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## TAKING IT TO THE PEWS: A CBPR-GUIDED HIV AWARENESS AND SCREENING PROJECT WITH BLACK CHURCHES

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### Abstract

Utilizing a community-based participatory research (CBPR) approach is a potentially effective strategy for exploring the development, implementation, and evaluation of HIV interventions in African American churches. This CBPR-guided study describes a church-based HIV awareness and screening intervention (Taking It to the Pews [TIPS]) that fully involved African American church leaders in all phases of the research project. Findings from the implementation and evaluation phases indicated that church leaders delivered TIPS Tool Kit activities on an ongoing basis (about twice a month) over a 9-month period. TIPS church members were highly exposed to TIPS activities (e.g., 91% reported receiving HIV educational brochures, 84% heard a sermon about HIV). Most (87%) believed that the church should talk about HIV, and 77% believed that the church should offer HIV screening. These findings suggest that implementing an HIV intervention in Black church settings is achievable, particularly when a CBPR approach is used.

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HIV/AIDS continues to be a major public health issue that disproportionately affects African Americans. A large number of past HIV prevention efforts have targeted African Americans in educational (e.g., Jemmott, Jemmott, & Fong, 1998), medical (e.g., DiClemente et al., 2004, Liang et al., 2005), public housing (e.g., Downing et al., 1999), social service (e.g., Sterk, Theall, Elifson, & Kidder, 2003), street outreach (e.g., Centers for Disease Control and Prevention [CDC], AIDS Community Demonstration Projects Research

Group, 1999), and community-wide settings (e.g., CDC, 2005; Kahn, Moseley, Thilges, Johnson, & Farley, 2003; Vargo, Agronick, O'Donnell, & Stueve, 2004). Although African American faith-based HIV initiatives have addressed HIV across the United States (e.g., Balm of Gilead's Black Church Week of Prayer for the Healing of AIDS [Avery & Bashir, 2003]; Black Faith-Based Health Initiative, 2009; Broward County's Churches United to Stop HIV [Agate et al., 2005]), only a few empirical studies have reported on implementation of HIV interventions facilitated in African American church settings. These studies have demonstrated the impact of churches facilitating the provision of HIV information and screening services with large numbers of African American community members (Agate et al., 2005; Collins, Whitters, & Braithwaite, 2007; MacMaster et al., 2007) and HIV awareness and screening activities with their church members (Agate et al., 2005). Also, church-based HIV awareness activities have been conducted with African American church youth (Marcus et al., 2004; Mertz, 1997). However, only two studies have reported (minimally) on church leaders' participation in the development and delivery of church-based HIV interventions (Agate et al., 2005; Marcus et al., 2004), and none have reported on their church leaders' participation in evaluation and interpretation of findings. Nor have these studies reported on church members' opinions about the church's participation in such activities.

The "Black church"—or evangelical churches predominantly made up of African American members—is an extremely influential institution in the African American community, and its faith leaders have historically mobilized their communities to address other important social and public health concerns (Billingsley, 2002; Lincoln & Mamiya, 1990; Thomas, Quinn, Billingsley, & Caldwell, 1994). However, issues related to HIV stigma, sexuality (Fullilove & Fullilove, 1999; Pew Forum on Religion and Public Life 2009; Poindexter, Linsk, & Warner, 1999), condom use (Collins et al., 2007), and limited resources and training on HIV have served as barriers to addressing HIV in many Black churches (Billingsley, 2002; Fullilove & Fullilove, 1999; Smith, Simmons, & Mayer, 2005). Utilizing a community-based participatory research (CBPR) approach may be an effective way to engage faith leaders in developing and implementing church-based HIV interventions and to mobilize church and community members to participate.

CBPR has been defined as "a collaborative approach to research that equitably involves all partners in the research process and recognizes the unique strengths that each brings" (Kellogg Community Health Scholars Program, 2009). Indeed, the African American church possesses many strengths that have allowed it to maintain its longstanding position of influence in communities of color. These strengths include a diverse membership of African American parishioners representing all age ranges and socioeconomic strata (Berkley-Patton et al., 2008; Lincoln & Mamiya, 1990; Pew Forum on Religion and Public Life, 2009; Thomas et al., 1994) who attend church frequently (Pew Forum on Religion and Public Life, 2009). Also, many African American churches having ongoing church services with church members and outreach activities with community members (Billingsley, 2002; Lincoln & Mamiya, 1990) that can serve as dissemination channels for HIV intervention components (Berkley-Patton et al., 2008; Tesoriero et al., 2000) and could expand their reach to underserved community members. Additionally, the stability of many Black churches and the long-term membership of their parishioners (Berkley-Patton et al., 2008; Pew Forum on Religion and Public Life, 2009) may assist in sustaining church-based HIV interventions and member participation in these interventions. Taken together, these assets position Black churches to extend the reach of HIV interventions to those who may otherwise go under- or unserved.

Studies on health issues that disproportionately affect African American communities have demonstrated that the Black church can be a practical setting for health promotion

interventions and that church leaders can serve key roles in developing and/or delivering interventions (e.g., Campbell et al., 2004; Duan, Fox, Derose, & Carson, 2000; Erwin, Spatz, Stotts, & Hollenberg, 1999; Kim et al., 2008). However, there is little research on how to develop and implement church-based HIV interventions and on how CBPR strategies can be used to do so. By engaging church leaders in all phases of the research, the faith community could become equal partners in gaining and contributing to the needed knowledge and capacity to extend the reach of HIV interventions to many more African Americans. We report on a CBPR-guided case study of a church-based HIV awareness and screening intervention (Taking It to the Pews [TIPS]). We first describe how African American church leaders were involved in establishing the research agenda, developing the intervention components and materials (including the creation of the church-based TIPS Tool Kit), and implementing the TIPS intervention. We then describe the project's evaluation procedures and early project findings followed by church leaders' participation in the interpretation and dissemination of findings. We conclude with a discussion of lessons learned, project challenges, and limitations.

