HHS Public Access

Author manuscript

Curr HIV/AIDS Rep. Author manuscript; available in PMC 2017 February 10.

Published in final edited form as:

Curr HIV/AIDS Rep. 2013 December ; 10(4): 324–332. doi:10.1007/s11904-013-0175-7.

SPIRITUALITY AND RELIGION AMONG HIV-INFECTED INDIVIDUALS

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Abstract

Spirituality and religion are important to many people living with HIV (PLWH). Recent research has focused on special populations (ethnic-minorities, women, and youth), spirituality/religion measurement, mediating/moderating mechanisms, and individual and community-level interventions. Spirituality/religion in PLWH has been refined as a multidimensional phenomenon which improves health/quality of life directly and through mediating factors (healthy behaviors, optimism, social support). Spirituality/religion helps people to cope with stressors, especially stigma/discrimination. Spiritual interventions utilizing the power of prayer and meditation and addressing spiritual struggle are under way. Faith-based community interventions have focused on stigma and could improve individual outcomes through access to spiritual/social support and care/treatment for PLWA. Community engagement is necessary to design/implement effective and sustainable programs. Future efforts should focus on vulnerable populations; utilize state-of the art methods (randomized clinical trials, community-based participatory research); and, address population-specific interventions at individual and community levels. Clinical and policy implications across geographic settings also need attention.

Keywords

Spirituality; Religion; Religiosity; Faith; Religious organizations; Faith-based organizations; HIV; AIDS; People Living with HIV; Outcomes; Well-being; Quality of life; Stress; Coping; Social support; Spiritual support; Spiritual health; Spiritual well-being; Stigma

INTRODUCTION

Spirituality and religion play an important role in people living with HIV (PLWH) [1–4]. Spirituality includes the internal, personal and emotional expression of the sacred and is often assessed by spiritual well-being, peace/comfort derived from faith, and spiritual coping [5, 6]. Religion has been defined as the formal, institutional, and outward expression of the sacred, and has been measured by importance of religion, belief in God, religious attendance, and prayer/meditation [7–9]. There is a growing body of knowledge about the associations between spirituality/religion and outcomes among PLWH. In a seminal, longitudinal study, spirituality/religion was found to increase after HIV diagnosis and predict

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slower disease progression (decrease in CD_4 counts or viral load) [10]. Higher levels of spirituality/religion have also been associated with less psychological distress, less pain, greater energy and will to live, better cognitive and social functioning, and feeling that life has improved since HIV diagnosis [1–3, 10, 11]. However, spirituality/religion can also worsen outcomes because of potential reliance on God and rejection of antiretroviral therapy and because of views of HIV as punishment from God for sinful lifestyles. HIV-related stigma beliefs and spiritual struggle (anger, alienation from God) have been associated with higher levels of depression, loneliness, and poorer medical adherence among PLWH [2, 12–14].

Medicine and other health disciplines have struggled with developing appropriate spirituality/religion-based interventions to help PLWH. Such interventions are not universally accepted by either patients or providers. More knowledge is needed to identify HIV-infected groups that would benefit from and accept these approaches. The nature of interventions also remains unclear because how spirituality/religion affects biopsychosocial outcomes in HIV is not well understood.

The purpose of this paper is to assess the current state of knowledge on spirituality/religion in HIV. First, we will clarify spirituality/religion-related concepts and definitions. Then, this review will examine: 1) the meaning and impact of spirituality/religion in specific HIV populations and sociocultural contexts; 2) psychosocial mechanisms through which spirituality/religion affect outcomes in PLWH; 3) measurement of spirituality/religion in PLWH; and, 4) development of spiritual and community interventions to address the needs of PLWH.

