

# **A Case Study in Collaborating with Atlanta-Based African-American Churches: A Promising Means for Reaching Inner-City Substance Users with Rapid HIV Testing**

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*This case study examined programmatic data from a federally funded faith-based rapid HIV testing initiative. In 2004, Recovery Consultants of Atlanta, Inc. (RCA, Inc.) began providing rapid HIV testing in collaboration with six Atlanta-based African-American churches. Of the 1,947 persons tested from January 2004 to July 2005, 1,872 (96.1%) were African-American, 1,247 (64%) were male, and 1,612 (82.8%) were between the age of 26 and 56. A total of 85 HIV-infected individuals were identified and 72 were identified as previously undiagnosed cases (positivity rate of 3.7%). This case study highlights and promotes rapid HIV testing offered in partnership with African American churches as a strategy for raising HIV awareness among inner-city substance users.*

**KEYWORDS** *African American church, HIV rapid testing, inner-city substance users, addiction treatment and peer-led recovery support services*

African Americans bear a disproportionate burden of America's HIV/AIDS epidemic. Of the estimated one million Americans living with HIV, 50% are African American (Centers for Disease Control and Prevention [CDC], 2003). Substance use related HIV-infection rates among African Americans are equally disturbing. Injection Drug Use (IDU) is the second leading cause of HIV infection among both African American men and women (CDC, 2003). Sharing infected syringes is not the only HIV risk related to substance use. An examination of risk factors reported by individuals tested for HIV in this case study show that a majority of those who disclose a history of casual or chronic substance use also report multiple high-risk behaviors that include unprotected sex, multiple sex partners, trading sex for drugs and money, and sex with an IDU. Persons living in inner-city communities with high prevalence of substance use may be at high risk for HIV-infection directly through IDU, or through sex with IDUs, or sex with persons who have sex with IDUs. Fulton and DeKalb Counties, host counties to the city of Atlanta, report the most HIV/AIDS cases in Georgia (Georgia Department of Public Health [GDPH], 2003). At one Fulton County drug treatment clinic, the HIV prevalence among minority clients was 18% to 19% (GDPH, 2003).

As an institution the Black church has established itself as a leading provider of social support services within the African American community (Billingsley, 1999; Taylor, Chatters, & Levin, 2004). According to one source, upwards of 90% of all Black churches provide some method of social, financial, spiritual, and/or educational support in their respective communities (Brown, 2003). Responding to a wide array of community criticism, the Black church has increased its involvement in addressing the HIV epidemic from a prevention, care, and spiritual perspective (Swartz, 2002). This criticism was

fostered in part by a public perception that the Black church either refused or was slow to respond to the HIV/AIDS crisis in the African American community. A recent and innovative HIV prevention strategy involving the African American church includes establishing partnerships with community-based organizations (CBOs) and implementing rapid HIV testing initiatives designed to raise awareness among African Americans. This method complements President Bush's recommendation, made during his February 2, 2006 State of the Union Address, which called for the implementation of rapid testing initiatives in partnership with African American churches as a strategy for raising HIV awareness within the African American community. Some researchers, however, postulate that in order to determine the effectiveness of these types of faith-based approaches, collaborative interventions of this nature must submit to rigorous statistical analyses and evaluations, confirming their ability for replication in subsequent African American communities (DeHaven, Hunter, & Wilder, 2004).

Rapid HIV tests such as OraQuick ADVANCE<sup>®</sup>, a relatively new HIV testing method, can produce HIV test results in 20 minutes. Because HIV test results require laboratory confirmation, organizations utilizing rapid testing methods are required to adhere to the guidelines of the Clinical Laboratory Improvement Amendments (CLIA) law of 1988. This law, referred to as the "CLIA waiver," allows an agency to act as a laboratory for the sake of conducting the rapid HIV test. This waiver and the fact that rapid HIV test kits that can be stored at room temperature offer community and faith-based organizations opportunities to implement a science-based intervention outside of traditional clinical or medical settings.

