIDS were 1,864. Cumulatively 3,103 AIDS cases include those living with HIV and those living with AIDS within the Nassau County area. All NYS data includes

prisoners, as they are not differentiated (NYS HIV/AIDS Surveillance Annual Report, 2015, pp 163-164).

Persons ages 13 and older living with HIV/AIDS in Nassau County totaled to 3,098. There were 2,100 males and 998 females within different age groups ranging from 13-19 years of age, 20-27 years of age, 25-29 years of age, 30-39 years of age, 40-49 years of age, 50-59 years of age and 60 and older. There were *N*=22 (0.71%) from age 13-19, *N*=58 (1.9%) from age 20-24, *N*=117 (3.8%) from age 25-29, *N*=279 (9%) from age 30-39, *N*=557 (18%) from age 40-49, *N*=697 (22.5%) from age 50-59 and *N*=370 (12%) from age 60 and older within the male population, resulting 50% more cases as females in Nassau County. The age groups represented by female population are *N*=10 (0.32%) from age 13-19, *N*=28 (0.90%) from age 20-24, *N*=56 (1.8%) from age 25-29, *N*=133 (4.3%) from age 30-39, *N*=265 (8.5%) from age 40-49, *N*=331 (10.7%) from age 50-59 and *N*=175 (5.6%) from age 60 and older. The top two risks found within male population were (a) Men who have sex with men and inject drugs (MSM) and (b) Injection drug users (IDU). The top two risks found within female population were (a) Heterosexual and (b) Female presumed heterosexual contact.

Males living with HIV/AIDS in Nassau County surveyed by race/ethnicity and risk, totaled sampled were 2,104. The race/ethnic groups represented by the male population of Nassau County are White *N*=605 (19.5%), Black *N*=828 (26.7%), Hispanic *N*=483 (15.6%), Multi-Race *N*=167 (5.4%), and Others *N*=22 (0.71%). White and

African American men in Nassau are the top two ethnic groups living with HIV/AIDS in the county.

Females living with HIV/AIDS in Nassau County also surveyed by race/ethnicity and risk, totaled sampled were 999. The race/ethic groups represented by the female population are of the same as the males, however, population size almost 50% less. White *N*=287 (19.2%), Black *N*=393 (12.7%), Hispanic *N*=229 (7.4%), Multi-Race *N*=79 (2.5%) and Others *N*=10 (0.32%). African American and White females in Nassau were also the top two ethnic groups living with HIV/AIDS in the county (NYS HIV/AIDS Surveillance Annual Report, 2015, pp 163-164).

Role of Black Churches

The Black Church Defined

For the objective of this investigation, the definition of the Black Church given by Lincoln and Mamiya (1990) in their book, The Black Church in the African American Experience:

> In this study, However, while we recognized that there are predominantly black local churches in white denominations such as the United Methodist Church, in the Episcopal Church, and the Roman Catholic Church, among others, we chose to limit our operational definition of "the Black Church" to those independent, historic, and totally black controlled denominations, which were founded after the Free African Society of 1787 and which constituted the core of black Christians. (p.1)

The Meaning of the Black Church in the Black Neighborhood

The history, structure, and unique role the Black Church plays in the lives and communities of African Americans are unquestionable. Lincoln and Mamiya (1990) in their book portrayed the centrality of the Black Church by stating that no other organization can challenge the Black Church with its' community involvement, traditional concerns such as worship, moral nurture, education and control. The black culture in all its' form is indebted to the black religious tradition as it nurtures all facets including black music, dram, literature, storytelling, and even comedy (pp. 7-8).

The Black Church is a powerful institution in the Black community. Berger and Frazier (1964) state the Black Church and the Black community have tremendous strength because they do not operate as separate entities. The importance and meaning of the Black Church not identified by whether you are a church member or not, it is the spiritual face of the community and support given not based on church affiliation (pp. 491-493). Historically, the Black Church has been the spiritual, emotional, cultural, political, educational, economic, and intellectual center of the Black community.

The literature review revealed the Black Church has an impeccable history of being one of the major support mechanisms for the Black community. Obong'o (2016) article on strengthening partnerships between Black Churches and HIV service providers in the United States provided significant insight into the relationship of the Black Church and HIV/AIDS. She and colleagues stated, historically the Black Church provides an array of support mechanisms and services for members and the community at large (pp.

1-5). Churches in Black communities have also served as agencies for health education and disease prevention programs for conditions such as hypertension, diabetes, teen pregnancy, cancer, and violence (Nunn, Cornwell, Thomas, et. al., 2013).

Nunn's (2013) affirmed the fact that there is a silence in the Black Church when it comes to addressing the HIV/AIDS issue in the Black community. On the other hand, their research did reveal that there was a potential role that the Black nurses, can play in the faith community in response to HIV/AIDS, which supports the role of the Black Church as a vital agency in the HIV/AIDS epidemic.

Collins (2015) addressed the role of the Black Church in health promotion programs, in her article in Social Work and Christianity, she pointed out; the Black Church is an ideal setting in which to offer health promotion activities for African Americans. This assertion made because several studies have found that the church can be an important conduit through which to inform racial and ethnic minorities about preventive care and the Black Church is well suited for health promotion.

Summary and Conclusions

This chapter included a review of the literature. In this chapter, search strategy described to conduct this review and the conceptual framework that was the foundation for this research. Current peer-reviewed research analyzed in relation to factors linked to how church leaders managed HIV/AIDS outreach strategies. Examined current research related to (a) family resiliency, (b) disclosure, (c) responsibility of black places of

worship, (d) religious congregations' involvement and (e) Queens, Brooklyn and Nassau counties demographics.

In conclusion, African Americans are the most disproportionately affected by HIV/AIDS compared to other ethnic groups (CDC, 2013). At the end of 2012, an approximated 496,500 African Americans were living with HIV, signifying 41% of all Americas living with the virus. Of African Americans living with HIV, around 14% do not know they are ill. Of African Americans identified with HIV in 2013, 79% connected to HIV medical care within 3 months, but only 51% kept in HIV care (receiving continuous HIV medical care). Only 37% of African Americans living with HIV at the end of 2012 given antiretroviral therapy (ART), the medicines used to treat HIV, and only 29% had reached viral suppression. In 2013, 3,742 Africa Americans died of HIV or AIDS, accounting for 54% of total deaths attributed to the disease that year.

Qualitative researchers try to learn new premises rather than test theories logically originated from known theories (Yin, 2015). Yin (2015) states qualitative researchers study new wonders and describe them from diverse viewpoints often using the approach of data triangulation. In this literature review, I analyzed studies that used qualitative methodology, such as grounded theory, action research, phenomenology and case studies. Some of the current research that I analyzed were qualitative in nature and included interviews with church leaders and personal narratives. The studies that I included in this review influenced me to design a qualitative study focusing on how church leaders manage HIV/AIDS outreach strategies.

This appraisal of the research literature specified that research is extensive in relationship to the disproportionate way HIV/AIDS affects African Americans and how church leaders of the black places of worship manage HIV/AIDS outreach strategies within the communities of Brooklyn, Queens, and Nassau counties. The exploration about how church leaders manage HIV/AIDS outreach strategies for each county included: 1. living HIV and AIDS cases by sex at birth, age, race/ethnicity and risk, 2. HIV cases, newly diagnosed by sex at birth, age, race/ethnicity and risk, 3. AIDS cases, newly diagnosed and cumulative by sex at birth, age, race/ethnicity and risk and 4. Deaths among HIV and AIDS cases by sex at birth, age race/ethnicity and risk (New York State HIV/AIDS Surveillance Annual Report, 2015). This assessment indicated that a gap exists about church leaders in terms of how they manage their HIV/AIDS outreach strategies. This examination used a qualitative research design to investigate this gap.

Chapter 3: Research Method

The purpose of this qualitative exploratory multi-case study was to understand what leaders of the Black Churches in the communities of Brooklyn, Queens, and Nassau Counties have on those persons living with HIV/AIDS and to provide preventive education for those potentially infected by this disease. The Black Churches in Brooklyn, Queens, and Nassau Counties formed the study group for this study. The outcome of the study uncovered strategies for Black Church leadership to use in supporting the HIV population. The recommendations looked for reverends, ministers, clergy, and pastors to begin contemplating a vision to plan, organize and coordinate HIV/AIDS prevention and awareness to their parishioners, local and surrounding neighborhoods. The findings of

this study can also support federal, state, county, and local government agencies in addressing the HIV/AIDS epidemic among Blacks through the Black Church.

Six church leaders interviewed two from the counties of Brooklyn, Queens, and Nassau. The focus was on African Methodist Episcopal, Baptist, Pentecostal, Church of God In Christ, and/or Nondenominational ministries. Each church leader participated in a semi-structured interview after receiving consent/permission. The purpose of the interview and additional criteria explained to the respondent prior to interview taking place.

Research Design and Rationale

I examined how the Black Church leaders of Queens, Brooklyn, and Nassau Counties develop their programs to support persons living with HIV/AIDS.

The overarching question was: What programs and education do church leaders use to support those with HIV/AIDS?

1. What are the church programs that support HIV/AIDSs in Brooklyn, Queens, and Nassau Counties?
2. How do the church leaders view their responsibility to support HIV/AIDS affected families, friends and/or parishioners?
3. What should the components be for an HIV/AIDS program focus on with respect to improving the life of those with HIV/AIDS?
4. What leadership styles do church leaders' exhibit?

I examined how the Black Churches in the Black communities of Queens, Brooklyn, and Nassau Counties could have a significant effect on those persons living with HIV/AIDS and provide preventive education for those potentially infected by this disease. This inquiry answered the research questions and to understand the significance of the impact the Black Church can have on addressing the HIV/AIDS epidemic among Blacks in Brooklyn, Queens and Nassau Counties.

I used a qualitative multi-case study methodology. Qualitative researchers tend to gather narrative, nonnumerical data. In a qualitative approach to research, the objective is to understand the mean of an experience. Morden et al. (2015) suggested,

> In the qualitative approach, the researcher tries to understand the whole in its natural, organic setting. The approach is less concerned with propositional knowledge and law-like generalizations and more concerned with understanding and a holistic appreciation for the extension of experience. (pp. 1564-1565)

The qualitative methodology allows researchers to study intricacies in distinctive behaviors from the viewpoint of the partakers regarding an existing incident (Yin, 2013).

For the study, data saturation related to the depth of the sample and the ability to find repetition in the data through interviewing six church leaders of Black Churches in Queens, Brooklyn, and Nassau Counties (Fusch & Ness, 2015). With an exploratory case study design, data saturation is reached by structuring interview questions to facilitate asking multiple participants, the same questions (Bernard, 2012). The sample for the study, six interviews, allowed for the greatest chance for repetition and significance for

the results (Walker, 2012). Additional qualitative research could answer questions about how HIV/AIDS strategies are developed, implemented, and sustained with increased detail (Abara et al, 2015). In comparison, Quick and Hall (2015) stated quantitative research is a statistical approach giving a numerical collection of results providing extra sets of data to examine. Conversely, numerical and statistical approaches do not allow members to give detail accounts about their encounters (Morgan, 2015). For this study, a qualitative method was the best of the options.

Given the nature of the problem, the exploratory case study design was appropriate. A case study focuses on the progress in a group, which results in comprehensive inquiry, and presents an all-inclusive view of issues from diverse data sources (Yin, 2013). Case studies are exploratory, explanatory, or exploratory and involve one organization and location, or in a comparative case study a number of organizations and locations (Yin, 2013). Other methods such as grounded theory, narrative, content analysis, ethnography, or phenomenology method would not have met the objective of the study. Phenomenological and ethnography research did not support the doctoral study because the design concentrated on a cultural group from a single data source, not a process within a group of individuals (Morgan, 2015). Grounded theory did not allow for integrating many comprehensive replies from participants within a business (Mellon, 2015). The narrative design is through and author's narratives and the process may have missed specifics and topics from the contributors (Wolgemuth, 2014).

According to Merriam (2014), the particular study methods themselves do not define and characterize the strengths and uniqueness of case study research. Rather, the uniqueness of case study research found in the types of questions being asked and the relationships to be found between the observed phenomena. The case study design integrates many ways to gather data and the ability to create common dynamics between the data (Meriam, 2014).

Merriam (2014), Babbie (2015), and Yin (2013) discussed case study research practiced by many disciplines for more than 50 years for example, anthropology has always been associated with case study methods and has contributed to the development of case study methods in many cultural environments around the world. Historians and members of the medical profession, ancient and modern, have used case study methods for a long time. Barzun and Graff (1977) defined and described the attributes, qualities, and skills required by the modern researcher, they rely heavily on the practices of historical investigation and reporting. Traditionally, the historian's methods included (a) the search for facts either unknown or not clearly understood and (b) the organization of the facts into principles, conclusions and explanations that make the otherwise disconnected facts into a history.

Yin (2013) explained how historical research, which is essentially descriptive often, overlaps with case study research. According to Yin, the case study relies on many of the same techniques as a history; but it adds the contemporary dimensions of direct observation and systematic interviewing. Historical research is limited to retrospective

investigations of physical and cultural artifacts and documents. Yin provided one of the first overviews of methods for case studies outside the field of anthropology.

A revised edition of Yin's book published in 1989 further clarifies the critical role of theory in designing case studies and in generalizing from them. In particular, Yin notes current trends in the use of case study research. The use of case study research is prominent in evaluation research, public policy studies, business, management and international studies in addition to its continued and growing use in social and psychological investigations. In his preface to the 1989 edition, Yin added, "Overall, a significant trend may be toward appreciating the complexity of organizational phenomena, for which the case study may be the most appropriate research method" (p. 12).

The term *case study* carries a variety of meanings and generates some confusion. One source of confusion regarding this familiar term comes from those who speak about field research. For example, Babbie (2015) claimed that field research is constantly being carried out in everyday life by all who observe and participate in social behavior and phenomena. Even though field research typically incorporates a number of characteristics common to case study research, namely observation and meaning-making, field research in practice may not be as well' blended' as qualitative case study research.

Merriam (2014) turned to numerous colleagues, especially the work of Stake, to argue in favor of the strengths and uniqueness of case study research. According to Merriam, it is not the particular study methods themselves that define and characterize

the strengths and uniqueness of case study research. Rather, the uniqueness of case study research found in the types of questions being asked and the relationships to be found between the observed phenomena.

Merriam (2014) reported that in Stake's presentation at the 1981 Minnesota Evaluation Conference in Minneapolis he articulated four ways in which knowledge learned from case study research differs from and is often more useful than other research knowledge. To paraphrase Stake's explanation that appears in Merriam's publication, knowledge gained from case study research is; (a) more concrete because it evolves from personal experience, (b) more rooted in context and therefore less abstract, (c) more developed by reader interpretation which leads to generalizations when new data are added and (d) the design of case study research enables the reader to extend the findings in one study to populations familiar to the reader.

Yin (2013) confirmed Stake's (2014) explanation and highlights the three most distinguishing features of a case study as empirical inquiry in the following way, (a) that the case study investigates a contemporary phenomenon within its real-life context, (b) that the boundaries between phenomenon and context are not clearly evident in a case study and (c) that multiple sources of evidence are used. In a thorough review of the literature related to case study methods, Merriam (2014) performed a valuable service for educators, social scientists and for the many others involved in case study research. She has organized a large number of similar and duplicative descriptors of case study research into four defining characteristics that recur as essential properties of a qualitative case

study; (a) particularistic, (b) descriptive, (c) heuristic and (d) inductive (pp. 201-202). These four characteristics defined as follows.