Concepts and Definitions

There is an ongoing debate about how to define spirituality and religion in health research [5, 7]. Numerous overlapping, but distinct terms, have emerged reflecting multiple facets of religion and spirituality and their specific associations with health. *Religion* is typically defined as “a system of beliefs and practices observed by a community, supported by rituals that acknowledge worship, communicate with, or approach the Sacred, the Divine, God (in Western cultures), or Ultimate Truth, Reality or nirvana (in Eastern cultures)” [7, p.11]. Religion is usually grounded in a set of scriptures/teachings that provide the meaning and purpose to the world and a moral code that guides members’ behavior. Beliefs and trust in a higher power are also referred to as *faith*. One aspect of religion known to be important to health is *religious activity*, or practices, which have been classified [7] as public, social, and institutional (e.g., attending religious services, group prayer, scripture study) or private, personal, and individual (e.g., private prayer, meditation, scripture reading). The two types of religious activity are labeled, respectively, as “organizational” and “nonorganizational” *religiosity,* or, *religiousness*. Notably, religiosity may, but do not have to, manifest itself in religious practices. For this reason, religiosity has also been assessed as the importance of religion in a person’s life (subjective religiosity) and motivation (internal, or “intrinsic,” versus external, or “extrinsic” religiosity). Other dimensions of religion include religious knowledge, religious coping, religious history, religious maturity, and religious well-being.

Non-traditional (by Western standards) aspects of religion have also been noted (e.g., spiritism).

Religion (theistic or other type) has historically provided a framework for discussion of spirituality, but contemporary definitions of spirituality extend beyond and sometimes have nothing to do with religion [7]. *Spirituality* has been defined as meaning and purpose in life, inner peace and comfort, connection with others, support, feelings of love or happiness, and other items. Weakened spirituality, on the other hand, may manifest itself, in spiritual struggle or distress. The broad concept of spirituality or spirituality/religion has been functional in clinical settings because patients often do not distinguish between "religious" and "spiritual." However, as illustrated below, studies typically define precise aspects of spirituality/religion which may have beneficial or harmful impacts on health/well-being. Nonetheless, the global term, *spirituality/religion*, is also commonly used for the purpose of an overarching discussion.

It should also be noted that religion has been used as both an individual and a cultural (social-level) variable. The role of religion in HIV at the social level has been captured as responses by: "organized religion," religious organizations, or religious/faith communities (basically, congregations); faith-based organizations (FBO; inclusive but not exclusive of congregations); or, religious/faith traditions, theologies, or denominations (systems of beliefs, doctrines). Therefore, we distinguish between individual-level effects of spirituality/religion and the sociocultural religious influences (e.g., stigma) on outcomes in PLWH. We also differentiate between individual-level (spiritual, clinic-based) and faith-community based interventions to improve outcomes in PLWH.

Meaning and Impact of Spirituality/Religion in PLWH

Qualitative research has become an important source of knowledge about the role of spirituality/religion in HIV. Qualitative methods are often employed to explore phenomena in-depth, clarify meaning of concepts, examine sensitive topics, and study unique settings or populations. Spirituality/religion is a complex, subjective phenomenon which cannot be easily studied with quantitative methods [6]. Recent qualitative studies have explored the meaning and impact of spirituality/religion in specific HIV-positive populations such as racial/ethnic-minority men who have sex with men (MSM), women, and youth. Special attention has also been given to the expanding HIV epidemics in the U.S. South/Southeast.

Spirituality and religion have historically played an important role in African American communities, especially in the "bible belt" of the Deep South. HIV remains a taboo subject in many faith communities, in a large part due to doctrinal positions on homosexuality. In a Mississippi-based study [15], young black MSM implicated religious doctrine, religious leaders, and the faith community as significant sources of homophobia and discrimination toward gay men. The men expressed these views despite their high religiosity and religious involvement. Some MSM actually agreed with the normative stance regarding the sinfulness of homosexual behavior and attempted to justify their alternative lifestyle within a religious framework. The findings suggest spiritual struggle and potential for internalized stigma among young black religious MSM which may lead to psychological problems.

