

Qualitative Inquiry into Church-Based Assets for HIV/AIDS Prevention and Control: A Forum Focus Group Discussion Approach

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Assets church members believed they needed to engage in effective HIV/AIDS prevention and control activities. We used the three-step forum focus group discussion (FFGD) methodology to elicit responses from 32 church leaders and lay members, representing five denominations in Aba, Nigeria. Concrete resources, health expertise, finances, institutional support, capacity building, and spiritual support connected to the collective interest of members were indicated as useful for church members to engage in HIV/AIDS prevention and control activities. Adequate planning and delivery of cost-effective, appropriate and sustainable health promotion programs require an understanding of perceived church-based assets. Key Words: Community-Based Programs, Closing Forum, Health Education, Health Promotion, HIV/AIDS, Prevention, Focus Groups, Forum Focus Group Discussion, Open Forum, Nigeria, Qualitative Methods.

More than 70% of people living with HIV/AIDS reside in Africa (Ahn, Grimwood, Schwarzwald, & Herman, 2003), and given limited resources for sustainable interventions many experts look for alternative self sustainable local efforts that can be managed so that affected individuals continue to have some resources as HIV/AIDS funding from foreign sources (i.e., UNAIDS, Global Fund) decreases. It has been argued that linking to the faith community is one such natural option but few neither understand how this can best be done nor is it clearly understood what the major barriers to the operation of such church based programs are and how to spark off such a movement. Anticipated complicating factors for the systematic use of faith based entities to provide HIV/AIDS services and programs are a lack of understanding of experiences churches have to operate such efforts, a lack of current collaboration between churches given denominational differences, and a general lack of readiness to “step up” in this way as many might feel that they have no assets to offer. In general terms, Christian churches have unique characteristics that hold access to “land, people, and history” (Simpson & King, 1999, p. 43), connections (Burkhardt, 1994), relationships (Dyson, Cobb, Forman, 1997), including social, spiritual and political awareness (Stillman, Bone, Rand, Levine, & Becker, 1993), and other resources that might be important to better serving the many needs of those affected by HIV/AIDS.

There is a wide range of empirical data on the role of churches in disease prevention research (Lasater, Wells, Carleton, & Elder, 1986), mammography promotion (Derose, Fox, Reigadas, & Hawes-Dawson, 2000) and screening (Stockdale, Keeler, Duan, Derose, & Fox, 2000), breast cancer screening (Fox, Pitkin, Paul, Carson, & Duan, 1998) and peer counseling (Derose et al., 2000). Thus, churches can serve as avenues for health promotion (Simpson & King, 1999) and specifically for recruiting and training nonprofessionals for behavior change (Stillman et al., 1993). However, little is known about what assets church members believe they need or have for HIV/AIDS prevention and control, including the extent to which they believe they are capable of helping to reduce HIV/AIDS. The purpose of this study was, therefore, to determine what assets churches believed they needed to have to engage in HIV/AIDS prevention and control activities.

This work is a part of a doctoral dissertation supervised by the co-authors of this paper. One of Dr. Modeste's research interests is HIV/AIDS prevention and she has done research internationally within church-based organizations. Dr. Montgomery has also been engaged in similar studies among African-American communities in the United States and schools in South Africa. Dr. Aja has been involved in working with church-based women support networks to develop culturally-oriented assets (i.e., focus group dialogue, drama, song, storytelling, cartoon, and quiz) for communicating women health issues in Nigeria). With the recent focus on the promotion of faith-based health education interventions, we think that information regarding church assets may not only assist health education program administrators or managers in addressing a wide range of health issues but also support them to effectively utilize church assets to plan and deliver cost-effective, appropriate and sustainable health promotion programs to underserved communities. Basically, this study aims to demonstrate the usefulness of isolating church needs and assets for HIV/AIDS prevention and control from the wider community needs and resources.