## **ESTABLISHING THE RESEARCH AGENDA**

### **CONTEXTUAL BACKGROUND**

Among the seven counties in Missouri and the four counties in Kansas that make up the greater Kansas City metropolitan area, the majority of all new HIV and AIDS cases (about 70%) have been within the Kansas City urban core located in Jackson County (Kansas City Health Department, 2008). Though African Americans comprise approximately 14% of the population in the Kansas City metropolitan area (about 2 million residents), they accounted for 44% of reported HIV cases and 42% of AIDS cases in 2007. Both Kansas City African American males and females have significantly higher risks of HIV infection than their White counterparts (2.8 and 17.8 times higher, respectively). Of the African American males diagnosed with HIV in 2007, 39% were between the ages of 35 and 44, and the primary at-risk group was men who have sex with men (MSM). In 2007, 69% of Kansas City HIV-positive women were African American and from 2001 to 2006, the rate of infection among African American women had increased by 26% compared with the previous 5 years. The primary HIV infection route for Kansas City African American women has been through heterosexual sex with a partner of unspecified risk. Furthermore, a local survey on barriers to HIV service utilization found that many Kansas City African Americans were not aware of locations for HIV testing and many were afraid to receive an HIV test (KC Health Department, 2008). Also, the local survey found that 25% of African Americans were "late testers" and entered care with an AIDS diagnosis.

### **THE BLACK CHURCH WEEK OF PRAYER FOR THE HEALING OF AIDS IN KANSAS CITY**

The Black Church Week of Prayer for the Healing of AIDS in Kansas City (BCWPKC) has been a long-time member of the Balm of Gilead's National Black Church Week of Prayer (Avery & Bashir, 2003) and has carried out the national organization's recommendations since 1997. BCWPKC's community-wide Week of Prayer and other quarterly events and ongoing advocacy encourage churches to raise HIV awareness, offer HIV testing, and confront issues of HIV risk behaviors, stigma and apathy. BCWPKC annual community-wide events have included Kansas City, Missouri versus Kansas City, Kansas clergy basketball games, interfaith prayer vigils, innercity parades, pampering events (e.g., makeovers, massages) for people living with HIV, theatrical performances, Kansas City, Missouri and Kansas City, Kansas school district-wide programs, and gospel concerts. All activities of the BCWPKC are coordinated by Calvary Community Outreach Network (CCON; a faith-based 501c3 organization) and a dedicated group of clergy and lay leaders from Black churches, people living with and affected by HIV/AIDS, representatives from

local AIDS service organizations (ASOs) and the school district, elected officials, community leaders, and business owners. There is no official listing of Black churches (nor corresponding demographics of their members) in the Kansas City area; however, CCON maintains a mailing list of 450 church leaders representing about 300 Black churches in the greater Kansas City area. On an annual basis, about 5,000 people attend BCWPKC events.

In 2003, to address the growing numbers of Missouri's African American HIV/ AIDS reported cases, the Missouri Governor's Task Force conducted strategic planning to update the state's "Emergency Response Plan to the African American Community" with assistance from representatives from the BCWPKC, Missouri state agency representatives, and a host of other community representatives from across the state. During the planning process, about 30 Kansas City clergy committed to attend BCWPKC activities and on a regular basis facilitate HIV awareness programs and screening events within their own churches. Subsequent to the planning process, CCON received funding from the Missouri Department of Health and Senior Services and the Office of Minority Health in 2004 for BCWPKC to address HIV in African American faith-based settings. CCON and BCWPKC volunteers then contacted clergy who had participated in the planning process and inquired about their HIV awareness efforts and found that none of the church leaders had carried out their commitments. Believing that one of the key barriers for pastors' was a lack of knowledge of possible intervention activities, the BCWPKC hosted a Commitment Breakfast in 2005 where a list of HIV awareness activities for church settings was presented to over 30 local KC pastors. The list was well received, and pastors again committed to facilitate events in their churches. After a few months, CCON staff implemented follow-up phone calls to the pastors to identify what had been accomplished, and still found a lack of activity within the churches. The clergy reported that their primary challenges in carrying out their pledges were related to their need for more: training on HIV, HIV awareness activities that could be easily implemented, and resources to carryout these activities.

### **BUILDING THE TIPS PARTNERSHIP**

The feedback from clergy on challenges to conducting ongoing HIV-related activities in their churches led to the initiation of a collaborative effort coordinated by CCON to develop a new church-based HIV intervention—"Taking It to the Pews (TIPS)"—as a programmatic extension of BCWPKC. The aim was to move beyond the traditional BCWPKC-delivered community events to exploring the feasibility of a more intensive, project structure that engaged churches individually and collectively in delivering an HIV intervention directly to their members with assistance from a local technical support team. In 2006, collaborating TIPS partners—including CCON staff members, church leaders from local African American churches of various denominations, and representatives from ASOs, the Kansas City Health Department, and the University of Missouri-Kansas City (UMKC) Psychology Department—came together to begin discussing the development of the TIPS project. Many of these partners were also active members of BCWPKC and had extensive knowledge about HIV and the Kansas City African American community.

### **REFINING THE RESEARCH AGENDA**

TIPS partners created a plan of action to shape the project research agenda, seek grant funding to support the project, create religiously tailored TIPS materials and activities, recruit TIPS churches, provide ongoing training and technical assistance, and to implement and evaluate project activities. In this planning process, the partners first reviewed efficacious HIV prevention models that had been used in African American community settings and were listed as CDC Diffusion of Effective Behavioral Interventions (e.g., CDC AIDS Community Demonstration Projects Research Group, 1999; DiClemente & Wingood, 1995) as possible interventions to adapt to the church setting. However, some of the church

partners were uncomfortable with having condom use as the primary intervention outcome and believed promoting condom use—particularly outside of a marriage relationship—would send messages that were not congruent with Christian biblical tenets. They also believed focusing on at-risk populations, such as MSM, would alienate some members and might encourage denial of level of risk among others. They instead wanted to unify the church to address HIV with strategies that would be acceptable for a wide audience. They believed other pastors would feel similarly and suggested having TIPS focus on addressing HIV awareness, including stigma reduction, with the general church congregation as a first step to getting churches involved in HIV interventions. In reviewing CDC's recommendations for more universal HIV screening in medical settings (CDC, 2006), they also wanted to encourage all adult church members to know their HIV status and to have the church be a supportive partner in local ASO HIV screening efforts. These discussions were used to develop the TIPS mission—addressing HIV awareness and screening among African American church and community members.

