



## DOCTOR OF NURSING PRACTICE (DNP) PROGRAM

### A DNP PROJECT

#### HIV & AIDS: A CALL FOR A BLACK CHURCH INITIATIVE

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### **Abstract**

African Americans have been disproportionately infected by HIV and AIDS with the largest rates of infection within the total population. Historically, for so many African Americans, the Black church has been a pillar in the community. The Black church provides guidance for individual, political, and systemic change. The aim of this study was to improve HIV and AIDS awareness among the African American population with hopes of increasing the Black church memberships' awareness and knowledge about these diseases by providing HIV education, conducting a seminar, and analyzing intent to obtain screening. This quasi-experimental pilot study with a 19 question pre-test and post-test design included a purposeful convenience sample of 21 Black men and women who were either a member of a targeted Black church or from the local community. The HIV-KQ-18 questionnaire, used to measure an individual's knowledge about HIV, contained 18 'true' or 'false' questions with the option of also choosing 'don't know.' A question was added to address intent to screen. Results showed an increase in knowledge baseline with a mean score improving from 13.7143 to 14.6198 with 18 being the highest score achievable. The intent to screen increased from 53% (n=11.13) to 88% (n=18.48) of participants reporting that they will get screened for HIV and AIDS. Additionally, a p-value of .009 indicates a statistical significance relating to the likelihood that the increase in the intent to screen was in response to the educational seminar. The implications for practice indicate that HIV and AIDS educational awareness initiatives in the Black church are feasible with the potential to increase disease awareness, thus increasing HIV screening rates.

*Keywords:* HIV/AIDS, African Americans/Blacks, Black church, faith-based, testing, screening, prevention services

## HIV & AIDS: A Call for a Black Church Initiative

### **Introduction**

Since the rise of human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS) rates of infection, African Americans have been disproportionately affected by the disease. Additionally, this population has shouldered the burden of high rates of death associated with the virus. It has been reported by the Centers for Disease Control and Prevention (CDC, 2018a) that African Americans have the largest rates of HIV and AIDS infection within the total population, and the highest number of those newly diagnosed. “In 2016, African Americans accounted for 44% of HIV diagnoses, though they comprise 12% of the US population” (CDC, 2018a, p.1).

Because HIV and AIDS have ravaged the lives of so many promising African Americans, torn apart families, and snuffed out the dreams of its youth, there has been a loud cry for the Black church to help combat this disease. Historically, for so many African Americans, the Black church has been a pillar in the community. It serves as a safe haven in times of trouble and it provides guidance for individual, political, and systemic change (Stewart, 2015).

Additionally, the church leadership, specifically the pastor, wields such a great level of influence that, at most times, its members will not question his/her authority as they perceive the individual as God’s messenger. With the church having so much leverage among African Americans, many are in favor of their involvement in the efforts to address HIV and AIDS within its communities (Berkley-Patton et al., 2013).

Recent research and focus groups conducted within the last 10 years suggests that many Black churches have a strong desire to help address HIV and AIDS in the communities they serve (Stewart & Thompson, 2016). However, the lack of knowledge about the disease and its

impact on African Americans has been a significant barrier to doing so. One suggestion to remove some of these barriers is to conduct an educational seminar and provide educational materials for both church leadership and the congregation. This can be as simple as handing out brochures, fact sheets, and literature about HIV and AIDS and how the disease is affecting the African American community. This in turn, may help facilitate the efforts in combating the disease.

### **Background and Significance**

As the statistical analysis highlights the epidemic in the African American community, HIV and AIDS continues to disproportionately affect this population of people compared to other communities. For example, gay and bisexual men account for over half (58%) of African Americans diagnosed with the disease, (CDC, 2018a). In 2015, African American women, as compared to white and Hispanic women, accounted for 42% of those who were diagnosed with HIV and AIDS (CDC, 2018b).

The African American youth are extremely vulnerable. For instance, black females ages 13-24 are six times higher than whites or Hispanic females to be infected with HIV and AIDS, (CDC, 2018a). Black males between ages 13-24 have higher rates of infection than any other race or ethnicity in the same age category (CDC, 2018a). The rate of infections among young black males is “11 times as high as that of young white males and four times as high as that of young Hispanic males,” (CDC, 2018a, p.2). Black young males who have sex with males (MSM) have the highest rates of infection among all categories, whether black, white, Hispanic, male, or female. Black young males who have sex with men comprise 86% of new infections among all young black men and they account for three times the rate among all MSM in the same age category (CDC, 2018a). “In a study of 21 major US cities in 2008, 21 percent of black

MSM between the ages 18-30 were HIV-infected and more than 70 percent of those infected were unaware,” (CDC, 2018a, p.1).

The rates of infection among African Americans are indeed staggering. However, the death rate of the population of people is alarming. “In 2016, there were 15,807 deaths among people diagnosed with HIV in the United States. Among those numbers, approximately 7,000 were attributed to blacks, the highest among any other race or ethnic group.” (CDC, 2018b, p.2). In examining the numbers between rates of infection and rates of deaths, it is abundantly clear that African Americans have been particularly hit hard by the HIV and AIDS epidemic. Additionally, compared to their limited ability to access care due to low poverty rates, lack of education, the growing sense of complacency around HIV and AIDS, African Americans are far more at a disadvantage (CDC, 2018a).

In attempts to decrease the rates of HIV infection and the number of deaths among African Americans dying from HIV related illnesses, the CDC has been engaged in efforts to deliver HIV prevention services for Blacks. Such services include the expansion of HIV surveillance and prevention programs which was initiated under the “New Integrated HIV Surveillance and Prevention Cooperative Agreement.” (CDC, 2019b). This agreement awards over \$400 million dollars per year to departments of health for areas of great need to support and implement comprehensive surveillance and prevention programs for African Americans (CDC, 2019b). The agreement is designed to improve health outcomes by providing services to help prevent new cases of HIV as well as achieving and sustaining viral suppressions (CDC, 2019b).

In 2017, the CDC also awarded over \$11 million to Community-Based Organizations (CBOs) to provide HIV testing to young gay, bisexual, and transgender youth of color, with the goals of implementing comprehensive HIV prevention programs. These programs are intended



to reduce health disparities, promote health equity, and reduce morbidity and mortality by increasing access to care, (CDC, 2019b). Therefore, with the efforts of the CBOs and its financial incentives, it is projected that HIV testing rates, linkage to care and medication adherence will improve for young gay, bisexual, and transgender youth of color (CDC, 2019b).

Education and prevention programs for African Americans are on the CDC's radar. For instance, the "Act Against AIDS" partnership campaign is designed to help address HIV and AIDS education in the African American communities through culturally sensitive messaging (CDC, 2019b). For example, campaigns such as "Let's Stop HIV Together" addresses stigma, "Start talking, Stop HIV" targets gay and bisexual men, and "HIV Treatment Works" highlights success stories of those infected with the disease (CDC, 2019b). These are a few of the many of the CDC's educational efforts that are focused on treatment and prevention efforts while raising awareness about the devastating effects of HIV and AIDS (CDC, 2019b).

Additionally, the Institute of Medicine (IOM), in response to the HIV epidemic, identified barriers to care and created policies that would promote clinical services especially for the disadvantaged and marginalized populations that are disproportionately affected by HIV and AIDS. Some policies such as the "Patient Protection and Affordable Care Act" expanded care coverage for people living with HIV and AIDS. Medicaid, Medicare, the Ryan White Program, Community Health Centers (CHCs), the Department of Veterans Affairs, and a combination of others are such programs that grew out this policy that has been initiated by the federal government designed to promote access to care (IOM, 2011). The overall goal is to expand HIV and AIDS testing and treatment to effectively accommodate new diagnoses (IOM, 2011).

As the CDC, IOM, and many other city and government entities are making efforts to raise awareness about prevention and treatment, it has also been noted that the Black church can

play a part in helping to reduce the numbers of African Americans infected with HIV and AIDS. For example, the social influence of the Black church has been so powerful that it has been categorized as symbolically being the protector of black bodies and the voice of those who have purposefully been forgotten. (Berkley-Patton et al., 2016). With this influence, the Black church is well positioned to help combat the HIV and AIDS epidemic among the African American community. It has leverage and the reach to mobilize change in its own community. “[C]hurch leaders could work with health departments to provide HIV testing in church and community settings and could encourage members to get tested” (Berkley-Patton et al., 2016, p. 484). According to the Pew Research Center and their 2014 Religious Landscape study, it is estimated that about 80% of African Americans self-identify as Christians and “more than half of all black adults in the United States (53%) are classified as members of the historically [B]lack protestant [church],” (Masci, Mohammed, & Smilth, 2018, p. 1).

### **Needs Assessment**

Although a global crisis, in the United States, high rates of HIV and AIDS infections coupled with high rates of poverty have led to disparate treatment and limited access to healthcare for African Americans. Additionally, the lack of education about HIV and AIDS and its prevention affects the health of those living with the disease and places others at risk for contracting it (Stewart & Thompson, 2016). Additionally, stigma, fear, and homophobia are impacted by the low rates of treatment. This also contributes to low outcomes, low linkage and compliance to care, and high rates of death associated with the disease (Stewart & Thompson, 2016).

In New York, specifically New York City, African Americans are just as disenfranchised as they are on a global and national level. Of all those diagnosed with HIV and AIDS, 77% of

African Americans were leading when it comes to newly diagnosed cases of HIV and AIDS related deaths (CDC, 2019a). And the issues are the same when it comes to socioeconomic status, education, poverty, and access to high quality care. This is also true when it comes to prevention challenges as there are a large number of African Americans who are HIV positive and are unaware of their status (CDC, 2019a). Although representing only 14% of the population, nearly half of HIV cases are among African Americans. Furthermore, “African Americans accounted for 56% of deaths due to AIDS in 2011, and their survival time after diagnosis is significantly shorter than survival time for other racial and ethnic groups” (Stewart, 2015, p.1).

To address this issue, there has been a call for the Black church to get involved to help address the HIV and AIDS epidemic. Because they have been successful in addressing issues like diabetes and hypertension, there is a potential that the Black church can have a great impact in helping to combat the HIV and AIDS crisis among the African American population.

For instance, just like African Americans lead in newly diagnosed cases of HIV and AIDS related deaths, they also share a disproportionate burden of hypertension, (Dodani, Sullivan, Pankey, & Champagne, 2011). As a result, the Black church has been instrumental in addressing hypertension in the African American community through a variety of strategies such as the initiation of the HEALS program (Dodani et al., 2011). HEALS is a faith-based hypertension control and prevention program that teaches members how to acknowledge and prepare healthy meals with the intention of reducing high blood pressure. In addition to reducing blood pressure levels, the goals of the program are to also encourage members of the church to modify their behavior (Dodani et al., 2011).

In addition to hypertension, the Black church has also been instrumental in addressing diabetes in the African American community. An example of this is a program instituted by four Northeastern urban Black Churches. The program, “the Faith Wellness Collaboration Diabetes Education Program,” was developed to provide diabetes education in these Black churches to address the diabetes health disparities affecting African Americans (Austin & Claiborne, 2011). The goal of the program is focused on teaching the membership about healthy eating, the need for exercise, and the role that friends and family members can have in supporting individuals with diabetes.

Furthermore, because the Black church has been effective in going beyond the four walls of the church and addressing health issues in the local community, it is believed that they have the reach and the potential to change lives by taking on the mantle to help combat HIV and AIDS in the African American community. Historically, the Black Church has been a force for justice in the Black community. As such, there is no doubt that the Black Church can lead the charge in addressing the HIV and AIDS crisis in its own communities (Berkley-Patton et al., 2016).

Consequently, the targeted Black church in central Harlem bears the same burden. Although, they have been successful in conducting health promotion sessions on teaching the membership about how to address health issues related to diabetes and hypertension, they, however, are in need of health promotion efforts designed to address HIV and AIDS. Therefore, this seminar will, to a small degree, help the church become involved in addressing the HIV and AIDS epidemic in its local community.

### **Problem Statement**

Understanding that there is an urgent need to address and help end the HIV epidemic among African Americans, community activists and researchers alike are calling for the Black church to up its efforts in helping to do so (Stewart, 2015; Stewart & Dancy, 2012; Stewart & Thompson, 2016).

### **Clinical Question**

The clinical question guiding this project is, “will providing education literature and a seminar to a targeted Black church membership increase HIV and AIDS awareness and the intent to screen?”

### **Aims & Objectives**

The overarching aim of this project is to improve HIV and AIDS awareness among the African American population with hopes of increasing the church memberships’ awareness and knowledge about HIV and AIDS. This will be accomplished by providing HIV education, conducting a seminar, and providing information on how to obtain screening. The objectives of this project are to:

- Provide an educational session with question and answer period and written materials to church leadership and members of the congregation.
- Evaluate changes in knowledge before and after the educational session using the HIV KQ-18.
- Analyze intent to screen for HIV and AIDS before and after the educational session.

## **Review of Literature**

Through qualitative studies, many have sought to understand the impact that HIV and AIDS have on the African American community and the role that the Black church plays in combating it. The literature search through CINAHL with Full Text (“the Black church and HIV and AIDS”), yielding 73 articles (selecting those published since 2007 which produced 54 total). The 54 articles were read in its entirety and were critically appraised. As a result, 11 articles helped answer and critically appraised the clinical question (see Appendix A).

### **Role of the Black Church**

Black churches have for so long promoted good health habits and encouraged its membership to live healthy and spiritually balanced lives. They have ministries targeted around hypertension and diabetes. Targeting and developing ministries centered on raising awareness about HIV and AIDS have been challenging. Stewart (2015) highlights the fact that Black churches feel a sense of duty to assist its community, but admits to the fact that a lack of knowledge plays a part in preventing the delivery of messages to their congregation about HIV prevention education. Additionally, there is a desire to create HIV ministries that are focused on helping those infected with the virus. However, an unwillingness to discuss sexuality, specifically promiscuity and homosexuality, was another barrier that prevented Black churches from implementing HIV programming (Stewart and Dancy, 2012).

For example, Stewart and Dancy (2012), through an ethnographic case study research design, gathered pertinent information in helping to understand the culture of the Black church and how it can relate, through religious messaging and influence, its understanding of the HIV and AIDS epidemic in the African American community. Data gathered demonstrated that Black churches can be effective in developing and maintaining a HIV and AIDS ministry. This

suggested that in order to be successful, leaders and their parishioners must have a strong knowledge base about HIV and AIDS, have compassion for those who are burdened by the disease, and must be willing participants in treating those infected with HIV and AIDS with dignity and respect. If this can be achieved, there will be a cultural and behavioral shift that would help promote the success of a HIV and AIDS ministry.

