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ABSTRACT

Examining the Community Outreach Efforts of Local African American Religious Organizations in Relation to Drug Use and HIV Transmission

By

Alyshia Jackson

04/26/2018

INTRODUCTION:

Faith-based organizations, such as churches, are pillars of the community that provide inspiration in times of need. Often serving as a gathering place for those seeking hope and refuge, the church is heavily relied on by the community. African Americans are considerably more religious compared to other races in the U.S. population as a whole in terms of level of affiliation, attendance to religious services, frequency of prayer, and religion's importance in life (Liu, 2009). Aside from spiritual functions, churches provide social, political, and educational activities (McNeal et al., 2007). Expanding the scope of HIV (Human Immunodeficiency Virus) services further than conventional medical locations to reach where African Americans live, work, and socialize has become a main focus of community-based HIV interventions (Berkley-Patton et al., 2012). Using the long standing platform of the church can impact the HIV epidemic greatly.

AIM:

The purpose of this study is to determine if and how churches are offering community outreach to persons at risk for HIV, STIs, drug use, and/or Hepatitis C. This capstone will examine the perceptions of church leadership on the impact of their community outreach efforts on the congregation and members of the community.

METHODS:

A sample of 51 organizations were randomly chosen for comprehensive evaluation (Rothenberg, 2004). This cross-sectional study sought to establish a clear understanding of the current outreach activities of each church. The questionnaire used in this study supplied researchers with comparable information and used open-ended questions to get participants to expound on their views and the work of the church.

RESULTS:

There were 51 interviews conducted using the Religious Organization Survey from the IMPACT Project study. Most of the FBOs were churches (84%), with the majority of survey participants being African American (78%). Respondents were mostly directors or church administration (52%), followed by senior pastors or leadership (37%). Mostly all of the ministries (92%) had conducted outreach activities for people at risk for drug use, STIs, HIV, and Hepatitis C. Majority of the activities and services offered included prevention counseling (49%). Surprisingly, only 21.5% of the FBOs included prevention services (such as condoms, needles, bleach, and HIV/STI testing).

DISCUSSION:

The African American community continues to lead in the rates of drug use and HIV diagnosis. This study provides rationale for the church's steadily increasing efforts from the religious organizations perspective. The results emphasize three main concerns hindering the engagement of FBOs: responsibility, involvement, and perception. With the expansion of knowledge, the perceptions of the community and FBOs will positively influence outcome exposure.

Examining the Community Outreach Efforts of Local African American Religious
Organizations in Relation to Drug Use and HIV Transmission

By

Alyshia Jackson

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APPROVAL PAGE

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Author's Statement Page

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Alyshia Jackson
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Examining the Community Outreach Efforts of Local African American Religious Organizations in Relation to Drug Use and HIV Transmission

Introduction

Faith-based organizations, such as churches, are pillars of the community that provide inspiration in times of need. Often serving as a gathering place for those seeking hope and refuge, the church is heavily relied on by the community. African Americans are considerably more religious compared to other races in the U.S. population as a whole in terms of level of affiliation, attendance to religious services, frequency of prayer, and religion's importance in life (Liu, 2009). Studies show that more than half of the African American population attends church on a weekly basis (Berkley-Patton et al., 2012).

Churches allow the community to come together and address issues affecting its residents. Aside from spiritual functions, churches provide social, political, and educational activities (McNeal et al., 2007). During slavery, the church was a meeting place for slaves to address their oppression and deliver news and information concerning their community. African American churches helped establish businesses, housing, and schools (Moore et al., 2010). Another influential event centered around churches was the civil rights movement. A lot of the meetings to plan various events throughout the movement were held in churches. During the civil rights movement many leaders were associated with the church or other religious organizations. Dr. Martin Luther King, a civil rights leader, was a pastor in a Baptist church in Atlanta, Ga. Malcolm X, another civil rights leader, was a Muslim minister in New York City.

Churches have always been a main resource of information for the community. Expanding the scope of HIV (Human Immunodeficiency Virus) services further than conventional medical locations to reach where African Americans live, work, and socialize has become a main focus of community-based HIV interventions (Berkley-Patton et al., 2012).

Using the long standing platform of the church can impact the HIV epidemic greatly. It is important for churches to get involved because of their potential to target the HIV-related stigma in African American communities (Berkley-Patton et al., 2013).

The rate of HIV infection among African Americans is greater than all other racial groups in the United States. The CDC reported that in 2016, 44% of estimated new HIV diagnoses in the United States were among African Americans, who comprise 12% of the US population (CDC, 2018). Lack of awareness, socioeconomic status, stigma, fear, discrimination, and negative perceptions about HIV testing are all contributing factors to HIV risk among the African American community (CDC, 2018). Initially, the religious response to HIV was negative based on moral attitudes towards those who were believed to have caused the outbreak. Although studies have shown a shift in religious involvement, church leaders have identified stigma towards controversial issues (such as, drug use and homosexuality) as a main issue in the adoption of HIV intervention programs (Berkley-Patton et al., 2013).