This case study describes how a federally funded peer-led addiction recovery and HIV prevention program partnered with a local coalition of African-American churches to provide rapid testing to a high-risk population. The goals of this project were to: (a) increase the number of high-risk persons who know their HIV status by providing rapid testing in predominantly African-American communities with high rates of substance use; (b) explore the feasibility of partnering with churches, local businesses, and community groups to provide rapid testing to a high-risk minority population; (c) gain practical programmatic experience from developing this model; and (d) determine if this model could be replicated throughout America's African American communities.

## Background

In the southwest Atlanta community settings for this project, heroin is generally 75% to 85% pure and is sold for \$10 to \$20 per packet. Similar to other major metropolitan communities, drug sales take place on streets and in open-air markets (Office of National Drug Control Policy, 2004). Heroin users in this community tend to be African-American men over the age of

30 and of low socioeconomic status. Though poverty in and of itself is not an HIV risk factor, studies have demonstrated a relationship between lower income status and higher HIV incidence (Diaz, Chu, Buehler, 1994).

Recovery Consultants of Atlanta, Inc. (RCA, Inc.) is a non-profit, faith-based organization founded by members of metro-Atlanta's 12-step and faith-based addiction recovery communities. Its primary function is to offer peer-led addiction recovery support services to members of Atlanta's inner-city recovery community, as a strategy for helping to sustain long term recovery (White & Whithers, 2005). The U.S. Department of Health and Human Services defines the recovery community as:

broad and encompassing and includes persons having a history of alcohol and drug problems who are in recovery or recovered, those currently in treatment, those seeking treatment, those in denial about their need for treatment, as well as their family members, supporters, and allies. (Substance Abuse and Mental Health Services Administration News, 2004, p. 1)

In 2001, RCA, Inc. received a Recovery Community Services Program grant from the federal Center for Substance Abuse Treatment (CSAT), a division of the Substance Abuse and Mental Health Services Administration (SAMHSA) and began collaborating with African-American churches in inner-city Atlanta neighborhoods, providing peer-led addiction recovery support services to substance users. In 2003, RCA, Inc. received a second CSAT award, a faith-based Targeted Capacity Expansion for Substance Abuse Treatment and HIV/AIDS Services (TCE: HIV) grant. This program has two components. The first is an OraQuick ADVANCE<sup>®</sup> rapid HIV testing initiative, offered in collaboration with Atlanta area churches. The second is a "street outreach" program involving outreach workers from metro-Atlanta's 12-step and faith-based addiction recovery communities (individuals who self-disclose that they are in recovery from an addictive disorder). In this program, outreach workers, utilizing the evidenced-based practice, Motivational Interviewing (MI), canvass inner-city Atlanta neighborhoods and engage homeless substance users in dialogue aimed at motivating them to participate in the HIV testing initiatives. These services are provided as methods for reducing HIV and hepatitis infections, substance use, homelessness, and incarceration, among Atlanta's inner-city substance using community.

### History of Faith-Based Rapid HIV Testing Initiatives

Regularly scheduled HIV testing initiatives rotated among our coalition of "faith-based service providers" (six African American churches). Each church is strategically located throughout inner-city Atlanta communities. Coalition members offer their churches as venues for testing without attaching

“religious” stipulations. At each initiative participants were treated to a light snack, and during the “20 minute wait period,” an HIV/substance use prevention education presentation, hosted by an “individual in addiction recovery who is also living with HIV.” In addition to HIV testing, participants were offered a variety of recovery support services, including linkage to HIV care for those who test positive, and linkage to drug and alcohol treatment for those who so desire. On the day prior to each event, outreach workers canvassed inner-city communities in close proximity of the church and engaged substance users in dialogue aimed at motivating them to participate in the testing initiative. Bright-colored flyers were distributed announcing the date, time, and location of the event, as well as the incentives offered for participating in the initiative (two free public transit tokens or one free meal from a local fast food restaurant). In addition, flyers were posted at venues (stores, laundromats, gas stations, restaurants, etc.) throughout the community, increasing event exposure.