In Nunn's et al. (2012), a study highlighting the high rates of HIV infection in Philadelphia, the faith leaders stated that they had some knowledge about how HIV was transmitted. However, they did admit that they were "unaware of the gravity of Philadelphia's epidemic and high rates of incidence in neighborhoods where churches were located" (Nunn et al., 2012, p.8). As a result, they suggested that Black churches should get involved in efforts to help address the HIV and AIDS crises especially in their communities. They believe that they not only have a responsibility and a duty to care for the spiritual aspect of their membership but they have a responsibility to address the physical aspect as well. This could be done through HIV prevention messaging through sermons, through community outreach programs, and educational workshops that target the youth and those at risk.

In an effort to examine how the role of the Black church can be instrumental in addressing the HIV and AIDS epidemic within the communities they serve, Berkley-Patton et al. (2013), through an ecological framework and a community-based participatory research (CBPR) approach, surveyed 124 Black church leaders' ability to disseminate HIV and AIDS education to their membership. Additionally, through the leadership's desire to learn and educate about the devastating effects of HIV and AIDS in the Black community, an HIV Tool Kit was implemented to help educate the leadership and to promote HIV and AIDS prevention related activities throughout the church.

Additionally, Berkley-Patton et al. (2016), examined the need for HIV and AIDS awareness in the Black church. Through the understanding that African Americans have been disproportionately affected by the disease and have shouldered the burden of high rates of death associated with the virus (CDC, 2018a), Berkley-Patton et al. (2016), guided by a social-ecological model combined with a community-based participatory research approach (CBPR) engaged four churches to participate in a “Taking It to the Pews” campaign. The campaign was aimed at providing HIV education and prevention activities, free HIV testing, and communicating compassion messages over the pulpit. The final analysis concluded that the Black church is well positioned to mobilize change. A step in helping to change the course of HIV and AIDS rates of infection among African Americans is by offering HIV testing services.

Because there is a need to reduce AIDS related deaths and rates of HIV infection among African Americans, many others have also taken on the mantle to advocate on behalf of the cause. For instance, using a community-based participatory research (CBPR) approach, Nunn et al. (2015) assembled a focus group of 52 Black church leaders to gather their recommendations on how to combat and reduce the high rates of HIV infections in Philadelphia. Through the understanding that “Philadelphia’s HIV infection rate is five times the national average, nearly 70% of new infections are among African Americans, and 2% of African Americans in Philadelphia are living with HIV/AIDS” (Nunn et al., 2015, p.1). The results of the focus group produced recommendations for how to implement the local policies that focus on HIV and AIDS prevention within the city.

### **Connecting the Black Church with HIV Initiatives**

Furthermore, Stewart (2015), through a qualitative and grounded theory approach, generated data through focus groups of African American church leaders that showed what it



would entail to develop and maintain HIV testing, referral, and linkage to care services within the church setting. The author's purpose of exploring the factors associated with such an initiative was through the belief that the Black church is a community-based organization that has influence over the lives of its parishioners. And as such, it should use its influence to help combat the HIV and AIDS epidemic in the community it serves. The methods used in extracting the data showed that for the Black church to provide HIV testing, referral, and linkage to care services within the church, the leaders must first be educated about HIV and AIDS.

Additionally, church leaders must be willing to support HIV and AIDS testing in the church setting, and there must be a shift of religious norms in moving away from believing that those infected with the disease live reprehensible lives to believing that treating those with HIV and AIDS is a social justice imperative.

Moreover, Stewart and Thompson (2016), through a qualitative approach, interviewed African American church leaders from four separate churches to assess their readiness to implement HIV testing and linkage to care in the Black church. The results showed that once the Black church is able to push through several striking themes, it does have the capacity to integrate HIV testing and linkage to care in the church setting. These themes included opposing HIV testing in the church due to broaching the topics of sexuality and promiscuity, the lack of education about HIV and AIDS and what does HIV testing entail, who would provide HIV testing, and understanding the need to becoming activists in the church and the community.

Lastly, using principles of grounded theory and interpretive description in Roman Isler et al. (2014), interviews of 12 leaders from churches in North Carolina were conducted about how to implement HIV prevention ministries within the context of the Black church. The findings suggest that in order to be successful in implementing these ministries, the church leaders must

first be willing to increase their knowledge about HIV and AIDS and have meaningful discussions about sexuality.

## **Conclusion**

Supporting the belief that the Black church can have a positive impact on combating HIV and AIDS in the African American community, conducting a seminar that is focused on educating its membership is one way of doing so. Thus, providing HIV and AIDS education can assist in helping the membership to become more aware and knowledgeable about HIV and AIDS, how it is contracted, and changes in behavior that are necessary to avoid further HIV infection in the local community. As a result, providing HIV and AIDS education can also encourage the membership to take steps towards getting screened and becoming aware of their status.

## **Theoretical Framework**

Because African Americans have been disproportionately affected by HIV and AIDS, the Black church is well positioned to help combat the epidemic by helping to reduce the rates of HIV transmissions and encouraging members of its own community to get tested. It has the social influence, the leverage, and the reach to mobilize such change.

Using the ACE Star Model of Knowledge Transformation theoretical framework to strategically implement change was advantageous to a targeted Black church (see Appendix B). Understanding that the ACE Star Model (Stevens, 2004) is used to understand evidence-based practice (EBP) as it relates to all aspects of knowledge gained from the inquiry process, the model helped provide the structure for educating the parishioners about the devastating effects of HIV and AIDS and the importance of getting tested. During phase one of the ACE Star Model of Knowledge Transformation, knowledge is discovered that would help shape the development

and implementation of change in a targeted setting. Berkley-Patton et al. (2016) and Nunn et al. (2012), using a community-based participatory research (CBPR) approach, have suggested that the Black church can be instrumental in addressing the HIV and AIDS epidemic within the communities they serve. Additionally, HIV toolkits have been established to help educate the leaders of the Black church about the epidemic and provides guidance on how to educate its membership about the importance of HIV and AIDS prevention and the need for testing, (Berkley-Patton et al., 2013).

This approach was used to educate the leadership of the targeted Black church that was identified. Offering a HIV toolkit in the form of HIV and AIDS education literature provided by the CDC and the New York City Department of Health was advantageous. This was the first phase that helped encompass knowledge development.

Phase Two of the ACE Star Model of Knowledge Transformation brings together the information gathered into a single, meaningful statement about the goals of the project, (Stevens, 2004). Hence, after reviewing literature recommending that efforts should be made by the Black church to help combat the HIV and AIDS epidemic, the question; Will providing education literature and a seminar to a targeted Black church increase HIV and AIDS awareness and the desire to accept testing referral? prompted this initiative. Additionally, this phase also guided the approach in presenting the proposal to the leaders of the selected church. There is power in numbers and when the leaders were able to see what other Black church leaders had done and how successful they were in implementing HIV education and prevention programs, it was hopeful that they were willing to follow. The body of evidence provided by the literature was a powerful driving force. The methodology suggests that it had the potential to produce sustainable results (Stevens, 2004).

The third phase of the ACE Star Model of Knowledge Transformation is where the interpretation of knowledge gained is contextualized to fit a specific population and setting (Stevens, 2004). In other words, it is where the recommendations are mapped out, shaped, and modeled to fit the target population. It is the translation of the evidence into practice. This phase was very important as it was the precise point in which the project was developed. The information that was gathered from the literature review was translated into an actual algorithm or context. The context was a targeted Black church, located in central Harlem, and the seminar, HIV and AIDS education, and HIV testing referral were the algorithm from which it flowed.

Practice integration phase is the step that involves bringing about practice change in hopes of changing cultural norms (Stevens, 2004). This is where everything comes together and theory becomes practice. Additionally, this is the point where the project was implemented. The HIV and AIDS informational seminar was conducted along with offering HIV testing referral. All necessary supplies were onsite such as HIV and AIDS educational literature, food, gift cards, and refreshments.

Evaluation is the last phase of the model. This is where the process and the project were evaluated. This included an assessment of whether goals were met, what worked well, what was learned, examining if the program made its intended impact and what was the final outcome (Stevens, 2004).

## **Methodology**

### **Setting**

The setting for this project was a non-denominational Black church, located in the heart of central Harlem. The church was established in 1917 to serve the people in the Harlem community. The congregation population was predominantly African American with more than

1,200 members. And on a monthly basis, the church serves more than 1,500 people within the community. On any given Sunday, one service can have up to 200 members in the congregation. Additionally, the age of the congregation ranged from infancy to 90+ years of age. Traditionally, the church ministerial staff comprised of both men and women who supports the ministry as well as the pastor. The pastor of the church was a fairly young man in his mid-fifties who had the influence to reach the older and the younger generation of his membership.

The church location was important as Harlem has the highest rate of African Americans infected with HIV than any other borough in New York City. In fact, its rate of infection is 4-5 times higher than the national average. Additionally, “the age-adjusted death rate for people living with HIV is nearly 50% higher in Harlem than for the Manhattan borough as a whole,” (New York City Department of Health and Mental Hygiene [NYCDOH], 2016, p.1).

### **Study Population**

This quasi-experimental pilot study with a pre-test and post-test design included a purposeful convenience sample of Black men and women who were either a member of the church or a member of the local community. The inclusion criteria included anyone who was Black, English speaking, and 18-89 years old. The exclusion criteria were those under the age of 18 and those aged 90 and above. The sample size, drawing primarily from the 10:30 am Sunday morning service, was based upon 10% of this 200 Sunday morning service sample population. Using the Raosoft, Inc. (2004) for a priori power analysis to calculate sample size based on a population 200, having a 5% margin of error and 95% confidence level, the necessary sample size included at least 20 participants. However, because the goal was to capture and educate as many members as possible, the target goal of the sample size was up to 50 participants.

In establishing a clear-cut number for a sample size, many experts suggest that there are no specific guidelines on the appropriate size of a pilot study. For instance, Connelly (2008), like many other experts, suggests that the pilot study should be 10% of the actual sample size. However, Viechtbauer et al., (2015) suggest that the sample size should be significantly large, such that the probability of detecting problems are high. Julios (2005) goes further by stating “the number of subjects in a clinical trial should always be large enough to provide a reliable answer to the questions posed. This number is determined by the primary objective of the trial” (p.291). Hertzog (2007) argues that there is not a clear number and provides a range between 10-50. She contends that feasibility, adequacy of instruments and methods being used are factors that can influence sample size. Lastly, Sim & Lewis (2010) suggest that a sample size of 50 is advisable in many circumstances.

### **Subject Recruitment**

Information about the HIV and AIDS seminar was shared by the pastor during bi-weekly announcements over the pulpit during the 10:30 am services. Additionally, announcements were made during the Wednesday 7:30 p.m. mid-week prayer service. The script during the announcements came from the pastor who read directly from the flyer (see Appendix C). Additionally, recruitment flyers were posted on the church’s electronic and vestibule bulletin boards. Recruitment of participants took place after the Sunday morning 10:30 am service in conjunction with the Elder who was the community program coordinator. Recruitment lasted for three weeks after IRB approval. Participants were given a copy of the flyer that explained the details of the program.

Access to potential participants was achieved through a sign-up sheet that was immediately generated after the 10:30 am Sunday morning service. Participants were provided a

handout summarizing the project as well as the contact information (email and telephone number) for any questions and/or concerns. Participants were informed that participation in the seminar was voluntary and they could withdraw from participating at any time. Also, if they desired not to answer the questionnaire, they were not required to do so.

### **Consent Procedure**

Approval to conduct the seminar was given by the Pastor and the Elder who oversaw community and outreach initiatives. On the day of the seminar, consent was obtained from the participants by handing out the consent forms, approved by Rutgers University Institutional Review Board, prior to the seminar. The purpose of the consent was explained to each individually. They were informed of the project's aims and objectives, the purpose of the study, and what activities would be expected, and the significance of their participation.

Additionally, the participants were instructed about the steps that were taken to maintain their confidentiality during the process. For example, the numbering process was explained stating that instead of using names for data collection purposes, a number system was used to generate information to help collect relevant data (see Appendix D). Additionally, it was explained that the de-identified data was used for data collection and only the de-identified data was used for analysis. And finally, it was also explained that upon completion of the project, closure of the IRB process, and final writing of the manuscript, all data will be destroyed in accordance with Rutgers University guidelines.

**Risks & Harms**

Participation in this study posed minimal risk. There was a small possibility that the participant's contact information may have been inadvertently shared by participating in this project. The participant's name and contact information were collected and assigned a number. This allowed the data to be reviewed without direct link to the participant's name. Only the research staff had access to the list linking the participant's name and contact information to the number associated with the data. The link between participant names and study ID number was destroyed at the conclusion of data entry.

There was no anticipated physical discomfort in this study, so risk to participants was minimal. It was possible that participants could have experienced psychological/emotional discomfort from discussing HIV and AIDS and how it is transmitted. If this occurred, referral information was provided. Additionally, the question and answer portion of the seminar may have caused the participants to think about their feelings regarding HIV and AIDS. This moment may have caused the participant to feel sad or upset; therefore, they were reminded that they could have withdrawn from the seminar at any time because their participation was voluntary. To mitigate the discomfort, referral information was provided (see Appendices E, F, G, & H). Regarding testing referral, all efforts were taken to eliminate the sharing of information regarding the request for testing referral.

**Subject Cost & Compensation**

There was no cost to participate in this project. There was no additional travel cost to the participants since they were already at the church for service. The seminar took place immediately after the 10:30 am Sunday morning service. Subjects received a \$5 Target Gift card



for their participation in the project. Gift cards were distributed at the conclusion of the seminar once the pre-survey (see Appendix I) and post-survey (see Appendix J) had been logged according to the number system that was used to maintain confidentiality. Free refreshments were served during the seminar.

### **Study Interventions**

The study intervention that was used for this project is the education about the HIV and AIDS seminar conducted at the church. The education was conducted by the co-investigator. The survey was used to assess the participants' baseline knowledge of HIV and AIDS, what is it, and how is it transmitted. The pre-survey was distributed by the co-investigator to consented participants immediately after the Sunday morning 10:30 am service. This pre-survey was to assess knowledge prior to the seminar. During the seminar, a PowerPoint presentation (see Appendix K) took place in a designated conference room highlighting the HIV and AIDS rates of infection within the African American community, specifically Harlem. Within 30 minutes of the seminar's conclusion, a post-survey was distributed. The purpose was to assess if participants HIV and AIDS knowledge baseline changed and determine participant's intent to screen. The questions were the same for the pre-survey and post-survey.

### **Outcomes to be Measured**

The outcomes that were measured included change in HIV and AIDS knowledge and the intent to screen for HIV and AIDS. This information was gathered from the pre-survey and post-survey results. The tool that was used to measure the success of the outcome was the pre-survey and post-survey (HIV KQ-18). The HIV-KQ-18 is a survey designed by Carey and Schroder (2002) to measure an individual's knowledge about HIV. It contains 18 'true' or 'false' questions with the option of also choosing 'don't know.' A question was added to address intent

to screen for a total number of 19 questions. The answers options were the same. The language was designed to provide knowledge from a street or field outreach method. Additionally, the scoring of the survey was simple in that its goal was to produce a single score. The higher the score, the greater the HIV related knowledge.