The purpose of this study is to determine if and how churches are offering community outreach to persons at risk for HIV, STIs, drug use, and/or Hepatitis C. This capstone will examine the perceptions of church leadership on the impact of their community outreach efforts on the congregation and members of the community.

Literature Review

Community Influence and Responsibility

African American churches have the ability to reach a significant number of people within their communities. In the United States, there are an estimated 65,000 to 75,000 African American churches of different denominations (McNeal et al., 2007). Studies have shown positive results from faith-based intervention programs for diabetes and hypertension (McNeal et al., 2007). Though the results of these efforts are auspicious, the impact of black churches need to be thoroughly explored. In doing so, prospective target groups for HIV/AIDS prevention in the African American community could be identified (McNeal et al., 2007). One of the many reasons why the African American church has such a strong influence, is the mutual trust between the church population and leadership (Francis et al., 2008). This mutual trust has the potential to result in health promotion opportunities through the church's social networks and support systems.

In the study conducted by McNeal and associates, one of the main variables of their survey was community relationships. Those relationships were used to examine linkages and collaborations or affiliations with the HIV/AIDS-related community and social service organizations (McNeal et al., 2007). This section also showed how leadership perceived the utilization of social networks and resources by their churches. Using a scale of low, medium, and high, respondents were asked to rate the community level of participation and trust. Results showed that most of the ministers and their members had medium participation in the community. Similarly, most ministers reported a medium level of trust between African American churches and community organizations (McNeal et al., 2007).

Involvement was found to be a major factor when integrating the role of the church and the community. Only ten percent identified communication as a major influence when integrating the roles (McNeal et al., 2007). In a study conducted by Moore et al. (2010), the communication efforts among church leadership in predominantly African American churches was explored. Examining the style of communication of faith-based intervention programs is crucial when educating people about HIV/AIDS and changing stigma related to HIV/AIDS (Moore et al., 2010). Four major themes were identified from the interview data: disseminating information about HIV/AIDS through a combination of communication modes, responsibility and obligation to create more awareness about HIV/AIDS, reducing stigma by example, and preaching and teaching compassion (Moore et al., 2010). Most of the communication described by survey participants was interpersonal, through formal meetings or communication during health related events about basic HIV/AIDS information (Moore et al., 2010). Information was distributed during health seminars and different print media forms such as, the church bulletin. Surprisingly, a church leader expressed that discussion through sermons and and/or workshops was not enough when stressing the importance of not engaging in risk related behaviors (Moore et al., 2010). Many leaders felt responsible for raising awareness within the African American community. Church leaders also felt that it was their duty to provide HIV/AIDS ministry within the community and support for people diagnosed with HIV/AIDS (Moore et al., 2010). To address stigma leadership advocated for members to get tested. Uniquely, one church leader was tested in front of the congregation during service (Moore et al., 2010). In teaching compassion, leaders reminded the congregation of the importance of proper care and resources for those in need (Moore et al., 2010).

A similar study done by Khosrovani et al. (2008), investigated if and how black ministers in Houston, TX communicate information about HIV/AIDS to church members. The church congregation and church leaders were surveyed to determine the role of black churches in HIV/AIDS education. The surveys from the congregation reported that church leaders did in fact discuss HIV/AIDS regularly. It was also reported that most of the congregation found the information useful in educating them about the disease (Khosrovani et al., 2008). Majority of church members felt that the church should get involved in educating the community (Khosrovani et al., 2008). Surprisingly, a few members thought the church should not get involved in educating the community (Khosrovani et al., 2008). However, compared to information obtained from other sources, information received from the church was minimal (Khosrovani et al., 2008). Similarly, survey results from the ministers showed that the topic of HIV/AIDS was “sometimes” included in the sermon (Khosrovani et al., 2008). All of the ministers reported that the church was responsible for informing and educating the public (Khosrovani et al., 2008).