Regarding eligibility, HIV testing was not mandatory for event attendees, but all persons, 18 years and older, that requested testing received it. All those receiving a test signed an HIV consent form and underwent pre- and post-test counseling. Well prepared pre- and post-test counselors ascertained demographic information regarding age, race, gender, history, and frequency of drug use and sexual activities and risk related to health-care status and blood transfusions. Sexual inquiries included history of assault; STD diagnosis; sex with males, females, or men who have sex with men; sex while using either injection or non-injection drugs; sex for drugs or money; sex with an IDU; and sex with a person with HIV/AIDS or with HIV/AIDS risk factors. Participants with perceived or clearly identified substance use disorders were engaged by outreach workers and encouraged to consider entering drug rehab. Outreach workers, utilizing their MI skills, attempted to motivate participants into addictive disorder treatment programs by educating them on the value of living life drug and alcohol free. At each testing initiative a minimum goal was set for the number of participants that would be linked with treatment. Generally, this number was set at five; a seemingly low but relatively difficult number to achieve, since many who were active in their substance use disorder were also in denial about their need for help. Also, individuals who were identified as HIV positive were linked with local Ryan White Title I HIV care providers, when requested and when possible. A significant number of difficulties in linking HIV-infected substance users with Ryan White Title I services have been clearly identified throughout the literature (Tobias, Brown, Rajabiun, Drainoni, & Young, 2005). We experienced many if not all of these same difficulties.

Each initiative lasted approximately four hours and typically 50 to 200 inner-city substance users were tested. In addition, between seven and 20 individuals tested positive per initiative. These numbers imply a potentially

high stressful experience for staff. To reduce risk of burnout and substance use relapse among recovering staff and volunteers we conducted a debriefing session following each rapid testing initiative. The debriefing sessions were helpful in determining if any respite mandates for staff, including volunteers, were necessary. In addition, it allowed counselors an opportunity to share their feelings and emotions related to the overwhelming experience of testing 50 to 200 inner-city substance users in a four hour time frame. All debriefing sessions were facilitated by the program's director, a licensed master's level social worker and nationally certified addictions counselor. Debriefing sessions typically lasted 30–45 minutes and proved very helpful at reducing burnout and relapse.

HIV testing data from January 2004 to July 2005 were analyzed and evaluated for: (a) the number of persons tested for HIV; (b) age, race/ethnicity, and gender of the sample population; (c) risk categories; (d) the number of persons found to be HIV-infected; and (e) the number of previously undiagnosed cases of HIV-infected individuals. We conducted univariate and multiple logistic regression analyses for HIV risk. All analyses were conducted using SPSS version 13.0 and SAS version 8.2.

## RESULTS

From January 2004 to July 2005, RCA, Inc. provided rapid HIV testing for 1,947 individuals. The number tested per month ranged from 11 to 492 (Table 1). Of the 1,947 persons tested, 1,872 (96.1%) were African-American and 1,247 (64%) were male. Ages ranged from <18 to 89 years, with most being in the age group 25 to 55 years (Table 2). A total of 85 HIV-infected individuals were identified; 72 were newly identified as HIV-infected.

Sexual and injection risk behaviors were highly prevalent in this population. In regards to lifetime HIV risk among all participants, 1,336 (68.6%) of those tested had used non-injection drugs and been sexually active, 958 (49.2%) had traded sex for money or drugs, 755 (38.8%) had a history of STD, 314 (16.1%) had sex with an IDU, and 260 (13.4%) had injected drugs themselves.

Although both sexual and IDU risk behaviors were more prevalent among men, a history of sexual assault was particularly common among women. One-third of women participants reported a history of sexual assault (data not shown).