The partners also reviewed intervention strategies of efficacious church-based nutritional intake interventions used in African American churches (e.g., Black Churches United for Better Health [Campbell et al., 1999]; Eat for Life [Resnicow et al., 2004]). Similar to the Campbell et al. and Resnicow et al. studies, the church partners desired to have TIPS church leaders deliver an intervention that could seamlessly “fit in” with regular church activities by using religiously tailored, packaged materials/activities—as opposed to having to create another stand-alone church program. The planning activities led to the partners' writing a grant to better understand and enhance local African American churches' capacity to facilitate HIV programs.

#### **ASSESSMENT OF CHURCH CAPACITY TO DELIVER CHURCH-BASED HIV INTERVENTIONS**

The partners wrote their first small grant that was subsequently funded to support TIPS' development of a local conference focused on church-based health ministries to address HIV and the initial creation of religiously tailored HIV awareness tools. The conference was named “The 2006 Reaching All God's Children Conference (RAGC)” and was attended by about 80 church leaders. The conference aimed to increase African American church leaders' knowledge about HIV and how HIV stigma was affecting churches' response to the HIV crisis and build health ministry capacities with workshop sessions on strategic planning and developing a 501c3. The conference also provided an opportunity to share information about TIPS with local church leaders in order to recruit their churches to sign up for the project.

Building on the strengths and resources of a given community is a key principle in the CBPR process (Israel, Eng, Schulz, & Parker, 2005). Therefore, conference was also used to conduct a needs assessment on church leaders' interest and church capacity (e.g., infrastructure, ministries, services) related to implementing HIV programs. The needs assessment survey was administered to a convenience sample of church leaders attending the 2006 RAGC Conference. The survey was also administered to church leaders attending a seminar on HIV and African Americans at a local Baptist convention in 2006. The survey was completed by a total of 121 church leaders ( $N = 121$ ; approximately 80% of attendees at the two conferences) who were primarily senior pastors ( $n = 56$ ; Berkley-Patton et al., 2008). Survey findings indicated that a significant majority of the senior pastors were interested in learning about how to share HIV information with their congregants. These senior pastors led churches that were engaged in regular weekly churchwide services (Sunday school, Sunday morning, and midweek Bible study), and the majority of their churches had several communication channels, such as church bulletins and announcements,

bulletin boards, responsive readings, pastoral comments, and resource tables. Additionally, many of their churches provided in-reach ministries (e.g., youth ministries, health ministries) and outreach ministries (e.g., food and clothing programs, school programs) that could be utilized to reach underserved populations who could potentially be at risk for HIV. Furthermore, some of their churches had facilitated various HIV-related activities, such as providing HIV educational information and participating in the BCWPKC activities. The partnership used these findings to identify how the intervention components could fit within the existing infrastructure of African American churches and how to maximize the churches' reach with their church and community members as described below.

## **DEVELOPING AND IMPLEMENTATING THE TAKING IT TO THE PEWS PROJECT**

The partners adapted elements of empirically proven African American church-based interventions (e.g., Black Churches United for Better Health, Eat for Life) to the TIPS project (Campbell et al., 1999; Resnicow et al., 2001; Resnicow et al., 2004). These TIPS-adapted components included (a) creating religiously tailored materials/activities packaged in the church-based TIPS Tool Kit, (b) implementing the initiative with trained pastors and church liaisons as key interventionists and evaluator, and (c) conducting a process evaluation to gather feedback from church leaders and to assess church members' beliefs about church involvement in HIV issues. The TIPS partners received a grant funded by the Health Care Foundation of Greater Kansas City to conduct a 12-month feasibility case study with a 3-month development phase (including development of the TIPS Tool Kit) and a 9-month implementation phase (including focus group discussions in the second month of the implementation phase) to carry out the above-mentioned TIPS intervention components.

### **DEVELOPING THE TIPS TOOL KIT**

Because the pastor partners wanted to primarily address HIV awareness and screening for the general population of African American churchgoers, the Tool Kit materials focused on issues related to HIV transmission and prevention, screening, stigma, and compassion for HIV infected and affected persons. The Tool Kit was designed to provide TIPS churches with user-friendly, religiously tailored materials/activities to assist them in delivering HIV awareness activities with their adult church and community members. Tool Kit materials were created to be easily implemented into the flow of existing church activities, as identified by the church capacity survey and by pastors and church liaisons. The materials were also created to be low cost in order to increase sustainability of the project beyond grant funding.

Faith leaders in the TIPS partnership assisted in determining what types of materials and activities were needed based on the church capacity survey findings and their experiential knowledge about which church activities were the most appropriate for the infusion of HIV awareness and screening messages. For example, a large majority of the church capacity survey respondents indicated that pastors delivered sermons and pastoral comments in Sunday services. Therefore, pastor partners wrote the sermon and pastoral observation guides from a biblical perspective with an emphasis on HIV in the Kansas City African American community, the need to reduce HIV stigma and increase compassion for people living with HIV/AIDS, and the need for everyone to know their status. Also, based on the finding that most of the churches passed out church bulletins during services, HIV awareness bulletins and brochures were designed to be distributed in a similar manner. The pastors also gave approval for condom use information to be included in one brochure on HIV transmission, and approval to include HIV information specifically for African American women since their congregations were primarily made up of women. Initial

materials were packaged in a Tool Kit box to keep them organized for easy use by TIPS church liaisons.