Spirituality and religion are also salient among African American women. In a sample of black, predominantly Christian women with HIV in the Southeastern U.S., 95% of participants considered spirituality as very or extremely important in their lives and half engaged in religious/spiritual activities such as praying, reading scripture, and regularly attending worship services [6]. Spirituality in this group emerged along three themes as: a process/journey or connection (to God), spiritual expression (church attendance, prayer), and spiritual benefits (healing, support). Notably, HIV brought most of the women closer to God and, despite their life struggle, they felt gratitude. This may not be unique to this group of women; similar findings have been reported in other samples [16]. Also, the women considered religion and church as part of their spirituality. These findings corroborate prior quantitative reports of increases in spirituality/religion after being diagnosed with HIV [10] and add to the ongoing debate about whether spirituality and religion are one or distinct concepts [5].

Another qualitative study notes the role of spirituality/religion as a stressor and source of support among HIV-infected Latino youth [17]. The study used Folkman's model of coping incorporating individual beliefs, values, and existential goals [18]. Faith emerged in this sample as an important facet of coping, possibly because of the salience of religion in the Latino culture. The findings also draw attention to the potential negative role of religion: some of the youth appeared to rely more on God than biomedical treatment for healing. How widely-spread this problem could be in this population remains unclear, but it could impact adherence to ART.

The role of spirituality/religion in HIV is multifaceted. Some new psychosocial aspects of this relationship are now gaining attention. One study [19] has considered spirituality as one "other identity" that changes after HIV diagnosis. Less than half of the study participants experienced an increase in the salience of the spiritual identity. Quantitative studies previously reported either similar levels of spirituality between HIV-positive and HIV-negative individuals [20] or increases in spirituality/religiosity after HIV diagnosis [21]. The evidence suggests that spiritual/religious responses to HIV vary. Although PLWH tend to have lower rates of religious affiliation and higher spirituality than the general population [22], some have both personal spirituality and formal active religious affiliations [12]. It is important for clinicians to have discussions about spirituality/religion with individual patients and determine a role for it in the management of HIV case-by-case. However, some studies suggest that many individuals, including health professionals, are not comfortable with discussing spirituality/religion [16, 23, 24]. Further guidance is needed about how to discuss spirituality/religiosity with PLWH.

Much has been written about the role of organized religion in HIV in the global context [25], but few international studies examine spirituality/religion in HIV from the individual perspective [26–33]. Several themes emerge in this literature: religion as a source of support [29], spirituality as a barrier to/facilitator of treatment [30, 31], personal faith as a coping strategy [28, 30], and spirituality in palliative AIDS care [27]. Although these themes are similar to those found in the West, it is encouraging to see such research in various geographic settings.

Spirituality/Religion Pathways to HIV-Related Outcomes

Multiple quantitative studies have examined the mechanisms through which spirituality/religion affects outcomes [1, 10, 34]. This evidence points to the dual role of spirituality/religion as a coping mechanism and a stressor. For example, Kremer and colleagues [35] showed that spirituality affected the view of HIV as a positive or a negative turning point in one's life. In their study, PLWHs who experienced increased spirituality and felt chosen by a Higher Power to have HIV perceived their infection as the most positive turning point in life. In contrast, those who experienced declines in spirituality saw HIV as the most negative turning point. Subsequent research by the same group further demonstrated that a positive view of God predicted slower while a negative view of God predicted faster HIV disease progression [36].

A few recent studies also address mental health outcomes, considering high rates of depression/behavioral problems among PLWH. For example, Chaudoir and colleagues [37] have examined the relationships between HIV stigma beliefs, coping, and spiritual peace (degree to which spiritual beliefs provide a sense of peace, meaning and comfort). A focus on stigma-related coping is critically important because PLWH often feel socially devalued and need to find ways to deal with distress and anxiety caused by social factors such as prejudice and discrimination. This study considered spiritual peace as a general coping resource that might buffer the negative effects of stress on psychological well-being [38]. In a sample of 465 PLWHs, spiritual peace and proactive coping predicted lower while HIV stigma predicted greater likelihood of significant depressive symptoms. Furthermore, an interaction effect was documented: at high levels of stigma, individuals reporting high spiritual piece were less likely that those reporting low spiritual piece to have significant depressive symptoms. These findings suggest the potential of spiritual peace-based interventions in PLWH.