The reliability and validity of the HIV-KQ-18 survey, along with its answer key (see Appendix L), was determined through clinical trials to be consistent, stable, and sensitive to detect knowledge gains about disease transmission and self-protective behaviors in low-literacy populations (Carey & Schroder, 2002). Furthermore, research evaluating the psychometric properties of the questionnaire determined it to be a dependable, effective, and feasible tool designed for researchers, program evaluators, and educators to easily administer and score with the goal of assessing HIV related knowledge (Carey & Schroder, 2002). The reliability analysis of the HIV-KQ-18 provides strong levels of internal consistency as indicated by its Cronbach's alpha which ranges from .75 to .89. These numbers exceed the recommended standard of .70 indicating stability in its test-retest assessment strength (Carey & Schroder, 2002).

### **Project Timeline**

The timeline of the project took approximately three weeks once approved by the IRB. The venue was established and the cost and finances were in place. The recruitment for the event lasted 3 weeks. This included the posting of flyers and announcements made by the Pastor. Additionally, the time to print surveys and purchase the refreshments and gifts cards took no more than one week to accomplish. The total time for recruitment took approximately 3 weeks.

The seminar lasted approximately three hours. Once the project was complete, it took no longer than two weeks to gather and assess the data. Once the statistics were evaluated using the

paired t-test, the final assessment was made in less than a week. The final writing of the project took place once the data was collected and assessed (see Appendix M).

### **Resources Needed**

The costs associated with this project were the sole responsibility of the co-investigator. Costs included recruitment materials, educational handouts, and material for the educational program such as gift cards, refreshments, & computer software. The budget is located in Appendix N.

### **Data Maintenance/Data Security**

Participants were provided with a randomized number by the co-investigator to use for both pre-survey and post-survey dissemination and data collection as well as assessment. Pre-survey and post -surveys were administered by the co-investigator. The master list linking the participants to the random ID number was kept separately from the actual surveys. During the seminar, the pre-surveys, post-surveys, and Target gift cards were secured in the locked box until the end of the seminar. Only the co-investigator had access to the cards, the key, and the locked box. The link between participant names and study ID number was destroyed at the conclusion of data entry. Only de-identified data was used for analysis. Data was stored on two password-encrypted flash drives, logged with the same sequential ID number assigned, and was also kept in a locked cabinet. Upon completion of the project, closure of the IRB process, and final writing of the manuscript, all data will be destroyed in accordance with Rutgers University guidelines. Hard copies of consents and aggregate data will be housed in office 1126 of the School of Nursing office at Rutgers University, Stanley S. Bergen Building (SSB), 11<sup>th</sup> floor, 65 Bergen Street, Newark, New Jersey 07107.

## Findings

Although there was a projected sample size of up to 50 based on the size of the membership, a total of 21 members chose to participate and completed the educational program. It is not clear why only 21 chose to participate as recruitment announcements were made to an estimated 500-800 people (200 members per service), twice a week for three weeks. However, it is to be noted that participation was voluntary. A paired t-test was used to compare the mean scores of the pre-test and the post-test. The mean scores were 13.7143 and 14.6190 for the pre-test and post-test, respectively (see Appendix O). The results failed to reach statistical significance as  $p > 0.05$  (0.191) because the sample size of 21 was too small to produce a statistically significant score. However, even though there was no statistical significance, the findings did show that there was a mean increase in HIV and AIDS knowledge baseline among the participants. Therefore, the program did, to a small degree, have a positive impact.

The results of the intent-to-screen were statistically significant. There was a significant difference in the score on the pre-test ( $M = 0.53$ ,  $SD = 0.514$ ) and the scores on the post-test ( $M = 0.88$  and  $SD 0.332$ );  $t = -2.954$ ,  $p = 0.009$ . Of the total number of participants, 35% ( $n=8$ ) more wanted screening after participating in the program. This indicated that the educational seminar had a positive effect on those willing to seek HIV and AIDS screening. The difference between the pre-test and the post-test was found to be statistically significant at  $p < 0.05$  (or 0.009). This is an indication that HIV and AIDS awareness initiatives in the Black church may increase the rates of HIV screening (see Appendices P & Q).

## Discussion

Overall, the presentation was well received. The participants were very passionate about the subject matter and spoke honestly about their limited understanding or lack of knowledge about HIV and AIDS. For instance, after reviewing the educational handouts (see Appendices R, S, T, U, & V) some participants did not realize that African Americans have a high rate of HIV and AIDS infections compared to other races. Some were unaware that there are people who are infected with HIV and/or AIDS and do not know their status. Other participants were alarmed when they discovered that Harlem has a high concentration of African Americans infected with HIV and AIDS compared to the other boroughs of New York City.

Other areas of HIV and AIDS knowledge deficiency were highlighted during the review of the post-survey session when the answers were given. Numerous participants shared that they did not know the answers to many of the survey questions. For example, question number 6 from the HIV-KQ-18 (Carey & Schroder, 2002) pre-test and post-test survey states the following: “All pregnant women infected with HIV will have babies born with AIDS.” Many of the participants shared that they believed the answer was true. However, it is false and was discussed that according to the CDC (2019c), there have been many medical advances that, with prevention and treatment, children can be born without being infected with HIV and AIDS to mothers who are positive. It has also been noted that the numbers of prenatal infection have declined by 95% since the 1990s.

Another question that several of the participants answered incorrectly was number 7. The question states “people who have been infected with HIV quickly show serious signs of being infected” (Carey & Schroder, 2002). Again, some of the participants assumed the answer

was true. According to the CDC (2019d), people can be infected with HIV and may not know it for years. This period is called the clinical latency or dormancy stage. People may not have any symptoms but the virus is active in their system. Therefore, during the discussion, the importance of getting tested for HIV and AIDS was highly emphasized.

Question number 8 was difficult as the majority of the participants answered true. “There is a vaccine that can stop adults from getting HIV” (Carey & Schroder, 2002). The answer is false and it was explained that there is no licensed vaccine for HIV. However, there is a Pre-exposure prophylaxis (PrEP). PreP, if taken daily, can help lower the risk of contracting HIV. Through sexual routes, Prep can lower the risk by about 99% and through the intravenous route, the risk can be lowered by 74% (CDC, 2019e).

There was a question-and-answer session immediately following the PowerPoint presentation. Participants asked many questions that pertained to their personal and family experiences with the diseases. Some even went as far as sharing about family members who had died from the AIDS virus and how those members contracted HIV. It was an intimate and informative session and many expressed their appreciation to those who were bold enough to share their stories.

This study, as indicated through these discussions and which is similar to Berkley-Patton et al. (2013), demonstrated that the Black church can play an instrumental role in educating the African American community about HIV and AIDS as well as helping to increase the HIV screening rates. Additionally, findings showed that there was an increase in knowledge baseline and a statistically significant increase in intent to screen indicating that the HIV and AIDS educational seminar had a strong impact on the participants overall awareness. This was also apparent in the post-test survey results which showed an improvement in mean scores compared to the pre-test results. This was partially due to the teaching points that covered the basics about the HIV and AIDS and how to protect oneself against these diseases (see Appendix W). For instance, they were taught what HIV and AIDS is, How HIV is spread; stages and symptoms of HIV; how to decrease one's risk of contracting HIV; the importance of getting tested; as well as where to find resources for HIV and AIDS treatment.

Based on previous studies conducted by Stewart (2015), Stewart & Dancey (2012), and Stewart & Thompson (2016), it was projected that there would be an improvement in both knowledge baseline and intent to screen. Given that the African American population is underserved when it comes to HIV and AIDS prevention and treatment (CDC, 2019b), the goal was to educate about awareness and ways to confront the epidemic. The seminar demonstrated that there was a gap in knowledge about how HIV and AIDS are contracted, transmitted, and how they can be prevented. Based on the scores, it is evident that there is still additional work to be done.

During the recruitment efforts, announcing at two services (200 members per service), twice a week for three weeks, it is estimated that the message regarding the educational seminar reached at least 500 – 800 people. However, the turnout only produced about 3% participation

from the membership. This could potentially be due to the topic itself, the fact that it was not a religious event, or because the seminar was not conducted solely by the pastor. There are many potential reasons why participation was low. However, based on the results (intent-to-screen scores pre-test ( $M = 0.53$ ,  $SD = 0.514$ ), post-test ( $M = 0.88$  and  $SD 0.332$ );  $t = -2.954$ ,  $p = 0.009$ ), there is potential for the Black church to have a lasting impact on helping to further increase HIV and AIDS awareness in the African American community. Because of its influence and reach, it is recommended that the HIV and AIDS education continues and more studies of this kind be conducted with the intent to increase awareness and prevention.

### **Barriers and Limitations**

This project included barriers and limitations. Since the study was conducted in the church and announcements were made on Sunday mornings and Wednesday evenings during service, those hearing the announcements varied. Therefore, some members who were present and made a commitment to participate after some of the announcements may not have shown up to participate on the day of the seminar. Efforts were made to recruit until the day of the seminar highlighting the Target card giveaway and free refreshments as incentives.

The small sample size was a limitation of this study. The targeted sample size was up to 50 participants however, only 21 people participated, with all completing the survey. The sample size could have been larger, perhaps, if recruitment efforts would have lasted longer. Also, a larger sample size could have been generated if the seminar was held in conjunction with other church programs, like the church's annual hypertension and diabetes screenings fairs. There is a possibility that more people would have volunteered to participate if this was the case. It is the church's leadership that sets the calendar of events and approves the setting, the dates, as well as the approved venue.



Additionally, although there was a statistical significance in the intent to screen based on the pre-test and post-test scores, a larger sample size may have provided more accurate mean values and a smaller margin of error (Berkley-Patton et al., 2013). Another limitation is the pre-test and post-test surveys themselves as they have limitations for causality. In other words, the mean values of the pre-test and the post-test were caused by the results of the seminar. There existed a cause and effect relationship. Because a pre-test and post-test design examines whether there is improvement as a result of an intervention, there is the possibility that the results can often lead to inaccurate conclusions. This is due to the exposure of the pre-test which teaches the answers to the post-test, thus potentially distorting the results. Call response biases is also a limitation. Participants' answers may not have been honest given the subject matter and the participants may not have wanted to reveal private details about their lives. Additionally, they may have wanted to present themselves in a favorable light. Overall, various biases may have affected some of the results such as the church setting, the idea of what it means to be a Christian and therefore, what it means to engage in risky behavior.

To address these barriers and limitations, further study could attempt to address the importance of open communication, the idea that anyone, regardless of religion, who engages in sexual practices is at risk for HIV and AIDS. So further and consistent teaching could address that the best way to arm oneself is to educate oneself.

## **Implications for Clinical Practice**

The success of the seminar has the potential to help improve HIV and AIDS awareness. This education, although not to a level of statistical significance, did increase the participants' knowledge baseline on how HIV is transmitted, how not to contract it, and how to recognize the risk factors associated with contracting the virus. Additionally, this education increased intent-to-screen scores (pre-test ( $M = 0.53$ ,  $SD = 0.514$ ), post-test ( $M = 0.88$  and  $SD 0.332$ );  $t = -2.954$ ,  $p = 0.009$ ) and has the potential to have a lasting impact on behavior change and the choices that individuals make when it comes to sex practices, decreasing one's risk for HIV and AIDS, and getting tested.

Because individuals were also introduced to the data linked to HIV-related mortalities among Blacks, there is a potential to increase the linkage to care, increase the continuity of HIV related care, and decrease the negative impact of HIV related outcomes (Siddiqi, Hu, & Hall, 2015). Overall the goal as it relates to public health is to decrease the health disparities, particularly among Blacks who are disproportionately impacted by the HIV and AIDS epidemic. Through the success of this study, based on the increase in intent to screen and the improvement in knowledge baseline, the overall outlook for Blacks has the potential to improve once the community is continuously educated and the rates of HIV infections decline. Additionally, with the success of this study that focused on a specific targeted Black church, using other non-healthcare sites, like other non-denominational Black churches in the five boroughs and beyond, as well as historically Black colleges and universities, could have the potential to further spread the knowledge about HIV and AIDS with the potential of improving community awareness.

## **Implications for Healthcare Policy**

This seminar was feasible and others like it have the potential to empower the Black community to educate itself on the devastating effects of HIV and AIDS. This as a result, can have a lasting impact on healthcare policy. If education continues on such a small scale and eventually evolves to reach the greater Black community, this has the potential to fall into the category of a high impact prevention approach that is designed to help decrease the mortality rates of Blacks diagnosed with or infected by HIV and AIDS (CDC, 2019b). For example, there is the potential for the expansion of HIV and AIDS treatment centers specifically in underserved communities (IOM, 2011). Currently there are 131 HIV testing sites within a 10 mile radius of people living in central Harlem with approximately 40 in Manhattan alone. Through grassroots efforts, it has now become the (co-investigator's) mission to advocate on behalf of this community to increase the number of free testing sites within Manhattan. Many people do not have the financial means or health insurance to afford HIV and AIDS testing through private medical practices. Therefore, as efforts will be made to encourage people to get tested for HIV and AIDS, concurrently, efforts will be made to get the appropriate responding bodies to meet the needs of the community by offering more free testing sites within central Harlem and the greater Manhattan area.

Moreover, the potential for expansion of practices that promote entry into clinical care is great and the provision of continuous care for people with HIV and AIDS (IOM, 2011) is promising. This would also lead to increased funding for HIV medication adherence programs (IOM, 2011) as well as other treatment programs for people living with other complex diseases that are complicated by HIV and AIDS. Overall, a comprehensive and consistent disciplinary approach is needed for people living with HIV and AIDS. As a result, this can be accomplished

with continued education, prevention, and treatment services that is especially targeted to African Americans who are marginalized and disproportionately affected by these diseases.

### **Implications for Quality and Safety**

Successful implementation of this seminar has improved the baseline knowledge of HIV and AIDS, the intent to get tested, and the overall awareness about the devastating effects of the disease on a population of people that has, historically, the largest rates of HIV and AIDS infection within the total population, and the highest number of those newly diagnosed.

Although these results are reflected in a small sample, this seminar suggests that more of its kind can change the landscape of health outcomes if more African Americans are educated about HIV and AIDS, how it transmitted, and how to arm themselves against the disease. This would help keep more African Americans safe, free from these diseases, and help improve the quality of life of a disadvantaged population of people.