The resulting Tool Kit consisted of religiously tailored materials for church-wide delivery during Sunday morning and Wednesday services with the entire congregation and included sermon guides, pastoral observations, responsive/liturgical readings (see Figure 1), bulletin inserts to address stigma (e.g., “Stop Hatin’ ... Start Lovin’,” “HIV Myths”), and fact sheets (e.g., “HIV Facts,” “Women & HIV,” “Bringing It Home: HIV and African Americans in Kansas City”) that included specific information on HIV transmission, prevention, and Kansas City’s high-risk groups. The Tool Kit also included a large poster containing HIV transmission and screening information and smaller similar posters for church restrooms. Also, local HIV resource guides with information about ASOs were included in the Tool Kit, and information on local HIV screening sites was provided on the back of all bulletin inserts. HIV educational games (e.g., “HIV Jeopardy,” “Wheel of Awareness,” “HIV Transmission Game”) and a video (*The Church Engaged in Reducing Stigma*) with an accompanying discussion guide were developed for group ministry meetings. The Tool Kit also included a manual that provided an overview of the project, instruction guides for each tool, and a sample of each tool. Each Tool Kit included an appropriate amount of printed materials for each TIPS church with additional materials delivered as needed.

## IMPLEMENTING THE TIPS PROJECT

Prior to project implementation, church leaders who expressed interest in TIPS at the RAGC or from their participation in the BCWPKC were visited by CCON and UMKC partners. These initial meetings were used to discuss participation in the project, review institutional review board protocols, train church liaisons on the TIPS Tool Kit, and plan how the tools could be used in their church. Then in late 2007, TIPS officially launched its 9-month implementation phase with a kick-off training event with pastors and church liaisons and with CCON, ASO and UMKC partners. The kick-off event focused on HIV transmission and prevention, evaluation activities, and further training on the church-based TIPS Tool Kit. The Kick-off also provided an opportunity for church liaisons and pastors to complete a planning form in order to enhance their commitment to quickly begin using the tools. Additionally, TIPS pastors signed a memorandum of agreement, which outlined the responsibilities related to TIPS participation along with requirements for receiving quarterly monetary stipends (\$750–\$2,000 total over 9 months). These requirements at a minimum included implementing at least two Tool Kit activities per month and having a church liaison collect and submit TIPS implementation data on a quarterly basis. Along with agreeing to the minimum requirements, some pastors also agreed to facilitate HIV testing in their churches, and some further agreed to permit administration of a survey on TIPS exposure and church-related HIV beliefs with their members.

During the 9-month implementation phase of the TIPS project, church liaisons came together to participate in focus group discussions, two booster meetings, and a wrap-up meeting. The focus group and booster meetings were used to discuss accomplishments and address challenges in conducting the TIPS project. The booster meetings were also used to further develop sustainable relationships between TIPS churches and ASO partners. In these meetings, ASO partners facilitated discussions on HIV facts and myths in the Black community, how HIV testing events could be coordinated at TIPS churches, availability of health educators for church presentations and group discussions, and availability of other local HIV resources and programs. Also, in the implementation phase, CCON and UMKC partners provided technical assistance by meeting with leaders at each church, making presentations about TIPS in their church services, and administering the TIPS survey with their members.

## **METHODS: TIPS EVALUATION PROCEDURES**

Consistent with the research questions established by the partnership, the TIPS case study conducted a process evaluation that included (a) focus group meetings to determine TIPS church leaders' early satisfaction with the project, (b) events logs to monitor church leaders' implementation of TIPS activities; and (c) a survey to assess TIPS church members' exposure to the intervention, HIV knowledge and stigma, and beliefs about the church's involvement in HIV projects. Evaluation activities were approved by the UMKC Institutional Review Board.

### **FOCUS GROUP DISCUSSIONS WITH TIPS CHURCH LEADERS**

To assess church leaders' early satisfaction with the TIPS project and to gain input to further refine the TIPS intervention, four focus groups with TIPS church leaders were conducted during month 2 of the 9-month implementation phase. Each of the four group discussions lasted about 2 hours, included a meal for participants, was digitally audio-recorded, and consisted of questions on challenges and successes with implementing the TIPS project, how to improve the TIPS project, and new materials/activities that were needed. The focus group discussions were facilitated by the first author and two assistants (third and seventh authors), who all then identified salient themes that emerged from transcripts and their notes and summarized the findings, which are reported. The findings were then reviewed with the TIPS partners during booster meetings to get their interpretation and to make adjustments to the project as needed.

### **ASSESSMENT OF TIPS IMPLEMENTATION BY CHURCH LIAISONS**

To document the implementation and reach of TIPS activities within each partnering church, church liaisons completed a project implementation event logs on a quarterly basis via paper and e-mailed electronic logs. Church liaisons used the event logs to plan TIPS events (e.g., materials needed, targeted event dates) and to record outcomes of implemented events, including (a) activities/ materials implemented from the Took Kit (e.g., pastoral sermons, brochures, interactive games) and other HIV-related activities, (b) number of people exposed to specific TIPS activities, (c) location of TIPS activity, and (d) comments from church member regarding TIPS. Church liaisons also provided archival materials of implemented TIPS activities, such as sermon recordings and printed materials from TIPS events. Frequencies of the delivery of TIPS Tool Kit and other HIV-related materials/ activities over the 9-month implementation phase are reported.

### **SURVEY ON CHURCH MEMBERS' TIPS EXPOSURE AND CHURCH-RELATED HIV BELIEFS**

With permission from the senior pastor and assistance from church liaisons, a survey was administered to church members on their exposure to TIPS activities, beliefs about their churches' involvement in HIV education and screening, perceived support for HIV testing in the church, and members' personal HIV knowledge, and HIV stigma. An evaluation of the efficacy of the TIPS intervention was beyond the scope of this study; rather the focus here was on the acceptability and feasibility of the newly developed TIPS intervention and identification of perceived facilitators and barriers to future implementation with the church membership. TIPS pastors identified a date (at least 6 months after implementation) on which the survey could be administered to their members, which resulted in survey completion between months 6 and 9 during the implementation phase. A baseline survey was not conducted. A convenience sample consisted of TIPS church members aged 18 and older who voluntarily completed surveys at the end of Sunday morning services and during church ministry meetings.