First, case studies tend to concentrate on particular individuals, groups or settings and to be problem-focused in the context of a broader situation. Second, the processes and findings of case study research generate rich descriptions of as many observable variables as possible in the study context instead of recording or reporting numerical data. Third, the heuristics of case study research reveal unexpected discoveries, relationships, understandings, explanations and confirmations of the phenomena studied. Lastly, the use of inductive reasoning in case study research, means that generalizations, concepts or hypotheses emerge or are reformulated in the course of the data analysis, whether the study is in progress or completed. Rather than determining cause and effect or verifying known relationships, qualitative case studies build and generate theory using inductive means (Merriam, 2014). Taken together, these four characteristics strongly suggest that case study researchers have two major concerns on their minds; (a) the processes they use to observe phenomena and (b) the meaning they are able to derive from the qualitative data they collect. In all these dimensions of case study research the researcher is the critical instrumentation for conducting the fieldwork and for becoming intimately knowledgeable about the phenomena studied.

Yin (2013) outlined the traditional prejudices against the case study strategy. The three major biases against case study research according to Yin are; (a) a lack of rigor, (b) little basis for scientific generalization and (c) too time consuming which results in

voluminous and thus unreadable documentation. In each case Yin argued that critics of case study research methodology continue to make inappropriate analogies of case study research with survey research and other more quantitative research methods.

From Yin's (2013), point of view, these analogies are based on erroneous assumptions. Because the case study approach is inductive, it does not try to determine whether one event caused or led to another. Instead, case study research is descriptive and exploratory. It does not pretend to make inferences or generalizations based on statistical data. The strength of case study research is in its ability to generate new ways of understanding a particular problem or situation through a series of careful analytical processes.

Role of the Researcher

The key role of the researcher for a qualitative exploratory multi-case study entails data collection, data organization, and analysis of the data outcomes (Smith, 2015). I connected and work together with participants through semi structured face-to-face audio-recorded interviews (McIntosh & Morse, 2015). To retain objectives and the reason for the study the researcher must uphold honorable principles at all times (Bryman & Bell, 2015). I adhered to the protocols of the Belmont Report to continue principles all through the study (Lolis & Goldberg, 2015).

A researcher's encounters, intimate beliefs, and viewpoints can generate bias in the review of research data (Bernard, 2012). A researcher who acknowledges their intimate beliefs is better at hearing the explanations of others (Seidman, 2013). As an

operative part of the research I made every attempt to guarantee that the explanations of the outcomes were from the participant's observations and encounters through member checking. Member checking is the process of confirming the meaning from the participants through their review of interview transcripts (Morse, 2015). As well, the written narratives of personal feelings during the data collection process helped to recognize any subjective preconceptions that may influence interpretations (Bernard, 2012). The quality of the data rested on the ability for a researcher to diminish preconception and substantiate the true explanation of the phenomenon (Chenail, 2011). I used interview questions that allowed for follow-up and clarification all through the case study (Smith, 2015).

As a resident of Queens County and having been a member of the church for the past 45 years, I have special friendships with churches in Queens, Brooklyn and Nassau Counties. Relationship risk is minimal, because I did not interview individuals with whom I have a long standing relationship. I identified the population to conduct the study, acquired approval from each partaker, and spoke with each partaker during the course of the study. After the completion of data collection and member checking, NVivo 11 Pro software assisted in creating themes and address the purpose of the study (Brandão, 2015). I assigned meaning to the data, summarize themes that emerge, review data with participants, asked the participants follow-up questions for transparency if necessary, and send to each church leader that have consented to participate in the study an interpretation of their interview as a form of member check.

Methodology

In this part, I dealt with the use of the qualitative research method and exploratory case study design including the correlation between the research question, pragmatic problem and objective of study. A researcher chooses a qualitative method that best deals with the research question (Wilson, Valera et al., 2015). The research design chosen after the research method to synchronize with the research problem statement and research question (Babbie, 2015). The utilization of a case study design by the researcher permits examination of events or action, the results of events or actions, and the significance of events or actions over time (Yin, 2013). In case studies, data collected by the researcher to comprehend multifaceted circumstances from participants to assist in analyzing the relationship between circumstances (Ritchie, Lewis et al., 2013). The qualitative exploratory case study research method and design are excellent for the researcher to answer the research question and to investigate the problem and purpose for the study (Hashimov, 2015).

Research Method

Qualitative researchers enhance the possibility to go further than depiction to find particulars in events through recognizing a person's behaviors and objectives (Roer-Strier, & Sands, 2015). Additionally, the researchers' rapport with a small group of participants might establish an atmosphere to assist in collecting thorough events (Hartas, 2015). Participants can talk candidly and contribute detailed data in a small group setting resulting in supplementary information compared to a quantitative method because of the

capability to ask follow-up inquiries right away (Pearce, Thøgersen-Ntoumani et al., 2014).

A researcher's use of qualitative analysis can generate unfathomable and more affluent appreciation of a specific phenomenon and may lead to vigorous models of comprehending and collaboration among church leaders (Kerr et al., 2015). The researcher can study a well-defined problem in vast detail by acquiring and examining information using a multi exploratory case study (Julien & Fourie, 2015), keeping in mind that transferability of the research (external validity) is up to the reader to decide (Noble & Smith, 2015). To help with the objective of the study, partakers can use recollections and occurrences to reflect on the HIV/AIDS strategies of the Black Church and/or faith-based organizations (Cantisano et al., 2015). Deep perceptiveness into knowledge and processes may come from the partakers' lived occurrences (Andersen et al., 2015). The knowledge in qualitative studies comes from deep perceptions and affiliations (Granek & Nakash, 2015).

A researcher may give fewer detail in his or her examination from quantitative studies because of the large amount of partakers and the absence of a special relationship with participants (Bryman & Bell, 2015). For the researcher to acquire specifics from the interviews, it is vital to have the participants expound on answers, ask questions to clarify meanings and apply follow-up questions (Hartas, 2015). The rapport with participants will generate a setting for the participants to speak candidly, furnish data, and present more material than in a quantitative method or a survey (Schwandt, 2015).

For the purpose of the study, I chose qualitative research over quantitative or mixed method research. A quantitative researcher emphasis is on the amount of information, sanctioning for a huge sample size and considerable volumes of numerical data to examine (Anyan, 2013). The research from a quantitative study may not allow for thorough narratives about experiences that qualitative studies may generate (Hartas, 2015), but instead provides numerical or statistical methods in data gathering (Maxwell, 2015). Quantitative research methodology assesses a preconceived theory and decreases examination that may not disclose the real events of people (Gravetter & Forzano, 2015). A mixed method style is a mixture of qualitative and quantitative study (Depoy & Gitlin, 2015). Mixed method research may utilize the values of both studies (Venkateshn et al., 2013); all the same, mixed method needs broad research expertise and produces extra time and data processing (Denscombe, 2014). Qualitative research may generate deeper perceptions on the important incentives with each church leader (Seidman, 2013).

Research Design

The reason for using the case study design was to investigate the consequences of events, experiences, activities, and processes on participants through many data sources over time (Fagbami et al., 2015; Yin, 2013). Case study researchers can help formulate an understanding of complicated circumstances and help in examining the relationship between circumstances (Yin, 2013). The research from case studies can produce genuine styles of capturing and scrutinizing data, and in a multi exploratory case study; the

researcher can study a distinct an intricate unsettled question in enormous detail (Maxwell, 2015).

Case studies researchers can seize multi-layered viewpoints in a precise setting and location over time (Gibson & Fair, 2015). In an exploratory case study, a researcher can help develop investigation and generate process oriented and comprehensive examination, where researchers have little influence over occurrences (Gibson & Fair, 2015). Case study research allows for data collection from more than one source to improve the legitimacy of a multi-case study (Lewis, 2015). For this study, data saturation linked to the complexity of the sample and the aptitude to find recurrence in the data through cross-examining church leaders of the Black Church in Queens, Brooklyn, and Nassau counties (Morse, 2015). With an exploratory case study design, data saturation comprised of those with the greatest knowledge to reply to the research topic (Morse, 2015). The sample for the study allowed for the greatest possibility for replication and importance of the findings (Yin, 2015). The transferability of case study research outcomes is up to the reader to determine (Noble & Smith, 2015).

I contemplated other research approaches including grounded theory, narrative, and phenomenology. Both phenomenological and grounded theory would not allow for integrating many data sources from contributors (Lewis, 2015) to enhance data. Grounded theorists try to lengthen the current theory (Corley, 2015), which is outside the purpose of the study. Narrative researchers use a story connecting to a person's experience and typically address distressed ethnicities (Eriksson & Kovalainen, 2015).

These research methods might be appropriate for the study; but the qualitative exploratory case study is the approach most appropriate given the timing and budget of the beginner researcher, as well as validity and reliability of the research objective.

Participant Selection Logic

The population for the study was African American church leaders, at least, twenty-five years of age from churches in Queens, Brooklyn, and Nassau counties. Using a convenience sample, I had direct permission and accessibility to pertinent information by making contact with the church leaders of the churches in Queens, Brooklyn, and Nassau counties (Berger, 2015). The sample included six church leaders in Queens, Brooklyn, and Nassau counties that manage a successful HIV/AIDS outreach ministry. Church leaders (Pastors, Ministers, HIV/AIDS Coordinators, etc.) may have access to resources that are specific to other HIV/AIDS outreach ministries that contributed to their success (Cahill et al., 2015). Thus, distributing the resources could help other church leaders increase the knowledge of how to manage HIV/AIDS outreach strategies (Cahill et al., 2015).

A multi-exploratory case study allows the researcher to acquire specifics in perspective with a thorough examination of experiences (Hancock & Algozzine, 2015). Data saturation connected to the complexity of the sample and the capacity to find replication in the data through interviewing the church leaders who manage an HIV/AIDS outreach program in the Black Church in Queens, Brooklyn, and Nassau counties (Morse, 2015). For data saturation, the sample should comprise of contributors

who have the most expertise to respond to the research questions (Morse, 2015). Data collection consisted of semi-structured audio-recorded interviews. Semi-structured, open-ended interviews with the designated contributors provided a chance to gain an understanding of the research problem (McIntosh & Morse, 2015).

I distributed and collected an invitation to participate in study letter (Appendix A) and informed consent form in person to all partakers with an HIV/AIDS outreach ministry. The letter to participate in the study included the focus of the study and explained the extent of participant contribution including a technique for data collection and that participation is intentional and private. The informed consent form (Appendix B) ensured participants there was no major risk linked with involvement in the study.

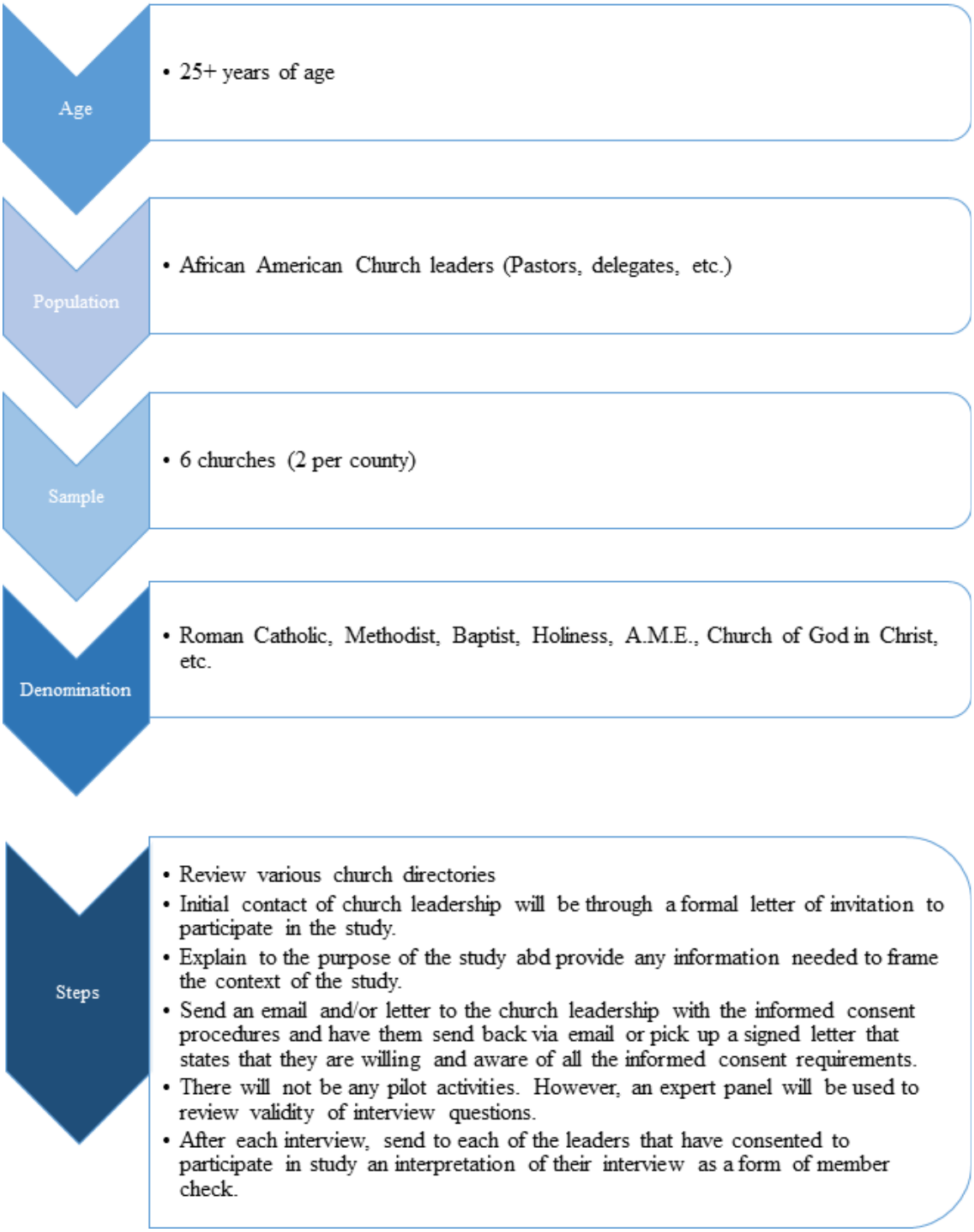

Figure 3. Population, Sample and Data Collection actions.

Instrumentation

I was the data collection instrument (Yin, 2015). The qualitative case study included semi-structured face-to-face audio-recorded interviews with the church leaders of the Black Churches of Queens, Brooklyn, and Nassau counties. The secondary data comprised of Faith-based Ministries and Services Resource directories from Department of Health coordinator of Faith Communities Project and Balm In Gilead, Inc. coordinator of Faith-Based Organization's within New York City containing churches in Queens, Brooklyn, and Nassau counties with active HIV/AIDS Faith-based ministries. Using document collection as a research instrument generated profound examination by revealing active and successful HIV/AIDS outreach strategies of the Black Church. The interview protocol functioned as an interview guide for all of the interviews in the study (see Appendix D). The triangulation of data improved validity and reliability through validation of the study findings and representing the presence of complete data (Santiago-Delefosse et al., 2016). The in-depth exploration demanded the rich depiction of the HIV/AIDS strategies that would be significant to other church leaders and their ministries.