A stress-coping framework was also used in a study examining the role of spirituality/religion in mental health among PLWH in Tanzania [39]. A structural equation model (SEM) was tested hypothesizing mediating effects of active coping, avoidant coping, and social support in the relationship of spirituality/religion to depression, anxiety, and stress with religiosity and spirituality treated as distinct factors. Results indicated that social support and coping mediated the relationships of religiosity and spirituality to psychological distress; the mediating mechanisms were slightly different for religiosity and spirituality (avoidant versus active coping, respectively).

Other research has examined sociodemographic factors -- age, gender, race, and sexual orientation -- that shape the relationship between spirituality/religion and outcomes in PLWH. Age differences and aging have been gaining attention because of increasing numbers of older PLWH [40–44]. Vance and colleagues [4] have developed a conceptual framework to study barriers to and components of successful aging with HIV, where spirituality is one of four key dimensions. Specifically, spirituality is hypothesized to buffer or exacerbate the effects of decreased social support, stigma (age- and HIV-related), and mental illness experienced by older PLWH. Although similar levels of spirituality/religiousness were reported by older and younger adults with and without HIV in one study, spirituality/religiousness among HIV-infected individuals was associated with larger social

networks, better mood, higher self-reported health, and fewer medical problems [20]. Thus, spirituality/religion may facilitate successful aging with HIV.

Sexual orientation is also a key factor in the relationship between spirituality/religion and HIV-related outcomes. One study compared the associations between religious practices and biopsychosocial outcomes (e.g., mood, social support) in homosexual versus heterosexual PLWH using SEM [45]. The results showed that religiosity was positively related to social support among homosexual PLWH, but religiosity did not mediate any of the outcomes in heterosexual PLWH. Similarly, the associations between spirituality/religion and outcomes have been shown to differ by race and age. Older African Americans appear to have higher spirituality and, in turn, higher levels of social support; however, religiosity does not seem to mediate psychosocial outcomes among Caucasians [46].

Furthermore, HIV disease affects women in unique ways because of their reproductive and family roles. Stress and coping in HIV-infected women have been examined in a recent meta-analytic review [47]. Coping by avoidance and social isolation predicted more severe mental health problems in women living with HIV. Notably, spirituality and positive reappraisal predicted better psychological adaptation than reliance on social support. The authors comment that women practicing the spiritual reframing of stress likely have higher perceived control and stress-related growth than women who rely on social support. This is consistent with some qualitative findings [6, 30].

Spirituality/religion has also been noted along other factors within the context of HIV treatment [48–50]. For example, research has found returning to HIV care to be associated with spirituality among U.S. inner-city clinic patients [51]; concurrent use of complementary and alternative medicine to be associated with less adherence to HIV medications in China [52]; and, faith healing to be “the third therapeutic system” in HIV management in sub-Saharan Africa [53].

Measurement of Spirituality/Religion in PLWH

Two recent studies [5, 6] review the spirituality/religion concepts and clarify their measurement in PLWH. The prevailing view is that spirituality and religion/religiousness are distinct but overlapping concepts; these concepts are multidimensional; and, the different dimensions of spirituality/religion can have beneficial or detrimental effects on individual outcomes in HIV. However, the empirical evidence is not all consistent, mainly due to variations in measurement approaches across studies. For example, there is no universal measure of spirituality/religion, and studies have utilized multiple, sometimes overlapping spirituality/religion measures. In addition, both global and disease-specific measures of spirituality/religion measures have been advocated.