**Beliefs About Church-Related HIV Activities**—Four survey items were adapted from Campbell, Resnicow, Carr, Wang, and Williams (2007) and asked church members to endorse statements using Likert-type responses ranging from 0 (strongly disagree) to 5 (strongly agree). Items focused on whether members believed (a) HIV testing is something that their pastor or the church should be talking about, (b) HIV testing should be offered in their church, (c) health screenings should be offered by their church, and (d) HIV testing should be offered in combination with other health screening services. Responses to these four items were summed to generate an HIV beliefs score.

**Support for HIV Testing**—Three survey items assessed church members' endorsement of statements that focused on support for annual HIV testing using a range from 0 (none) to 5 (a lot), including “How much encouragement to get an annual HIV test do you get from (a) your family, (b) your friends, and (c) your church members?” A repeated measures analysis of variance was conducted to explore encouragement participants received from these sources. Planned contrasts and post hoc comparisons were conducted between groups.

**HIV Knowledge**—Ten true/false items about HIV transmission knowledge were included (e.g., “A condom should be completely unrolled before it is placed on the penis”; “You can get HIV if you share a drink, sink, shower, or toilet seat with someone who has AIDS”). Correct responses to these ten items were summed to generate an HIV knowledge score.

**HIV Stigma**—Five survey items on HIV stigma were adapted from Herek, Capitano, and Widaman (2002). Sample items include “How afraid are you of people infected with HIV?” with responses ranging from “not at all afraid” (1) to “very afraid” (4); and How concerned would be that you might be treated differently or discriminated against if you tested positive for HIV with responses ranging from “not at all concerned (1) to “very concerned” (4).

**Exposure to TIPS**—Church members completed a nine-item checklist with a yes/no format that included questions about their exposure to Tool Kit materials/activities distributed to all participating TIPS churches (e.g., brochures, pastoral sermons about HIV/AIDS, responsive readings, bulletin boards, interactive educational games) and other church-based HIV-related activities, as adapted from Campbell et al. (2006). Frequencies of participants' exposure to TIPS intervention components are reported. Mann-Whitney tests for nonparametric data were used to determine the relationship between church member participants' TIPS exposure (high/low), beliefs on church involvement in HIV issues, and their HIV knowledge, and HIV stigma.

## RESULTS: EARLY PROJECT FINDINGS

Twelve churches (7 Baptist, 4 nondenominational, and 1 Methodist) were recruited to participate in the TIPS project with seven of the churches located in Kansas City, Missouri, and five located in Kansas City, Kansas. These TIPS churches serve Sunday morning service membership sizes ranging from 50 to 700 members, for a total of about 3,200 church members who were potential participants in the TIPS project. Of the 12 TIPS churches, 11 had church leaders who participated in focus group discussions, 10 had church liaisons who completed implementation event logs, and 9 had adult church members participate in survey completion on their exposure to the TIPS project and church-related HIV beliefs.

## SUMMARY OF FOCUS GROUPS FINDINGS

Twenty-six TIPS church leaders (61% females) from 11 of the 12 TIPS churches participated in one of the four focus group meetings. A summary of the findings are briefly reported here. Overall, findings from the focus groups indicated that TIPS pastors and

church liaisons felt that the TIPS tools were very easy to use within their churches' existing activities. Overwhelmingly, church leaders said that their members appreciated hearing about HIV transmission and prevention in the church, and they also appreciated learning more about how HIV was affecting the African American community. Several church leaders' commented that their members reported being glad to see the church finally talking about HIV and sex—"It was about time that the church started dealing with this topic!" commented one member.

Church leaders also provided comments on how to improve TIPS activities and materials, including bringing in ASO guest speakers to TIPS churches' Sunday morning services, having pastors with experience in talking about HIV topics "buddy up" with less experienced TIPS churches in facilitating HIV church services church services, having more HIV educational games for large and small groups, and developing peer-to-peer groups (e.g., among teens). Some of the most frequent comments related specifically to enhancing Tool Kit materials included: having more materials that covered abstinence *without* inclusion of condom information, developing more materials designed especially for youth and men, and developing more TIPS tools to address HIV testing. The most frequently stated concerns regarding the TIPS project included the need to continue addressing HIV stigma, especially stigma related to receipt of HIV testing, and to figure out how to deal with some of the more difficult HIV-related issues (e.g., condom use, homosexuality, premarital sex) within a biblical context while also dealing with these issues from a public health standpoint.

## TIPS PROJECT IMPLEMENTATION FINDINGS

All of the 12 TIPS churches appointed one to two church liaisons to assist in delivering the Tool Kit materials/activities and to collect event log implementation data during the 9-month implementation phase. However, two of the smaller churches with less than 100 members had difficulty maintaining church liaisons. Therefore, event log monitoring data were submitted by only 10 of the 12 participating churches. As shown in Figure 2, 162 instances of Tool Kit activities and materials were implemented in 10 of the TIPS churches. On average, TIPS churches implemented almost two Tool Kit materials/activities per month. Brochures, sermons, responsive readings, and pastoral comments were used most frequently (by 10 out of 10 churches that submitted event logs). HIV awareness games, church-based HIV testing events, and youth awareness activities were implemented less frequently—primarily because these tools/activities were not added to the TIPS project until Months 5 and 6 of the 9-month intervention phase. Ten churches had coordinated HIV testing with local ASOs as part of their church health fairs; however, ASO representatives did not show up to conduct two of the HIV screening events. As reported in events logs by church liaisons, approximately 3,000 TIPS church members and 400 community members were exposed to the TIPS project.

Overwhelmingly, church liaisons reported that church members responded favorably, and in many cases with enthusiasm, to the TIPS project. Some anecdotal comments reported by church liaisons from church members included: "Everyone young and old said they were glad to receive information [from] brochures and bulletins." "We received thank-yous for doing the responsive reading," and "Members are glad the church was doing something about HIV."