Faith-Based Prevention

In a study conducted by Francis et al. (2008), faith-based HIV prevention programs were examined to provide recommendations when establishing educational partnerships with faith-based organizations (FBOs). Four faith-based HIV prevention programs were chosen for review. The first program, Churches United to Stop HIV (CUSH), focused on the collaborative efforts of a Florida county health department and a local religious organization (Francis et al., 2008). FBO leaders were trained to develop educational programs and services for those diagnosed with and affected by HIV (Francis et al., 2008). Training materials were developed by the CUSH staff to meet the objectives target population using faith-based prevention (Francis et al., 2008). This

program proved successful through reaching hundreds of churches within the community. The second program, Teens for AIDs (TAP), is a church based program targeting youth by training youth group members as peer educators (Francis et al., 2008). Using a curriculum developed by a youth advocacy group peer educators were trained during a weekend retreat (Francis et al., 2008). This program suggest that FBOs could be a potential setting for sexuality and HIV prevention education forums (Francis et al., 2008). The third program, the Metropolitan Community AIDS Network (Metro Can), was established to address the increasing number of African American substance abusers at risk for HIV/AIDS (Francis et al., 2008). The primary goal of this program is to provide the target population with a coordinated continuum of care incorporating spirituality from a faith-based perspective (Francis et al., 2008). The program showed reduced substance use and HIV/AIDS risk behaviors, increased life-enhancing behaviors, and decreased participation in illegal activities (Francis et al., 2008). These results supported the concept of a faith-based approach of spirituality rather than an aggressive approach (Francis et al., 2008). The fourth program, Project BRIDGE, was a community-based project focusing on the program design, implementation, and evaluation of a faith-based substance use and HIV/AIDS prevention program for African American youth (Francis et al., 2008). Researchers used various participation methods to engage the FBOs and target population in the development of the program (Francis et al., 2008). In partnering with a local African American church in Houston, TX access to an active community outreach program was obtained (Francis et al., 2008). The intervention program was spread over three years including four main components: Life Skills Training, Spreading the Word, Choosing the Best, and a faith component (Francis et al., 2008). Bridge was assessed using focus groups with parents, students, and teachers (Francis et al., 2008). Results confirmed the support of faith-based HIV and

substance abuse programs (Francis et al., 2008). Reports showed a decrease in the use of marijuana and other drugs and more fear of contracting AIDS compared to those who did not participate (Francis et al., 2008).

The literature review study by Francis et al. (2008), indicates that public health and faith-based organizations can work together in developing successful intervention and prevention programs. A similar study conducted by Griffith and associates, sought to change the standard of churches by creating a more accepting and open environment for young adults to discuss HIV/AIDS and the risk factors and behaviors associated. The YOUR Blessed Health (YBH) intervention took place in Flint, Michigan, a predominantly African American city (Griffith et al., 2010). The program used a multilevel system to increase the scope of the FBO and its leaders when addressing HIV/AIDS and STIs (sexually transmitted diseases (Griffith et al., 2010). Researchers found that intensive training on effective communication and negotiation were needed (Griffith et al., 2010). However, young people were able to understand the intricacy of sexual relationships (Griffith et al., 2010). Uniquely, church leaders and their spouses were trained to convey the YBH curriculum (Griffith et al., 2010). The training increased their knowledge improved their level of comfort (Griffith et al., 2010). The final components of this study were to have church leaders implement church-wide and community-wide activities to raise awareness about HIV/AIDS and STIs (Griffith et al., 2010). Results from each event showed an increase in awareness and level of comfort among the community (Griffith et al., 2010).

Another study examining the churches' ability to create and implement HIV intervention programs, showed the importance of African American church-based HIV education and screenings (Berkley-Patton et al., 2012). Berkley-Patton and associates tested this notion using a

HIV tool kit known as the Taking it to the Pews (TIPS) (Berkley-Patton et al., 2012). TIPS was developed in collaboration with FBOs, health organizations, and the University of Missouri-Kansas City Psychology Department Community Health Research Group (Berkley-Patton et al., 2012). Using the socio-ecological model as a guide to create a multilevel system approach consisting of 40 tools (Berkley-Patton et al., 2012). Researchers found church leaders and congregation members to be capable of distributing HIV educational messaging and testing support (Berkley-Patton et al., 2012).

Religious Perception

Pastors have a strong influence over program implementation and those who support such programs (Timmons et al., 2009). Furthermore, aside from implementing programs research-based programs are needed to incorporate guidelines and outcome evaluation for future use (Timmons et al., 2009). This study focused on the attitudes and beliefs of pastors towards research-based health programs and their role as FBOs (Timmons et al., 2009). Timmons and associates used focus groups and group interviews to establish comfort and trust encouraging free talk and interactive brainstorming (Timmons et al., 2009). Four themes were established as a result: 1. Congregant Needs 2. Shared Programming Ethics 3. Common Understanding of Programming Processes 4. Care for the Church and Congregation (Timmons et al., 2009). Study participants stated that the congregants needed to be educated about the basic HIV signs and symptoms and contributing risk factors (Timmons et al., 2009). Programs that were non-intrusive and mindful of the congregants' time and engagement were preferred (Timmons et al., 2009). Surprisingly, Pastors also preferred programs that did not interfere with the church's regularly scheduled program (Timmons et al., 2009). Studies have found the key barriers to faith-based

program implementation to be funding, church member's motivation and time, and pastors as role models (Timmons et al., 2009).