Method

Design

This study used a qualitative design to obtain data on perceived assets from forum focus groups (Christian churches) in Aba North and Aba South Local Government Areas of Abia State, Nigeria (a local government area is an equivalent of a city in the United States).

Study Setting

This study was conducted in Aba, a major commercial center in Abia State, south east of Nigeria. It serves as a sub-regional, regional or a national headquarters to many of the Christian churches in Nigeria. Abia State is one of the 36 states of the Federal Republic of Nigeria, located within the forest belt of Nigeria.

Participants

Participants included 32 church leaders and lay members, representing five denominations in Aba, Nigeria.

Procedure

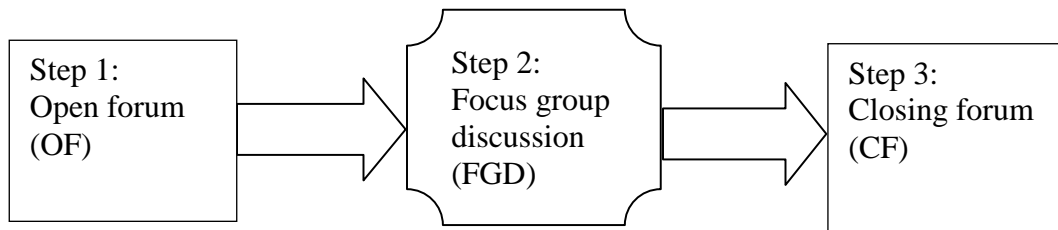
There were two sessions of Forum Focus Group Discussion (FFGD) conducted in two zones: Aba North and Aba South, on different dates. All of the 120 churches that had operated in the area for five years or more, with a resident pastor, church building and membership of 100 or more were visited and given a flyer inviting them to participate in a FFGD. The resident pastor/priest/bishop/leader signed a letter of cooperative agreement before nominating members to attend the FFGD. Furthermore, selected members from all the churches signed a consent form before participating. At the venue, the purpose of the study was highlighted and all those in attendance were reminded that participation was purely voluntary. Sign-in sheets were provided and a list of participating churches (not individuals) was compiled in order to determine the range of representation from the churches. To limit travel time for participants, the FFGD was held on different dates in the two local government areas designated for this study: Aba North (Zone A) and Aba South (Zone B).

The venue for the Forum Focus Group Discussion (FFGD) was centrally located (at public secondary schools, considered a neutral ground especially for those who did not feel comfortable attending such a meeting in a church or church-related facility). The student investigator and four field assistants contacted the churches in both zones directly and invited them to participate. Flyers specifying the date, time and location of the FFGD were distributed to the churches, as well as posted at strategic locations. To ensure that a diverse number of churches were represented at the forum, participating churches were contacted and reminded a few days before the scheduled date.

Data Collection

To obtain qualitative data needed for this study, the Forum Focus Group Discussion (FFGD) approach was used as shown in Figure 1. The three-step FFGD method started as an open forum (OF), progressed to a traditional focus group discussion (FGD) and reconvened as a closing forum (CF).

Figure 1. *A Three-Step Forum Focus Group Discussion Method*



Open Forum (OF)

(a) An open invitation was sent out to all churches to participate in a forum focus group to discuss what assets they thought they would need and what they already had to help protect members from getting HIV/AIDS, and support members infected with or affected by HIV/AIDS. Both church leaders and lay members were invited to attend.

(b) At the forum, participants were reminded that participation was purely voluntary. The student investigator explained the purpose of the study, and participants signed the consent form. They were divided into two focus groups (made up of leaders and lay members) in each of the two zones. In zone A, seven leaders and eight lay members participated, while nine leaders and eight lay members participated in zone B. Overall, there were 32 participants.