Based on the data from this study, equity to care access has the potential to improve for African Americans because more people would get screened. This would require more prevention and treatment services and as the CDC (2019b) has proposed, more people would enter into clinical care services before they reached advanced stages. Access to expert HIV care providers would also help decrease health disparities among African Americans impacted by HIV and AIDS. This would enable them to get adequate treatment in a timely manner thus prolonging and increasing the quality of life.

## **Implications for Education**

The church can be used as a forum for educating the Black community. Such pilot studies like this one and others conducted by Stewart (2015), Stewart and Dancy (2012), and Stewart and Thompson (2016) have demonstrated such success. HIV and AIDS ministries with educational focus increased HIV intent to screen, testing, linkage to care, and safer sex practices that help reduce the spread of HIV related infections. Additionally, because there was such a strong focus on educating the local communities about HIV and AIDS, the church leadership became more involved in developing, implementing, and helping maintain HIV and AIDS ministries in the Black church (Stewart, 2015).

Furthermore, because of the membership's heavy involvement in developing and maintaining the HIV and AIDS ministries within the church, they became successful in helping to reinforce what was already known about the disease to other Black churches in the local community (Stewart, 2015). Moreover, in an effort to reach the greater community of this targeted Black church, it would be advantageous to network with the church's leadership to continue the education. In order to increase HIV and AIDS testing, the community needs to be better equipped with information to protect themselves against these diseases. Therefore, more seminars, like the one done in this study, can help produce a community of people that are better educated about the devastating effects of HIV and AIDS.

## **Economic Implications**

Implementation of this quasi-experimental pilot study may have economic implications that are far reaching. For instance, for those who get screened and avert HIV and AIDS treatment, the cost gained is a quality of life that would be valued beyond economic dollars. The individual life span would not be reduced by the effects and complications of such diseases.

Concurrently, for African Americans who are screened and test positive for HIV and AIDS, the cost for treatment during the early stages would avert entering into clinical services at advanced stages. There would be a decrease in mortality rates and years of life lost (IOM, 2011). The CDC (2019b) estimates that with early and adequate treatment, there has been an increase in life years from 10.5 years to 22.5 years from 1996-2005 (IOM, 2011). Additionally, HIV and AIDS prevention programs are intended to extend life. When individuals are screened, retained in care, and are adherent to treatment, these, too can contribute to life years gained that would have otherwise been lost to HIV and AIDS related deaths (CDC, 2019b).

### **Professional Reporting and Dissemination**

The findings of this study will be disseminated to Rutgers University School of Nursing as part of the requirements for the Doctorate of Nursing Practice. A manuscript will be submitted for consideration to the *International Journal for the Study of the Christian Church*. This will aid in the education of its readers about the HIV and AIDS epidemic surrounding the Black church. Additionally, the findings will be presented to the church's membership and those who participated in the study where the project was conducted. Furthermore, the project will be presented at Rutgers University's poster day and consideration will be given to presenting at HIV conferences and other professional organizations where the topic is appropriate.

**Sustainability/Plans for Future Scholarship**

After the seminar, the participants expressed their appreciation for a seminar of this kind. They talked about the need for Blacks to become more aware about the devastating effects of HIV and AIDS. They were so appreciative that the invitation was extended, by the pastor, to return again to do another seminar. An invitation was also extended (and accepted) to attend other social events offered by the church, such as an ice cream social, to educate the rest of the membership about the importance of protecting themselves against HIV and AIDS as well as the significant need to get tested. In addition to continuing to educate the membership at the targeted Black church identified in this study, the project has the potential to evolve via continued community outreach to educate other local Black churches about HIV and AIDS affecting the African American population for years to come. Networking will continue with the local churches to further educate about the topic. Churches, like the one targeted in this study, are umbrellas for others that fall under it. Through grassroots efforts, it would be advantageous for the African American community to take the education as far as it can go.

It would be also advantageous to continue the teaching efforts by reaching out to other non-healthcare sites such as schools and universities that are predominantly Black. The African American youth need to be educated on the disturbing effects of HIV and AIDS and these venues provide an ideal setting for addressing issues of healthcare disparities. If not, then the marginalization and the disparity will continue.

## **Conclusion**

The results of this project concluded that the knowledge baseline of participants did improve as a result of the HIV and AIDS seminar. There was a statistically significant increase in the intent to get tested for HIV and AIDS. Even by a small margin, the HIV and AIDS seminar proved to be valuable to a population of people that has, for so long, been burdened by the effects of these diseases. The project has shown to be feasible with participants now armed with a body of knowledge that can help improve the HIV and AIDS outcomes for the individual and for the African American community as a whole.



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## Appendix A

### Table of Evidence

#### Johns Hopkins Nursing Evidence-Based Practice Appendix G: Individual Evidence Summary Tool

**EBP Question:** “Will providing educational literature and seminar (s) encourage the Black church to increase health promotion initiatives for HIV and AIDS prevention services and offer testing referral?”

**Date:** December 29, 2018, 2018

**Submitted by:** Daitasha Miller

| Article # | Author & Date   | Evidence Type                        | Sample, Sample Size & Setting | Study findings that help answer the EBP question  | Limitations                              | Evidence Level & Quality |
|-----------|---|--------------------------------------|-------------------------------|---|--|--------------------------|
| 1         | CDC. <i>Fact Sheet: HIV Among African Americans</i> ; October 2017. | Systematic Review with Meta-Analysis | N/A                           | <ul style="list-style-type: none"> <li>17,528 African Americans received an HIV diagnosis in the United States (12,890 men and 4,560 women).</li> <li>More than half (58%, 10,223) of African Americans with diagnosed HIV were gay or bisexual men.</li> </ul> | Data has not yet been reported for 2017. | Level III – High Quality |

|   |  |                                      |     |  |   |                            |
|---|--|--------------------------------------|-----|--|---|----------------------------|
|   |  |                                      |     | <ul style="list-style-type: none"> <li>Among African American gay and bisexual men who received an HIV diagnosis, 39% (3,993) were young men aged 25 to 34.</li> </ul> <p>Blacks/African Americans account for a higher proportion of new HIV diagnoses, those living with HIV, and those who have ever received an AIDS diagnosis, compared to other races/ethnicities. In 2016, African Americans accounted for 44% of HIV diagnoses, though they comprise 12% of the U.S. population.</p> |   |                            |
| 2 | <i>CDC. HIV Surveillance Report, Diagnoses of HIV Infection in the United States and Dependent Areas, 2016, Vol. 28;</i> | Systematic Review with Meta-Analysis | N/A | <p>Diagnoses of HIV infection</p> <p>1) From 2011 through 2015, the annual number and the rate of diagnoses of HIV infection in the United States decreased.</p> <p>2) Race/ethnicity:<br/>In 2016, the highest rate was 43.6 for blacks/African Americans, followed by 17.0 for Hispanics/Latinos, 12.9 for</p>   | The HIV diagnosis and stage 3 (AIDS) classification data for the year 2016 are preliminary (subject to change) because they are based on only a 6-month reporting delay and therefore should not be included when assessing trends. | Level III – A High Quality |

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|  |  |  |  | <p>persons of multiple races, 10.2 for American Indians/Alaska Natives, 8.5 for Native Hawaiians/other Pacific Islanders, 5.5 for Asians, and 5.2 for whites.</p> <p>3) Stage 3 (AIDS) In HIV Surveillance Report 7 Vol. 28 2016, the highest rate was 21.1 for blacks/African Americans, followed by 9.7 for persons of multiple races, 7.2 for Hispanics/Latinos, 4.3 for American Indians/Alaska Natives, 2.6 for Native Hawaiians/other Pacific Islanders, 2.2 for whites, and 1.9 for Asians.</p> <p>4) Deaths of persons with diagnosed HIV infection: In 2015, the highest rate of deaths was for blacks/African Americans: 17.5.</p> <p>5) Deaths of persons with infection ever classified as stage 3 (AIDS): In 2015, the highest death rate was for blacks/African Americans:</p> |  |  |
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|  |  |  |  | <p>14.0.</p> <p>6) Prevalence: Persons Living with Diagnosed HIV Infection and Persons Living with Infection Ever Classified as Stage 3 (AIDS) Prevalence of diagnosed HIV infection: At year-end 2015, the highest rate (1,017.8) and the largest percentage (42%) were those for blacks/African Americans. Among the remaining race/ethnicity groups, the rates were 577.3 for persons of multiple races, 379.4 for Hispanics/Latinos, 160.3 for Native Hawaiians/other Pacific Islanders, 150.9 for whites, 122.6 for American Indians/Alaska Natives, and 74.8 for Asians.</p> <p>7) Prevalence of stage 3 (AIDS): At year-end 2015, the highest rate (539.2) and the largest percentage (41%) were those for blacks/African Americans. Among the</p> |  |  |
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|   |                       |                                |  | <p>remaining race/ethnicity groups, the rates were 339.9 for persons of multiple races, 214.4 for Hispanics/Latinos, 81.3 for Native Hawaiians/other Pacific Islanders, 78.8 for whites, 63.0 for American Indians/Alaska Natives, and 36.1 for Asians.</p>  |   |                        |
| 3 | Stewart, J. M. (2015) | Qualitative Ethnographic Study | <p>In this study, data were gathered via in-depth semi-structured interviews of pastors, lay leaders, and congregants (n-9), congregant surveys (n-50), observations (n-7), and review of documents (n-9) of the church and ministry in a year. Interview participants were those involved in the development, implementation, and/or maintenance of the HIV/AIDS Ministry in the church. A large African American</p> | <p>Data were gathered via in-depth semi-structured interviews of pastor, lay leaders, and congregants, congregant surveys, observations, and review documents of the church ministry over a year. Interviews participants were those involved in the development, implementation, and/or maintenance of the HIV/AIDS Ministry in the church.</p> <p>The HIV Ministry provided multiple HIV and AIDS related services including monthly HIV/AIDS educational sessions and forums. It also provided HIV testing 2-3 times per years with</p> | <p>Limitations of this study include that it was a non-randomized study of a single church, which limits generalizability. Additionally, a portion of the data consisted of information that was collected via retrospective self-report and may be biased.</p> | Level V – Good Quality |

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|   |  |             | church (8,854 membership) in an urban setting was chosen (where the median income was \$43, 201) which had an unusually long-standing HIV Ministry.  | immediate linkage to care for positive results. The HIV Ministry also conducted HIV related outreach events and trainings in the surrounding community and other churches and offered housing and counseling for HIV and AIDS infected individuals. Condoms, educational brochures, skilled based guidance on HIV prevention was also provided.   |  |                        |
| 4 | Roman Isler, M., Eng, E., Maman, S., Adimora, A., & Weiner, B. (2014). | Qualitative | Data were collected in eight black Baptist churches in North Carolina, all members of the same church association. Seven focus groups were conducted with 36 congregants, and 12 church leaders (including 8 pastors) participated in individual, in-depth interviews. | Most focus group participants had at least some college (94.4%) and were married or living with partner (52.8%). Most individuals in both respondent groups reported having at least some knowledge about HIV (91.7% and 86.1%), but a larger proportion of focus group participants reported knowing someone with HIV (33.3% versus 61.1%). Based upon interpretative analysis, respondents outlined two worldviews that were used to define and conceptualize HIV/AIDS prevention modalities within the participating black | This study is not without limitations. First none of the churches sampled for this study actively engaged in HIV prevention. Second, as a qualitative study, they did not sample the churches or participants within the churches to be able to generalize these finding to all black churches. This study was designed to explore | Level V – Good Quality |

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|   |                       |             |   | <p>Baptist churches: a church-based perspective and a secular, public health perspective. The church-based perspective centers on the avoidance of sin, whereas the public health perspective centers on the core concept of avoiding disease.</p>   | <p>the topics in-depth with a small, purposive sample of individuals who could share their informed perspectives. Third, though currently 71% of HIV in North Carolina is sexually transmitted, HIV transmission does occur via intravenous drug use or other unidentified risk behaviors. In this study, we only explored preventive interventions for sexually transmitted HIV.</p> |                        |
| 5 | Stewart, J. M. (2015) | Qualitative | <p>A total of 4 focus groups with church leaders and 4 in depth interviews with pastors, were conducted between November 201 and June 2013 to identify the constructs most important to supporting Philadelphia</p> | <p>Participants in the focus groups ranged from ages 19-74 (mean age 52) with 63% being female. The church leaders were identified by the pastor as being in leadership positions for health and HIV related ministries, programming for adults and youth, and/or financial support positions for the church</p> | <p>The results are limited by the small sample size and may not be applicable to other church settings. Because each church is not representative of African American churches as a whole,</p>  | Level V – Good Quality |

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|  |  |  | <p>churches' involvement in HIV testing, referral, and linkage to care.</p> <p>Church 1 identified as Baptist, church 2 as non-denominational, church 3 as Pentecostal, and church 4 as Church of God in Christ (COGIN).</p> <p>All participants self-reported as black or African American. Pastors ranged from age 44-61 (mean age 48) and were all male. Participants in focus groups (n=39) ranged in age from 19-74 (mean age 52) with 63% being female. The church leaders were identified by the pastor as being in leadership positions for health and HIV-related ministries, programming for adults and youth, and/or financial support positions for the church</p> | <p>ministries and programs. Churches were similar in size with a high of 250 members and a low of 150.</p> <p>In general, there were some misconceptions of what HIV is, how it is transmitted, and some conspiracy theories among those participants in churches without HIV testing in place. These participants stressed their need for HIV education. There was also a strong desire to reinforce what was already known about HIV across all churches, regardless of their level of engagement in HIV testing. Churches without testing in place needed to dispel myths with training and knowledge. This with testing in place needed additional information to keep up-to-date and to give correct information during testing, counseling, and advocacy.</p> | <p>one cannot assume the findings will be applicable to African American churches in other geographical locations.</p> |  |
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|   |  |                             | ministries and programs. Churches were similar in membership size with a high of 250 members and a low of 50.  |  |  |                        |
| 6 | Stewart, J. M., & Thompson, K. (2016). | Qualitative Research Design | The data were collected from interviews with pastors (n=4), and focus groups with church leaders (n=39) across four churches. These four Churches were selected from an urban community in Philadelphia with the highest incidence of HIV. The congregations reported a Black or African American population of $\geq 60\%$ . The participating churches had to identify the head pastor of the church who also had to be over the age of 18, and be willing and able to provide informed consent, have input on the promotion of HIV testing, or directly | The churches with HIV testing in place, church leaders and pastors spoke in great detail and accuracy of HIV as a disease and related HIV knowledge. There was also more reporting of feelings of compassion toward people infected with HIV and AIDS and a focus on love rather than condemnation. Churches without HIV testing focused more on the obstacles to integrating it into their church, which included a desire for more training and education and several statements that were interpreted as potential indications of association of HIV with homosexuality, stigma against homosexuality and fear. | The study is Limited by its sample size. However, the qualitative study design allowed for an in-depth exploration of the factors readiness for implementation HIV testing in African American church setting. | Level V – Good Quality |