To move the field forward, one study [5] examined a collective of 56 spirituality/religion items (some HIV-specific) according to a conceptual framework developed by a consensus panel. Results based on confirmatory factor analyses using adult HIV patient data suggest eight dimensions of spirituality/religion: meaning/peace, tangible connection to the divine, positive religious coping, love/appreciation, negative religious coping, positive congregational support, negative congregational support, and cultural practices. The authors

propose a refined measure of spirituality/religion that should be tested in other HIV-positive samples. The measure is comprehensive, but it may be too long for use in clinical settings. Studies may consider individual dimensions of spirituality/religion or shorter versions of the measure developed using item response theory.

Another study has validated a measure of spiritual well-being, “Spirit 8”, for use in palliative care African populations [54]. Dimensionality of items was examined using factor and Rasch analyses. The measure appeared to be unidimensional and psychometrically robust; it enables researchers to identify patients at increased risk of spiritual distress. Additional international studies have included spirituality/religion as one of the factors in the measurement of other HIV-related psychosocial constructs, such as coping with depressive symptoms [55]. There is also growing evidence about limitations of the spiritual component of the HIV-specific quality of life measure, WHOQOL-HIV, in international contexts [32].

Spirituality/Religion-Based Interventions

Much of the spirituality-HIV literature has elucidated ways to incorporate spirituality/religion into the management of HIV disease as a way of coping to improve physical and mental health outcomes. In the meantime, a new focus has emerged on HIV-related community interventions. Recognizing the power of faith communities (esp. among African Americans) to influence HIV-risk behaviors and attitudes toward PLWH, a body of research evaluates faith-based community interventions to reduce stigma and enhance HIV prevention/care.

Spiritual, Clinic-Based Interventions—There are few publications describing the development and testing of spiritual interventions aimed at improving HIV-related outcomes among PLWH [2]. One reason has been mixed support for conducting spiritual assessments and providing spiritual care in healthcare settings. Tuck [24] has described a spiritual intervention that her group developed and tested using a decade-long, clinical trial which included PLWH. The essence of the intervention was sharing personal and communal views of spirituality as a way to connect with the self, nature, and God. In the initial phases, the intervention appeared to have positive effect on the well-being of the participants, but, ultimately, there was limited support for causality and treatment effects.

Mixed results have also been found in other interventions. For example, a mantram program helped HIV-positive participants to increase calm/peace, adjust behaviors, manage symptoms, and enhance relationships [56]. The spiritual component of the intervention was noted as helpful because it was a convenient and portable tool for coping with HIV disease. However, the expected decreases in anxiety and perceived stress were noted in both intervention and control groups. Thus, a clear link to outcomes using this intervention is yet to be determined. The strength of the research trial, however, was use of qualitative methods within a random clinical trial [RCT], which allowed for participants’ experience with the intervention be captured from their perspective.

Another study suggests that a group-based self-management intervention can increase spiritual well-being in PLWH [57]. The ten-week intervention consisted of discussing theory with participants, establishing social support, discussing physical activity, learning

meditation, understanding spirituality, relapse prevention, and social gathering/celebration of changes. Increases in both spirituality and optimism were noted at the end of the intervention. The results were similar to a spiritual coping intervention published earlier [58].

Despite limited literature on spiritual interventions, more work is under way. Dallas and colleagues [59] describe the design of a longitudinal pediatric AIDS palliative care intervention which addresses spiritual struggle. Spiritual struggle is hypothesized to impact adolescent/family decision-making, treatment preferences, and communication. This will be the first longitudinal effort documenting an AIDS-specific model of advanced care planning with adolescents. The authors state that, if successful, the intervention could be easily adapted on a large scale.

Faith-Community Based Interventions—Numerous studies have examined the role of religious organizations in shaping public views on and providing care/support to PLWH in the U.S. [60–62] and globally [25, 63]. Mixed responses of faith communities – from compassion and support to stigma and discrimination – have been reported across religious and geographic contexts [64, 65]. Decreasing stigma and enhancing faith-based HIV programs could significantly improve the well-being and outcomes among PLWA, along with prevention at the population level. Therefore, attention is shifting to sociocultural and community interventions.