The interview protocol (see Appendix D) stayed the same for all the semi-structured audio-recorded interviews to bring about reliability and validity of the research instruments (Taylor, Bogdan & DeVault, 2015). The interview protocol permitted for suppleness of the application as well as offered participants the chance to elaborate on interview questions (Hancock & Algozzine, 2015). The use of member checking permitted all participants the chance to assess transcriptions to verify the correct meaning

from the interviews (Roig-Tierno, Huarng, & Ribeiro-Soriano, 2015). To attain an in-depth level of examination, a researcher can use a data collection approach that incorporates document review and individual interviews to enhance reliability and validity of the study (Yin, 2013).

Pilot Study

I did not conduct a pilot study because the sample was so small that to find enough people to pilot the study was not feasible within the religious community being studied and region (Zaugg, Child, et al., 2016). In addition, I did not conduct a pilot study due to time constraints (Sahin, 2013). Finding people to participate in this investigation took more time than expected reducing time required to conduct a pilot study if considered. However, consulted several experts in setting up outreach programs were on the review of the interview questions to ensure validity. Dissertation chair, dissertation-contributing faculty and faculty coordinator reviewed interview questions first. No changes occurred as the result of the initial review.

I did reach out to individuals who had the expertise of setting up outreach programs, which included an independent certified coach from The John Maxwell Team, a consultant from Global Performance Consulting, LLC and the President and CEO from The Center for Rapid Recovery, Inc. (Bowen & Caron, 2016). As the result of the second review no changes occurred.

Procedures for Recruitment, Participation, and Data Collection

For the qualitative exploratory case study, data collection comprised of document collection and semi-structured interviews. Using a multi-case study, the researcher produces a chance for comprehensive qualitative data from many members of a single establishment (Yin, 2013). Through the case study process of data collection and organization methods, the research may help to display the consequences from the research data (Morse, 2015). Initial contact with church leaders was through a formal letter of invitation to participate in the study. I explained the purpose of the study and provided any information needed to frame the context of the study.

An email and/or letter sent to the church leadership with the informed consent procedures requested that they send an email back or I would pick up the signed letter that stated that they were willing and aware of all the informed consent requirements. There were no pilot activities; however, used an expert panel to review the validity of interview questions. After each interview, I sent to each of the church leaders that have consented to participate in the study an interpretation of their interview as a form of member check. Member checking according to Harper and Cole (2012) supports the quality and accuracy of a qualitative study.

Semi-structured interviews and the collection of Faith-based Ministries and Services Resource directories containing active HIV/AIDS Faith-based ministries in Queens, Brooklyn, and Nassau counties were the research instruments utilized to gather data for the case study. A researcher utilizing an exploratory case study design can help

improve the complete exploration of in-depth data (Fagbami et al., 2015). Using a multi-case study, the researcher provides a chance for exhaustive qualitative data from multiple members of a single establishment (Yin, 2013).

Upon obtaining permission (Appendix B), I arranged face-to-face semi-structured audiotaped interviews with each participant and used semi-structured interviews to let the respondents tell their stories and provoke discussion. Semi-structured interviews permitted participants the liberty to convey sentiments in their words (McIntosh & Morse, 2015). Semi-structured interviews assist in producing a setting of energetic participants and provoke individual experiences (Wolgemuth et al., 2015).

The suggested length for the semi-structured interviews was 45 minutes to an hour as pointed out in the consent form. The interview timespan rested on the participant's particulars concerning their lived experiences and insights concerning the research questions (Pichon & Powell, 2015). Each interview took place in a selected private room chosen by the church leader in Brooklyn, Queens and Nassau counties and followed the same interview protocol and questions (Peters & Halcomb, 2015). I recorded each interview and instantly transcribed each interview manually. Before loading into NVivo 11 software, each respondent inspected transcriptions for meaning permitting all respondents the chance to inspect transcriptions to make certain the correct meaning from the interviews (Harvey, 2015). NVivo 11 software helps to code and accentuates concepts and narratives that helped in comprehending the essence of the event (Brandão, Bazeley & Jackson, 2015). A distinct code symbolized each interview.

The storage of data is on a password-protected computer in home office, and soft copies locked in a fire-resistant file cabinet. I assigned each contributor a code for data collection (QU01, QU02, BK01, BK02, NA01, and NA02) and all data are in sequential order according to date. I manually transcribed each interview from the audio recording. To guarantee reliability after data collection, a protocol from tendencies in the data and the coding system avoided needless breakdown of data and helped in enhancing the multifaceted explanations of the data (Yin, 2015). All hard and soft copies holding examination information are inaccessible by anybody else. After the examination ended, all contributors received a thank you letter from the researcher for taking part in the study. As instructed by Walden University, the researcher's retention of all examination information will extend over a maximum of 5 years and then demolish the data.

Further doubts in the interview phase of the study occurred and to alleviate the doubts the use of adaptable timetabling helped to integrate lengthier interviews and events. To attend to technical difficulties, testing of the recording instruments and software took place to circumvent failures (Tesch, 2013). In addition, after each interview, I have transcribed as well as provided my interpretations of the participant's interview, which were forwarded to the participants for member checking.

There are possible drawbacks to semi-structured interviews (Seamon & Gill, 2015). The researcher must not project their thoughts, feelings, or views to participants; participants must be able to talk liberally about their insights on the phenomenon (Fitzpatrick & Olson, 2015). The researcher needs to build an environment of lively

involvement and cultivate proficiencies of cautious listening, unspoken communication, and observation (Doody & Noonan, 2013).

Researchers often gather secondary documents during a case study to triangulate the information (Rouse & Harrison 2015). The purpose of the qualitative exploratory case study was to explore how church leaders manage HIV/AIDS outreach programs, the use of secondary documents suggested further understandings into which churches in Queens, Brooklyn, and Nassau counties had active HIV/AIDS ministries. Reviewed documents from the study did not contain the names, addresses, and contact numbers of the churches to protect Pastors and church leaders' privacy (Cunliffe, & Locke, 2015). Churches HIV/AIDS outreach program ministry records are not public so the researcher worked with the church leaders who managed the outreach programs to provide soft copies of the program mission, documents relating to outreach strategies, and purpose. No documents the church leaders made available included the name of the church.

The use of secondary data authenticates reliability and may offer additional examination on the outreach strategies of the Black Church (Fagbami et al., 2015). Furthermore, information gathering in a case study can come from more than one source (Merriam & Tisdell, 2015) and written information could substantiate data from other sources offering detailed content in an intricate setting (Roer-Strier, & Sands, 2015). Attaining data reliability comes from validating or double-checking data with other sources (Lampard & Pole 2015).

There are boundaries to a document review including the translation of documents offering distinct outcomes (Derose et al., 2015). In addition, monitoring data for consistency throughout the research study may improve the accuracy of results (Schwandt, 2015). The researcher will only collect documents from the church leaders that pertain to outreach strategies to aid in representing a chain of proof in answering the research questions (Thomas, 2015).

For data arrangement, I have an excel spreadsheet that tracked data gathering including respondent number (e.g. QU01, QU02), consent form, email and personal communication documentation, transcription review completion, and date and time of interview. For the ease of data recovery, an electronic filing technique organized interview notes and transcriptions using the identical respondent number (e.g. QU01, QU02) that is only accessible by the researcher. The safeguarded storing of all information is on a password-protected computer with backup electronic storage, and soft copies kept in a fire resistant file cabinet. After each interview, I transcribed the interview, went over transcriptions with respondents for meaning to guarantee the correctness, and then loaded the data into NVivo software to begin the coding procedure. Once the research was finish, all respondents received an appreciation letter from the researcher, thanking them for their participation in the study. As instructed by Walden University, the retention of all research data will extend over a maximum of 5 years before destroyed.

Data Analysis Plan

The purpose of the qualitative exploratory case study was to explore how church leaders manage their HIV/AIDS outreach program strategies. The interview questions were as follows:

1. Can you tell me how you came to participate in this HIV/AIDS outreach program?

2. Are you currently pastoring: Full Time (40 or more hours per week), Part Time (less than 40 hours per week). If part time, approximately how many hours per week?

3. What do you feel the Black Church can do to assist with this problem?

4. What were your reasons for participating?

5. Tell me about a time when you had a very successful experience working with a community outreach program or a faith-based outreach program.

6. If you have not participated before, what are your experiences with outreach?

7. What was it about this experience made it successful?

8. What specific words would you use to describe how you feel about participating in outreach strategy and development?

9. Have you conducted any workshops, seminars, etc. on HIV/AIDS in your church?

10. If so, what were they, when was it held, and did you have good attendance?

11. Have you conducted any workshops, seminars, etc. on HIV/AIDS in your church?

12. If so, what were they, when was it held, and did you have good attendance?

13. What do you think needs to be done to promote understanding of HIV/AIDS in the Black community?

14. Why do you think some pastors may not want to have their church participate in HIV/AIDS prevention?

15. Do you have a Health Ministry that addresses HIV/AIDS?

16. What have they done in response to the HIV/AIDS crisis in Queens, Brooklyn, and Nassau?

17. Have any HIV/AIDS prevention services been conducted at or by your church? If yes, what were they?

18. What are some barriers that would prevent your church from having a HIV/AIDS ministry/program?

19. Are you aware of any church programs in the area? What kind of services do they provide?

20. What kind of leader are you?

21. What kind of leadership do you feel needs to be in place to develop an Outreach program?

22. Are there any other leadership positions in the Black Church that might be helpful to you to conduct HIV/AIDS prevention activities?

23. What leadership role do you think the Black Church could play in addressing HIV/AIDS in the African American community?

24. What key words would you use to describe the required leadership in the Black Church to support HIV/AIDS outreach programs.

25. Is there anything else you would like to share about outreach program strategies?

Table 5 shows the relationship between the above interview questions and stud research questions.

Table 5

Relationship between interview questions and research questions

Interview Question (s)	Research Question #	Research Question
Have you conducted any workshops, seminars, etc. on HIV/AIDS in your church? - If so, what were they, when was it held, and did you have good attendance?	1	What are the church programs that support HIV/AIDs in Brooklyn, Queens, and Nassau Counties?
What do you think needs to be done to promote understanding of HIV/AIDS in the Black community? Why do you think some pastors may not want to have their church participate in HIV/AIDS prevention?	2	How do the church leaders view their responsibility to support HIV/AIDS affected families, friends and/or parishioners?
Do you have a Health Ministry that addresses HIV/AIDS? What have they done in response to the HIV/AIDS crisis in Queens, Brooklyn, and Nassau? Have any HIV/AIDS prevention services been conducted at or by your church? - If yes, what were they? What are some barriers that would prevent your church from having a HIV/AIDS ministry program? Are you aware of any church programs in the area? What kind of services do they provide?	3	What should the components be for an HIV/AIDS program focus on with respect to improving the life of those with HIV/AIDS?
What kind of leader are you? What kind of leadership do you feel needs to be in place to develop an Outreach program? Are there any other leadership positions in the Black Church that might be helpful to you to conduct HIV/AIDS in the African American community? What key words would you use to describe the required leadership in the Black Church to support HIV/AIDS outreach programs?	4	What leadership styles do church leaders' exhibit?

A researcher using a case study design can help point to difficulties and discover questions to conduct additional data collection and analysis (Morse, 2015). The objective of the case study was to display the research results from the research data (Morse, 2015). To guarantee the data is trustworthy I conducted a detailed review of each interview before continuing with in-depth data analysis (Devotta et al., 2016).

The aptitude to do a complete review of documents relating to managing successful HIV/AIDS outreach program strategies allowed for the assessment of data from the interviews, checking for accuracy and analysis that leads to the production of further information. Methodical triangulation is the use of several data sources to guarantee the collection of complete data to answer the research questions (Henwood et al., 2015). The use of methodical triangulation when conducting case study research enhances data analysis through precise comparisons in data collection (De Jesus et al., 2016).

Data analysis is hands-on, as I included the contributors in the interpretation procedure. Following the assessment and arrangement of the data in NVivo software, I conducted an additional comprehensive analysis of the data to locate themes and relationships (Woods et al., 2015). NVivo is a computer-aided qualitative data analysis software (CAQDAS) used to code and categorize qualitative data (Zamawe, 2015). The document review comprised of establishing patterns in HIV/AIDS Faith Based Ministry trends of Queens, Brooklyn, and Nassau counties in the document data. I asked follow-up questions for lucidity and explained the data in a formal report.

Issues of Trustworthiness

Credibility

To guarantee credibility, I explained the purpose of this study to each participant and allowed him or her to ask questions. I followed the same methods for data collection for all participants, using the same interview questions. I also asked several subject matter experts with expertise in managing HIV/AIDS outreach programs to review the findings of this study for their credibility.

Transferability

To guarantee transferability, I provided meticulous depictions of the data collection and data analysis processes that I followed so that readers distinctly comprehend how I conducted the research. I also depicted the research context in detail, including the site, date, and time of the interviews, the county where the HIV/AIDS outreach programs resided, and assumptions and limitations that were significant to this study.

Dependability

To guarantee dependability, I described any unfavorable conditions that transpired during the interview process and expressed how these conditions may have influenced the way I conducted this study. Dissertation committee members also examined this study carefully to ensure that data analysis was precise and that I did not exclude or modify any findings.

Validity & Reliability

It remains necessary that researchers and specialists undoubtedly comprehend the conceptions of validity and reliability (Mertler, 2015). Qualitative researchers may grapple with objectivity, truth, reliability and validity (Sandelowski, 2015). In case study research, trustworthiness and credibility relate to the validity, while, transferability relates to the reliability (Roller & Lavrakas, 2015). For the study data saturation related to the complexity of the sample and the capacity to find replication in the data through interviewing the church leaders of churches in Queens, Brooklyn, and Nassau counties. With an exploratory case design data saturation involved those with the greatest familiarity to answer the research topic (Bernard, 2012). The subsequent section contains a narrative of the approaches adopted to guarantee reliability and validity.

Reliability

The conception of reliability in a qualitative case study is to acquire trustworthy results that have transferability to other contexts (Roller & Lavrakas, 2015). The researcher must use research instruments that can provoke data that remains steady all through the study (Allison, 2016). However, the transferability of a research study is up to the reader to determine (Quick & Hall, 2015). For the study data saturation related to the complexity of the sample and the capacity to find replication in the data through interviewing 6 – 9 church leaders of Black Churches in Queens, Brooklyn, and Nassau Counties (Fusch & Ness, 2015). To speak to reliability in the present study, I applied

various strategies including, methodical triangulation, member checking and continuous input and feedback from participants throughout the research process.

I established methodical triangulation from the semi structured interviews and the compilation of documents relating to faith-based organizations with active HIV/AIDS outreach programs. Methodical triangulation is the use of multiple data sources to ensure the compilation of all-inclusive data to answer the research questions (Modell, 2015). The potential to do a thorough assessment of documents referring to faith-based organizations with active HIV/AIDS outreach programs can allow for comparisons of data from the interviews, checking for accuracy and analysis that leads to the formation of extra information . The use of methodical triangulation when conducting case study research improves data analysis through rigorous similarities in data gathering (Noble & Smith, 2015).

Member checking is a quality control procedure where researchers enrich the significance of their data through participant appraisal of transcriptions (Harvey, 2015). For the present study, member checking transpired with each interview all through the study. Respondents took as much time as they needed to guarantee transcripts reflected their meaning. Communications with respondents is all through the research study to offer clarity and contribute in the data analysis procedure. The advantages from member checking come from the opportunity for participants to confirm the meaning of their interview and data analysis refining accuracy throughout the study (Roig-Tierno, Huarng, & Ribeiro-Soriano, 2015).