Focus Group Discussion (FGD)

(c) Each group discussed (in two sessions of 60 minutes each) two sets of pre tested focus group statements developed by the investigators using information from local articles and unpublished reports. Session one focused on what assets members perceived their churches NEEDED to help protect members from getting HIV/AIDS and support members who are or may be infected or affected with HIV/AIDS, while Session two addressed what they perceived their churches HAD to help protect members from getting HIV/AIDS and support members who are or may be infected or affected with HIV/AIDS.

Closing Forum (CF)

(d) At the end of the two sessions, the focus groups reconvened at the closing forum for 10 minutes (to share any new key idea related to the topics, which might have occurred after the focus group discussion).

(e) A field assistant was assigned to each of the focus groups to serve as a facilitator, observer, recorder, time keeper, and note taker. He/she tape-recorded and transcribed the responses verbatim. Emerging themes were used to develop the survey questionnaire.

Instrumentation

To obtain qualitative information on perceived HIV/AIDS prevention and control assets, a set of open-ended statements, based on our review of local articles and unpublished report, were developed. It contained eight statements on what resources/capacities (manpower, material, method) members thought their own churches and other churches had or did not have to help protect members from getting HIV/AIDS, support members living with HIV/AIDS and their families.

To ensure that the Forum Focus Group Discussion (FFGD) protocol was reliable, sensitive and meaningful and to familiarize the field assistants with the tool and the setting of this study, a pilot test was conducted in Umuahia, a neighboring town

considered homogenous and as close to the study population as possible. The pilot tests did not result in the revision or elimination of any of the questions.

Recruitment of Field Assistants

To ensure that data was collected in a timely manner field assistants with at least a high school diploma, fluent in both English and Igbo Languages, were recruited from School of Nursing, Aba for this study. The student investigator trained four field assistants in qualitative focus group methods and their respective roles. The team conducted the Forum Focus Group Discussion (FFGD); served as facilitators, observers, recorders, time keepers, and note takers. They transcribed the tape-recorded responses verbatim, while the student investigator reviewed and analyzed the data. The session time for the FFGD was 2½ hours (20 minutes to convene the opening and closing forums and 120 minutes for the focus group discussion) with refreshment break of 10 minutes. This process was completed in two weeks.

Training of Field Assistants

Field assistants were trained by the student investigator in one location for three hours. Formal instructions on the purpose of the study were discussed. Items and sub-items on the forum focus group protocol were fully explained. Question and answer sessions were conducted during which further clarifications were made. Mock interviews where field assistants interviewed themselves to ensure efficiency in the execution of their assignment were organized. The student investigator closely supervised the field assistants throughout the period of the survey.

Data Analysis

Data analysis was conducted on all transcribed responses from the Focus Group Discussion (FGD) (step 2) and the Closing Forum (CF) (step 3). It was not seen as necessary to transcribe and analyze the Open Forum (OF) (step 1). The OF was to serve as an introduction to the later discussions, as well as a platform for the main facilitator to explain the goals, procedures and scope of the study, go over confidentiality and focus group rules, and entertain questions regarding the nature of the study.

We used Dudley and Phillip's (2007) guide in this analysis. First, field assistants transcribed the data shortly after the Focus Group Discussion (FGD). Second, one of the co-investigators reviewed the topic guide (protocol), listened to the tapes, read the transcripts and notes from the two sessions, including data from the Closing Forum (CF), and created a unique identifier (code) for participants allowing us to later know the source of comments by type of respondent and zone.