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|   |                                       |                         | involved with HIV testing.  |   |   |                        |
| 7 | Stewart, J. M., & Dancy, B. L. (2012) | Ethnographic Case Study | The sample consisted of 9 individuals involved in the development, implementation, and maintenance of the HIV ministry: one pastor emeritus, one associate pastor, and six church members identified by these pastors as having had a role in the development, implementation, or maintenance of the HIV ministry. An additional 50 members of the general congregation were asked about their awareness of the HIV ministry to gain additional information about their general acquired knowledge of the HIV ministry. | In the development of the HIV ministry, acquiring knowledge was paramount for ministry members and congregants. The major theme was the promotion of knowledge for members and congregants. The major theme was the promotion of knowledge for members and congregants. The members and pastor created informational sessions for the congregants and mandatory trainings for HIV ministry volunteers to reduce the stigma and ignorance surrounding HIV. Training sessions covered basic knowledge of HIV (pathophysiology, transmission, terminology, resources, prevention, etc). The HIV ministry training manual gave information on the history of HIV, HIV terminology, and pathophysiology of HIV, as well as HIV prevention and resources. Specifically, the manual provided information on when the HIV | One possible limitation to this study was that it took place within a church belonging to a denomination that was open and affirming to homosexuality. African American churches with a doctrine that supports homosexuality tend to be more willing to discuss topics concerning sexuality, particularly homosexuality and promiscuity, and as such may be more willing to develop, implement, and maintain a HIV ministry than African American | Level V – Good Quality |

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|   |   |  |   | <p>virus was recognized, what a retrovirus was, how the HIV virus attached to CD4+ T cells, the HIV replication process, the effects of HIV on the immune system, modes of transmission through bodily fluids, signs and symptoms of infection, how HIV could be diagnosed, common treatments (antiretroviral drugs), prevention of infection through safe sex practices (including reduction of partners, condom use, and abstinence), as well as numbers for hotlines, case management resources, clinics' support groups, and substance abuse services. Information about HIV was also provided to the congregation via newsletters, information in church bulletins, resources tables, posters, and forums.</p> | <p>churches that are unwilling to have these discussions. The results from this study may not be generalized to those churches</p> |                        |
| 8 | Berkley-Patton, J., Thompson, C. B., Martinez, D. A., Hawes, S. M., | Qualitative Ecological Framework and Community – | A convenience sample of 124 African American church leaders participating in one of | Nearly all of the church leader participants wanted to learn more about HIV and how to discuss it with their members, and most had  | Participating church leaders who completed capacity surveys were a   | Level V – Good Quality |

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|  | Moore, E., Williams, E., & Wainright, C. (2013) | Based Participatory Research (CBPR) Approach | four CCON (a faith-based nonprofit organization focused on improving the quality of lives of individuals and families with innovative community programs) sponsored health ministry training and capacity building conferences and events in KC completed the 10-15 min survey on church capacity. The majority of the leaders were male (65%) and aged 50 and older (63%). Senior pastors were highly represented (47%) and most had 21 or more years of pastoral experience. Most of the church leaders were Baptist (72%) and 86% attended church at least twice a week. | been tested for HIV; however, most feared discrimination if they were to test positive for HIV... They also addressed tools that addressed HIV stigma and compassion for HIV-positive persons. Similar to other studies, this study found that most church leaders were very interested in learning more about HIV in order to better inform their members, and 455 of their churches had participated in HIV/AIDS prevention education activities. | convenience sample attending health ministry training events that included topics on HIV; thus, their opinions (and their church's experiences) may not be generalized to other African American faith leaders. |  |
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| 9  | Berkley-Patton, J., Thompson, C. B., Moore, E., Hawes, S., Simon, S., Goggin, K., Martinez, D., Berman, M., ... Booker, A. (2016) | Qualitative Ecological Framework and Community – Based Participatory Research (CBPR) Approach | Four African American churches (N=543 participants) located in Kansas City metropolitan area. The participants were randomized to intervention and comparison groups. Receipt of an HIV test was assessed at baseline and at the 6- month mark.          | The findings of the intervention and comparison groups indicated that intervention participants were 2.2 times more likely to receive a HIV test than the comparison groups. Additionally, the church leaders delivered about 2 tools per month.  | This pilot study included a small number of participating churches. This limited the analysis on differential intervention effects on church and community members. Participant selection bias was possible due to the first come first serve recruitment strategy. | Level V – Good Quality |
| 10 | Nunn, A., Cornwall, A., Chute, N., Sanders, J., Thomas, G., James, G., Lally, M., Trooskin, S., Flanigan, T. (2012)               | Grounded Theory Qualitative Interviewing Approach   | A semi-structured interview guide to conduct focus group discussions was used. 38 faith leaders participated in the focus group. The focus group interview guide was informed by key informant interviews among over twenty local African American faith | Participants generally understood how HIV is transmitted, but were surprised to learn about the gravity of Philadelphia's local epidemic.<br><br>Participants also commented extensively that homophobia and fear of being perceived as gay prevents many African American clergy from discussing HIV/AIDS. | The limitations of this study are approximately half of the sample was based on churches and mosques that had existing relationships with the Mayor's Office of Faith Based Initiatives or the principles   | Level V- Good Quality  |

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|  |  |  | <p>leaders, peer-reviewed literature related to the local and national HIV/AIDS epidemic, engaging faith leaders in HIV prevention, other literature highlighting the importance of spirituality and churches in African American culture, and the opinions and experience of the Director of the Mayor's office of Faith Based Initiatives. The focus guide included questions about faith leader's knowledge of HIV transmission and the local Philadelphia epidemic, factors contributing to Philadelphia's HIV/AIDS epidemic, existing HIV/AIDS programs in their congregations, challenges and opportunities for addressing HIV/AIDS in a faith-based context,</p> | <p>Participants cited challenges with balancing theological messages with candid conversations about human sexuality and reproductive health.</p> <p>Numerous participants commented that a major barrier to addressing the HIV/AIDS epidemic was a tacit "code of silence" about HIV/AIDS in the African American community.</p> <p>Participants cited several resource challenges associated with addressing HIV/AIDS in faith contexts for that church and attendance and tithing with be affected.</p> <p>Participants identified young age and lack of pastoral experience as impediments for faith leaders to address HIV/AIDS.</p> <p>There was a strong consensus among the participants that faith the community should play a critical role in HIV/AIDS prevention in the African American community.</p> | <p>investigator and are not necessarily representative of the broader Philadelphia faith community or the national African American faith community. Their perceived barriers and recommendations may not be nationally reprehensive of all African American faith leaders' opinion.</p> |  |
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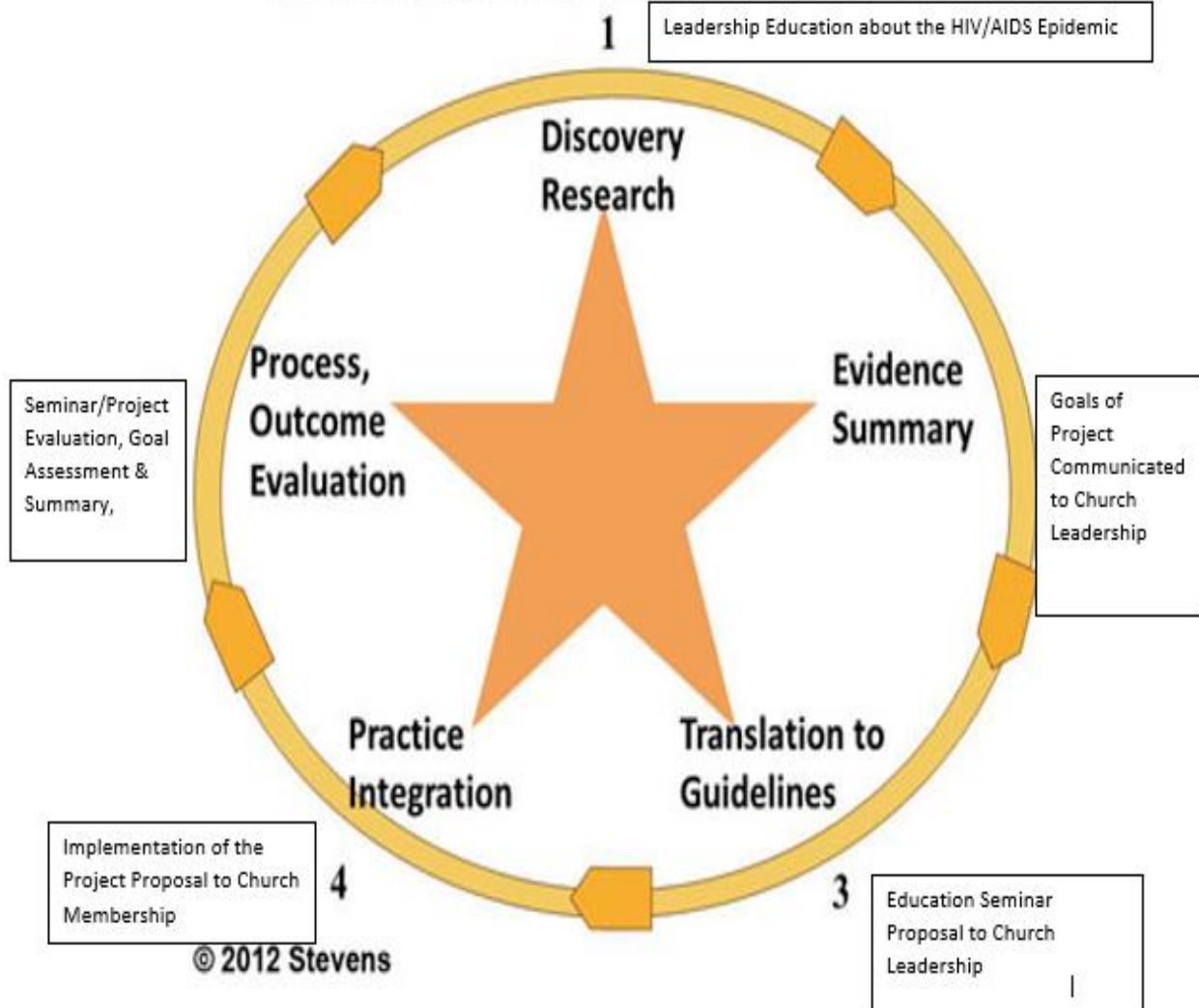
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|    |  |  | and leaders' normative suggestions for how the faith community can enhance HIV prevention in Philadelphia.   |  |  |  |
| 11 | Nunn, A., Sanders, J., Carson, L., Thomas, G., Cornwall, A., Towey, C., ... Green, D. (2015) | Qualitative – Community-Based Participatory Research Approach (CBPR) | Nine focus groups with 52 African American community leaders from diverse backgrounds to solicit normative recommendations for reducing Philadelphia's racial disparities in HIV infection. They were recruited from private sector, the non-profit sector, the public sector and other diverse advocates. | <p>Four main themes and policy recommendations emerge from the focus groups. The group recommended:</p> <ol style="list-style-type: none"> <li>1) The Philadelphia Department of Public health should increase educational and media efforts to raise community awareness about the local epidemic, including locally tailored media efforts to raise community awareness about the local epidemic, including locally tailored media campaigns promoting HIV testing.</li> <li>2) HIV prevention efforts should address social and structural drivers of the local epidemic rather than focusing exclusively on behavioral interventions and mode of HIV transmission.</li> <li>3) Publicly funded HIV/AIDS</li> </ol> |  |  |

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|  |  |  |  | <p>resources should be distributed to the most highly impacted neighborhoods, noting that addressing racial disparities requires addressing the city's geographic disparities in HIV infection.</p> <p>4) African American faith leaders should play a greater role in local HIV prevention and promote HIV testing in their houses of worship.</p> |  |  |
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## Appendix B


### Conceptual Framework

#### ACE Star Model of Knowledge Transformation




## Appendix C

### Recruitment Flyer



# RUTGERS

School of Nursing



HIV/AIDS & A Call for A Black Church Initiative

### A SEMINAR TO INCREASE HIV & AIDS AWARENESS IN THE LOCAL BLACK COMMUNITY

*Will providing education literature and a seminar to a targeted Black church increase HIV and AIDS awareness and the desire to accept testing referral?*

**WHO:** This Rutgers University research project is seeking participants between ages 18 and 85. These individuals can be members of the church or they can be visitors from within or outside of the community who are Black and English Speaking.

**PURPOSE:** This project is intended to improve HIV and AIDS awareness among the African American population with hopes of decreasing the rate of HIV infections by providing HIV education.

**WHERE:** Bethel Gospel Assembly  
2 E 120th St, New York, NY 10035

**WHEN:** TBD


**TIME:** 12:30 pm – 2:30 pm (Immediately following the 10:30 am service)

**COST:** FREE!

**COMPENSATION:** Each participant will receive a \$5 Target gift card. Free refreshments will be served!

**CONTACT:** Daitasha Miller @ 718-415-3365; Rutgers University, 65 Bergen Street, Newark, NJ 07107

Version 2; June 10, 2019



Rutgers, The State University of New Jersey

## Appendix D

### Informed Consent



# RUTGERS

## School of Nursing

### CONSENT TO TAKE PART IN A RESEARCH STUDY

**TITLE OF STUDY:** Will providing education literature and a seminar to a targeted Black church membership increase HIV and AIDS awareness and the intent to screen?

**Principal Investigator:** Tracy Vitale, DNP, RNC-OB, C-EFM, NE-BC

**Co-Investigator:** Daitasha Miller, MSN, MDiv, MS, FNP-BC, NP-C, RN

**Co-Investigator:** Patricia Hindin, PhD, CNM

**STUDY SUMMARY:** This consent form is part of an informed consent process for a research study and it will provide information that will help you decide whether you want to take part in this study. It is your choice to take part or not. The purpose of the research is to find out if a seminar about HIV and AIDS can improve knowledge awareness and encourage the intent to get screened for HIV and AIDS. If you take part in the research, you will be asked to complete a short test before and after reading the handout. Your time in the study will take about one hour and 30 minutes total to listen to a PowerPoint presentation about HIV and AIDS and complete tests. Possible harms or burdens of taking part in the study may be feeling remorse about some things listed in the handout and possible benefits of taking part may be gaining new important knowledge. Your alternative to taking part in the research study is not to take part in it.

The information in this consent form will provide more details about the research study and what will be asked of you if you choose to take part in it. If you have any questions now or during the study, if you choose to take part, you should feel free to ask them and should expect to be given answers you completely understand. After all of your questions have been answered and you wish to take part in the research study, you will be asked to sign this consent form. You are not giving up any of your legal rights by agreeing to take part in this research or by signing this consent form.