## CHURCH-BASED HIV SURVEY FINDINGS OF TIPS CHURCH MEMBERS

Nine of the 12 TIPS pastors permitted consent forms and surveys to be distributed to their members after church services. A convenience sample of 345 members volunteered to complete the survey. Because of an inadvertent omission of a key survey page on TIPS

exposure and church-related HIV beliefs at one of the larger TIPS churches, data reported here are based on 211 surveys from 8 of the 12 TIPS churches. An average of 26 members (range 17–44; approximately 14% of total adult members) completed surveys in the 8 churches.

As shown in Table 1, the majority of the 211 survey participants were African American (85%), female (64.6%), and Baptist (73%). The mean age of participants was 46 years ( $SD = 14$ ), and almost all had completed high school or received their GED (93%). The average length of church membership was 12.8 years ( $SD = 14.2$ )

**Church-Related HIV Beliefs and Knowledge**—Most of the participants believed that it was important for their church to talk about HIV testing (87%) and that the church should offer HIV testing (77%) and other health screenings (84%). In addition, participants felt more strongly encouraged to get an HIV test by their fellow church members (56%) than by their friends (35%) or family (32%). Our results indicated that encouragement from church members was significantly greater than encouragement from friends and family members ( $p < .000$ ).

The average HIV knowledge score was 7.82 (out of 10;  $SD = 1.57$ ). The most frequent incorrect responses were related to proper condom use (50% incorrect) and whether a person can get HIV from giving blood (50% incorrect). Overall, 70% of participants felt very comfortable sharing a pew with an HIV-infected person. However, 42% were afraid of people with HIV and half (52%) were concerned about possible discrimination following a positive HIV test result.

**Intervention Exposure**—Overall, church members reported high exposure to many of the TIPS materials and activities, as shown in Table 2. Tools with the greatest exposure included printed materials, pastoral sermons, and responsive readings, which were primarily delivered in Sunday morning worship services. Tools and activities with the least exposure included educational games, group discussions, and HIV testing events. Participants with high TIPS exposure had significantly stronger positive beliefs related to church involvement in HIV education and screening service ( $p = .009$ ), had significantly lower HIV stigma ( $p = .022$ ) and were significantly more likely to report being ready to get tested for HIV ( $p = .014$ ) compared with participants with low TIPS exposure. However, high HIV knowledge scores were not found to be related to high intervention exposure ( $p = .169$ ).

## INTERPRETATING AND DISSEMINATING TIPS FINDINGS

### INTERPRETING RESULTS AND REFINING THE TIPS INTERVENTION

Booster meetings were used to discuss the evaluation findings from focus groups with church leaders, event log data submitted by church liaisons, and survey findings from church members to determine next steps for the project. For example, discussions on focus group findings on the need for more interactive HIV awareness games and activities for youth resulted in TIPS church leaders creating the “Wheel of HIV Awareness” game and HIV awareness skits targeting youth audiences. Also, in response to focus group suggestions to “buddy up” TIPS churches to increase collaboration among churches, four Wednesday night “TIPS Revival” services were conducted where TIPS pastors delivered HIV/AIDS sermons at other TIPS (and non-TIPS) churches and Tool Kit materials were distributed. These revival services were so successful that they are now held as a precursor to the annual BCWPKC events. In addition, to increase the capacity of clergy equipped to discuss HIV/AIDS with their congregations, a pastoral training event was held at a local seminary with their school students, faculty, and staff.

In discussing the large percentage of respondents who incorrectly answered a survey question related to condom use, it was learned that most of the pastors believed that the church wasn't an appropriate place to teach members how to use condoms. They believed that condom use information should be delivered by health providers to members in small group settings outside of the church. They also believed it was important for the church to teach sex education to youth, and in later booster meetings, some shared their biblical resources to assist others in conducting youth meetings focused on sexual health. These discussions resulted in a sex education seminar for youth and parents (including explicit information about condoms) and Youth Health Fairs facilitated jointly by TIPS churches. Additionally, to address survey and focus group findings related to HIV stigma and screening, they decided to conduct additional focus groups specifically focused on facilitators and challenges related to church-based HIV testing.

The booster meetings were also used to celebrate TIPS churches' implementation progress by cheering on pastors and church liaisons with award plaques and gift cards and by distributing church stipends based on their church's accomplishments of memorandum of agreement requirements. At the end of the implementation phase, we held a wrap-up booster meeting where the TIPS pastors and liaisons reported that they felt fully included in shaping the project design and the tools used in the TIPS project and that this inclusiveness promoted their level of commitment to the project and created a sense of accomplishment and ownership. They also expressed their desire to create new TIPS components on youth sexual health development with an emphasis on parent communication. Their ongoing input led the partners to write additional grants, which were funded to address their interests in sexually transmitted infection/HIV prevention programming for youth and in normalizing church-based HIV testing.

## **DISSEMINATING FINDINGS**

Several strategies have been used to communicate TIPS project findings and lessons learned internally with TIPS churches and externally to other relevant audiences. Findings similar to those summarized here were disseminated through a quarterly TIPS newsletter, the annual RAGC Conference, and project booster meetings. Also, church liaisons shared TIPS findings (and award plaques) with their members. External, TIPS partners have jointly reported on findings in local newspapers, and through presentations at local, regional, and national conferences.

## **DISCUSSION**

We reported on findings from one of the first studies using a CBPR approach to develop and implement a church-based HIV intervention with African American churches. Findings from this case study indicated that implementing an HIV intervention within existing church activities was feasible and extended reach to approximately 3,400 church and community members, particularly owing to the inclusion of church leaders in all phases of the research process. Also, several lessons learned and challenges were identified from the TIPS case study.

## **LESSONS LEARNED**

Inclusion of church leaders in the TIPS planning/development phase and ongoing refinement process fostered an exchange of skills and capacity to develop appropriate HIV awareness tools. Church leaders played a key role in providing input on and in creating TIPS tools, including pastoral sermon and observation guides, which were used with great frequency. By having regular project meetings, many of these leaders made stronger connections with ASOs, shared their HIV resources, and began writing grants and holding HIV-related events

together. In project meetings, the church leaders commented often on how they felt included in the development process, how their concerns had been addressed, and how they were pleased to see their input materialize into TIPS tools—all key empowering principles in the CBPR process (Isreal et al., 2005).