A similar study by Wooster et al. (2011), suggested that aside from attitudes and funding, stigma was a key barrier to the church's involvement. The Minority AIDS Initiative was developed in 1998 to focus on the effect of HIV/AIDS on minorities (Wooster et al., 2011). By developing this program the U.S. government sought to reduce HIV-related health disparities (Wooster et al., 2011). Through this initiative the Center for Disease Control and Prevention (CDC) funded HIV prevention programs that strengthened the response of the community to health disparities (Wooster et al., 2011). A few of the programs sought to increase capacity of FBOs (Wooster et al., 2011). To assess the capacity of the programs funded by the MAI, the CDC developed the Community Systems Analysis (CSA) (Wooster et al., 2011). The purpose of this study was to examine the HIV prevention needs of four communities using the CSA qualitative assessment (Wooster et al., 2011). Data were collected annually over the course of 3 years from interviews of individuals involved in HIV prevention in Chicago, IL, New York (Harlem), NY, Jackson, MS, and Phoenix, AZ (Wooster et al., 2011). Results showed a change in attitude toward HIV by the FBOs (Wooster et al., 2011). HIV activities within faith-based communities increased over time (Wooster et al., 2011). However, participants attributed this change in attitude and involvement to funding (Wooster et al., 2011). The availability of funding increased the scope of faith-based community participation and helped FBOs understand the effects of HIV on the African American community (Wooster et al., 2011).

Although the faith community's reported an increase in involvement, a few participants stated that the attitudes of faith leaders and church members was still an issue affecting the implementation of HIV prevention programs (Wooster et al., 2011). Furthermore, some church

leaders stated that FBOs were more inclined to address HIV/AIDS programs for women and youth because they were not associated with homosexual risk behaviors (Wooster et al., 2011).

“Traditionally, stigma has been defined as negative attitudes towards preventable or controllable illnesses with causes identified as undesirable/immoral behaviors (e.g., having sex outside of marriage) and associated with certain groups (e.g., men who have sex with men) who are blamed for their illness” (Berkley-Patton et al., 2013). A pilot test to assess the usefulness of the Taking it to the pews (TIPS) project was conducted by Berkley-Patton and associates (Berkley-Patton et al., 2013). Researchers also assessed HIV related stigma as a result of the HIV prevention intervention (Berkley-Patton et al., 2013). Majority of the participants in this study attended church weekly and were considered highly religious (Berkley-Patton et al., 2013). This showed the capacity and significance of churches incorporating messages of support to raise HIV awareness thus reducing stigma (Berkley-Patton et al., 2013).

Methods

Study Design

A street survey was conducted in 4-6 target neighborhoods in Atlanta, Ga, that were previously identified in another study (Inner City Atlanta Case-control Study), to determine the FBOs active in the community (Rothenberg, 2004). The same study (Inner City Atlanta Case-control Study) was used to determine the church's level of interest and their outreach activities. Other FBOs were identified using referrals from umbrella organizations and key informants. The list of organizations was then arranged by congregation size (<50; 50-150; > 150). A sample of 51 organizations were randomly chosen for comprehensive evaluation. This cross-sectional study sought to establish a clear understanding of the current outreach activities of each church.

Logistics

Religious organizations were contacted via letter or phone call to the pastor or organization leader. Next, a member of the research team reached out via phone call to set up a formal meeting. The interview was scheduled thereafter to conduct the survey. This familiarized the FBOs with members of the research team before the initial interview.

Verbal consent was obtained for general discussion and informed consent from church leaders and administration for particular information about leadership. Study participants were given a \$50 incentive at the end of their interview (Impact Project, 2014). Only general sociodemographic data was requested for the FBOs assessment. Open-ended questions were used to assess the knowledge and beliefs toward HIV, practices associated with said belief, and those at risk.

Interview Instrument

The questionnaire used in this study supplied researchers with comparable information and used open-ended questions to get participants to expound on their views and the work of the church.

The survey was used to establish the following:

- The churches' experience with prevention programs
- The sense of responsibility to prevention and intervention efforts
- The community impact of the outreach efforts
- Members involved in the programs
- How the churches perceive program success and their role as FBOs to the fight against drug use, HIV, and other infections.

In connection with another assessment (of target population and community), the survey will also provide information exploring the relationship between the FBOs activities and target outcome (HIV-negative).

Data Management and Analysis

Data was entered, edited, and compiled utilizing the database manager (MSACCESS). Interviews were entered after team members reviewed and edited all data manually. Respondents were assigned separate files (maintained by MSACCESS) for information referring to them. Data was then extracted from each file, then downloaded and converted to SAS.