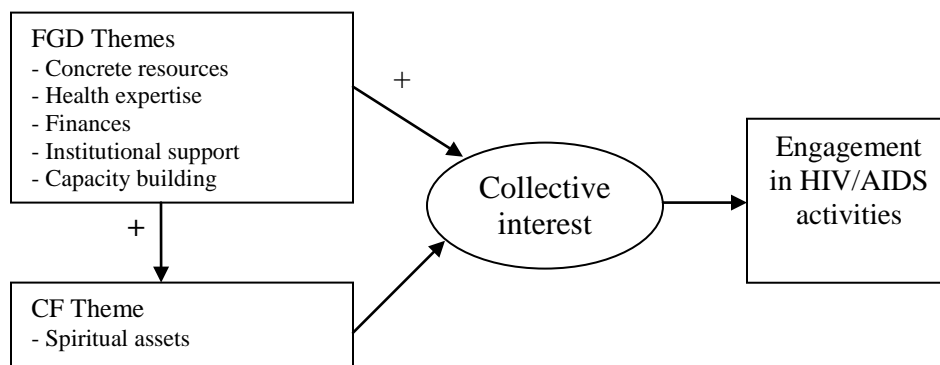
Transcripts of the focus groups were then coded using emergent coding for code book development to classify the responses into meaning units (any word or expression that suggested church asset). Similar meaning units were grouped together and assigned a code or sub-code label. To sort the differences and similarities within the meaning units, we created sub-themes, compared them with the meaning units, and further sorted them into emerging themes.

As mentioned earlier for data analytic purposes the Closing Forum (CF) narrations were treated the same way as the Focus Group Discussion (FGD) narrations and combined to make up our qualitative data set. To maintain data integrity, other co-investigators reviewed, revised and validated the data in constant comparison with the transcript using the code book developed by the original coder. In all cases the whole context of the narration was considered after reading the transcript repeatedly. To ensure that no data was intentionally or unintentionally omitted, and to guard against adding irrelevant data (Kristiansen, Hellzen, & Asplund, 2006), we compared the themes and sub-themes back and forth. Several discussions were held between the co-investigators until we reached an agreement on the interpretation of the data.

Results

The FGD resulted in six main themes while the CF generated one major theme as shown in Figure 2 below:

Figure 2. *Church-Based Needs and Assets Model for HIV/AIDS Model for HIV/AIDS Prevention Activities*



Focus Group Discussion (FGD) Themes

The report of the emerging themes and patterns from the FGD were grouped into six asset categories. The main categories in the model were labeled as concrete resources, health expertise (health assets), money (financial assets), institutional support (denominational assets), capacity building, and collective interest to engage in HIV/AIDS prevention and control.

Concrete resources. There were six dimensions to the concrete resources theme. They are as follows:

1. Food and clothing for those infected and affected by HIV/AIDS. The church members highlighted the importance of the basic necessities of life as they affect people living with AIDS (PLWA) and their families. They thought that as a church, they would need to have food and clothing to support infected and affected members.

I think that my church is doing a lot to help people who are affected. For example, if a woman dies of AIDS, whether the church knows she has that disease or not, so far as the children are living, we give arms [gifts], foods, clothing to support the family. We also help pay things like school fees for kids in those families. So, we do a lot.

2. Scholarships for orphans. The church members felt it was quite necessary to offer scholarship opportunities to affected children who lost their parents to HIV/AIDS. Such an endeavor, they stated, would enhance the potential of the church in the future since the beneficiaries would grow up to become leaders of the church and community.

3. Job placement plan for HIV/AIDS affected families. The church members indicated that a more sustainable way of supporting families of PLWA is to provide an opportunity for them to work and earn money to meet their own needs. As one of the participants echoed:

The best way to help them is not to give them money or stipend. Let's teach them how to fish. Create job opportunities for them in the church, in our homes, at our individual workplaces. Hire them, pay them, and they will take care of themselves. That's the way to go.

4. Time allotted for HIV/AIDS education during regular church worship. The participants recognized the importance church members attach to messages that come from the pulpit. Hence, they indicated that they would need to allot time for HIV/AIDS education when members gathered for worship.

5. Home outreach services and visitation teams for those who have HIV/AIDS and affected families. The church members reiterated the need to create an opportunity to reach out to PLWA and their families and friends recognizing that at such a critical and stressful point of their journey through life, they may not be excited about coming to church to fellowship with other members.

6. Women, men, and youth ministries. The church members were clear in stressing that existing ministries of the church should be a springboard for launching an effective visitation and home outreach services to PLWA and their families.