U.S. religious and faith-based organizations are considered to be uniquely suited to address HIV-related needs of their communities [64]. PLWH often draw on congregations for spiritual and social support, but congregations do not always respond to or welcome HIV-infected individuals, because of stigma and moral judgments about HIV [21, 60]. PLWH who are unaware of their HIV infection could also benefit from congregational HIV screening programs and opportunities to be linked with care and treatment. Early diagnosis and treatment are essential to individual outcomes, including the health status, quality of life, and survival. Several U.S.-based studies have assessed congregations' readiness to address HIV, levels of congregational HIV involvement, and outcomes of faith-based HIV interventions. This research encompasses quantitative, qualitative, mixed-method, evaluation, and community-based participatory research (CBPR) [60–62, 66–69]. In the CBPR design, researchers engage with community stakeholders to assess the needs and opportunities of communities and work together to improve community-level health; community engagement is essential at all stages of the research process – design, implementation, evaluation, and dissemination. CBPR is considered a "gold standard" in community interventions, especially for addressing health disparities [70].

Survey-based research indicates that over 10,000 U.S. congregations have PLWH, and congregations located in high HIV prevalence and incidence areas are more likely to have PLWH [71]. In addition, results from the Cincinnati Census of Congregations [61] showed that 36% of Black Protestant congregations had HIV prevention and counseling programs, compared with 5–18% of other types of congregations. However, the effects of theology-polity in that study were mediated by broader community involvement and racial composition. This study suggests that many black congregations have no HIV programs and,

thus, their potential to address HIV in the African American community remains untapped. A national study [72] supports and complements the regional data, showing that external engagement, not liberal-conservative theological orientation, predicts the probability of a black church having a HIV-related program.

Research indicates diverse views on HIV and PLWH across congregations. Studies find attitudes ranging from highly judgmental and exclusionary to accepting [60]; such a range previously emerged in both clergy's and PLWH's reports [73]. Differences in HIV-related attitudes depend on HIV involvement with low-activity congregations being more likely to view homosexuality as a sin and promoting sexual abstinence before marriage; medium-activity congregations transitioning from a position of fear about HIV to understanding and acceptance; and, high-activity congregations more fully engaging in advocacy and stigma reduction on behalf of PLWH [60]. However, HIV stigma can also be an issue in high-activity congregations [60].

One way to reduce stigma is to educate clergy and engage them in the development of community interventions. Researchers in Philadelphia solicited faith leaders' views on the drivers of the HIV epidemic and possible faith-based interventions [67]. First, the findings showed that the pastors were unaware of the extent of the HIV epidemic in their community. Second, the pastors openly discussed homophobia and stigma; a "code of silence" about HIV in congregations was a major concern. The faith leaders recommended interventions that enhance leadership and advocacy efforts; normalize testing and sexuality-related discussions to reduce stigma; are tailored to individual organizations; and, encourage interfaith collaborations. Stigma interventions were recommended to be framed as a healing/wellness issue. The faith leaders emphasized the importance of creating safe environments for PLWH to disclose their status, for their benefit and to increase HIV awareness in congregations. A framework for faith-based HIV interventions, incorporating similar input from clergy, has recently been proposed [68]. This framework incorporates individual, organizational, and community inputs into intervention design and implementation; enabling, inhibiting, and mediating factors; and, outputs as individual, organizational, and community-level changes. Several recent reports note CBPR efforts to mobilize U.S. black faith communities to address HIV [62, 66, 67, 74–76]. Emerging research focuses on assessing and building faith-based HIV program capacity in the Deep South and Southeastern U.S. [69, 77]. However, systematic evidence about the effectiveness of faith-based community interventions remains scarce [75], especially vis-à-vis other community interventions and in relation to outcomes in PLWH. Further research is needed to garner support for public financing of such efforts.