The cross-sectional evaluation contained qualitative (attitudes) and semi-quantitative (programs) data. The information received from the open-ended conversations with organization leaders or administration were organized using four sections: 1. the level of obligation; 2. Association between religious teachings and obligation; 3. Resources for programs; 4. Level of

disagreement among the church organization. Results will describe the scope of the religious organizations' programs in the target area for drug use and disease intervention. The research team was trained to structure the open-ended discussions around the four categories.

Although it was challenging to examine the outreach efforts of the FBOs in relation to drug use and disease intervention, researchers will use the qualitative and semi-quantitative data in a way that determines an "Exposure Score". The "Exposure Score" will show the influence of the FBO's intervention on the target population. To formulate the score, data collected from the target population about their participation and influence is needed.

Results

Demographics

There were 51 interviews conducted using the Religious Organization Survey from the IMPACT Project study. Most of the FBOs were churches (84%), with the majority of survey participants being African American (78%). More than half of the respondents were male (60.7%), and many had some college education or more (86%). Many of the religious denominations were Baptist (33%) and Christian (27%), followed by non-denominational (7%). Respondents were mostly directors or church administration (52%), followed by senior pastors or leadership (37%) (Table 1). The average attendance, for the majority of churches, was more than 100 people (76%).

Table 1. Ministry Leadership by Position

Ministry Staff	
Pastor	5
Church Admin	6
Deacon/Elders	7
Imam	2
Lay Minister	2
Other	14
Senior Pastor	15
Grand Total	51

Outreach Activities

Mostly all of the ministries (92%) had conducted outreach activities for people at risk for drug use, STIs, HIV, and Hepatitis C. Majority of the activities and services offered included prevention counseling (49%). Surprisingly, only 21.5% of the FBOs included prevention services (such as condoms, needles, bleach, and HIV/STI testing). A list of services offered by the majority of FBOs is outlined in Table 2. FBOs Outreach Activities and Services. Majority of those services were offered weekly, serving more than 200 people in the last six months. All of those organizations collaborated with other ministries or agencies (Figure 1). When asked if funding was received for the prevention services more than half responded no (Figure 1). However, resources other than funding were received by most of the FBOs. More than half of the FBOs provided services to people other than active church participants.

When asked, “In the last 12 months, do you know anyone in your Ministry who has been told that he/she had: Tuberculosis, Gonorrhea, Syphilis, Chlamydia, Genital Herpes, Hepatitis C,

Trichomonas, or HIV/AIDS?” 50.9% of respondents said HIV/AIDS. Of those respondents, 19% stated that they knew 25 or more people diagnosed with HIV/AIDS. These ministries referred most of their clients to care with local health organizations such as, Grady Health Centers Infectious Disease Program.