Health assets. This category comprises of four dimensions as follows:

1. General education about health for church members. Church members strongly felt they needed to know more about health issues other than just HIV/AIDS. They thought that knowledge about general health would help influence the attitude of members toward healthy lifestyle practices and in turn prepare them as advocates of HIV/AIDS prevention and control.

2. Special HIV/AIDS education. The church members did not mince words on the need for specific and consistent HIV/AIDS education messages and activities targeting women, men, and children at the right developmental and social level.

3. Church HIV/AIDS action committee. The church members strongly noted that they needed a core group recruited from different levels of the church's hierarchy and supported by the church to coordinate HIV/AIDS prevention and control activities.

4. Church members who are health professionals. The participants were in the affirmative of having church members who are health professionals to take over leadership on issues relating to health in general and HIV/AIDS in particular.

I believe in every church they are professionals in medical lines. If the church can fish out those that are medical professionals in their churches and now hand them over this particular program at least once in a week or twice in a month, such/type of program will be organized in the church and people will benefit.

Financial assets. Two dimensions were discussed under this category as follows:

1. Special offerings for HIV/AIDS programs. Many of the participants highlighted that they needed to have the capacity to mobilize internal resources. One of the participants stated as follows:

We need to look inwards. Just as we ask members to donate money to build new churches or renovate old ones, we can ask them to support HIV/AIDS programs. It is just a matter of eliciting the interest of members to recognize the seriousness of the AIDS disease.

2. Financial support from non-members. Church members discussed in depth how successful they have been in raising funds for other church-based activities in the past from external sources. One of them, while acknowledging the importance of internally generated resources reaffirmed the need to have external support.

Those resources are good but they are not enough. In fact, we need outside help/assistance in that we can inform individuals who are rich like we have philanthropists who can help. Then our church members who are well-to-do, who are not within [the church]; some are outside [the church]. They can help when they are informed. We can also ask for organizations [within and outside] – they can help.

Denominational assets. Denominational assets refer to assets that are centrally controlled by the denomination and might be generally accessible to the local churches.

The dimensions by which members looked at institutional support (denominational assets) to engage in HIV/AIDS activities are described as follows:

1. Hospital, clinic, and school. The church members felt that cost effective infrastructures such as hospital, clinic, and school are essential in HIV/AIDS prevention and control and should be funded, maintained and made accessible to local churches by the denomination.

2. Inter-denominational funds for HIV/AIDS programs, free HIV/AIDS drug and free drugs for opportunistic infections. The members indicated that they needed to have a central fund coordinated and supported at the denominational level, and dedicated to providing free HIV/AIDS drugs and free drugs for opportunistic infections. HIV/AIDS counseling, testing, treatment, referral, manpower/leadership training and rehabilitation centers. Participants were vehement in pointing out that specialized HIV/AIDS services were needed by churches to engage in sustainable HIV/AIDS programs. They thought that it was essential for churches to be able to follow up on HIV/AIDS counseling with testing. Where necessary, referral and rehabilitation support should be provided.

It would have been very good for the denomination to establish a center where members who are financially constrained go periodically to have the test because many don't have the means to go for HIV test as required.

3. Testing kit, blood bank for members, and orphanage. The church members were concerned about the reliability of HIV/AIDS tests conducted in other facilities other than their own. As such they said they needed their denominations to get testing kits for local churches and other equipment needed to maintain a functional blood bank exclusively for church members who may need blood transfusion. To ensure that children of families affected by HIV/AIDS were properly taken care of, they suggested the need for an orphanage. Local churches, they argued, are limited when it comes to providing materials that are cost intensive. The church members asserted that they expected a lot from the denominations, with contributions from the local churches.