Also, by meeting churches at their level of readiness and providing a safe environment during project meetings, the church leaders were able to discuss and debate each other on their biblical and personal beliefs related to condom use and other controversial HIV issues (e.g., homosexuality, sex outside of marriage). The collaborative process in the research planning phase gave full consideration to the church partners' concerns about these issues and to their suggested intervention focus (i.e., HIV awareness and testing with adult members). TIPS church leaders' input and the church capacity needs assessment findings heavily shaped TIPS intervention strategies and resulted in a project that was broadly accepted by their pastoral peers and strategies that could be distributed widely in church settings. Although all of the TIPS pastors continue to stress abstinence as the best way to prevent HIV, many more have begun to address condom use in their sermons and small group meetings based on the ABC (*abstinence, be faithful, use condoms*) model. Also, discussions continue on whether TIPS intervention goals should be expanded to include condom use promotion more prominently. One church-based study that has incorporated condom use as a core intervention component is the SAVED SISTA project (a faith-based adaptation of the Sisters Informing Sisters About Topics on AIDS) for Black women in addiction recovery (Collins et al., 2007). Unfortunately, Collins et al. reported that inclusion of condom use education in their project has made it difficult to recruit churches. In fact, their study had only one participating church whose primary role was to serve as a host site only providing transportation and meeting space. Although we are experiencing more success in incorporating condom use information in our efforts, the SAVED SISTA study's experience and our own suggests that this may continue to be a controversial issue in future HIV research in the church setting.

In the implementation phase, pastors and church liaisons were able to deliver the Tool Kit materials and activities on an ongoing basis (almost twice a month) with positive feedback from their church members. Furthermore, TIPS church members reported high exposure to many of the TIPS materials and activities (i.e., printed materials, sermons, and responsive readings). These tools were primarily delivered during Sunday morning services, where traditionally a large number of church members gather on a regular basis. Future participatory research should focus on how these well-attended services along with small group church meetings and church-facilitated community events can be used as communication channels for increased intervention exposure and reach, particularly for high-risk populations.

In the data collection and interpretation phases, TIPS church leaders' participation was critical to understanding how TIPS intervention activities were implemented and whether the intervention was well received by their church members. Furthermore, their input and interpretation of evaluation findings were invaluable in the processes of refining study procedures, updating Tool Kit materials, and addressing other issues of importance to TIPS church members. The project meetings provided opportunities to discuss study findings as they became available and quickly make project adjustments as needed. Research suggests that collection and feedback of monitoring data may be key factors for building capacity and sustaining CBPR-guided community mobilization efforts (Roussos & Fawcett, 2000). Further CBPR research is needed to determine how faith partners' participation in data collection and interpretation activities may impact church capacity to evaluate, improve, and sustain HIV interventions.

## CHALLENGES

The TIPS CBPR process still had its challenges. First, balancing church partners' priorities and research procedures was a struggle at times. For instance, when church liaisons from one of the large TIPS churches were provided with a "last-minute" opportunity to conduct the survey with their members, they did not contact the UMKC partners and inadvertently omitted a key survey page. This omission resulted in a large number of surveys ( $n = 134$ ) that were not included in the data reported here. Also, liaisons sometimes struggled with consistently recording all of the TIPS activities that they had facilitated, which leads the partnership to believe that some TIPS activities were underreported. Additionally, TIPS church liaisons tended to be highly active members in their churches and at times needed to shift their attention to other church priorities. Second, staff capacity issues existed among some of our ASO partners. For instance, two scheduled TIPS churches' testing events were canceled due to ASO "no-shows" because their staff members became unavailable. Lastly, to keep the TIPS Tool Kit fresh, relevant, and responsive to church leaders' input, the intervention continued to evolve. However, funding constraints made it difficult to respond to all church partners' requests and to fully evaluate the project to determine how the CBPR process impacted the project.

## LIMITATIONS

In addition to these challenges, this study had limitations. First, we used subjective event log data reported by church leaders to monitor TIPS implementation. However, to augment reported event log data, church liaisons provided samples from TIPS-related activities (e.g., copies of church bulletins, sermon CDs), and church members' reported TIPS exposure matched church liaisons' reports. Future studies should consider additional and more objective data collection methods. Second, self-report data collected from TIPS church members may have been hampered by poor recall and/or socially desirable responding. Finally, with limited grant funding over a 12-month period, we were unable to (a) assess intervention dose effects with pretest-posttest comparison churches methods, (b) test CBPR effects on overall church capacity to facilitate HIV interventions, and (c) conduct a process evaluation of our CBPR activities (e.g., interviews with church leaders about the CBPR process). Despite these limitations, we successfully accomplished our primary goal of exploring the feasibility of a church-based HIV awareness and screening intervention employing a CBPR-guided process.

To our knowledge, this is one of the first studies to report on African American church members' interest in the church's involvement in HIV interventions. In a study by Smith, Simmons, and Mayer (2005) with African American pastors, 83% of their participants reported that they believed there was a need for HIV prevention services in their churches. Similarly, TIPS church members reported that they believed their church should be involved in providing HIV information and screening services. They also reported receiving significantly more encouragement to get tested for HIV from their church members than from family members or friends. Yet survey findings also indicated that church members were quite concerned about discrimination if they tested positive for HIV, which has been found in other studies with African Americans (e.g., Payne et al., 2006). Therefore, church screening interventions should be designed to reduce HIV stigma and should include strategies to normalize receipt of HIV screening as a regular health practice.