Figure 1. Outreach Activity Logistics

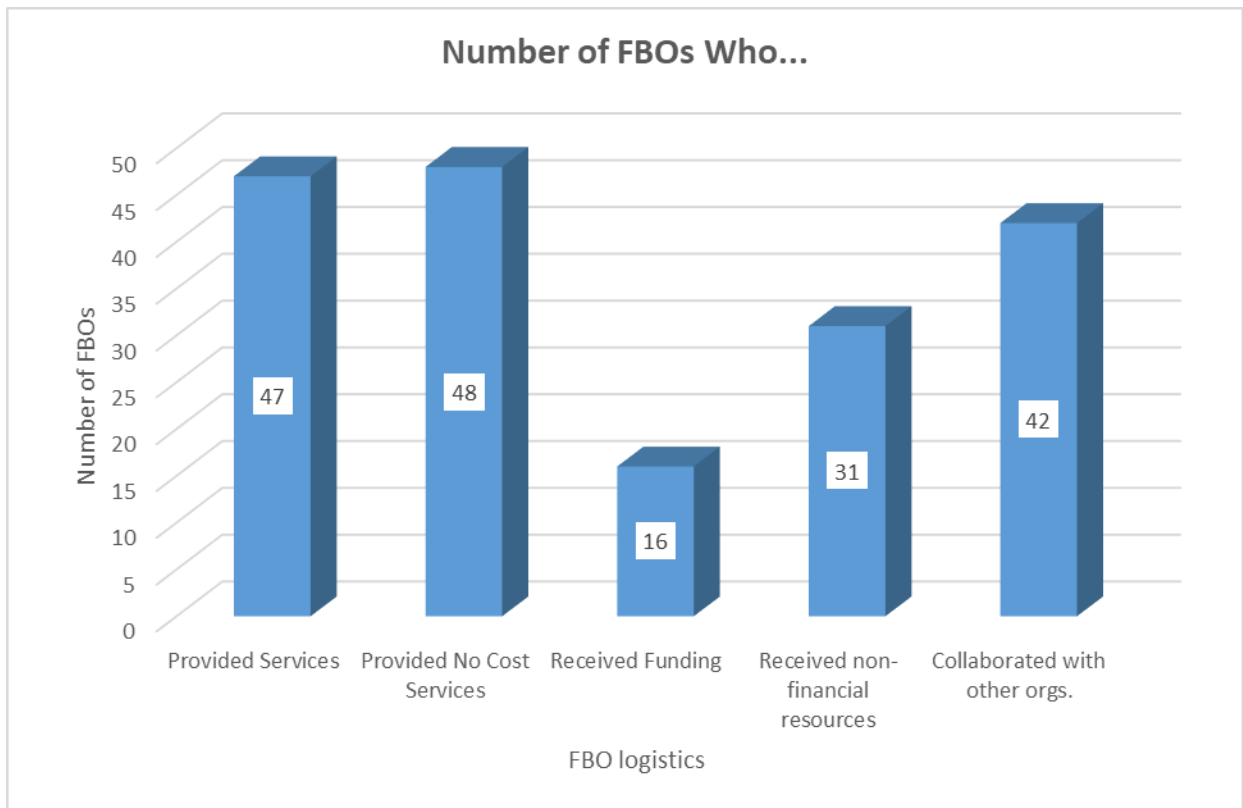


Table 2. FBOs Outreach Activities and Services

Activities and Services Provided	# of FBOs
Food	47
Clothing	40
Shelter	16
Healthcare	22
Prevention Counseling	24
Prevention Services: Condoms, Needles, Testing, etc.	11
Social Service Referral	30
Pastoral Counseling	38

Drug Use

A significant number of the churches knew clients abusing alcohol (90%), followed by Marijuana (64%) and Crack Cocaine (43%). Many were linked to or already receiving treatment (47%) and nearly as many were not (49%).

HIV Transmission

Survey participants were asked questions based on their knowledge of how HIV is spread. Unfortunately, many believed that people who were provided outreach by their ministry had a high (37%) chance of contracting HIV. Other rated their probability as medium (25%) and low (23%). When asked to rate their congregation, most responded low (60%). Most respondents rated their personal chances for getting HIV as none (68%), followed by low (29%). Many of the organizations were open to developing HIV/AIDS outreach and providing prevention services

such as, HIV testing and condom distribution; however, some responded that they were not open to these programs.

Discussion

Although survey results from the community about their involvement in the FBO's outreach programs were not reviewed, the critical role FBOs play in drug use and HIV prevention has been established. The African American community continues to lead in the rates of drug use and HIV diagnosis. This study provides rationale for the church's steadily increasing efforts from the religious organizations perspective.

The prevention and outreach efforts of these churches are reaching thousands of community members. This shows a cause for concerns when leadership perceives the risk of the community for HIV transmission to be high. Knowing the immediate needs of the community and having the platform should result in active change. The results emphasize three main concerns hindering the engagement of FBOs: responsibility, involvement, and perception. Churches feel a sense of responsibility for the communities they serve. They are open and willing to develop the programs necessary for the target population. However, many of the programs are only serving church members. Referring the client to care is just half of the battle. The follow-up of care has long been an issue affecting the target population. The sense of responsibility needs to extend beyond referrals.

Involvement and collaboration can also impact the outreach efforts of FBOs. Community members need to be a part of the planning and implementing process. Programs can effectively reach their target population by understanding their needs first hand and shaping the program to

fit their needs. Many churches were offering the same outreach programs, by collaborating these efforts support and the staff required will be expanded. Funding is also a main concern for many FBOs. A joint effort is another way to ensure funding for prevention and intervention programs.

Perception is a recurring theme throughout every study. The perception of church leadership and the community can heavily impact program success. Church leaders influence their congregation and the community by establishing trust. Historically, they have been trusted to lead the community towards what is morally correct. Knowledge is a proven method of change. With the expansion of knowledge, the perceptions of the community and FBOs will positively influence outcome exposure.

Limitations

There are several limitations within this study. First, the perspective of the community members participating in the outreach programs were not reviewed. Their account of the program is key to assessing the outcome exposure. Secondly, there are no details about how the information on drug use and HIV prevention are communicated. Communicating the information through a sermon can have a very different impact than delivering the information through intervention and prevention specific workshops. Thirdly, training was not specified within the survey. This could explain the lack of confidence in their outreach efforts and their risk perception for the community they serve. Lastly, many of the programs stated that they provided prevention counseling. Information is needed detailing the specifics of this service.

Conclusion

This study examines the importance of the church as a staple within the African American community. As HIV rates continue to rise among the African American community, the influence of FBOs will have a significant impact. The platform they hold in the lives of African Americans has influenced change through many historic events. Creating prevention and intervention programs addressing the specific needs of the target community within the church has been effective. It is important that the knowledge and perception of those leading these efforts is understood. Stigma has long been an issue within the African American church concerning HIV and drug use. Religious perception has hindered the involvement of FBOs in HIV prevention. Knowledge has always been the leading prevention method. Proper training, resources, and funding are also essential to both the community and FBOs.