#### **Who is conducting this research study?**

Dr. Tracy Vitale is the Principal Investigator. Daitasha Miller is the co-investigator of this research study. A Primary Investigator of this research study has the overall responsibility for the conduct of the research. However, there are often other individuals who are part of the research team.

Primary Investigator, Dr. Tracy Vitale, may be reached at 973-972-1584 and Rutgers School of Nursing, 65 Bergen Street, Newark, NJ 07107.



Co- Investigator: Daitasha Miller may be reached at 718-415-3365.

The co-investigator or another member of the study team will also be asked to sign this informed consent. You will be given a copy of the signed consent form to keep.

**Why is this study being done?**

The study is being done to see if a seminar consisting of a PowerPoint presentations and handouts is effective in improving knowledge about HIV and AIDS.

**Who may take part in this study and who may not?**

Participants will be identified based on the inclusion criteria. This includes any member of the church congregation who is Black, English speaking, and ages of 18 - 89. The exclusion criteria is ages 90 and above.

**Why have I been asked to take part in this study?**

You represent the population this study is aimed at, which is Black men or women between the ages 18 and 89 who speaks English.

**How long will the study take and how many subjects will take part?**

The overall study will be done in one day, and up to 50 men and women will participate. Your participation will require approximately 90 minutes.

**What will I be asked to do if I take part in this study?**

You will be given a 19-question pretest. After, you will participate in a seminar that will have a PowerPoint presentation about HIV and AIDS. After the seminar, you will then be given the same 19 question test to complete, also known as posttest.

**What are the risks and/or discomforts I might experience if I take part in this study?**

There's a potential risk of feeling uncomfortable with some of the questions listed in the pretest and posttest.

**Are there any benefits to me if I choose to take part in this study?**

The benefits of taking part in this study may be gaining important knowledge which you can also share with your friends and family. However, it is possible that you may not receive any direct benefit from taking part in this study.

**What are my alternatives if I do not want to take part in this study?**

There are no alternative available. Your alternative is not to take part in this study.

**How will I know if new information is learned that may affect whether I am willing to stay in the study?**

During the course of the study, you will be updated about any new information that may affect whether you are willing to continue taking part in the study. If new information is learned that may affect you after, you will be contacted.

**Will I receive the results of the research?**



In general, we will not give you any individual results from the study. If we find something of urgent medical importance to you, we will inform you, although we expect that this will be a very rare occurrence.

**Will there be any cost to me to take part in this study?**

There will be no cost for you to participate.

**Will I be paid to take part in this study?**

No money will be paid, but you will receive a \$5 Target card as a thank you at the conclusion of the program after you complete the post-test.

**Who might benefit financially from this research?**

Nobody will benefit financially from this research.

**How will information about me be kept private or confidential?**

All efforts will be made to keep your personal information in your research record confidential but, total confident cannot be guaranteed. The list, the pre-test, and the post-test that will be collected will not have any information that will identify who you are. Additionally, all efforts will be made to keep any collected information confidential. The information will be kept secure in a password protected computer.

**What will happen to my information or biospecimens collected for this research after the study is over?**

The information collected about you for this research will not be used by or distributed to investigators for other research.

**What will happen if I do not wish to take part in the study or if I later decide not to stay in the study?**

It is your choice whether to take part in the research. You may choose to take part, not to take part or you may change your mind and withdraw from the study at any time.

If you do not want to enter the study or decide to stop taking part, your relationship with the study staff will not change, and you may do so without penalty and without loss of benefits to which you are otherwise entitled.

You may also withdraw your consent for the use of data already collected about you, but you must do this in writing Dr. Tracy Vitale; Rutgers School of Nursing; 65 Bergen Street, Newark, New Jersey, 07107.

Any data that has already been sent to project chair Dr. Patricia Hindin's office cannot be withdrawn because there may not be any identifiers with the data.

**Who can I call if I have questions?**

If you have questions about taking part in this study or if you feel you may have suffered a research related injury, you can call the co-investigator: Daitasha Miller, MSN, MDiv, MS, FNP-BC, NP-C, RN, at 718-415-3365 or email millerd6@sn.rutgers.edu

If you have questions about your rights as a research subject, you can call the IRB Director at: Newark HealthSci (973)-972-3608 or the Rutgers Human Subjects Protection Program at (973) 972-1149.

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## **AGREEMENT TO PARTICIPATE**

### **1. Subject consent:**

I have read this entire consent form, or it has been read to me, and I believe that I understand what has been discussed. All of my questions about this form and this study have been answered. I agree to take part in this study.

Subject Name: \_\_\_\_\_

Subject Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### **2. Signature of Investigator/Individual Obtaining Consent:**

To the best of my ability, I have explained and discussed all the important details about the study including all of the information contained in this consent form.

Investigator/Person Obtaining Consent (printed name): \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Appendix E

## HIV Testing Location Manhattan Handout



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School of Nursing

## HIV TESTING

### MANHATTAN

- **Chelsea**  
303 Ninth Avenue  
Take the 1, C or E train to 23rd Street, the 1, 2, 3, A, C or E train to 34th Street, or the 7 train to Hudson Yards.  
*(Closed on the first Wednesday of each month. Remain open on Wednesday, January 2, 2019)*
  - **Chelsea Sexual Health Clinic:** Monday–Friday: Intake begins at 8:30 a.m. and ends at 3:30 p.m. Saturday: Intake begins at 8:30 a.m. and ends at 12:30 p.m.
  - **Chelsea Express:** Monday–Friday: Intake begins at 8:30 a.m. and ends at 3:30 p.m. Also open Tuesday and Thursday evenings, 5 p.m. to 7 p.m. [Learn more about Chelsea Express](#), a fast and easy place for people who don't have any symptoms to get tested for chlamydia, gonorrhea, syphilis and HIV without seeing a nurse or doctor.
- **Central Harlem**  
2238 Fifth Avenue, 1st Floor  
Monday–Friday: Intake begins at 8:30 a.m. and ends at 3:30 p.m.  
*(Closed on the third Tuesday of each month. Limited services\* available the first Thursday of each month.)*  
Take the 2 or 3 train to 135th Street.
- **Riverside**  
160 West 100th Street  
Monday–Friday: Intake begins at 8:30 a.m. and ends at 3:30 p.m.  
*(Closed on the second Tuesday of each month. Will remain open on Tuesday November 13, 2018. Limited services\* available the third Thursday of each month.)*  
Take the 1, 2, 3, B or C train to 96th Street.  
*\*Limited services include STI and HIV testing for people without symptoms; counseling services.*

National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention

Version 1; May 4, 2019

## Appendix F

## HIV Testing Location Brooklyn Handout



**RUTGERS**  
School of Nursing

## HIV TESTING

### BROOKLYN

- **Crown Heights**

1218 Prospect Place, 2nd Floor

Monday–Friday: Intake begins at 8:30 a.m. and ends at 3:30 p.m.

*(Closed on the last Wednesday of each month. Limited services\* available the first Tuesday of each month.)*

Take the 3 or 4 train to Utica Avenue, or the B65 bus.

- **Fort Greene**

295 Flatbush Avenue Extension, 2nd Floor

Monday through Friday: Intake begins at 8:30 a.m. and ends at 3:30 p.m. Saturday: Intake begins at 8:30 a.m. and ends at 12:30 p.m.

*(Closed on the second Wednesday of each month)*

Take the 2, 3, 4 or 5 train to Nevins Street, or the B, Q or R train to Dekalb Avenue.

*\*Limited services include STI and HIV testing for people without symptoms; counseling services.*

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## Appendix G

## HIV Testing Location Bronx Handout



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## HIV TESTING

### BRONX

#### Morrisania

1309 Fulton Avenue, 2nd Floor

Monday–Friday: Intake begins at 8:30 a.m. and ends at 3:30 p.m.

*(Closed on the second Friday of each month. Limited services\* available the third Wednesday of each month.)*

**Take the Bx15, Bx21 or Bx35 bus.**

*\*Limited services include STI and HIV testing for people without symptoms; counseling services.*

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## Appendix H

## HIV Testing Location Queens Handout



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## HIV TESTING

### QUEENS

- **Jamaica**

90-37 Parsons Boulevard, 1st Floor, Jamaica

Monday–Friday: Intake begins at 8:30 a.m. and ends at 3:30 p.m. (*Closed on the last Thursday of each month. Limited services\* available the second Wednesday of each month.*)

Take the E, Z or J train to Jamaica Center, or the F train to Parsons Boulevard.

- **Corona**

34-33 Junction Boulevard, Jackson Heights

Monday–Friday: Intake begins at 8:30 a.m. and ends at 3:30 p.m.

Take the 7 train to Junction Boulevard, or the Q72 bus.

(*Closed on the second Thursday of each month. Limited services\* available the last Tuesday of each month.*)

*\*Limited services include STI and HIV testing for people without symptoms; counseling services.*

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## Appendix I

## HIV/AIDS Pre-Test



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## HIV-KQ-18

For each statement, please circle "True" (T), "False" (F), or "I don't know" (DK). If you do not know, please do not guess; instead, please circle "DK."

|   | True | False | I don't know |
|---|------|-------|--------------|
| 1. Coughing and sneezing DO NOT spread HIV.   | T    | F     | DK           |
| 2. A person can get HIV by sharing a glass of water with someone who has HIV.   | T    | F     | DK           |
| 3. Pulling out the penis before a man climaxes/cums keeps a woman from getting HIV during sex.                            | T    | F     | DK           |
| 4. A woman can get HIV if she has anal sex with a man.  | T    | F     | DK           |
| 5. Showering, or washing one's genitals/private parts, after sex keeps a person from getting HIV.                         | T    | F     | DK           |
| 6. All pregnant women infected with HIV will have babies born with AIDS.  | T    | F     | DK           |
| 7. People who have been infected with HIV quickly show serious signs of being infected.                                   | T    | F     | DK           |
| 8. There is a vaccine that can stop adults from getting HIV.  | T    | F     | DK           |
| 9. People are likely to get HIV by deep kissing, putting their tongue in their partner's mouth, if their partner has HIV. | T    | F     | DK           |
| 10. A woman cannot get HIV if she has sex during her period.  | T    | F     | DK           |
| 11. There is a female condom that can help decrease a woman's chance of getting HIV.                                      | T    | F     | DK           |
| 12. A natural skin condom works better against HIV than does a latex condom.  | T    | F     | DK           |
| 13. A person will NOT get HIV if she or he is taking antibiotics.   | T    | F     | DK           |
| 14. Having sex with more than one partner can increase a person's chance of being infected with HIV.                      | T    | F     | DK           |
| 15. Taking a test for HIV one week after having sex will tell a person if she or he has HIV.                              | T    | F     | DK           |
| 16. A person can get HIV by sitting in a hot tub or a swimming pool with a person who has HIV.                            | T    | F     | DK           |
| 17. A person can get HIV from oral sex.   | T    | F     | DK           |
| 18. Using Vaseline or baby oil with condoms lowers the chance of getting HIV.   | T    | F     | DK           |

19. Do you intend to get tested for HIV?

T F DK

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## Appendix J

## HIV/AIDS Post-Test



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## HIV-KQ-18

For each statement, please circle "True" (T), "False" (F), or "I don't know" (DK). If you do not know, please do not guess; instead, please circle "DK."

|   | True | False | I don't know |
|---|------|-------|--------------|
| 1. Coughing and sneezing DO NOT spread HIV.   | T    | F     | DK           |
| 2. A person can get HIV by sharing a glass of water with someone who has HIV.   | T    | F     | DK           |
| 3. Pulling out the penis before a man climaxes/cums keeps a woman from getting HIV during sex.                            | T    | F     | DK           |
| 4. A woman can get HIV if she has anal sex with a man.  | T    | F     | DK           |
| 5. Showering, or washing one's genitals/private parts, after sex keeps a person from getting HIV.                         | T    | F     | DK           |
| 6. All pregnant women infected with HIV will have babies born with AIDS.  | T    | F     | DK           |
| 7. People who have been infected with HIV quickly show serious signs of being infected.                                   | T    | F     | DK           |
| 8. There is a vaccine that can stop adults from getting HIV.  | T    | F     | DK           |
| 9. People are likely to get HIV by deep kissing, putting their tongue in their partner's mouth, if their partner has HIV. | T    | F     | DK           |
| 10. A woman cannot get HIV if she has sex during her period.  | T    | F     | DK           |
| 11. There is a female condom that can help decrease a woman's chance of getting HIV.                                      | T    | F     | DK           |
| 12. A natural skin condom works better against HIV than does a latex condom.  | T    | F     | DK           |
| 13. A person will NOT get HIV if she or he is taking antibiotics.   | T    | F     | DK           |
| 14. Having sex with more than one partner can increase a person's chance of being infected with HIV.                      | T    | F     | DK           |
| 15. Taking a test for HIV one week after having sex will tell a person if she or he has HIV.                              | T    | F     | DK           |
| 16. A person can get HIV by sitting in a hot tub or a swimming pool with a person who has HIV.                            | T    | F     | DK           |
| 17. A person can get HIV from oral sex.   | T    | F     | DK           |
| 18. Using Vaseline or baby oil with condoms lowers the chance of getting HIV.   | T    | F     | DK           |

19. Do you intend to get tested for HIV?


T F DK


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## Appendix K

## PowerPoint Presentation for Targeted Black Church


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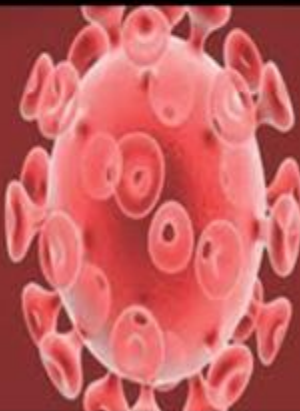

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**HIV & AIDS: Promoting Awareness  
 in the Black Community**  
**Rutgers School of Nursing**  
**Daitasha Miller, MSN, MDIV, MS, FNP-BC, NP-C, RN**



### What Are HIV & AIDS?

- **HIV** (Human Immunodeficiency Virus) is the virus that causes AIDS (Acquired Immune Deficiency Syndrome).
- HIV attacks the body's immune system and makes the person more likely to get other infections.
- If not treated, HIV weakens the body's immune system and can lead to AIDS.

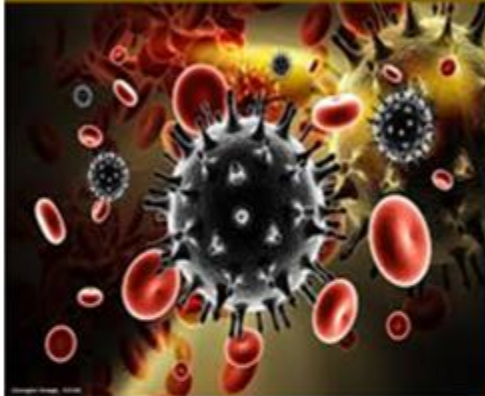


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## How Does HIV Spread?