This study demonstrated that partnerships inclusive of faith leaders can play a significant role in the development, delivery, evaluation, and dissemination of results of African American church-based HIV interventions. This study also demonstrated that church congregants may be ready to fully participate in these interventions, particularly when these interventions are integrated within existing church activities. These findings are timely,

especially with the recently introduced National Black Clergy for the Elimination of HIV/AIDS Act of 2009, which is intended to appropriate funding to engage Black clergy in HIV prevention and screening efforts (U.S. House Committee on Energy & Commerce, 2009) and CDC proposed strategies, which include working with faith leaders to reduce HIV/AIDS among African Americans (CDC, 2007). As churches continue to be prominent institutions with powerful influence in minority communities, partnerships that fully engage African American faith leaders as key partners and their churches as intervention settings may provide promising strategies for reducing HIV disparities.

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**Responsive Reading**

***For People Living With HIV/AIDS***

**LEADER:** Forty million men, women, and children around the world are suffering with an incurable, deadly disease called HIV/AIDS. To date this disease has claimed the lives of 3.1 million people worldwide.

**PEOPLE:** We have the power to stop it. But we must act now, before it's too late. We offer our prayers to people around the world living with HIV/AIDS.

**LEADER:** In the United States alone, 1.1 million people have been diagnosed with HIV and over 900,000 have been diagnosed with AIDS.

**PEOPLE:** We have the power to stop it. But we must act now, before it's too late. We will lend our voices on behalf of people in the United States living with HIV/AIDS.

**LEADER:** Though HIV/AIDS affects everyone of every race, African-Americans are disproportionately impacted. Though we represent 12% of the U.S. population, African-Americans account for more than 50% of all new HIV infections and HIV is the leading cause of death for African-Americans ages 25-44.

**PEOPLE:** We have the power to stop it. But we must act now, before it's too late. We must be vigilant and act to stop the spread of HIV/AIDS in the African American community.

**LEADER:** In Kansas City, there are 4,617 individuals living with HIV or AIDS. Nearly 39% of these are racial minorities and 18% are women. Seventy six percent of all women infected with HIV/AIDS in Kansas City are women of color.

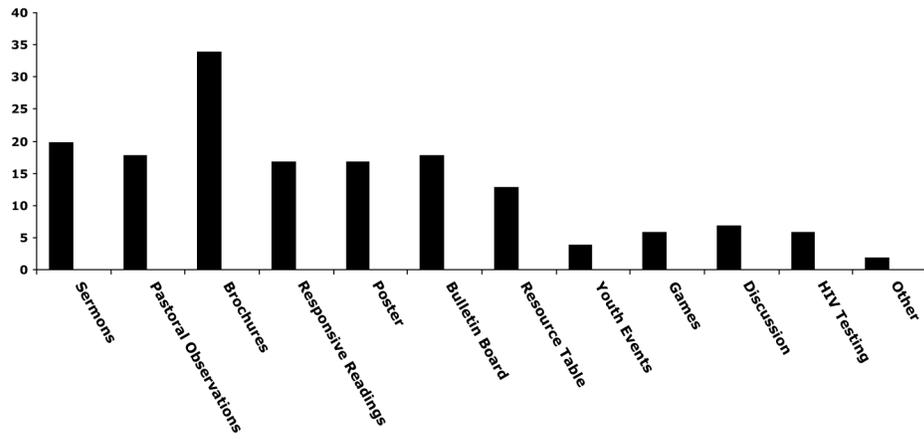
**ALL:** We are witnessing the destruction of human life in our own communities. Let us join hearts with the faith community—in prayer, in spirit, and in action, to let our brothers and sisters living with HIV/AIDS in Kansas City know that God loves them and so do we.

***Amen.***

*If we are rich and see others in need, yet close our hearts against them, how can we claim that we love God.*

1 John 3: 17 (TEV)

**FIGURE 1.**  
TIPS responsive reading.



**FIGURE 2.**  
TIPS Implementation ( $N = 162$  delivered activities/materials).

TABLE 1

## Church Member Participants' Demographics

Demographic Variables	(mean $\pm$ SD or %)
Gender	
Male	35.4
Female	64.6
Age (mean $\pm$ SD)	45.99 $\pm$ 14.3
Ethnicity	
American Indian/Alaska Native	4.3
Black or African American	84.9
White or Caucasian	2.4
Sexual Orientation	
Heterosexual	91.0
Homosexual	2.1
Bisexual	2.1
Highest Level of Education	
Below 8th grade—some high school	7.2
High school degree/GED	26.9
Post-high school technical training—some college	38.0
College degree and/or above	27.9
Marital status	
Single	24.4
Committed relationship	3.9
Married	46.3
Separated	4.4
Divorced	15.1
Widowed	5.9
Children	
Yes	82.7
Number of children (median)	3
Church Denomination	
Baptist	73.4
Church of God in Christ	5.8
Nondenominational	13.5
Other	3.0
Length of membership at Church (mean $\pm$ SD)	12.8 $\pm$ 14.2
Medical Insurance	
Yes	84.4
Medicare	18.0
Medicaid	5.1
Private Insurance	77.0
Other	10.1

<b>Demographic Variables</b>	<b>(mean <math>\pm</math> <i>SD</i> or %)</b>
No	15.2
Average monthly income	
\$0 – \$500	3.4
\$501 – \$1,000	6.3
\$1,001 – \$2,000	17.9
\$2,001 – \$3,000	33.4
More than \$3,000	29.5
Don't know/Declined to answer	9.6

**TABLE 2**

## Exposure to TIPS Intervention Materials and Activities

<b>Exposure</b>	<b>(%)</b>
I have received information about HIV/AIDS (brochures, bulletins) at my church.	91.0
I have heard my pastor deliver sermons about HIV/AIDS from the pulpit.	83.7
I have participated in responsive readings that focus on HIV/AIDS at my church.	83.9
I have seen an HIV/AIDS bulletin board at my church.	80.4
I have looked at HIV/AIDS information at a resource table at my church.	79.3
My church has shown HIV/AIDS information on the sanctuary projection screen.	69.2
I have participated in a church group discussion about HIV/AIDS prevention.	66.4
I have attended a health fair where HIV testing was offered at my church.	56.5
I have participated in a Jeopardy game to learn about HIV information.	30.5