4. HIV/AIDS policy, research, and radio and TV ministry. Church members strongly felt that they needed to have a policy framework that clearly articulates HIV/AIDS research agenda for denominations at zonal and district church levels. Church members attested to the fact that since denominations currently sponsor gospel ministry programs on radio and television, they also have the capacity to inculcate HIV/AIDS prevention and control programs into these media and have an obligation to do so.

5. Linkages with other churches, government, treatment centers, and private agencies. The church members discussed how to harness other opportunities and potentials to effectively engage in HIV/AIDS prevention and control. In the discussion, the need for linkages was mentioned in that participants felt that there might be the need for churches to share resources with each other, and to cooperate with government,

treatment centers and private agencies such as companies and non-governmental organizations in HIV/AIDS prevention and control activities.

Capacity building assets. The theme on capacity building comprises of dimensions as follows:

1. Training church members as HIV/AIDS counselors and advocates. Specific needs for training was emphasized and re-emphasized during the discussion. The church members were vehement in recommending training on HIV/AIDS prevention and control for the women, men, and youth ministries to enable them serve as counselors and advocates.

2. School based education. The church members considered training as having a multiplier effect. They opined that if women, men, and youth are trained as counselors then they can reach out to schools within the neighborhood with HIV/AIDS prevention and control programs.

Well, my church started the journey in 1996 when they discovered that the infection was getting to the church. So we started the attack in our theological colleges because we know that the pastors are going to be sent to different places, so we started it by sensitizing them. Then by 1997, we discovered that it was not enough. To get through the fact, we have to make an impact in the church. So, by 1997 we launched a project with women's guild in Aba, it was a time when women's guild from Aba sent their opinion leaders. They were educated and then sent out to go and spread the message.

Collective interest. The church members stressed the point that a general interest by all the members was pertinent for effective use of all other resources that church members might need to have to engage in HIV/AIDS prevention and control activities.

Closing forum theme. One major theme Spiritual support (asset) emerged from the closing forum discussion which comprises of four dimensions described as follows:

1. Compassion for those infected. The church members discussed the mission of the church which included sharing the love of Jesus Christ to all under any circumstance. Thus, they were keen to see everyone in the church show love and acceptance to PLWA. Even if people felt that PLWA have "sinned", the participants emphasized, Jesus Christ also died for them.

2. Compassion for those affected with HIV/AIDS. The church members agreed that the burden borne by PLWA is shared with friends and families. Hence, church members need to have love and compassion for them as well.

3. Faith that God is able to heal people living with HIV/AIDS. Faith is considered one of the principal elements of the Christian religion. In the discussion, participants indicated that just as church members exercised faith in other things they asked from God, they also needed to have faith in the power of God to bring healing to those who have HIV/AIDS.

4. Prayer for those who have HIV/AIDS which we interpreted as spiritual assets. Similarly, participants felt that church members needed to have special prayer sessions for PLWA and their families and friends. They strongly emphasized that faith and prayer were great tools church members needed to have to effectively engage in the war against HIV/AIDS.

Jesus was compassionate to sinners. Even if we think people who have HIV/AIDS and their families have sinned, we need to show compassion to them. We need compassion for each other. We need it so much. We need it.

This was amplified by another participant:

I see God as an asset to the church. We need Him to help those who are suffering from HIV/AIDS. Without Him, we cannot do anything. We pray to him by faith and He can heal the worst of diseases, including HIV/AIDS.