- HIV can be found in certain fluids of an infected person's body, including blood, semen, anal and vaginal fluids, and breast milk. © 2011, Dept. of Health, 2010

### During sex

- HIV can enter your bloodstream when tiny tears in your anus, rectum, vagina, penis or mouth come into contact with an infected partner's blood, semen, or anal or vaginal fluids. © 2011, Dept. of Health, 2010

## How Does HIV Spread?

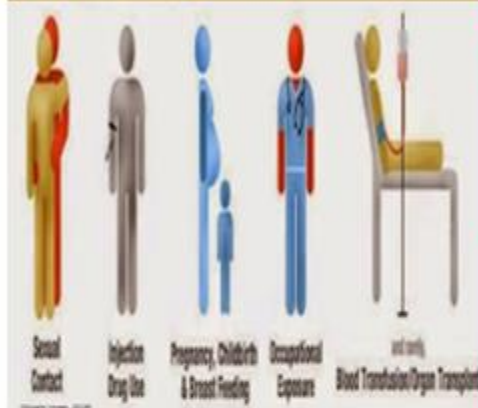
HIV may also enter your body through open sores like those caused by herpes or syphilis.

- Your risk of HIV depends on what kind of sex you have and how much virus is in your partner's body.
- Condoms, PrEP and emergency PEP reduce the risk of HIV infection.
- People who are on HIV treatment and maintain an undetectable viral load do not transmit HIV through sex. © 2011, Dept. of Health, 2010





## How Does HIV spread?



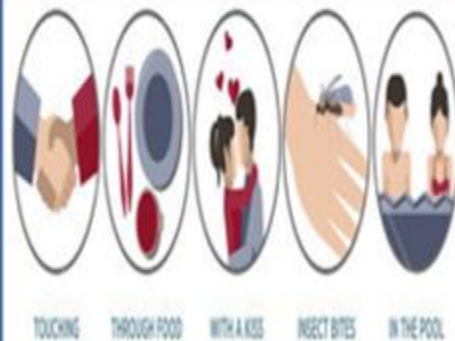
### While injecting drugs

- HIV can enter your bloodstream when you share a syringe, drug solution, or other injection equipment with someone that has HIV.
- If you inject drugs, always use a new syringe and never share injection equipment to prevent HIV and other viruses like hepatitis B and C.

## How HIV Does NOT Spread?


### How HIV does NOT spread

- Other human body fluids and waste—like saliva, sweat, tears, urine and feces—do NOT contain enough HIV to infect you.
- HIV does NOT spread through hugging, kissing, coughing, shaking hands, or sharing a toilet or drinking fountain.





## What Are The Stages & Symptoms Of HIV?



**Exposure**

- It takes a few days for an HIV infection to develop in your body. If you may have been exposed to HIV in the past 36 hours, immediately go to a clinic or emergency room and ask for PEP (Post-Exposure Prophylaxis) to prevent HIV.

## What Are The Stages & Symptoms Of HIV?

### Recent or "Acute" Infection

- People who were recently infected with HIV have a lot of virus in their bodies and can easily pass HIV to others.
- In the first few weeks after HIV infection, as the virus multiplies in the body, some people develop flu-like symptoms—including fever, swollen glands, aches and pains.
- If you experience symptoms, or may recently have been exposed to HIV, avoid having sex and go to a clinic or hospital and ask for a test for acute HIV infection.







## What Are The Stages & Symptoms Of HIV?



### Chronic Infection

- Most people with HIV show few symptoms for years after infection.
- They may look and feel healthy, but without treatment HIV will slowly damage their body and they can pass HIV to others. Protect yourself and others.
- Know your status get tested regularly for HIV. If you have HIV, get treated.

## HIV TRANSITION TO AIDS

### AIDS

- If not treated, HIV infects and destroys CD4 cells (or "T cells")—an important part of your body's immune system.
- If HIV destroys enough CD4 cells, rare cancers and infections begin to attack the body. This stage is called AIDS.
- To prevent AIDS, get tested and get treated for HIV.





## HIV & AIDS: The Black Population

Promoting HIV/AIDS Health Initiatives



*...will be diagnosed with HIV in their lifetime.\**

## The BLACK COMMUNITY

- In the U.S, the Black community bears the greatest burden of the HIV/AIDS epidemic. (CDC, 2007)
- African Americans represent only 12% of total population. (CDC, 2007)
- However, they account for 41% of all people living with HIV. (CDC, 2007)
- And account for 44% of all new infections. (CDC, 2007)

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## THE BLACK COMMUNITY



- In 2015, 17,670 African Americans were diagnosed with HIV. (CDC, 2015)
- That is 13,070 men and 4,524 women. (CDC, 2015)
- More than half (58%, or 10,315) were gay or bisexual. (CDC, 2015)
- And 38% (3,888) were young men aged 13 to 24. (CDC, 2015)

## Background & Significance

### The Years

- In 2012, 54% of African Americans who had HIV, were retained in continuous HIV care & 49% had a suppressed viral load. (CDC, 2017)
- At the end of 2013, 498,400 African Americans were living with HIV (40% of total pop). (CDC, 2017)
- 1 in 8 **DID NOT KNOW** they were infected. (CDC, 2017)





## Background & Significance



- In 2014, of those diagnosed with HIV, 72% were linked to HIV medical care within 1 month. (CDC, 2017)
- In 2014, 3,591 African Americans died of HIV or AIDS, accounting for 53% of total deaths attributed to the disease that year. (CDC, 2017)

## NEEDS ASSESSMENT



In all communities, lack of awareness of HIV status contributes to HIV risk.

- For African American communities, the risks are multiplied due to high poverty rates.
- Socio-economic including access to high-quality health care. (CDC, 2017)





## NEEDS ASSESSMENT

The lack of HIV prevention education also increase the risk for HIV infection.

- Affects the health of people living with and at risk for HIV
- Contributes to low outcomes on the HIV continuum of care
- Low Rates of Linkage to Care
- Low Rates of Viral Suppression



How to Decrease Your Risk of HIV Infection?

**GET  
TESTED!!!**

**STOP  
AIDS  
GET TESTED**

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### How Do I Know If I Have HIV?



The only way  
to know for  
sure if you  
have HIV is to  
**GET TESTED.**

### How Do I Know If I Have HIV?

- An HIV test is the only way to know if you or a partner has HIV. Free or low-cost tests are available for anyone 12 and older at NYC Sexual Health Clinics, regardless of immigration status.
- You do not need to have consent from a parent or guardian to get tested.
- Getting tested and knowing your HIV status is the first step toward taking care of your health.
- If you test negative, you can learn about pre-exposure prophylaxis (PrEP) and other HIV prevention options.



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## How Do I Know If I Have HIV?



- If you **test positive**, you should meet with a health care provider and start HIV medications right away.
- Getting and staying on treatment keeps you healthy and prevents transmission to your sex partners.
- In New York City, HIV treatment is available, regardless of your immigration status or whether you have insurance.

## HIV TESTING

### Different Types of HIV Tests

- **Standard laboratory blood tests** are very accurate and provide results within a few days.
- **Finger-stick blood tests** provide results in 20 minutes or less.
- **Oral swab tests** do not require giving blood and provide results in 20 minutes.
- **Home test kits** are available for purchase — they use an oral swab and allow you to test yourself in private.





## HIVE TESTING LOCATIONS



### Testing Locations

- You can find free or low-cost HIV testing locations near you by:
- Visiting a NYC Sexual Health Clinic, where anyone 12 or older can get a confidential, anonymous test
- Searching the NYC Health Map
- Texting "TESTNYC" to 877-877
- Calling 311
- You can also purchase a kit to test yourself kit at home.

## HIV TESTING

### When to Get Tested

- You should ask your medical provider how often you should get tested for HIV.
- Generally, if you are having sex or using street or injectable drugs, you should get tested at least once a year. People in the following groups should be tested every three to six months:
- Men and transgender people who have sex with men
- People who have a sex partner with HIV
- People who use PrEP







## HIV TESTING



### Recent Exposure

- If you think you were exposed to HIV, start taking emergency post-exposure prophylaxis (PEP) immediately.
- PEP can stop a new HIV infection if you start taking it within 72 hours of exposure.
- To get started on PEP right away, go to a clinic or emergency room, or call the 24/7 NYC PEP Hotline at 844-3-PEPNYC (844-373-7692).

## Are there HIV treatments?

**Care and treatment services** are available to all New Yorkers living with HIV, even if you do not have health insurance.



Jacobs-Patterson, J., Thompson, C.B., Winterstein, D., Coatsworth, S.M., Malone, C., Williams, A., & White, L.C. (2012). Examining Church Capacity to Develop and Disseminate a Religiously Appropriate HIV Test Kit with African American Churches. *Journal of Urban Health: Bulletin of the New York Academy of Medicine*, 89(3), 460-469. <http://dx.doi.org/10.1007/s12148-012-9243-0>

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T.O. Robinson, K.L. & Bennett, K.A. (2010).

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Mason, B., Sanders, I., Carroll, A., Thomas, G., Connolly, A., Tenney, F., Hughes-Lane, N., Tassi, M., Shalish, M., Nelson, R., Smith, T., Bell, S., Fisher, S., Smith, S., Jarrett, S., Vaughan, B., & Green, S. (2015). African American community-based participatory research approaches for reducing racial disparities in HIV infection, treatment and care results from a community-based participatory research project in Philadelphia, PA. *Health Promotion Practice*, 16(1). <https://doi.org/10.1177/1524903914568001>

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<http://dx.doi.org/10.1007/s12148-010-9168-8>

Schifano, M., Vaughn, L.M., Chavira, C., Harris, M., Robins, A., Weiss, V., Sheline, Y., ... Smith, C. (2014). Engaging Religious Institutions to Address Racial Disparities in HIV/AIDS: A Case of Academic/Community Partnership. *The international journal of research on religion spirituality and community engagement*, 2(1), 95-104.

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## Appendix L

### HIV/AIDS Pre-Test & Post-Test Answer Key



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#### Appendix Q

#### HIV/AIDS PRE-TEST & POST-TEST ANSWER KEY

#### Answer Key HIV KQ 18

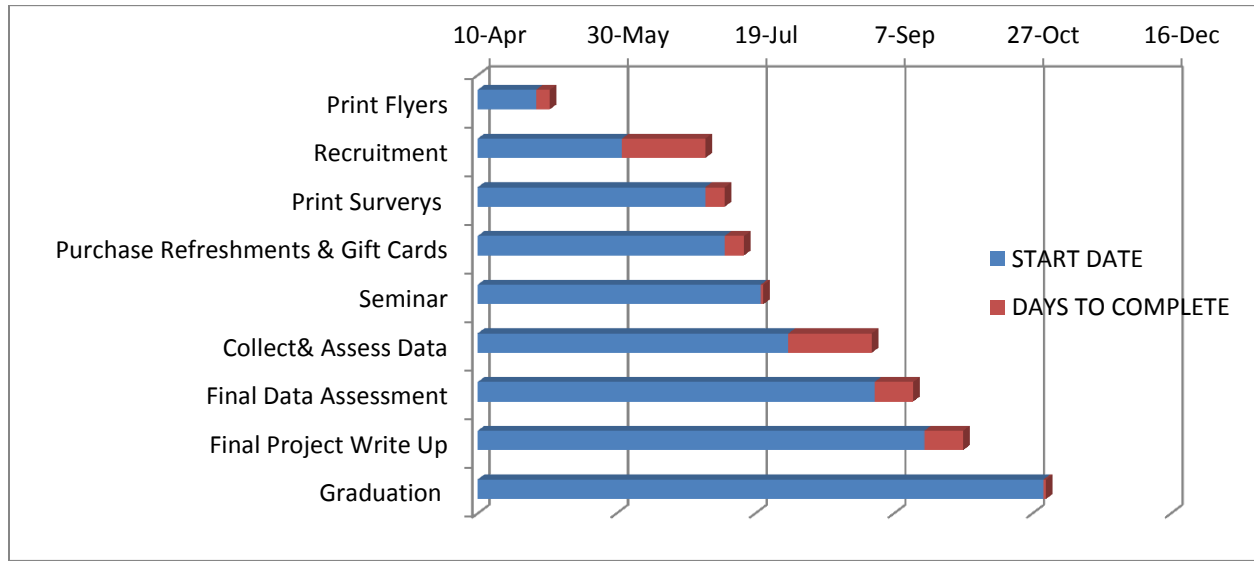
|    |       |
|----|-------|
| 1  | TRUE  |
| 2  | FALSE |
| 3  | FALSE |
| 4  | TRUE  |
| 5  | FALSE |
| 6  | FALSE |
| 7  | FALSE |
| 8  | FALSE |
| 9  | FALSE |
| 10 | FALSE |
| 11 | TRUE  |
| 12 | FALSE |
| 13 | FALSE |
| 14 | TRUE  |
| 15 | FALSE |
| 16 | FALSE |
| 17 | TRUE  |
| 18 | FALSE |

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## Appendix M

### Project Timeline





## Appendix N

### Resources Needed/Economic Considerations

| <b>RESOURCES</b>                        | <b>COST</b>              |
|---|--------------------------|
| <b>1. Recruitment Flyers</b>            | <b>~\$5.00</b>           |
| <b>2. DOHMH HIV &amp; AIDS Handouts</b> | <b>~\$0.00 (free)</b>    |
| <b>3. Target Gift Cards</b>             | <b>~\$250.00</b>         |
| <b>4. Refreshments</b>                  | <b>~\$150.00</b>         |
| <b>5. Pre-Survey &amp; Post-Survey</b>  | <b>~\$10.00</b>          |
| <b>6. Computer Software/USB Device</b>  | <b>~\$10.00</b>          |
|   | <b>Total = ~\$425.00</b> |

## Appendix O

## SPSS Paired T-Test Table for Knowledge Baseline

## Paired Samples Statistics

|        |                   | Mean    | N  | Std. Deviation | Std. Error Mean |
|--------|-------------------|---------|----|----------------|-----------------|
| Pair 1 | <u>PreScoreF</u>  | 13.7143 | 21 | 3.27327        | .71429          |
|        | <u>PostScoreF</u> | 14.6190 | 21 | 3.35375        | .73185          |

## Paired Samples Correlations

|        |                                   | N  | Correlation | Sig. |
|--------|-----------------------------------|----|-------------|------|
| Pair 1 | <u>PreScoreF &amp; PostScoreF</u> | 21 | .573        | .007 |