Key areas of focus have been identified through this study. Involving the community, partnering with other FBOs, and local health organizations can improve outreach efforts. The organizations surveyed were all duplicating efforts within the community. The impact of those efforts has not been reviewed, but could be highly effective if integrated. Many of the pastors and church leaders expressed their willingness to develop programs and services that could result in positive outcome exposure.

Results of the target community should be reviewed to expand on the impacts of FBO's outreach programs. These results will also identify the frequency and intensity of their involvement. Further research is needed to assess the gaps in these prevention and intervention programs contributing to the risk perception of church leaders. The establishment of a stable and sustainable connection between the community and FBOs is necessary for strengthening the fight against drug use and HIV amongst African Americans.

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Appendix

The IMPACT Project

Religious Organization SURVEY

Respondent ID#: _____

Date: ____/____/____

Interviewer ID#: _____

Interview Start Time: _____am/pm

Interview Site: _____

Category: Church Street Ministry Mission Outreach

If Consent Form was completed at an earlier time, please review these points with the Faith Leader

- Compensation \$50 at end of interview
- Importance of honesty and accuracy
- Answer any questions that faith leader may have
- Confidentiality of Information

SECTION A: DEMOGRAPHICS

1. Gender:	0 Male 1 Female 2 Transgender 3 Other [Specify: _____]
2. Race/Ethnic Group:	0 Black (African American) 1 Black (Caribbean) 2 White 3 Hispanic (Black) 4 Hispanic (White) 5 Native American Indian/Alaskan Native 6 Asian/Pacific Islander 7 Mixed: Black/White 8 Other [Specify: _____]
3. Birth Date:	_____ / _____ / _____ mm dd yyyy
4. Age:	

5. What is your current marital status?

- 0 Single, never married
- 1 Married/ Common Law/ Domestic Partnership
- 2 Divorced
- 3 Separated
- 4 Widowed

6. What is the last grade you finished in school? *[If respondent did not finish High School, ask if he/she completed GED]*

- 0 No schooling
- 1 Elementary school (Grade K-8)
- 2 Some High School (Grade 9-11)
- 3 High School Equivalency (GED)
- 4 High School Graduate (Grade 12)
- 5 Some College or Technical Training
- 6 Associate Degree
- 7 Bachelor Degree
- 8 Graduate Degree
- 9 M.Div. (Master of Divinity)
- 10 M.T.S. (Master of Theological Studies)

7. How would you describe your religious denomination or affiliation:

- 0 Christian
- 1 Catholic
- 2 Baptist
- 3 Methodist
- 4 Pentecostal
- 5 Apostolic
- 6 Holiness
- 7 Muslim (Islamic)
- 8 Black Muslim
- 9 Jewish
- 10 Protestant
- 11 Buddhist
- 12 Hindu
- 13 No particular religion
- 14 Atheist (no belief in God)
- 15 Refused

16 Don't know/no answer

17 Other [Specify: _____]

8. What is your position in this Ministry? **[Interviewer, Please Circle Response]**

Senior Pastor, Associate Pastor, Pastor, Are you ordained? Yes _____ No _____

Minister, Lay Minister, Are you Ordained? Yes _____ No _____

Deacon, Other: _____

8a. What is the total number of years you have worked in Ministry? _____

8b. Have you led or worked in a church ministry in the last six months? Yes _____

No _____

[If answer to Q. 8b is No, skip to Q. 9]

8c. Is this a paid or volunteer position? PAID _____

VOLUNTEER _____

8d. What is the name of the church ministry?

8e. Where is the Ministry located?

8f. How long has the Ministry been in existence?

9. What is your average attendance? _____

9a. What is your active weekly membership? _____

9b. What percentage of members live in the zip code where the church or street ministry is located?

9c. Does any church staff live in this zip code? Yes _____

No _____ If Yes, what percentage? _____

9d. Does the Senior Pastor live in the zip code where the church is located? Yes _____

No _____ If No, why not? _____

9e. Do you live in this zip code? Yes _____ No _____

SECTION B: OUTREACH ACTIVITIES

[INTERVIEWER READ: Now, I'd like to ask you questions about outreach activities conducted by your ministry. Let me remind you that all information you provide is confidential.]

10. In the last six months, has the MINISTRY conducted outreach activities or services to persons at risk for Drug Use, Sexually Transmitted Infections, HIV, or Hepatitis C?