The researcher needs to be cognizant about prejudices throughout the research process (Roulston & Shelton, 2015). The semi structured interview questions came from my literature review. All through the study, I confirmed that data collection was uniform using the interview protocol. The semi-structured interviews were constant, and all participants replied to the same questions. Additionally , audio recordings and word for word transcriptions guaranteed data accuracy by participants rereading data to validate accuracy and NVivo software helped in spotting themes from the respondents through thematic analysis (Brandão, Bazeley & Jackson, 2015).

Validity

The idea of validity is to guarantee the trustworthiness and credibility of the data (White, Oelke, & Friesen, 2012). Construct validity is the authenticity of the ideas and the correlation of research theory with the research measurements (Mathieu, et al., 2015). The objective of construct validity is to guarantee that a linkage exists between the objective of the study and the outcomes of the data collection (Cahoon, Bowler, & Bowler, 2012). Construct validity entails the interpretation of data (Mathieu, et al., 2015). In a case study, the researcher reaches authentication through a number of procedures and approaches such as triangulation, clarifying researcher bias, prolonged engagement, negative case analysis and peer review analysis peer review analysis (Sinkovics & Alfoldi, 2012). The researcher also tackles validity through member checking and methodological triangulation (Bekhet & Zauszniewski, 2012).With an exploratory case study design, data saturation comprised of those with the greatest knowledge to reply to

the research topic (Morse, 2015). The sample for the study allowed for the greatest possibility for replication and importance of the findings (Yin, 2015).

I used Methodical triangulation of multiple data sources to ensure the compilation of all-inclusive data to answer the research questions (Modell, 2015). The use of triangulation allows for a relative correlation of the data as well as reexamination of the data (Bekhet & Zauszniewski, 2012). The use of methodical triangulation when conducting case study research improves the integrity of the results through rigorous similarities in data gathering (Noble & Smith, 2015). The transferability of case study research outcomes is up to the reader to determine (Noble & Smith, 2015).

Dependability happens when another researcher can follow the judgements of the current researcher (Shaw, 2013). To improve dependability, I supplied details of steps taken throughout the study as well as genuine respondent replies in audio recordings and word for word transcriptions. Member checking is the process of confirming the meaning from the participants through their review of interview transcripts (Morse, 2015). For the study, member checking happened after each interview. Member checking also happened after the study through participant's examination of the study or synopsis of the study. The advantages from member checking come from the opportunity for participants to confirm the meaning of their interview and data analysis refining accuracy throughout the study (Roig-Tierno, Huarng, & Ribeiro-Soriano, 2015).

Confirmability

In relation to confirmability or objectivity, I asked leaders with doctorate degrees of a not-for-profit, non-governmental organization (NGO) whose mission is to prevent diseases and to improve the health status of individuals who are disproportionately affected by high rates of health disparities conduct a peer assessment of this study. I tackled any apprehensions these members had about this study, which reinforced its objectivity. I also looked for inconsistent data that disputed the key findings. I included an audit trail that explains the choices I made from the start of this research study to the reporting of findings.

Ethical Procedures

Before the start of data collection, the Walden University IRB, approval number 12-22-15-0016080, confirmed the proposal met ethical protection guidelines. Upon receiving IRB approval, I continued my study with data collection and addressed all ethical concerns all through the study, guaranteeing the study exhibited trustworthiness while upholding standards for a quality research practice (Kornbluh, 2015). Ethical ideologies guide the researcher to guard participants and to guarantee credibility throughout the research process (O'Reilly & Kiyimba, 2015). The subsequent sections of the study cover the agreement procedure, including how participants may withdraw from the study, upkeep of data, and inventory of agreement documents.

Initial contact with church leaders was through a formal letter of invitation (Appendix A) to participate in the study. I explained the purpose of the study and

provided any information needed to frame the context of the study. The researcher sent an email and/or letter to the church leadership with the informed consent procedures (Appendix B) requested that they send an email back or I would pick up the signed letter that stated that they were willing and aware of all the informed consent requirements. Participants had full access to the researcher to discuss further their participation and any details of the study. There were no pilot activities; however, an expert panel reviewed the validity of interview questions. After each interview, I will send to each of the church leaders that have consented to participate in the study an interpretation of their interview as a form of member check.

I reviewed interview transcriptions with each respondent to inspect for the correct meaning then enter each interview conversation into NVivo 11 Pro software. NVivo is computer-aided qualitative data analysis software used to enhance coding and save time in the organization of data (Brandão, Bazeley & Jackson, 2015). NVivo also helped to systematize all the interview replies aiding in data accuracy and analysis and a 14-day free trial download on the internet before purchase of one-year student license (Bernauer et al., 2013).

The study exemplified the Walden University ethical guidelines and followed the Belmont Report protocol to preserve ethical standards all through the study (Anderson et al., 2012). The consent form specified that participation is voluntary, private, and without price. The participants could have removed themselves from the study at any time

without getting in touch with the researcher directly. If participants retracted, they would have gotten interview transcripts and recordings for their disposal.

I am the only one to have access to all the accumulated information in a locked fireproof file cabinet, in my home office, and all hard copies on a password-protected computer. Each respondent received a number (e.g. QU01, QU02) as a fictitious name, and the number represented each participant through the research process. The safekeeping of all data is on an Excel spreadsheet to track each respondent by number, with the signed consent form, e-mails, communication record, and date and time of interview. The confidentiality process was conveyed all through the study and all shredding and expunging of records will occur after 5 years from the conclusion of the study.

Summary

The purpose of the qualitative exploratory multi case study in Chapter 3 was to research how the church manages HIV/AIDS outreach strategies within Queens, Brooklyn, and Nassau counties. Church leaders from 2 churches in each county participated in the qualitative exploratory case study. The findings of the study may affect social change by religious leaders serving as peer educators and advocates within their church community for HIV/AIDS prevention education and testing. This study may also help to increase the number of individuals who voluntarily test for HIV/AIDS. I collected data with open-ended face-to-face semi structured interviews and document review. The participants were the church leaders who managed HIV/AIDS outreach strategies within

their ministries in Brooklyn, Queens and Nassau counties. The participants came from a convenience sample I conducted. The face-to-face interviews consisted of four research questions with several open-ended sub-questions. The questions focused on HIV/AIDS outreach strategies that help the success of the program pointing to the overarching question, what programs and education do church leaders use to support those with HIV/AIDS and how can the leaders of the Black Church within the Queens, Brooklyn and Nassau Counties, provide preventative education forums within their congregations? Secondary data came from the collection of Faith Based Ministries relating to active HIV/AIDS Ministries in churches in Brooklyn, Queens and Nassau counties. I will preserve the data from the study and keep the findings in a locked fire resistant file cabinet for 5 years. All data sources and each participant received a code listed as QU01, QU02, BK01, BK02, NA01 and NA02. I used NVivo 11 Pro software to gather and analyze information, create codes and identify themes. I guaranteed the same reliability and validity methods all through the study through methodical triangulation, member checking, acknowledging bias, and continuous input and feedback from participants throughout the research procedure.

Chapter 4 includes the results of this research. This chapter describes the research setting and the participant demographics as well as the data collection and data analysis processes. Described strategies utilized to establish dependability, transferability and confirmability. Finally, results of this examination presented in relation to an analysis of the overarching research question.

Chapter 4: Results

The purpose of this exploratory case study was to explore how church leaders manage HIV/AIDS outreach program strategies. The purpose reflected again in the following overarching research question: What programs and education do church leaders use to support those with HIV/AIDS and how can the leaders of the Black Church within the Queens, Brooklyn and Nassau Counties provide preventative education forums within their congregations?

The chapter addressed the research-setting, participant demographics and data collection process. Additionally, I presented a description of data analysis procedures used to determine key findings and I described evidence of trustworthiness for this qualitative research. Finally, I offered results of this research in relation to an analysis of the overarching research question.

Pilot Study

I did not conduct a pilot study because the sample was so small that to find enough people to pilot the study was not feasible within my region (Zaugg et al., 2016). In addition, I did not conduct a pilot study due to time constraints (Sahin, 2013). Finding people to participate in this investigation took more time than expected reducing time required to conduct a pilot study if considered. However, I consulted several experts in setting up outreach programs on the review of the interview questions to ensure validity. Dissertation chair, dissertation-contributing faculty and faculty coordinator reviewed interview questions first. No changes occurred as the result of the initial review.

I then reached out to individuals who had the expertise of setting up outreach programs, which included an independent certified coach from The John Maxwell Team, a consultant from Global Performance Consulting, LLC and the President and CEO from The Center for Rapid Recovery, Inc. (Bowen & Caron, 2016). As the result of the second review no changes occurred.

Research Setting

The church leaders who participated in this examination lived in Queens, Brooklyn, and Nassau counties of New York. The Black communities of Queens, Brooklyn, and Nassau counties are significantly impacted by the HIV AIDS epidemic. According to the CDC (2013), AIDS affects nearly seven times more African Americans and three times more Hispanics than Whites. Cumulatively 20,677 AIDS cases include those living with HIV and those living with AIDS of all neighborhoods within the Queens area. In Nassau County, 3,127 residents of the county diagnosed with AIDS and 1,882 people have died from the disease.

Bedford-Stuyvesant and Crown Heights are areas in Brooklyn that have great history, abundance in self-esteem, and high quality in customary beliefs and social forums, but less than adequate in health. Bedford-Stuyvesant and Crown Heights are comprised of one of the largest inhabitants of African-Americans in the state of New York. They are also the areas where most of HIV/AIDS cases exist in all of Brooklyn.

According to New York State Surveillance Annual Report (2015), Bed-Stuy and Crown Heights are the focused areas in Brooklyn due to the high volume of HIV/AIDS

cases. The concern is the increase of cases as the average new HIV and AIDS diagnoses throughout all of Brooklyn were 114 cases. Bedford-Stuyvesant including Crown Heights had 351 newly identified HIV cases and 355 newly identified AIDS cases in 2002. African Americans reported with HIV/AIDS, and estimated to be living with HIV/AIDS, than any other racial or ethnic group in the United States.

Demographics

The six participants in this research were all church leaders who manage HIV/AIDS outreach strategies in their ministries in Queens, Brooklyn, and Nassau counties. Of the participants who manage these strategies, all were 25 years of age or older, two of the six participants were males. One of the six participants gave full-time (40 hours or more) support to the HIV/AIDS outreach program while all the others could only give part-time support to their ministries. Only one participant was a program director and one participant was the pastor. The remaining participants' classifications were coordinators. See table six for a full description of these participants.

Table 6

Description of Participants managing HIV/AIDS outreach strategies

Participant QU01	Female, 25+	Part-time	Program Director
Participant QU02	Male, 25+	Full-time	Pastor
Participant BK01	Female, 25+	Part-time	Coordinator
Participant BK02	Male, 25+	Part-time	Coordinator
Participant NA01	Female, 25+	Part-time	Acting Coordinator
Participant NA02	Female, 25+	Part-time	Community Coordinator

Data Collection

Interviews with respondents served as the source of data for this exploratory case study. I collected each type of data from six participants. I reached out to 24 persons of whom six responded and consented to participate in this research investigation. A letter of introduction was sent and a call made to each potential participant during the week of January 12 - 23, 2016, using a script that described the study and inviting him or her to participate in this research. I asked each participant to sign a consent form at the face-to-face interview. Conducted interviews during the months of January, February, March no interviews were conducted and April 2016, I conducted interview with the final respondent. These interviews took place at the church where they maintain membership and private residences. Table 7 includes a description of the interview protocol for church leaders who managed HIV/AIDS outreach strategies.

Table 7

Interview Protocol for Church Leaders

	Date	Time	Place	Duration
Participant QU01	1/22/16	8:00 PM	Church	15:10 Minutes
Participant QU02	2/08/16	4:43 PM	Church	30:02 Minutes
Participant BK01	2/22/16	9:33 PM	Private Residence	95:01 Minutes
Participant BK02	2/24/16	6:24 PM	Private Residence	26:57 Minutes
Participant NA01	2/26/16	7:19 PM	Church	31:17 Minutes
Participant NA02	4/03/16	6:46 PM	Private Residence	14:13 Minutes

All interviews were audio-recorded using the application SoundNote. SoundNote was an application used on an IPad to collect the interviews.

I transcribed each interview verbatim. The tablet utilized was password protected and stored in a locked office. All consent forms kept in a folder in a locked file cabinet. All transcriptions stored on a password-protected computer. During each interview, focus was on the words each participant spoke. It was important that I truly listened to the participants and not allow any personal emotions to surface. Using prewritten questions helped keep the focus on the content of their responses and not on how I felt about the topic. The data followed the data collection process described in Chapter 3 without deviation. Unusual circumstances in data collection did not occur because interviews took

place with no distractions and each participant was questioned the same. Finally, follow up questions posed as necessary.

Data Analysis

I did an initial coding of the data manually by creating a hierarchy layout in PowerPoint containing three levels. Level 1 represented the overarching question, Level 2 represented the themes derived from the icebreaker questions, research questions and sub-questions in the approved interviewed guide, and level three represented the responses. Using an inductive approach for the data analysis, I entered the raw interview data into the NVivo 11 Pro qualitative analysis software. I did a secondary coding of the data by assigning key words or phrases to similar data. Using this secondary coding, I reread the text to determine that the secondary codes were accurate. Then I used axial coding to review the secondary codes for relationships between concepts and any related categories that emerged. Using axial coding, I reviewed the data again to confirm key factors that influenced church leaders on how they managed HIV/AIDS outreach program strategies. Initial and axial coding revealed five factors that influenced church leaders' management of HIV/AIDS outreach program strategies.

The first was participation, the opening theme designed to draw the interviewee into a positive mindset at the beginning of the session increased the chance of sharing openly by the church leader. Learning from church leaders how they became involved in managing HIV/AIDS outreach program strategies is essential for churches to increase support from the leaders of their ministries. The second was church programs, the

workshops and/or seminars conducted internally. Understanding the types of workshops held, the frequency of the workshops and how well they are attended will help in the decision-making process for the church and its' leaders to become involved in HIV/AIDS outreach ministry strategies. The third was responsibility, how church leaders view their obligation to support people in their communities affected by HIV/AIDS. Discovering the tools required to promote understanding of the epidemic in the Black communities as well as identify some reasons church leaders may not want to participate in HIV/AIDS prevention. The fourth was HIV/AIDS program components, uncovering what have church leaders done in response to the HIV/AIDS crisis in Brooklyn, Queens and Nassau counties, prevention services conducted, barriers and other local programs in the area. Realizing mindset and fear of the unknown are impediments in managing HIV/AIDS outreach program strategies. The last emerging theme was leadership styles, defining the style of the church leader, what kind of leadership need to be in place to develop and manage HIV/AIDS outreach program strategies and what role the Black Church plays in addressing HIV/AIDS in the African American community. In illustrating leadership, respondents articulated the need for vision and for upholding forward motion against the disease. Being a visionary expressed as a significant attribute in a leader. I gave each participant a coding summary of the HIV/AIDS strategies discovered in his or her interview, and none of the participants sent back changes. During the initial phase, specific themes emerged and quotes accompanied themes to emphasize their importance (see Table 8).

Table 8

Initial Coding Report

Major Theme	Quotes that helped derive the theme
Participation	"We need a lot of help with prevention and education". "Well I felt it necessary to create a program". "Pastor said I'm doing a health program and I need you to work on it". "Personal". "I came to participate I this program based on community need".
Church Program	"Sure, we have done several". "Yes, we do testing and workshops". "We have health fairs". "Yes, we have seminars daily and community outreach programs monthly". "We do monthly workshops and seminars". "From the onset we started off with a workshop".
Responsibility	"More outreach". "Bring about a greater understanding". "Pamphlets should be given out daily". "I think it needs to be more discussion".
HIV AIDS Program Components	"Holistic ministry". "We collaborate with the health department". "We have a wellness community". "We have an active health ministry that addresses HIV/AIDS at this location".
Leadership styles	"Go-getter". "I'm more autocratic in the sense that I'll have to take the initiative sometimes to move things forward". "Think I am a quiet leader". "I think I am a strong positive leader". "I think I am a democratic leader". "I believe I am a servant leader".