## Paired Samples Test

|        |                               | Paired Differences |                |                 | 95% Confidence Interval of the Difference |
|--------|-------------------------------|--------------------|----------------|-----------------|---|
|        |                               | Mean               | Std. Deviation | Std. Error Mean | Lower                                     |
| Pair 1 | <u>PreScoreF - PostScoreF</u> | -.90476            | 3.06439        | .66870          | -2.29965                                  |

## Paired Samples Test

|        |                               | Paired Differences                        |        |    |                 |
|--------|-------------------------------|---|--------|----|-----------------|
|        |                               | 95% Confidence Interval of the Difference |        |    |                 |
|        |                               | Upper                                     | t      | df | Sig. (2-tailed) |
| Pair 1 | <u>PreScoreF - PostScoreF</u> | .49013                                    | -1.353 | 20 | .191            |

## Appendix P

### SPSS Paired T-Test Table for Intent-to-Screen

#### Paired Samples Statistics

|        |          | Mean | N  | Std. Deviation | Std. Error Mean |
|--------|----------|------|----|----------------|-----------------|
| Pair 1 | PreKQ19  | .53  | 17 | .514           | .125            |
|        | PostKQ19 | .88  | 17 | .332           | .081            |

#### Paired Samples Correlations

|        |                    | N  | Correlation | Sig. |
|--------|--------------------|----|-------------|------|
| Pair 1 | PreKQ19 & PostKQ19 | 17 | .387        | .125 |

#### Paired Samples Test

|        |                    | Paired Differences |                |                 | 95% Confidence Interval of the Difference |
|--------|--------------------|--------------------|----------------|-----------------|---|
|        |                    | Mean               | Std. Deviation | Std. Error Mean | Lower                                     |
| Pair 1 | PreKQ19 - PostKQ19 | -.353              | .493           | .119            | -.606                                     |

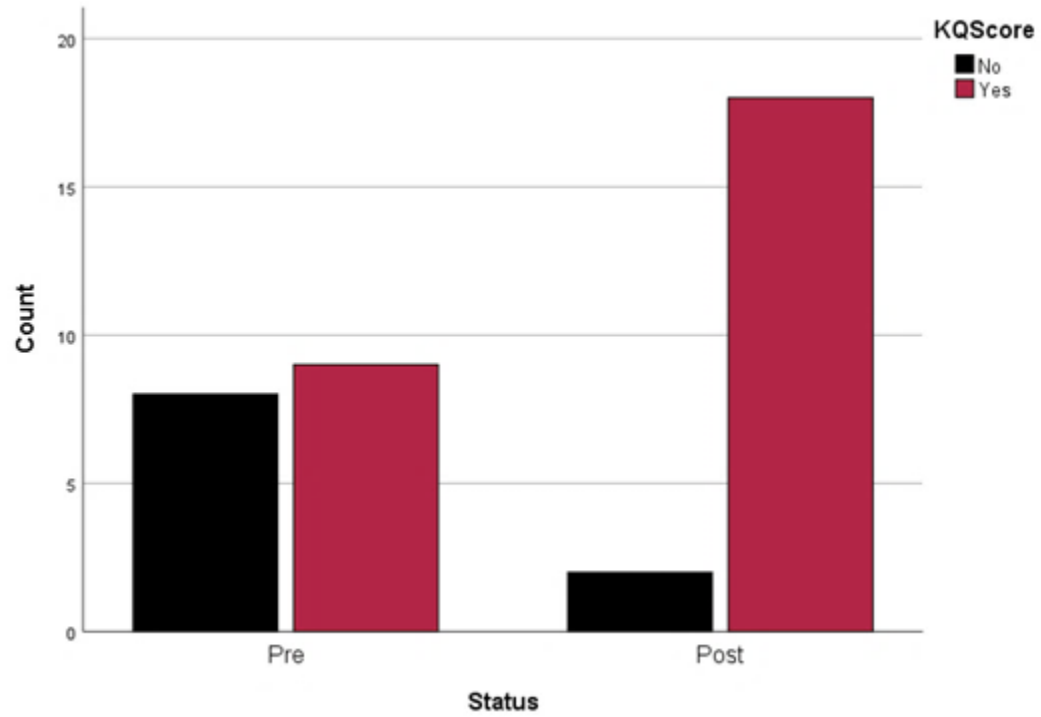
#### Paired Samples Test

|        |                    | Paired Differences                        |        |    |                 |
|--------|--------------------|---|--------|----|-----------------|
|        |                    | 95% Confidence Interval of the Difference |        |    |                 |
|        |                    | Upper                                     | t      | df | Sig. (2-tailed) |
| Pair 1 | PreKQ19 - PostKQ19 | -.100                                     | -2.954 | 16 | .009            |

p-value is less than 0.05, therefore, it's statistically significant

## Appendix Q

### SPSS Paired T-Test Graph for Intent-to-Screen



### SPSS PAIRED T-TEST INTENT TO SCREEN

## Appendix R

## HIV 101 Handout



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(Page 1 is in English, Page 2 is in Spanish)

February 2018

## HIV 101

Without treatment, HIV (human immunodeficiency virus) can make a person very sick and even cause death. Learning the basics about HIV can keep you healthy and prevent transmission.

### HIV CAN BE TRANSMITTED BY



Sexual Contact



Sharing Needles to Inject Drugs



Mother to Baby During Pregnancy, Birth, or Breastfeeding

### HIV IS NOT TRANSMITTED BY



Air or Water



Saliva, Sweat, Tears, or Closed-Mouth Kissing



Insects or Pets



Sharing Toilets, Food, or Drinks

### Protect Yourself From HIV

- Get tested at least once or more often if you are at risk.
- Use condoms the right way every time you have anal or vaginal sex.
- Choose activities with little to no risk like oral sex.
- Limit your number of sex partners.
- Don't inject drugs, or if you do, don't share needles or works.



- If you are at very high risk for HIV, ask your health care provider if pre-exposure prophylaxis (PrEP) is right for you.
- If you think you've been exposed to HIV within the last 3 days, ask a health care provider about post-exposure prophylaxis (PEP) right away. PEP can prevent HIV, but it must be started within 72 hours.
- Get tested and treated for other STDs.



### Keep Yourself Healthy And Protect Others If You Are Living With HIV

- Find HIV care. It can keep you healthy and help reduce the risk of transmitting HIV to others.
- Take your HIV medicine as prescribed.
- Stay in HIV care.



- Tell your sex or drug-using partners that you are living with HIV. Use condoms the right way every time you have sex, and talk to your partners about PrEP.
- Get tested and treated for other STDs.



For more information please visit [www.cdc.gov/hiv](http://www.cdc.gov/hiv)

National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention  
Division of HIV/AIDS Prevention



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## Appendix S

## HIV &amp; African Americans Part I Handout



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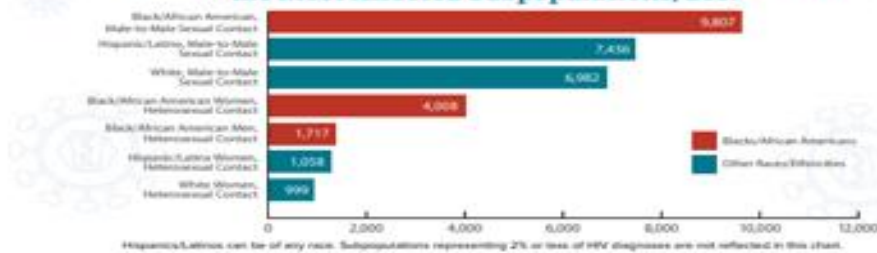
# HIV & AFRICAN AMERICANS

February 2019

## HIV and African Americans

Of the 38,739 new HIV diagnoses in the US and dependent areas\* in 2017, **16,694 (43%) were among blacks/African Americans.\*\***

### New HIV Diagnoses in the US and Dependent Areas for the Most-Affected Subpopulations, 2017



From 2010 to 2016, HIV diagnoses decreased 12% among blacks/African Americans overall.<sup>†</sup> But trends varied for different groups of blacks/African Americans.



\* American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, the Republic of Palau, and the US Virgin Islands.  
 \*\* Black refers to people having origins in any of the black racial groups of Africa, including immigrants from the Caribbean, and South and Latin America. African American is a term often used for Americans of African descent with ancestry in North America. Individuals may self-identify as black, both, or choose another identity altogether. This fact sheet uses African American, unless referencing surveillance data.  
 † In 50 states and District of Columbia.  
 ‡ Includes infections attributed to male-to-male sexual contact and injection drug use (men who reported both risk factors).

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## Appendix T

## HIV &amp; African Americans Part 2 Handout



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# HIV & AFRICAN AMERICANS

Around 13 million people are living with HIV in the US.\* People with HIV need to know their HIV status so they can take medicine to treat HIV. Taking HIV medicine as prescribed can make the level of virus in their body very low (called viral suppression) or even undetectable.



A person with HIV who gets and stays virally suppressed or undetectable can stay healthy and has effectively no risk of transmitting HIV to HIV-negative partners through sex.

## Why are African Americans at higher risk?

- 1 in 7 blacks/African Americans with HIV are unaware they have it. People who do not know they have HIV cannot take advantage of HIV care and treatment and may unknowingly pass HIV to others.
- Some African American communities continue to experience higher rates of other sexually transmitted diseases (STDs) when compared to other races/ethnicities. Having another STD can significantly increase a person's chance of getting or transmitting HIV.
- Limited access to quality health care, lower income and educational levels, and higher rates of unemployment may place some African Americans at higher risk for HIV.
- Stigma, fear, discrimination, and homophobia may also place many African Americans at higher risk for HIV.

## How is CDC making a difference?

- Collecting and analyzing data and monitoring HIV trends among African Americans.
- Conducting prevention research and providing guidance to those working in HIV prevention.
- Supporting health departments and community organizations by funding HIV prevention work for African Americans and providing technical assistance.
- Supporting community organizations that can increase access to HIV testing and care and other services for African Americans.
- Promoting testing, prevention, and treatment through campaigns like *Act Against AIDS*.

AT THE END OF 2015,

AN ESTIMATED  
**468,800**

BLACKS/AFRICAN AMERICANS  
HAD HIV.\*

**6 in 7**  
KNEW THEY HAD THE VIRUS.

FOR EVERY 100  
BLACKS/AFRICAN  
AMERICANS  
WITH HIV IN 2015:



## Reduce Your Risk

- Not having sex
- Using condoms
- Not sharing syringes
- Taking medicine to prevent or treat HIV



## HIV IS A VIRUS THAT ATTACKS THE BODY'S IMMUNE SYSTEM.


It is usually spread by anal or vaginal sex or sharing syringes with a person who has HIV. The only way to know you have HIV is to be tested. Everyone aged 13-64 should be tested at least once, and people at high risk should be tested at least once a year. Ask your doctor, or visit [gettested.cdc.gov](http://gettested.cdc.gov) to find a testing site. Without treatment, HIV can make a person very sick or may even cause death. If you have HIV, start treatment as soon as possible to stay healthy and help protect your partners.

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## Appendix U

## Expect The Test Handout



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# EXPECT THE TEST

This health care facility follows good medical practice and public health law by offering HIV testing to all patients aged 13 and older.

## Routine Lab Tests


|   |                      |
|---|----------------------|
| ✓ | Glucose              |
| ✓ | Cholesterol          |
| ✓ | HIV Test             |
| ✓ | Complete Blood Count |
| ✓ | Lipid Profile        |

## HERE'S WHAT YOU NEED TO KNOW ABOUT HIV TESTING

- HIV testing is voluntary and all HIV test results are confidential (private).
- HIV can be spread through unprotected sex, sharing needles, childbirth, or breastfeeding.
- Treatment for HIV is effective, has few or no side effects, and may involve taking just one pill a day.
- Partners can keep each other safe by knowing their HIV status and getting HIV treatment or taking HIV pre-exposure prophylaxis (PrEP). Not sharing needles and practicing safer sex will help protect against HIV, hepatitis C and other STDs.
- It is illegal to discriminate against a person because of their HIV status.
- Anonymous HIV testing (without giving your name) is available at certain public testing sites.
- HIV testing is a routine part of health care but you have the right to object or decline an HIV test.
- If you wish to decline HIV testing, inform the health care provider.

Talk to your health care provider about how and when you will learn your HIV results.

Worst HIV status: unknown. Testing puts you in control. [HIVtestNY.org](http://HIVtestNY.org)



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## Appendix V

### HIV Testing 101 Handout



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(Page 1 is in English, Page 2 is in Spanish)

February 2018

## HIV Testing 101

Many HIV tests are now quick, **FREE**, and painless.

### Should I Get Tested For HIV?

- Everyone ages 13 to 64 should get tested for HIV at least once.
- If you're pregnant or planning to get pregnant, get tested as early as possible to protect yourself and your baby.
- You should get tested at least once a year if:
  - You're a sexually active gay or bisexual man. Some sexually active gay and bisexual men may benefit from more frequent testing (every 3 to 6 months).



- You've had sex with an HIV-positive partner.
- You've had more than one partner since your last HIV test.
- You've shared needles or works to inject drugs.
- You've exchanged sex for drugs or money.
- You have another sexually transmitted disease, hepatitis, or tuberculosis.
- You've had sex with anyone who has done anything listed above or with someone whose sexual history you don't know.

### Where Can I Get Tested?



Ask your doctor for an HIV test, or find a testing site near you by

- visiting [gettested.cdc.gov](http://gettested.cdc.gov),
- texting your ZIP code to KNOW IT (566948), or
- calling 1-800-CDC-INFO (232-4636).



Many testing locations are **FREE** and confidential. You can also buy a home testing kit at a pharmacy or online. Most HIV tests are covered by health insurance.

### What If My Test Result Is Negative?

- You could still have HIV. Ask your doctor about the "window period," a period of time after a person is infected during which they won't test positive.
- To stay negative, take actions to prevent HIV. Visit [www.cdc.gov/hiv/basics](http://www.cdc.gov/hiv/basics) to learn more.



### What If My Test Result Is Positive?

You may be given a follow-up test to confirm the result.

- Finding out you have HIV can be scary, but you can still live a healthy life if you take action.
- If you have HIV, start medical care right away. HIV treatment can keep you healthy for many years and reduce your chance of transmitting the virus to others. Learn more at [www.cdc.gov/HIVTreatmentWorks](http://www.cdc.gov/HIVTreatmentWorks).



For more information please visit [www.cdc.gov/hiv](http://www.cdc.gov/hiv)

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## Appendix W

### Seminar Talking Points



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# HIV & AIDS: A Call For A Black Church Initiative

## Seminar Talking Points

1. What are HIV and AIDS?
2. How does HIV spread?
3. What are the stages and symptoms of HIV?
4. HIV & The Black Community
5. How to decrease one's risk of contracting HIV?
6. How do I know if I have HIV?
7. Are there treatments for HIV?
8. HIV Testing?
9. HIV Testing Locations
10. Question & Answers

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