0 No

1 Yes

98 Refused

99 Don't know

If Yes to any of the above [Go to Q. 11] If No, Go to Q. 18

11. What kind of activities or services have been conducted?

Interviewer, if respondent does not mention any of the following activities or services, please prompt for each of these items:

- 1. Food
- 2. Clothing
- 3. Shelter
- 4. Healthcare
- 5. Prevention Counseling (HIV/ STI Testing)
- 6. Prevention Services: Condoms, Needles, Bleach,
- 7. Social Service Referral
- 8. Pastoral Counseling/Spiritual Guidance
- 9. Other _____

98 Refused

99 Don't know

11a. How often are these activities conducted?

12. How many people have you served in the last six months? _____

13. Do you work in collaboration with other ministries or agencies to provide these services?

Yes _____ No _____ **[If Yes, go to Q. 14]**

13a. If No, are you open to collaboration with other churches or organizations to provide services?

Yes _____ No _____ **[Go to Q. 18]**

14. Is there a cost to the client for these services? Yes _____ No _____

15. Do you receive funding from any source to provide services? Yes _____

No _____

15a. Do you receive resources (other than financial resources) from any source to provide services?

Yes _____ No _____

16. What is the number of staff/volunteers required to carry out these activities?

17. What is the number of paid staff? _____ What is the number of volunteers?

17a. How many of the clients that you provide services to, are active participants in the church ministry? _____

18. In the last 12 months, do you know of anyone in your Ministry who has been told that he/she had: *[Read each choice from the column below and circle Yes or No for each one]*

	NO	YES	How Many	DK
a. Tuberculosis?	0	1		99
b. Gonorrhea?	0	1		99
c. Syphilis?	0	1		99
d. Chlamydia?	0	1		99
e. Genital Herpes?	0	1		99
f. Hepatitis C?	0	1		99
g. Trichomonas?	0	1		99
h. HIV/AIDS?	0	1		99

[If No or DK to all of the above, go to Section C.]

19. Where were the client(s) referred?

SECTION C: DRUG USE

[INTERVIEWER READ: In this section I'm going to ask you some questions about alcohol, drugs, and injection drug use. Let me remind you that all information you provide is confidential.]

20. In the last 12 months, do you know anyone in your Ministry who has used: *[Read each choice from the column below and circle Yes or No for each one]*

a. Alcohol	b. Marijuana	c. Crack (not powdered Cocaine)	d. Powdered Cocaine	e. Heroin by itself	f. Amphetamines/ Methamphetamines (e.g., speed, uppers)	g. Other: [Specify: _____ _____]
Y N DK How Many?	Y N DK How Many?	Y N DK How Many?	Y N DK How Many?	Y N DK How Many?	Y N DK How Many?	Y N DK How Many?

21. If yes to any of the above, were they linked to treatment and care? Yes _____ No _____

[If No to all of the above, go to Section D.]

22. Where were the client(s) referred? _____

SECTION D: HIV TRANSMISSION

[INTERVIEWER READ: In this section I'm going to ask you some questions about HIV. Remember, all of the information you give will be confidential.]

23. Based on what you know about how HIV is spread, how would you rate the chances of the persons you provide outreach to, getting the HIV infection?

Please Circle One:

1. High 2. Medium 3. Low 4. None
5. Already Infected 98. Refused 99. Not Known

24. Based on what you know about how HIV is spread, how would you rate the chances of your congregants getting the HIV infection?

Please Circle One:

1. High 2. Medium 3. Low 4. None
5. Already Infected 98. Refused 99. Not Known

25. Based on what you know about how HIV is spread, how would you rate your personal chances of getting the HIV infection?

Please Circle One:

1. High 2. Medium 3. Low 4. None
5. Already Infected 98. Refused 99. Not Known

[INTERVIEWER READ: We are almost done, I just have a few more questions about HIV. Remember, all of the information you provide is confidential.]

26. If given the opportunity, is your Ministry open to developing HIV/AIDS Outreach?

Yes _____ No _____

27. Would your Ministry be open to providing prevention activities such as testing for HIV, STIs or distributing condoms?

Yes _____ No _____

INTERVIEWER: PLEASE READ

We have now completed the interview. If you have any questions about this interview, please feel free to ask me now. [PAUSE FOR QUESTIONS] If there are no questions, I would like to thank you for your participation.

[INTERVIEWER: IF RESPONDENT HAS ANY QUESTIONS, RECORD THEM IN THE SPACE BELOW]

1. _____

2. _____

Interview Finish Time: _____ *AM/PM*

In what condition was the participant during this interview [*Circle all that applies*]?

- Alert and responsive 01
- In a hurry 02
- Drowsy or sleepy 03
- Distracted 04
- Other (_____) 05

On a scale of 1 to 5, how truthful would you rate the information gathered from this interview (1=not truthful at all, 5=completely truthful)?

01 02 03 04 05

Comments:

Was this questionnaire reviewed for consistency and accuracy by the:

INTERVIEWER: Initials _____ Date ___/___/___

DATA MANAGER: Initials _____ Date ___/___/___