Research outside the U.S. has focused on religious organizations' responses to HIV in Brazil and Africa. Parker, Munoz-Laboy, and colleagues have published a series of papers examining the role of religious traditions (Catholic, Evangelical, and Afro-Brazilian) in HIV prevention/care in Brazil [63, 78–83]. These studies utilizing various qualitative methods (e.g., ethnography, case studies) have demonstrated initial resistance of the religions to addressing HIV. This position was often rooted in moral judgments about HIV and contributed to the stigmatization of HIV and PLWH. However, more positive responses emerged over time due a common concern over access to treatment [63].

Many studies have also examined the role of religion in HIV in Africa. Cambell et al. [25] have synthesized much of this knowledge through a systematic review focusing on facilitators and barriers to HIV stigma and care/support for PLWH in sub-Saharan Africa. The findings highlighted the complex and contradictory role of the church in that region, characterized by stigma, moralistic attitudes, and gender inequalities, on the one hand, and involvement in prevention and care, on the other. The authors conclude that the knowledge of factors in faith-community based responses to HIV is in its infancy and more work needs to pave way for community interventions.

CONCLUSIONS

Spirituality and religion are important to many PLWH and affect their HIV outcomes, including disease progression, physical/mental health, and quality of life. The multidimensional nature of spirituality/religion in PLWH has been refined through qualitative and measurement studies. Both positive and negative influences of spirituality/religion on outcomes have been identified, and several mechanisms incorporating or mediating the effects of spirituality/religion on HIV outcomes have been elucidated in studies utilizing state-of-the art methods (e.g., SEM). In particular, HIV stigma beliefs, stress, and coping appear to have strong spirituality/religion components. This knowledge has guided spiritual interventions for PLWH. There is not much new evidence about these efforts, and findings from clinical trials have been mixed. Prayer/meditation- and group-based management appear to have some potential. There are concerns, however, with their implementation in clinical settings due to reluctance of healthcare providers and limited resources. There appears to be more interest in palliative care interventions focusing on end-of-life spiritual struggle.

Several future directions are indicated by the current literature. First, there is currently an overwhelming amount of information about the role of spirituality/religion in HIV, but this information is dispersed. *Targeted systematic reviews and meta-analyses* are needed to integrate knowledge about specific populations, sociocultural, and geographic contexts from across various disciplines. Certain populations (e.g., bisexual men, transgenders) and ethnic/religious contexts (e.g., non-Christian religions) have been neglected and further research on these groups is warranted. Second, future studies should utilize *state-of-the-art designs/methods,* including RCTs, CBPR, and longitudinal and multilevel studies – to better understand the social and individual-level impacts of spirituality/religion on PLWH. Advanced statistical techniques such as SEM and hierarchical linear modeling (HLM) offer ways to refine the existing knowledge. Third, *tailored, population-specific interventions* are recommended. Such interventions should be developed with community/stakeholder participation. Implementation and dissemination science offers ways to incorporate stakeholder perspectives in health care interventions. Fourth, *clinical and policy implications* of spirituality/religion-based approaches (e.g., financing) across geographic settings also need attention. Particularly, *comparative effectiveness studies* of spirituality/religion-based versus other types of interventions are lacking and would be helpful. Finally, *cross-national/comparative research* can inform development of some universal interventions that could be applied in various settings.

There is no easy future for spirituality/religion-based HIV interventions in clinical and community settings. Funding is scarce, and responses of providers, healthcare organizations, faith communities, and even PLWHs have been mixed. Further discussions that include various stakeholder groups, especially PLWH, are needed to determine the next steps.

Acknowledgments

This work was partially funded by the *Eunice Kennedy Shriver* National Institute of Child Health and Human Development, Grant #5R21HD050137-02. The content is solely the responsibility of the author and does not necessarily represent the official views of the NIH.

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