Based on Table 8 participation emerged from icebreaker interview question, church program emerged from Research Question 1, responsibility emerged from

Research Question 2, HIV/AIDS program components emerged from Research Question 3, and leadership styles emerged from Research Question 4. Code develop themes was based on keywords. Program, HIV, and experience were keywords that emerged from participation theme occurring 42 times during data analysis. Seminars, workshops, and testing were keywords that emerged from church program theme occurring 44 times during data analysis. Keep, people, and aware were keywords that emerged from responsibility theme occurring 24 times during data analysis. Family, Information, and prevention were keywords that emerged from HIV/AIDS program components theme occurring 27 times during data analysis. Leader, democratic, and servant were keywords that emerged from leadership styles theme occurring two times during data analysis. Outliers or discrepant cases did not exist therefore were not factored into the analysis because none existed.

To explore all potential HIV/AIDS outreach program strategies in all interviews, I methodically combed each strategy by keyword and reread all transcripts to guarantee I had assigned all unchanged elements correctly. This arrangement and recoding procedure also resulted in a modification of the themes uncovered in the initial round of coding. I arranged the HIV/AIDS outreach program strategies into subcategories that would offer additional detail and importance to major themes. In Table 9 below, I list the final coding outcome, arranged by major themes and thematized into subcategories suitable to HIV/AIDS outreach program strategies within the Black Church.

Table 9

Final Coding Report

Major Theme	Sub-category
Participation	Time spent, successful why, successful experiences, reasons for participating, program role, problem assistance and initial involvement
Church Program	Workshops, seminars, event frequency, conducted workshops and attendance
Responsibility	Promote understanding, and non-participation
HIV AIDS Program Components	Response to the HIV/AIDS crisis, health ministry, barriers, and area programs
Leadership styles	Required leadership keywords, other church leadership, leadership type needed, leadership type-church leaders, and Black Church addressing HIV/AIDS

Evidence of Trustworthiness

Credibility

Credibility in qualitative research refers to the consistency of the findings with reality (Mertler, 2015). To guarantee credibility initial contact with church leaders was through a formal letter of invitation to participate in the inquiry. I explained the purpose of this study to each participant and allowed him or her to ask questions to ensure everyone had clear understanding before verbal and signed consent to participate. The same data collection method used for all participants. I arranged face to face, semi structured audiotaped interviews. I utilized the same interview questions for all

interviews. I interviewed participants at their church or private residences. I also interviewed participants from early to late evening. Additionally, I interviewed both male and female participants. An independent certified coach from The John Maxwell Team, a consultant from Global Performance Consulting, LLC and the President and CEO from The Center for Rapid Recovery, Inc., subject matter experts with expertise in managing HIV/AIDS outreach programs reviewed the findings of this research for their credibility.

Transferability

Transferability in qualitative research, according to Schwandt (2015), means the extent to which the findings of an examination applicable to other situations. This idea is supported by the strategies of rich, thick description and either maximum variation or typicality of the sample (Schwandt, 2015). I used the strategy of rich, thick description by describing the setting, the participants, and the findings in detail so that readers are able to understand the extent, which the findings of this research are transferable to other situations. Another strategy that I used was typicality of the sample. Schwandt (2015) defined typicality as how "typical" an individual measures up to others in the same group. This typicality of sample allows the readers to make comparison with their own situations. For this investigation, I selected and described typical church leaders who managed HIV/AIDS outreach programs in Queens, Brooklyn, and Nassau counties. I provided meticulous depictions of the data collection and data analysis processes that I followed so that readers distinctly comprehend how I conducted the research. I also depicted the research context in detail, including the site, date, and time of the interviews,

the county where the HIV/AIDS outreach programs resided, and assumptions and limitations that were significant to this study.

Dependability

Dependability ensures that the research findings are consistent and are repeatable. Strategies that qualitative research could use to ensure dependability of research include peer examination, clarification of the researcher's position, and an audit trail (Mertler, 2015). I used the strategy of peer examination by expert panel with advanced degrees in management to review this research and to determine if the results were supported by the data. The dissertation committee members also examined this study carefully to ensure that data analysis was precise and that I did not exclude or modify any findings.

Research to reveal strategies for faith-based HIV/AIDS outreach programs involved numerous repetitions of coding and analysis, including four rounds of review and thematizing, and two member-checking events. The first member-checking event was to send each interview transcription summary back to the participant for evaluation to guarantee I captured the meaning of what was said. The second event was to send the collected set of HIV/AIDS outreach program strategies back to all participants. To establish dependability, I documented my procedures by manual note taking regularly. Writing things down physically made it easy to document my views and activities immediately. Manual note taking provided immediate access to my notes as well.

Data saturation was obvious after all six interviews. HIV/AIDS outreach program strategies among all six participants were consistent due to the similar managing

experiences within their HIV/AIDS ministries. All of the interviews produced comparable interview responses. There were no unlike cases as each church leader participated in an active HIV/AIDS ministry at the time of this examination.

Confirmability

Confirmability refers to the objectivity of qualitative research. One approach that researchers often use to improve the objectivity of qualitative research is reflexivity. Roulston and Shelton (2015) defined reflexivity as a way to discuss and clarify the assumptions, experiences, and theoretical understandings of the researcher to what they are studying. I used the method of reflexivity by explaining my position about the role of church leaders and how participants were selected. Additionally, I explained my assumptions and what impact it may have on the data collected. Time was taken for critical self-reflection and how my role as the researcher, might affect this investigation as well.

To authenticate confirmability literature supported emerging themes. Theme 1 (Icebreaker) was developed as relationship builder and opening general scope. Pichon et al. (2015) confirms Theme 2 (participation) as an organization, the Black Church has recognized itself as a chief contributor of community support benefits within the African American community. The Black Church has improved its commitment in tackling the HIV/AIDS plague from a prevention, concerned, and religious outlook (Pivnick, 2015). Theme 3 (church program) and Theme 5 (HIV/AIDS program components) development was supported by Hardy (2015) who mentioned engaging in executing national

HIV/AIDS prevention plans, carrying out customized curriculums in their places of worship, seminars, and colloquiums as program and component possibilities. Cook et al. (2015) the development of Theme 4 (responsibility) by stating as HIV/AIDS influences the health of an individual, it also alters family operation by shifting family responsibilities. Sometimes a church family is all one may have. For further confirmation, Stewart (2015) stated church leaders and congregants become more involved in HIV/AIDS efforts once they recognize the impact of HIV on their congregations and communities. However, in order to move forward, it is the responsibility of church leaders to identify opportunities for improvement. Theme 6 (leadership styles) developed by the support of Obong'o (2016) who says historically the Black Church provides an array of support mechanisms and services for members and the community at large.

Study Results

The main research question that guided the study was as follows: How do church leaders manage HIV/AIDS outreach program strategies. Through a convenience sample, I was able to access relevant information by contacting the church leaders to obtain permission to conduct my research at the place where they were most comfortable. The sample for the study allowed for greatest chance for recurrence and significance of the findings for data saturation (Fusch & Ness, 2015). The church leaders met the research study criteria of church leaders 25 years or older managing a Black Church in the communities of Queens, Brooklyn and Nassau counties. The church leader (Pastor, Coordinators, Directors, etc.) who managed HIV/AIDS outreach program strategies for

the church participated in semi structured interviews. The Department of Health Coordinator of Faith Communities Project and Balm In Gilead, Inc. provided Faith-Based Ministries document, including Services Resource Directories. The Coordinator of FBO's within New York City provided the HIV/AIDS Faith-Based Ministries document, including active ministries in Brooklyn, Queens, and Nassau counties.

To initiate the research study, I emailed twenty-four church leaders presenting a letter of introduction and consent form. I reached out to twenty-four church leaders and six of the church leaders signed the consent form and agreed to have the interview recorded. I conducted interviews over a 4-month period, and participants provided feedback during and after the interviews to reinforce validity of the results through member checking. Each interview lasted no more than 1 hour and a half. I conducted each interview in a private room at the church location or residence, whichever was preferred by the respondent.

I replaced the names of the participants with codes: QU01, QU02, BK01, BK02, NA01, and NA02. The participants clarified their responses as needed. Review of external documents occurred with the Department of Health Coordinator and Coordinator of FBO's within New York City occurred one week before the start of interviews and one week after completion of interviews. Secondary data received codes of D1 and D2. The use of secondary data documents allowed for systematic triangulation of the data. After personally transcribing each interview and manually coding, I loaded transcriptions and secondary data documents into NVivo 11 Pro software for coding and assistance with

analyzing themes. In the following section, I define the key themes and present the findings related to each research question. Five themes emerged during data analysis: (a) participation (b) church programs (c) responsibility (d) program components and (e) leadership style.

Research has described the development and management of church-based HIV/AIDS outreach strategies, however, there is a significant lack of frameworks and approaches available to guide the implementation and maintenance of HIV/AIDS outreach strategies within church-based settings (Stewart, 2015). The purpose of this examination is to help develop a strategy of the process of managing a church-based HIV/AIDS outreach program. The themes found in the investigation demonstrate a common set of factors that may affect a church's ability to make a change in support of developing and managing HIV/AIDS outreach strategies. Because of these similarities, knowledge from church leaders who manage HIV/AIDS outreach strategies can guide the design of other outreach program strategies.

Icebreaker

Theme 1 – Participation

The first theme discovered was participation. Participation is the state of being related to a larger whole, to possess some of the attributes of a person, thing, or quality, to take part in or experience something along with others. HIV/AIDS outreach program resources may become more available during formal participation than through informal community outreach (NA01, private exchange, February 26, 2016; NA02**,** private exchange, April 3, 2016). Faith-based ministries resource directory from New York City,

Faith Communities Project and Balm In Gilead, Inc. identifies the churches' that have active HIV/AIDS ministries for church leaders to participate. All of the respondents gave reasons of initial involvement in the HIV/AIDS outreach program strategies in their church ministries. Two participants mentioned their involvement was due to personal experience and because there was an alarming rate of HIV/AIDS in the African American community (QU01, private exchange, January 22, 2016; QU02, private exchange, February 8, 2016). The next two participants mentioned they were involved because their pastor appointed them and because interest was sparked which resulted in becoming a volunteer for the program (BK01, private exchange, February 22, 2016; BK02, private exchange, February 24 2016). The final two participants stated their involvement was due to pastor suggestion, and to provide community NA01, private exchange, February 26, 2016; NA02, private exchange, April 3, 2016). During member checking respondents listed specific reasons they participated in HIV/AIDS outreach program strategies. One participant stated am I my brother's or my sister's keepers, if your answer is yes then you do not have a problem creating a program (BK01, private exchange, February 22, 2016). Another participant said I believe that outreach program strategies should be implemented just as if I would pursue a business, it should be given the same amount of dedication because we are talking about life here, and we are talking about saving and protecting lives (BK02, private exchange, February 24, 2016). Participating in a HIV/AIDS outreach ministry may provide guidance as well as motivate the church to seek support in developing a HIV/AIDS outreach program ministry. Table 10 shows the

participant occurrence and reference occurrence for the theme participation, including the interview questions related to each node.

Table 10

Nodes Related to Theme 1 - Participation

Name	Sources	References
Theme 1: Q1 Initial involvement	6	7
Theme 1: Q2 Program	6	6
Theme 1: Q3 Time spent	6	6
Theme 1: Q4 Assist with problem	5	10
Theme 1: Q5 Reasons for participating	6	8
Theme 1: Q6 Successful experiences	6	10
Theme 1: Q7 Participant feelings	5	11
Theme 1: Document 1	3	2
Theme 1: Document 2	3	2
Total	46	62

Four participants mentioned that participation was a key factor in providing community awareness. The participants expressed that prevention and education requires a great deal of help (NA01, private exchange, February 22, 2016). Informing the community and educating them about this crisis is vital (NA02, private exchange, April 3, 2016). Providing community awareness, prevention and education stems from the support of the church leaders. Pastors and Deacons play a big role in the church. Four participants mentioned support provided by Pastors and Deacons will increase the

support from membership and ease the stigma that accompanies the disease (QU02, private exchange, February 8, 2016; BK01, private exchange, February 22, 2016). Pastors and Deacons would be great assisting with spiritual prayer for those whom are impacted by HIV/AIDS as well as praying with them (BK02, private exchange, February 24, 2016; NA01, private exchange, February 26, 2016). Table 11 indicates that the top two reasons church leaders participate in managing HIV/AIDS outreach strategies are that it is personal and need help with prevention and education of HIV/AIDS.

Table 11

Reasons for Participating in HIV/AIDS outreach strategies

Reasons	# of Participants	Percentages
Personal	2	22%
Like to help people	1	11%
Increase knowledge	1	11%
Help needed with prevention & education	2	22%
Disproportionate statistics	1	11%
Community Service	1	11%
Break down barriers	1	11%

In many other research studies on church leaders, managing HIV/AIDS outreach strategies found participation to be a fundamental part of HIV/AIDS outreach program strategies for church leaders (Coleman et al., 2012). Discovering from other successful church leaders that manage HIV/AIDS outreach program strategies, could assist in an

increase in HIV/AIDS associated information. It can also show new optimistic mindsets toward discussing HIV/AIDS and toward HIV positive people, an improved amount of ease in discussing HIV/AIDS in a faith venue, reduced HIV/AIDS-related shame, and a yearning to know more about HIV/AIDS. Participation plays a critical role when implementing and expanding a faith-based health prevention program because congregations within communities are more approachable, more empathetic, and more willing to support (Pichon et al., 2012). Many of the studies showed that church leaders may have marginal understanding of HIV/AIDS outreach program strategies, and participation helped improve this understanding (Bluthenthal et al., 2012).

RQ1 What are the church programs that support HIV/AIDSs in Brooklyn, Queens, and Nassau Counties?

Theme 2 – Church Program

Church program was the second theme that materialized from the data. Church leaders managing HIV/AIDS outreach strategies, possessing the ability to develop and implement an outreach program is a critical factor to success.

In the past, the Black Church has functioned as an instrument for distributing information, a means for shaping the community, and the foundation for tackling social, political, and health issues distressing the African American community, and it continues to execute these functions today. Even with its crucial function in the African American community, faith-based organizations (FBOs) have proceeded with difficulty to react efficiently to the HIV/AIDS epidemic happening among African Americans in Brooklyn,

Queens and Nassau counties. The Black Church has suggested many health programs, but comparatively few HIV/AIDS prevention programs. This can be the result of the shame of HIV/AIDS and related dangerous activities. Constricted funds and the task of locating programs that are compatible with churches' principles can also be the result of few HIV/AIDS programs offered. A number of evaluations have found that African American ministers, pastors, and other church leaders understand the need to deal with HIV/AIDS within their churches, think HIV/AIDS is an urgent health issue among African Americans and have a longing to introduce HIV/AIDS outreach programs in their churches. Table 12 shows the participant occurrence and reference occurrence for the theme church program, including the interview questions related to each node.