Discussion and Conclusions

Scaling up HIV/AIDS prevention, treatment, and sustainability (WHO, 2005) is important. A participatory approach (National Action Committee on AIDS, 2005) that seeks to harness church-based human, material, and spiritual potentials of members to increase HIV/AIDS prevention and control activities and improve services on a wider scale is equally essential. Given that “Religious entities are perceived as contributing to health, wellbeing and the struggle against HIV/AIDS through tangible and intangible means” (African Religious Health Assets Programs, 2006, p.3), participants in this study viewed strongly the need to have spiritual support to engage in HIV/AIDS prevention and control activities in addition to having concrete resources, health expertise, finances, institutional support, capacity building, and collective interest of members. Access to important resources and opportunities increases perceived behavioral control (Ajzen, 1991) and self-efficacy (Bandura, 1991). The spiritual elements emanating from the Closing Forum (CF) creates a useful connection to the other resources that church members felt they needed to have. With the recent focus on the promotion of universal access to prevention, treatment, care, and support (African Religious Health Assets Programs 2006), identifying resources (Sharpe, Greaney, Lee, & Royce, 2000) is very crucial. Community resources might include persons, physical structures, natural resources, institutions, businesses, or informal organizations (Berkowitz & Wadud, 2003). Our study provides a model for understanding church-based concrete resources, health expertise, finances, institutional support, capacity building, and the collective

interest of church members as necessary to engage in HIV/AIDS prevention and control. Such an understanding can help churches to harness their health promotion capacities, improve on them (asset building), and develop a feasible plan to sustain them over time (asset maintenance).

Churches, as an entity, can play a major role in identifying and allocating their own resources to meet the needs of their members. As they understand their health conditions, manage and give meaning to their situations (Antonovsky, 1987) they might be more willing to use their capacities (assets) to promote HIV/AIDS prevention and control. Asset building is important in addressing risky behaviors (Kegler et al., 2005) and risk factors (Yanicki, 2005), the World Health Organization's (WHO) Asset for Health Development Program (AHDP) emphasized the need for salutogenic health assets (Harrison, Ziglio, Levin, & Morgan, 2004).

The Forum Focus Group Discussion (FFGD) methodology used in our study revealed six categories from the FGD and one from the CF. The addition of the CF revealed spiritual assets (compassion for those infected and affected with HIV/AIDS, faith that God is able to heal people living with HIV/AIDS, and prayer for those who have HIV/AIDS) which we see as critical assets to move churches closer to making the decision to become actively engaged in such work. While the other named assets were quite practical and indicated a general ability to serve in this fashion, this last asset – revealed only in the end using the Closing Forum (CF) method is seen as critical in actually moving the churches forward as it is closely tied to their identity as faith institutions and thus allows a general “blessing” of such activities, in and of itself not a minor issue. It contributed new and frankly quite critical insights that might have been missed especially as they are now linking a theoretical discussion to an implicit action step that will make it more likely for the represented faith based institutions to adopt such a role. It might not be quite clear why the participants highlighted the spiritual asset elements at the CF rather than during the Focus Group Discussion (FGD) session; however, we think that the interval between the FGD and the CF seemed to have refreshed the participants and helped generate new data. Furthermore, the CF data might have helped to account for the “[reduced] drops in attention” (Colucci, 2007, p. 1431) during the FGD. Without the spiritual asset emanating from the CF, our findings on church-based assets for HIV/AIDS prevention activities would have been incomplete. While “focus group data are limited to interaction in discussion groups” (Suter, 2000, p. 2), we postulated that a FFGD approach might provide additional data on assets for HIV/AIDS prevention that could be harnessed after participants engaged in the traditional approach which we thought might make them ponder and initiate new ideas and concepts in their thinking. To fully identify resources (Sharpe et al., 2000) and expertise of participants (Potts, 2004), innovation and creativity (Deacon, 2000) is required. Sometimes, it may involve a modification of data collection process (Gamson, 1992) based on definite criteria (Press & Cole, 1999) or combination of methods to “encapsulate the multidimensionality of the human experience” (Deacon, 2000, p.1).

The steps we have used in the data collection process might not be applicable in every setting or for every research focus. Further studies may be needed to assess the applicability of the Forum Focus Group Discussion (FFGD) methodology in other settings and situations. Despite the overall limitations, this study provides the basics for understanding church-based health assets; thus enabling health promotion specialists to

help support churches to create a database of health assets for sustaining health programs organized church-by-church and classified by geographic location.

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