Table 12

Nodes Related to Theme 2 – Church Programs

Name	Sources	References
Theme 2: Q1 Conducted Workshops	6	6
Theme 2: Q2 Types of Workshops/Seminars	6	18
Theme 2: Q3 Held	5	5
Theme 2: Q4 Attendance	6	6
Theme 2: Document 1	3	2
Theme 2: Document 2	3	2
Total	31	40

During member checking participants mentioned that their ministries conducted workshops and/or seminars (QU01, private exchange, January 22, 2016; QU02, private exchange, February 8, 2016; BK01, private exchange, February 22, 2016; BK02, private exchange, February 24, 2016; NA01, private exchange, February 26, 2016; NA02, private exchange, April 3, 2016). Workshops, seminars, awareness sessions and health fairs played an important role in managing HIV/AIDS outreach strategies. The opportunity to conduct workshops, etc. paved a way for church leaders to begin to deal with HIV/AIDS within their churches and communities. Two participants mentioned that HIV/AIDS awareness sessions were during Sunday morning service (BK01, private exchange, February 22, 2016; BK02, private exchange, February 24, 2016). The types of workshops that church leaders held within the communities of Brooklyn, Queens and Nassau counties were program startup workshops, funding workshops, men health fairs, safe sex seminars, senior workshops, teen workshops, transmitted-contracted workshops, women health fairs, testing, and youth health fairs. The church leaders took advantage of the opportunity given to them by their pastors to share HIV/AIDS information to their congregations and communities. Participants revealed workshops were held monthly, quarterly and/or annually (QU01private exchange, January 22, 2016; NA02, private exchange, April 3, 2016; QU02, private exchange, February 8, 2016; BK02, private exchange, February 24, 2016; NA01, private exchange, February 26, 2016). Participants mentioned that workshops were well attended because of trust and confidentiality, organizational partnership, outsource & referrals and extending to the community. Trust and confidentiality can reduce the fear of seeking care due to bias and judgement. Table

13 indicates that trust and confidentiality is the reason workshops have good attendance internally or externally.

Table 13

Reasons for Good Attendance

Reasons	# of Participants	Percentages
Trust & confidentiality	2	40%
Organizational partnership	1	20%
Outsource & referrals	1	20%
Extended to the community	1	20%

RQ2 How do the church leaders view their responsibility to support HIV/AIDS affected families, friends and/or parishioners?

Theme 3 – Responsibility

The third theme that surfaced from the data was responsibility. Three participants stated responsibility was to promote understanding through education, which includes condom distribution, how one contracts HIV/AIDS and how to live with it (BK01, private exchange, February 22, 2016; BK02, private exchange, February 24, 2016; NA02, private exchange, April 3, 2016). One participant revealed it is the responsibility of the leader or the head to set the precedence, being the catalyst to motivate parishioners to support HIV/AIDS outreach strategies (BK01, private exchange, February 22, 2016). Another participant cited that it is a responsibility to have more discussions around

HIV/AIDS. Discussions outside of the walls of the church i.e. schools, etc. The participant goes on to point out that it is the responsibility of church leaders who manage HIV/AIDS outreach strategies, to take a bigger role in prevention and testing, collaborate with public health providers, and become more engaged in providing care and support services (QU01, private exchange, January 22, 2016). Church leaders have the responsibility of verbalizing honestly and taking the needed action to control the spread of HIV/AIDS. As reliable and esteemed members of the society, society listens to church leaders; their deeds set an example. Their influences and trustworthiness and their intimacy to the communities allow them the chance to make a real difference in immobilizing the spread of HIV/AIDS (QU02, private exchange, February 8, 2016). Any ideas on HIV/AIDS communicated by church leaders may be vital to the success in changing the mindset and the social patterns of their membership and communities about HIV/AIDS (NA01, private exchange, February 26, 2016). The goal of the study was to explore how church leaders managed HIV/AIDS outreach program strategies. Using strategies of active HIV/AIDS ministries for responsibility is a strategy used by church leaders to create, build and manage HIV/AIDS strategies in their churches and communities (D1, Faith-Based Ministries and Services Resource Directories, January 14, 2016; D2, New York City Faith-Based Ministries, January 23, 2016). Table 14 shows the participant occurrence and reference occurrence for the theme responsibility, including the interview questions related to each node.

Table 14

Nodes Related to Theme 3 – Responsibility

Name	Sources	References
Theme 3: Q1 Promote understanding	6	12
Theme 3: Q2 Refuse to participate	6	12
Theme 3: Document 1	3	2
Theme 3: Document 2	3	2
Total	18	28

During member checking three participants mentioned reasons why some pastors may not want to have their church participate in HIV/AIDS prevention. Three participants said one of the reasons pastors refuse to participate is due to the stigma associated with HIV/AIDS. HIV/AIDS interpreted as a taboo, a chastisement from God for sexual transgressions. Church leaders believe that those who are HIV positive are from the gay and lesbian communities. Because they do not want to be caught up in the stigma, church leaders refuse to participate at all (BK01, private exchange, February 22, 2016; BK02, private exchange, February 24, 2016; NA01, February 26, 2016). Two participants said the reason pastors may not have their church participate in HIV/AIDS outreach strategies is due to fear of the unknown and fear of how it will affect their membership along with the social statement connected to it (QU02, private exchange, February 8, 2016; BK01, private exchange, February 22, 2016). Two participants expressed the reason pastors may not have their church participation in HIV/AIDS

outreach strategies is due to not being educated. Church leaders are stuck in the old mindset of the nature of the disease and still not aware or knowledgeable about HIV/AIDS and how it influences the lives of their constituents (BK01, private exchange, February 22, 2016; BK02, private exchange, February 24, 2016). Table 15 indicates that stigma, fear, and lack of education of HIV/AIDS are the main reasons church leaders refuse to consider managing HIV/AIDS outreach strategies in their ministries and communities.

Table 15

Reasons for Refusal to Participate

Reasons	# of Participants	Percentages
Stigma	3	25%
Fearful	2	17%
Uneducated	2	17%
Personal protection of Ministry	1	8%
Personal	1	8%
Opposition	1	8%
Old Mindset	1	8%
High-risk	1	8%

RQ3 What should the components be for an HIV/AIDS program focus on with respect to improving the life of those with HIV/AIDS?

Theme 4 – Program Components

The fourth theme that developed from the data was program components. Four participants stated health ministries were active in their churches (QU01, private exchange, January 22, 2016; QU02, private exchange, February 8, 2016; BK01, private exchange, February 22, 2016; BK02, private exchange, February 24, 2016). The health ministry's addresses HIV/AIDS; holistic ministry focuses overall on the total man. The health ministry focuses on the physical and the holistic ministry focuses on the mental emotional and spiritual being of an individual (BK01, private exchange, February 22, 2016). Qualified experts (nurses, doctors) agree to come in and address health ministry attendees. Collaboration with the Health Department brings about additional awareness to the church and community (BK02, private exchange, February 24, 2016). Health ministry's not only increase awareness it gives people a sense of belonging. It removes the feeling of isolation and restores a sense of normalcy knowing someone cares for them in spite of their health challenge (QU02, private exchange, February 8, 2016).

One participant stated they had a wellness outreach, which focused on other health disparities not HIV/AIDS. However, the wellness outreach conducts HIV/AIDS outreach prevention services and offer referral sources including testing to attendees upon request (NA02, private exchange, April 3, 2016). One participant did not know whether a health ministry existed. The Clergy United Community Empowerment organization

utilizes the second floor of their family life center where information on prevention and referral sources activity may take place (NA01, private exchange, February 26, 2016). Table 16 shows the participant occurrence and reference occurrence for the theme program components, including the interview questions related to each node.

Table 16

Nodes Related to Theme 4 – Program Components

Name	Sources	References
Theme 4: Q1 Health Ministry	6	13
Theme 4: Q2 Response to crisis	5	15
Theme 4: Q3 Prevention services	5	5
Theme 4: Q4 Barriers	6	10
Theme 4: Q5 Local programs	6	16
Theme 4: Document 1	3	2
Theme 4: Document 2	3	2
Total	34	63

During member checking participants stated that HIV/AIDS prevention services were available in their ministries. HIV/AIDS prevention outreach strategies are interferences that intend to immobilize the spread of HIV/AIDS. HIV/AIDS prevention services placed into operation to both safeguard an individual and their community. One participant reveals the distribution of condoms is a form of prevention with full approval from the pastor. Discrete distribution of condoms take place but the word gets out that they are available (BK01, private exchange, February 22, 2016). Another

participant mentioned that, as a church leader there was opposition to distributing condoms because on one hand, we are preaching no sex before marriage but distribute condoms. The ultimate concern was what message the church was sending. Are we going to focus on the morality aspect or are we going to focus in on the problem at hand. The realization was that we have a health epidemic and people were going to indulge whether we agreed with it or not. When the opportunity to manage HIV/AIDS outreach program strategies became available, we had to be in prevention mode and be open to distribute condoms and other things that might have made us uncomfortable (QU02, private exchange, February 8, 2016).

The church leaders in Queens, Brooklyn and Nassau Counties have responded to the HIV/AIDS crisis by providing testing, bringing in expert staff (internal or external) and building partnerships with other organizations. One participant stated that the night set aside for Bible Study has served a dual purpose. The nights that Bible Study is not taking place, HIV/AIDS testing is available for those within the church as well as for those in the community (BK01, private exchange, February 22, 2016). One of the factors that contributed to the response of the church leaders was getting support from church membership to move forward. Support or approval to proceed described as the level of willingness and distinct actions easing the acceptance of HIV/AIDS outreach program strategies.

Leadership support expounded outside the pastor and included support from other church leaders and people who are not members of the clergy. Another participant

reveals that in response to HIV/AIDS crisis proper testing procedure training is available to show how to do testing without contaminating the test (BK02, private exchange, February 24, 2016). Another factor to the response of HIV/AIDS crisis is taking a part in current partnerships with other Faith-based organizations or HIV/AIDS organizations. Two participants mentioned that they have collaborated with The Department of Health, Nurses & Doctors, The Black Leadership Commission on AIDS, and Watchful Eye to assist with getting the word out because this crisis is not one person's disease it is all of ours (QU02, private exchange, February 8, 2016; NA01, private exchange, February 26, 2016). The faith of the community is imperative to managing effective HIV/AIDS outreach program strategies.

Managing HIV/AIDS outreach strategies can come with challenges. Two participants revealed that the lack of support is one of the impediments of HIV/AIDS outreach program strategy success. The first participant stated that a hindrance to HIV/AIDS outreach program strategy success is self as well as the lack of support from membership therefore causing discouragement and progression. Although barriers exist, giving up is not an option (NA01, private exchange, February 22, 2016). The second participant also revealed that an obstacle to HIV/AIDS outreach program strategy success is the lack of support from the community. Lack of community support would not diminish the need for HIV/AIDS outreach program strategies (NA02, private exchange, April 3, 2016).

Two participants stated that mindset is another hurdle of HIV/AIDS outreach program strategy success. Because church leaders still believe that HIV/AIDS is a demonic homosexual transmitted disease, if not been personally impacted agreement to move forward with HIV/AIDS outreach strategies will not be something they would agree to participate in (BK02, private exchange, February 24, 2016; QU02, private exchange, February 8, 2016). This investigation has revealed other barriers that may contribute to the success of HIV/AIDS outreach program strategies, which are condom distribution, lack of knowledge, lack of awareness and fear. All participants expressed that they were aware of church programs in their local areas. The local church programs provided HIV/AIDS services, medicine management services, mental health services, nutrition services, resources and referral services and testing and awareness services. Parts to HIV/AIDS outreach program strategies that improve the lives of those with HIV/AIDS.

RQ4 What leadership styles do church leaders' exhibit?

Theme 5 – Leadership Styles

The last theme that materialized from the data was leadership styles. Leadership the method through which an individual (church leader) persuades the actions of supporters (membership) in order to accomplish structural objectives (HIV/AIDS outreach program strategies). Two participants mentioned they were democratic leaders. A democratic leader makes discussions easier, inspires people to convey views, and combine all the presented views into one resolution. The participants expressed high

interest in involving other people in the decision-making, and helping with educating to prepare other church leaders to branch out in other ministries adopting their own leadership styles (BK02, private exchange, February 24, 2016; QU01, private exchange, January 22, 2016). One participant described their leadership style as strong, positive and direct. This style of leadership has provided a sense of safety and trust to those who approach with any type of HIV/AIDS confidential discussion (NA02, private exchange, April 3, 2016). One participant described their leadership style as servant. Leading by example defines the servant leader. One who is there to serve, adopting transformational leadership model. Jesus Christ had compassion, giving love to the unlovable and the outcast. Jesus accused of dinning with the sinners and that is the leadership style I adopt (QU02, private exchange, February 8, 2016). Another participant stated his or her leadership style was quiet. Throwing out ideas not received but posed by others and claimed as the owner. To manage HIV/AIDS outreach program strategies, a quiet leadership style will not deem beneficial until cultivated into a more aggressive, take-charge style (NA01, private exchange, February 26, 2016). Lastly, participant style described as an enterprising person. Every effort towards making things materialize. In addition, bringing others on board and empowering them with the tools to manage HIV/AIDS outreach program strategies effectively (BK01, private exchange, February 22, 2016). Table 17 shows the participant occurrence and reference occurrence for the theme leadership styles, including the interview questions related to each node.

Table 17

Nodes Related to Theme 5 – Leadership Styles

Name	Sources	References
Theme 5: Q1 Leadership type	6	10
Theme 5: Q2 Leadership type required	6	16
Theme 5: Q3 Other church leadership	6	22
Theme 5: Q4 Addressing HIV/AIDS	6	10
Theme 5: Q5 Required leadership keywords	6	23
Total	30	81

During member checking participants stated that development of an outreach program needs a certain kind of leader in place to manage HIV/AIDS outreach program strategies. One participant stated that one who is an enterprising person, who is not going to back down when the naysayers come. The individual managing HIV/AIDS outreach strategies should be someone who will not quit, who is accepting of all people and someone who has a certain amount of compassion and humbleness for others. Someone who is servant minded and do not mind coming down off an authoritative leadership role to become a servant (BK01, private exchange, February 22, 2016). The next participant states the differences between transformational and transactional leadership depicting the kind of leader that needs to be in place to manage HIV/AIDS outreach program strategies. Transactional leadership is more corporate or concerned with the bottom line and not really concerned with the individual as a human being.

Transformational leadership will see a person with HIV/AIDS and not look at them as a disease or social outcast but as a loving person. The compassion and love will transfer in spite of their condition (QU02, private exchange, February 8, 2016).

Although the Pastors and Deacons play a huge role in the church there are other leadership positions that may be helpful in conducting HIV/AIDS prevention activities. One participant Youth Ministry, seniors, Evangelists and Ministers can assist in managing HIV/AIDS outreach strategies (BK01, private exchange, February 26, 2016). The Board of Directors, Choir Director, auxiliaries and administration within the church is encouraged to attend HIV/AIDS strategy meetings as well as seminars to learn how to interact with those impacted by HIV/AIDS (BK02, private exchange, February 24, 2016; QU02, private exchange, February 8, 2016). Drama and women ministries can have an impact in conducting prevention activities. The drama ministry can perform different scenarios drawing people in and women's ministry can offer the nurturing aspect for those who feel alone and displaced (QU01, private exchange, January 22, 2016). Every group in the church should have one person delegated to inform, even if it is a quick informational service. Every leadership program should have a health leader in place to conduct health services for HIV/AIDS as well as other diseases (NA02, private exchange, April 3, 2016).

When addressing HIV/AIDS in the African American communities of Queens, Brooklyn, and Nassau counties the church needs to take the initiative, come to the forefront, and stop laying in the background waiting for someone else to save their

communities (BK01, private exchange, February 22, 2016). Another participant shares if we look at the church historically around slavery time it was the Black Church where people were educated and values taught. The Black Church has taken a step back, allowed the government to step in while we sit back and wonder what to do next (BK02, private exchange, February 24, 2016). The Black Church has a duty to be engaged as their vocation should be to extend and be responsible for ethical and benevolent assistance to those who HIV/AIDS impact.

The participants disclosed several key words used to describe the required leadership needed to manage HIV/AIDS outreach program strategies in the Black Church. Participants of Queens Communities described the required leadership needed as non-judgmental, open-minded, democratic, compassionate, emotionally strong, mentally strong and visionary. Brooklyn Communities described the required leadership needed to manage HIV/AIDS outreach program strategies as acceptance, teachable, strong, humbleness, backbone, openness, and willingness. Lastly, participants from Nassau Communities key words were knowledgeable, confident, sincere, non-judgmental, health conscious, health awareness, multifaceted, approachable and confidentiality.

The participants revealed that HIV/AIDS outreach strategies are essential (QU02, private exchange, February 8, 2016) and there is a need to address HIV/AIDS in the black community (BK01, private exchange, February 22, 2016). As one would pursue a business venture, outreach program strategies should exemplify the same passion and

dedication (BK02, private exchange, February 24, 2016). Participation should come from everyone, not only the church leaders. Replace assumptions about HIV/AIDS with stepping forward and becoming the change agent by supporting, committing and taking responsibility for those impacted by HIV/AIDS (NA02, private exchange, April 3, 2016). Collaborating with community base and faith base organizations is imperative to increase effectiveness and reach larger audiences (QU01, private exchange, January 22, 2016). If we say, we are our brother's or sister's keeper, then the answer should be yes when the opportunity arises to manage HIV/AIDS outreach program strategies (NA01, private exchange, February 26, 2016).

All themes that emerged from this investigation were included. No discrepant cases or unconforming data existed.

Summary

This chapter included the results of this case study. Workshops, health fairs, awareness sessions and seminars supported HIV/AIDS outreach strategies in Brooklyn, Queens and Nassau county communities. Church leaders deemed it their responsibility to promote understanding of the epidemic and the need for outreach strategies by being an example, setting the precedence, soliciting more discussion, providing more education, being more compassionate and receptive to managing HIV/AIDS outreach strategies in their ministries. Wellness ministries, holistic ministries and prevention services were components of HIV/AIDS outreach program strategies to improve the life of those with HIV/AIDS.

The church leaders who took part in this examination want to see leadership styles that exhibit persistence, acceptance of all people, compassion and humbleness. HIV/AIDS outreach program strategies requires leadership that displays tenacity to stand up to those who reject programs such as these because of stigma and ignorance. Though church leaders are reacting, programs are inept, they have a resource deficit and a deficiency in skilled personnel, bridging this gap may increase the desire to implement and manage HIV/AIDS outreach program strategies. Chapter 5 includes the interpretation of findings, limitations of the study, recommendations, implications and conclusions.

Chapter 5: Discussion, Conclusions, and Recommendations

The purpose of this examination was to understand how church leaders of Black Churches in the communities of Brooklyn, Queens, and Nassau Counties manage strategies of their HIV/AIDS outreach programs and provide preventive education for those possibly infected by this disease. I used a qualitative multi-case study methodology to understand the strategies of managing successful HIV/AIDS outreach programs because both case study and exploratory design stimulated a thorough analysis, which for this examination was the process that church leaders experienced in managing HIV/AIDS outreach programs and preventive education. Review needed because the focus was on church leaders who successfully managed HIV/AIDS outreach programs within their ministries. Another reason why this review was required was that the focus was on African Americans who are disproportionately affected. Foster et al. (2011) looked at HIV/AIDS ministries often accentuated although churches are reacting, programs are inept, and have insufficient resources. Programs also have a deficit of experienced counselors in the church.

The findings that emerged from the data analysis for this investigation related to the factors that influenced church leaders' management of HIV/AIDS outreach program strategies. The first factor that influenced church leaders' management of HIV/AIDS outreach program strategies was participation, learning from church leaders how they became involved. The second factor that influenced church leaders' was church programs, understanding the types of workshops, the frequency of the workshops and how well attended. The third factor that influenced church leaders' was responsibility,

how church leaders viewed their obligation to support people in their communities. The fourth factor that influenced church leaders' was program components, uncovering church leaders' response to the HIV/AIDS crisis in Brooklyn, Queens and Nassau counties. The fifth and final factor that influenced church leaders' was leadership styles, what kind of leadership needed to be in place to develop and manage HIV/AIDS outreach program strategies and what role the Black Church played in addressing HIV/AIDS in the African American community.

This final chapter presented in three parts. The first part includes an interpretation of the findings in relation to the literature review and the conceptual framework. The second part includes a discussion of the limitations of the study and recommendations for future research. The last part includes a discussion of implications for positive social change.

Interpretation of Findings

The purpose of this qualitative exploratory case study was to explore what programs and education church leaders use to support those with HIV/AIDS. Additionally, how church leaders manage HIV/AIDS outreach program strategies.

Exploration of the experiences of managing HIV/AIDS strategies by church leaders supplied actionable approaches upon which church leaders may use to create HIV/AIDS outreach programs in future ministries. Discovering tactics for developing and sustaining effective faith-based HIV/AIDS outreach programs involved analyzing earlier research for material on previous programs and following up with a qualitative study to

substantiate or expand the outcomes of the literature review. I utilized this methodology because it generated deeper perceptions on the important incentives with each church leader (Seidman, 2013). The focus of my literature examination was on empirical inquiries of religious congregations and their involvement with HIV/AIDS outreach program strategies. The literature on church-based HIV/AIDS outreach programs included church leaders' involvement and responsibility with HIV/AIDS prevention programs. During the literature review, I found, church leaders were open to carrying out HIV/AIDS outreach program strategies in their places of worship as long as the curriculums stayed in agreement with the church principle (Stewart, 2015). Church leaders were willing to work with community-based groups in applying program strategies. The Black Church has improved its commitment in tackling the HIV plague from a prevention, concerned, and religious outlook (Pivnick, 2015). The literature review was comprehensive concerning HIV/AIDS prevention, led to a gap in the literature concerning coordination of program initiatives, and qualified counselors in faith-based organizations. However, outreach program strategies I uncovered in the literature review were similar to those mentioned by the participants in the study. In table 18, I show similar church addressed HIV/AIDS outreach program strategies found in the literature review and those found in the study. In the following section, I will expand on the similarities between the two sources.

Table 18

Similarities of literature and study church addressing outreach program strategies

Literature church addressing strategies	Study church addressing strategies
Primary Vehicle (Pastors)	Set precedence (Pastors)
Sex positive messages	Address from the pulpit
Homosexuality stigma	HIV/AIDS stigma
Partnerships	Collaboration
Church HIV/AIDS prevention (source)	Church is viable
Integrate sexual and total health	Focus on total man
Lack training	Lack awareness, knowledge & support

The literature states pastors are the primary vehicle to leading congregants to accept the possibility of implementing HIV/AIDS outreach program strategies into their ministries (Powell, et al., 2016). The study mentions pastors are the catalyst to more education, receptiveness and compassion towards persons with HIV/AIDS (BK01, set precedence, February 22, 2016). The Black Church hold pastors in high regard and their leadership is crucial in moving HIV/AIDS outreach program strategies forward.

Addressing sexual health and HIV/AIDS in sermons would allow other ministries to address the topics more freely (Coleman, et al., 2012). The investigation found that speaking about HIV/AIDS ministry from the pulpit has become common practice (NA01, address from the pulpit, February 26, 2016). Sex positive messages addressed from the pulpit reduce the shame, increase awareness, and pave the way for future strategies.

Derose, Mendel, et al. (2011) mentions religious messages about HIV/AIDS connects the disease with sin and religiously based stigma towards homosexuality have created a hindrance to HIV/AIDS action by the faith community. The analysis reveals church leaders do not participate in HIV/AIDS outreach program strategies due to the stigma associated with the disease or because church leaders may not know how to respond (BK01, they don't want to get caught up in that whole stigma, February 22, 2016). Church leaders say it is hard to answer why others are reluctant to participate, but most churches may be stuck in the old mindset of the nature of the disease and have not became aware or knowledgeable about the disease and how it impacts the lives of their constituents. (BK02, view as death sentence or taboo, February 24, 2016). Church leaders think those who are HIV positive are always from the gay and lesbian community. However, that is not always true, they could be drug users who use the same needle, born with it or contracted from blood transfusion (not so much today). The stigma or mindset requires a shift because it is not just the gay/lesbian community it is everyone and their lifestyles (NA01, the biggest thing is still the stigma, February 26, 2016).

Stewart (2015) pointed out that collaborations and partnerships are critical to the development of a HIV/AIDS ministry. Collaborations and partnerships will provide educational materials, trainings, HIV testing kits, condoms and other crucial assets, as well as discussion on handling the details of development. Church leaders in this analysis described their experience with collaboration and partnership. For continuous awareness, they partner with corporations and partner with other community outreach to get them on board with assisting in enhancing management of HIV/AIDS outreach strategies (QU02,

partner, February 8, 2016). Church leaders disclose specific partnerships such as Department of Health, Black Leadership Commission on AIDS, and Watchful eye showing the criticality of collaboration for HIV/AIDS outreach program strategies (BK01, collaboration, February 22, 2016). Collaboration with the Health Department brought about awareness and the provision of services that the ministry skill set lacked. Certified individuals who were qualified to perform those services were utilized (BK02, collaboration, February 24, 2016). Collaborations with groups, agencies, and/or programs are of great interest to HIV/AIDS ministries because specific services provided enhance the development of the program. Disease state awareness and chronic illness combined with a spiritual component if applicable is the focus (QU01, collaboration, January 22, 2016).

The African American church is a vital community affiliate in the development of HIV/AIDS prevention strategies (Stewart, 2015). Coleman and associates (2012) also identifies the church and other faith-based organizations (FBOs) as vital resources for HIV prevention and education efforts in African American communities. The analysis reveals historically the Black Church educated and taught core values (BK01, take the forefront, February 22, 2016). Church leaders today have seem to have gotten away from being the source in the community that people are seeking to drive HIV/AIDS outreach program strategies (BK02, take the forefront, February 24, 2016).

The literature reveals that sexual health is one component of total health and well-being and discussions should happen within the congregations of faith-based

organizations (Powell et al., 2016). Church leaders will minister and provide care to the dying, however, but neglect to encourage disease prevention. The exploration talks about holistic ministries focusing on the whole and total man. Tackling one aspect of the problem without focusing on all aspects of the issue is impossible. If we are going to focus on the physical, then we need to also, focus on the mental, emotional and spiritual qualities of an individual dealing with HIV/AIDS (BK01, total man, February 22, 2016).

Significant barriers that hinder development of HIV/AIDS outreach strategies are lack of training, awareness, knowledge, support and inexperience in discussing HIV/AIDS related topics (Stewart, 2015). The analysis discloses that the lack of knowledge may form a discriminatory attitude towards the congregation and toward the people who are involved with the HIV/AIDS ministry. In order to maintain the spiritual content of the church increasing the knowledge and decreasing discrimination may be one way to bridge the gap (QU01, lack of knowledge, January 22, 2016; BK02, lack of awareness, February 24, 2016). Church leaders feel that they do not receive the support that is required to implement HIV/AIDS outreach program strategies. The lack of support becomes discouraging but giving up is not an option (NA01, lack of support, February 26, 2016; NA02, not participating, April 3, 2016).

Limitations of the Study

Limitations of this study included a small sample size limited to Queens, Brooklyn, and Nassau counties in New York City. During execution of this examination, collected data from two church leaders per county, 25 years of age or older, male or

female, and managed strategies in an active HIV/AIDS outreach program ministry. Although, interview research is susceptible to bias (Lomagino, 2015) the church leaders did not try to prove the programs' success. Those managing HIV/AIDS outreach strategies shared honestly the pros and cons of their ministries. The church leaders pointed out improvement possibilities and welcomed collaboration with community members. They also addressed possible ways to improve how they manage their HIV/AIDS outreach program strategies. The analysis revealed community members and program participants invested very little into the HIV/AIDS ministries resulting in minimal bias. I made every effort to conduct interviews that will allow minimal bias.

The second limitation was the time it took to conduct interviews, transcribe interviews and analyze the results. I included time for transcriptions and analysis of the detailed data. The interviewee was comfortable and I appeared interested in answers. I avoided yes/no and leading questions, I used appropriate body language, and kept all personal opinions safeguarded.

A final limitation is that when conducting in-depth interviews, there is an inability to create overviews about the results because of the selection of small samples and utilization of random sampling methods. Data saturation became apparent when the stories, themes, issues, and topics surfaced were the same accomplishing an adequate sample size of six interviews.

Recommendations

Recommendation for Practice

Research regarding HIV/AID outreach programs in relation to managing strategies is still deficient. The first recommendation for practice is to examine the structure of an active African American HIV/AIDS outreach ministry defining current processes, identifying improvement opportunities, implement improvements, sustain, control and roll-out to other church leaders that need assistance in managing their HIV/AIDS outreach program strategies. In Brooklyn, Queens, and Nassau counties, there are 43 active faith-based HIV/AIDS ministries that will benefit from understanding the health, heartbeat, and pulse of their ministries by assessing the current structure. The assessment will help the faith-based organization single out possible chances for improvement at a high level and provide understanding of the HIV/AIDS outreach program strategies before change happens. After a complete investigation has taken place guarantee buy-in from church leaders (Pastors, minister, deacons, ministry leads). The most critical component of an assessment is and will be the people. Once HIV/AIDS outreach program strategies have become a priority in faith-based organizations, once bettered, will significantly improve the Black Church HIV/AIDS outreach program strategies.

The final recommendation for practice is to synchronize programs and increase resources required to manage HIV/AIDS outreach program strategies in faith-based organizations. Faith-based organizations should follow the practice ‘each one, teach one’,

an African proverb originated in the United States during slavery. Faith-based organizations need to learn how to learn from each other, no program will be a perfect fit because localities will be different, the audience will be different and church curriculum will be different. However, collaborating with each other, and sharing individual successes will ignite conversation and a much-needed plan for progression, structured framework and strategies for HIV/AIDS outreach programs within the Black Church and community. Creating a sense of oneness, standardization, and streamlining may remove the difficulty of obtaining resources required. Resources such as, external agency contacts, HIV/AIDS supplies (literature, testing kits, gloves, funding, etc.) for faith-based perspective, and a leadership team that will coach and lead those managing HIV/AIDS outreach program strategies within faith-based organizations.

Recommendation for Further Research

Additional research focusing on how HIV/AIDS outreach strategies will help families affected by HIV/AIDS, individuals with HIV/AIDS, and/or parishioners within the congregation who may be infected could create knowledge regarding mechanisms for using outreach strategies for additional support to those who choose to expose their status or association with someone who is suffering from HIV/AIDS. Conducting additional quantitative studies could help in creating a precise exploration into strategies that work for active HIV/AIDS outreach ministries. Future studies could expand the knowledge Pastors and church leaders have to share about the success of their HIV/AIDS outreach strategies.

For future research, the use of open-ended questions may allow participants to expand on their thoughts and provide details that are used for quantitative analysis.

In conclusion, the recommendations for further research are to utilize open-ended questionnaires in quantitative research to gain experiences and details on the strategies of HIV/AIDS outreach ministries. In addition, researching ways Pastors can better broadcast information on HIV/AIDS could prove useful by creating alliances. The ability to look at more than one HIV/AIDS ministry could also help in discovering similarities to increase the number of HIV/AIDS outreach ministries in faith-based organizations in other cities and states.

Implications

Significance to Social Change

By conducting this investigation, I was helpful in recognizing strategies that may help in successful HIV/AIDS faith-based outreach programs by empowering the development of HIV/AIDS ministry opportunities for church leaders. Stewart (2015) explained that African Americans are more likely to attend a church, pray regularly, and report themselves as very religious, in comparison with other racial and ethnic groups. The church plays a prominent role in social and political scopes of African American lives since its beginning. People seek safety in the church and trust in its' leadership and because of the positive impact it displays, church leaders have the venue to increase awareness of HIV/AIDS prevention, care and treatment within the Black community. Positive social change occurs when church leaders and congregations address the

HIV/AIDS outreach program strategies within Black communities decreasing stigma and confusion and increase the engagement of Black communities in HIV/AIDs prevention and treatment services. The impact of positive social change on church leaders includes additional opportunities to address the HIV continuum from prevention, to testing, to care of AIDS-infected congregants (Stewart, 2015). Church leaders' buy-in is the substance for most HIV/AIDS outreach program strategies and therefore has the same impact on society as managers in secular organizations.

Significance to Theory

The normative decision leadership theory tells leaders how they ought to act. This theory built on ethical ideologies or norms provide guidelines for endorsing ethical leader behavior (Minor, 2015). Normative decision leadership theory calls for managers to select a leadership style according to the amount of participation in decision making appropriate for the situation. Leaders use variations of authoritative, consultative, group-based, and delegative styles. These styles lead to different decision-making processes for solving both individual and group problems. The purpose of this qualitative exploratory multi-case study is to explore the HIV/AIDS outreach strategies of the Black Church in Brooklyn, Queens, and Nassau counties that will show how the church leaders manage established and successful programs.

Normative decision leadership theory and the church constructed on moral principles. This management theory contributes to developing pastors and church leaders by their use of various leadership styles such as authoritative, democratic, consultative,

delegative, and group based. Church leaders display various leadership styles that results in different decision-making processes when managing HIV/AIDS outreach program strategies. Pastors and/or church leaders make choices, formulate visions, set objectives, lay routes to reach the objective, and make all attempts with congregation and others who follow in accomplishing it.

Significance to Practice

Faith-based organization activities play a vital role in the community, and faith-based organizations can learn from each other's successes in developing and managing HIV/AIDS outreach strategies (Abara et al., 2015). Faith-based organizations are able to establish new associations and alliances with many HIV/AIDS agencies and churches with comparable HIV/AIDS prevention goals (Coleman et al., 2012). Faith-based organizations that create new associations and alliances within the congregation and community increase HIV/AIDS-related knowledge, attitudes, and changes in HIV/AIDS-related shame.

The churches' role in HIV/AIDS prevention intervention can begin to open conversations about HIV/AIDS, willingness to get tested for HIV, increase general knowledge about HIV/AIDS, and dismiss the fabrications about its transmission (Coleman et al., 2012). Highlighting the church HIV/AIDS program strategies that will work in HIV/AIDS prevention intervention will help to demonstrate the success of the church as a go-between in addressing dynamics in HIV/AIDS prevention like HIV/AIDS-related humiliation and normative feelings and understanding about HIV testing and safe

sex. The immersion of the church in overseeing HIV/AIDS strategies will assist in alleviating HIV/AIDS shame. The church leaders are able to grant the freedom to hold sermons from the pulpit that will focus on the impact of HIV/AIDS within the African-American community (Nunn et al., 2012). The study affects many church leaders in the Black Church because the findings contribute to their understanding of how to manage HIV/AIDS outreach strategies to develop maintainable and longstanding approaches that address elements that may otherwise hinder HIV/AIDS reduction efforts in African American communities.

Moreover, HIV/AIDS outreach strategies within Black Churches exist the least as oppose to other outreach strategies managed by church leaders, but for reasons that may not be fully understood (Pichon et al., 2015). This investigation helped provide strategies specific to HIV/AIDS outreach for the church leaders of the Black Church.

HIV/AIDS epidemic is disproportionately affecting the black communities of Queens, Brooklyn, and Nassau counties, thus successfully developing and managing HIV/AIDS outreach strategies by way of church leaders can be vital to individuals and nearby communities for addressing the racial and ethnic disproportion that is associated with this virus (Stewart & Thompson, 2015). Communicating how to manage successful and established HIV/AIDS outreach strategies will increase the chances that other church leaders will provide preventative education forums, support and resources to increase the number of programs within Queens, Brooklyn, and Nassau county areas (Pichon & Powell, 2015). Providing training and re-certification training will increase the number of

qualified counselors in the church. Preparing individuals may increase willingness to participate in HIV/AIDS outreach program strategies. Preparation may increase comfortability in engaging in discussion of HIV/AIDS within surrounding communities.

Providing church leaders with necessary training to manage HIV/AIDS outreach program strategies will increase their receptiveness and compassion towards those who HIV/AIDS impact. Providing the necessary training to church leaders will increase understanding of how people contract HIV/AIDS, how to live with it, and how to impress upon people that HIV/AIDS is a disease that you can live with and not a death sentence. Providing necessary training to church leaders will enhance technological capabilities that offer virtual ways of reaching the masses. As the world continues to evolve it is crucial for initial training to take place as well as annual refresher training to guarantee church leaders are aware of the latest information on HIV/AIDS outreach program strategies.

Organizationally there are many reasons employers conduct training and development among their employees. Increase self-esteem, employee enthusiasm, effectiveness in procedures, ability to accept new methods, improvement in strategies and company persona. Church leaders who manage HIV/AIDS outreach strategies should adopt the same concept, as the church is also an organization that can benefit from these general benefits of training and development.

This study contributes to business practice by providing knowledge to church leaders' about how to manage and develop HIV/AIDS outreach strategies to increase effectiveness of the church.

Conclusions

African Americans disproportionately affected by HIV/AIDS all across the United States. The Black Church has a presence and voice that people are seeking to see and hear. Pichon et al. (2012) stated it is crucial that we fill the gaps in understanding the role that predominantly African American faith-based organizations and faith leaders can play in addressing the HIV/AIDS epidemic. Effectively managing HIV/AIDS faith-based outreach program strategies is an obligation not a choice.

The exploratory multi-case study provided understanding of how church leaders in Queens, Brooklyn, and Nassau counties view their responsibility to support and manage HIV/AIDS strategies. This examination revealed that it is the responsibility of the church and its leaders to set precedence in promoting awareness and initiating enthusiasm in HIV/AIDS outreach strategy support. Church leaders have the responsibility to have open discussions about HIV/AIDS because viewed as reliable and esteemed members of society. Church leaders set examples that influence people to listen, therefore already providing a platform to hold HIV/AIDS forums. Conveying messages of concern and love to the congregation and surrounding communities through supporting the vision of the ministry and HIV/AIDS outreach strategies from the pulpit

will increase awareness, reduce stigma, and build cohesiveness between all of God's people.

Components needed to manage HIV/AIDS outreach program strategies emerged as one of the predominant themes. Holistic, wellness, testing and awareness, nutrition, mental health, prevention services, medicine management and HIV/AIDS services are elements to managing successful outreach program strategies. Church leaders managing HIV/AIDS outreach program strategies attempt to encourage physical, mental, and spiritual completeness. Church leaders in Queens, Brooklyn and Nassau counties undertaking is to deliver material that will help people identify and deal with their health knowledge. In order to reach this objective, church leaders and their ministries have to be devoted to working with people in the community, the congregation and churches of other denominations.

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Appendix A: Invitation to Participate in the Study

Dear Sir/Madam,

As part of my doctoral study research at Walden University, I would like to invite you to participate in a research study I am conducting to explore the HIV/AIDS outreach strategies of the Black Church in Brooklyn, Queens, and Nassau counties. The intent of this study is to show how these outreach programs are established and, I would like to try to understand how successful programs are managed by the church leaders. I contacted you to participate because you are a church leader from Brooklyn, Queens and/or Nassau Counties. Participation in the research study is voluntary, and will be confidential. Please read the enclosed consent form carefully. If you have any questions before acting on the invitation to participate, please do not hesitate to contact me. If you meet the criteria below, I would very much appreciate your input to the study. The criteria is (a) church leader 25 years of age or older; and (b) manage a Black Church in Brooklyn, Queens, and/or Nassau counties. If you satisfy this criteria and have agreed to participate in the study, please notify me via the contact information. I will contact you again to deliver the consent form, and to set up the face-to-face interview of no more than 1 hour.

The interviews will be audio recorded and participants will have the opportunity to review the transcribed interview interpretations for accuracy prior to inclusion in the study. I sincerely appreciate your valuable time, and thank you in advance for your cooperation.

Sincerely,
Angela Hicks-Bennett

Appendix B: Informed Consent Form

You are invited to take part in a research study that explores how HIV/AIDS outreach program strategies are developed and managed by religious leaders in the Black Churches of Queens, Brooklyn, and Nassau Counties. You were chosen for the study because you are 25 year or older and manage a Black Church in the communities of Queens, Brooklyn and Nassau counties. This form is part of a process called 'informed consent' to allow you to understand this study before deciding whether to participate. Angela Hicks-Bennett, who is a doctoral student at Walden University, is conducting the study.

Background Information:

The purpose of this case study is to show how the Black Churches in Queens, Nassau and Brooklyn Counties can have a considerable affect on those persons living with HIV/AIDS, and how outreach programs are managed.

Procedures:

If you agree to be part of the study, you will be asked to:

- Participate in a face-to-face interview that will be audio recorded and will span approximately 45 minutes – one hour.
- Review my interpretation of the interview and provide feedback on the same as member check.

Voluntary Nature of the Study:

Your participation in the study is absolutely voluntary. This means that everyone will respect your decision regarding whether or not you choose to participate in the study. No one will reprimand you if you decide not to participate in the study. However, if you decide to join the study now, you are at liberty to opt out if you change your mind during the study. You may choose to stop at any time if you feel stressed during the study, and you may ignore any question(s) that you are not comfortable answering or feel are too confidential.

Risks and Benefits of Being in the Study:

Given the nature of the study, possibility of participants experiencing any harm is extremely minimal as the study focuses only on developing a list of recommendations regarding the development of outreach programs of the Black Church on the HIV/AIDS epidemic in the communities of Queens, Brooklyn and Nassau Counties. No confidential information will be sought. The potential benefit of being in the study is your contribution to providing insight on how to manage a successful and/or establish an HIV/AIDS outreach strategy program.

Compensation:

No compensation will be given to participants in the study.

Confidentiality:

Any information you provide is confidential. The researcher will not use your information for any purposes outside of the research project and will not include your name or anything else that could identify you or the church in any reports of this study.

Contacts and Questions:

You may ask any questions you have now. However, you may contact the researcher via email ahick001@waldenu.edu or via telephone 1-917-915-0850 if you have questions later. If you want to discuss privately about your rights as a research participant, you may call the Walden University's Research Participant Advocate, Dr. Leilani Endicott on +1-612-312-1210 or email irb@walden.edu. The researcher, Angela Hicks-Bennett, will provide you a copy of this form for your records.

Statement of Consent:

I have read and understood the above information and the purpose of the study sufficiently to make an informed decision about my participation. By signing below or by sending back an email with my email address, I am agreeing to the terms described above.

(Please include this in your email when you return it to the researcher)

Printed Name of participant ----------

Date of Consent ----------

Participant's Written or Electronic * Signature ----------

Researcher's Written or Electronic * Signature ----------

Electronic signatures are regulated by the Uniform Electronic Transactions Act. Legally, an electronic signature can be the person's typed name, e-mail address, or any other identifying marker. An electronic signature is just as valid as a written signature as long as both parties have agreed to conduct the transaction electronically.

Appendix C: Interview Guide

Interview Guide:

The questions will be sequenced in a specific order. The opening questions will always be an appreciative inquiry, designed to draw the interviewee into a positive mindset at the beginning of the session. The questions for my qualitative exploratory multi-case study design are:

Relationship Building and Opening General Scope

- Can you tell me how you came to participate in this HIV/AIDS outreach program?
    - Are you currently pastoring: Full Time (40 or more hours per week), Part Time (less than 40 hours per week).
    - If part time, approximately how many hours per week?

- What do you feel the Black Church can do to assist with this problem?

- What were your reasons for participating?

- Tell me about a time when you had a very successful experience working with a community outreach program or a faith-based outreach program.
    - If you haven't participated before, what are your experiences with outreach?

- What was it about this experience made it successful?

- What specific words would you use to describe how you feel about participating in outreach strategy and development?

RQ1 What are the church programs that support HIV/AIDSs in Brooklyn, Queens, and Nassau Counties?

- Have you conducted any workshops, seminars, etc. on HIV/AIDS in your church?
    - If so what were they, when was it held, and did you have good attendance?

RQ 2 How do the church leaders view their responsibility to support HIV/AIDS affected families, friends and/or parishioners?

- What do you think needs to be done to promote understanding of HIV/AIDS in the Black community?

- Why do you think some pastors may not want to have their church participate in HIV/AIDS prevention?

RQ 3 What should the components be for an HIV/AIDS program focus on with respect to improving the life of those with HIV/AIDS?

- Do you have a Health Ministry that addresses HIV/AIDS?
    - What have they done in response to the HIV/AIDS crisis in Queens, Brooklyn, and Nassau?

- Have any HIV/AIDS prevention services been conducted at or by your church?
    - If yes, what were they?

- What are some barriers that would prevent your church from having a HIV/AIDS ministry/program?

- Are you aware of any church programs in the area?
    - What kind of services do they provide?

RQ 4 What leadership styles do church leaders' exhibit?

- What kind of leader are you?
    - A few questions that will move discussion forward
    - Leadership style or attributes.

- What kind of leadership do you feel needs to be in place to develop an Outreach program?

- Are there any other leadership positions in the Black Church that might be helpful to you to conduct HIV/AIDS prevention activities?

- What leadership role do you think the Black Church could play in addressing HIV/AIDS in the African American community?

- What key words would you use to describe the required leadership in the Black Church's to support HIV/AIDS outreach programs.

Closing

- Is there anything else you would like to share about outreach program strategies

Appendix D: Interview Protocol

Interview: Exploring how HIV/AIDS outreach program strategies are developed and managed by religious leaders in the Black Churches of Queens, Brooklyn, and Nassau Counties.

1. The interview session will commence with relationship building, salutations, introducing myself to the research participant, after which I will introduce the research topic.

2. I will thank the participant for taking the time to respond to the invitation to participate.

3. I will request the participant to read the consent form, ask any questions before proceeding to sign the consent form.

4. The participant will be given a copy of the consent form for their records.

5. The audio recorder (or electronic storage device) will be turned on, and I will note the date, time and county the interview is taking place in.

6. The coded sequential interpretation of the participants' name and/or church name e.g. 'respondent Q1…' will be indicated on the audio recorder, documented on my copy of the consent form and the interview will begin.

7. The interview will span approximately 45 – 60 minutes for responses to the 4 research questions, including any additional follow-up questions.

8. I will remind participants of the purpose of the study. The purpose of the case study is to explore how HIV/AIDS outreach program strategies are developed and managed by religious leaders in the Black Churches of Queens, Brooklyn, and Nassau Counties.

9. Then, I will inform the participant regarding the review of the interview report that I will make available after my transcription.