In the logistic regression model, three variables were significant predictors of HIV diagnosis. These included history of: sex with someone who has HIV (Odds Ratio (OR) 5.8, 95% confidence interval (CI) 3.2–10.3), sex with men who have sex with men (OR 2.5, 95% CI 1.4–4.7), and STD (OR 1.8, 95% CI 1.2–2.9). No other variables were significant predictors (data not shown).

**TABLE 1** Numbers and Results of Persons Tested for HIV, by Date, 2004–2005

Year	Month	# Tested	# Positive	Newly diagnosed	New positivity rate
2004	Jan.	25	2	2	8.0%
	Feb.	56	3	3	5.4%
	Mar	113	0	0	0.0%
	Apr	48	2	2	4.2%
	May	70	2	2	2.9%
	Jun	50	1	1	2.0%
	Jul	69	0	0	0.0%
	Aug	148	12	9	6.1%
	Sep	162	6	5	3.1%
	Oct	30	0	0	0.0%
	Nov	29	3	3	10.3%
	Dec	129	9	9	7.0%
2005	Jan	83	7	6	7.2%
	Feb	137	9	9	6.6%
	Mar	88	0	0	0.0%
	Apr	11	0	0	0.0%
	May	90	3	3	3.3%
	Jun	117	2	2	1.7%
	Jul	492	24	16	3.3%
Totals		1,947	85	72	3.7%

**TABLE 2** Demographics, All Person Tested, Atlanta Target Neighborhoods with High Prevalence of Substance Abuse, 2004–2005\*

Category	<i>n</i>	%
Male	1,247	64.0
Female	700	36.0
Total	1,947	100.0
Black	1,872	96.1
White	60	3.1
Hispanic	4	0.2
Age group		
<18	16	0.8
18–25	151	7.8
26–35	304	15.6
36–45	712	36.6
46–55	596	30.6
≥56	166	8.5

Note. \*Sum of categories may not equal total due to missing data.

## Lessons Learned

Our main challenge was linking HIV-infected individuals with medical care; including addictive disorder treatment services and Ryan White Title I care services. There were long waiting periods for care for participants testing positive for HIV and/or in need of addiction treatment services. A large number of those who participated in the HIV testing initiatives were individuals who repeatedly cycle through the criminal justice system, live in shelters, with various friends and family, or are homeless. Consequently, the “window of opportunity” (i.e., the time available for linking them with services) is relatively short. This was a major challenge to linking them with care services. In metro-Atlanta, there is only one Ryan White Title I funded addictive disorder treatment program designed solely to service HIV positive substance users. This program does not accept individuals with an “appearance” of a co-occurring mental disorder and has an assessment criterion and wait list that is sometimes one to two weeks in length. We have had several HIV-infected substance users “fall out of care” as a result of being placed on a waiting list for addiction treatment.

A “treatment on demand” system that provides services that are available when a participant acknowledges that he or she is ready for treatment and care would benefit clients immensely. As a strategy for reducing the wait period for linkage to care for individuals who test positive, we are also exploring the use of the Antiretroviral Treatment Access Study (ARTAS) case management model. ARTAS, a CDC-funded initiative, provides previously undiagnosed HIV-infected individuals with intensive case management as a strategy for retaining them in care (Gardner et al., 2005). We currently link newly diagnosed HIV-infected participants with two local community-based organizations funded through this initiative.

Although our grant provides housing for up to 31 individuals in early addiction recovery—many of whom are living with HIV—the lack of inexpensive living environments managed by individuals who are themselves in recovery remains a barrier for some participants. Peer-led transitional housing is a science-based intervention that has proven helpful at sustaining individuals seeking recovery from addiction, including substance users practicing behaviors considered high risk for HIV infection. Providing shelter for HIV positive participants waiting to be linked with care may reduce attrition (clients falling out of service) and the risk of others being exposed to HIV. Identifying peer-led transitional housing services for recipients waiting for linkage to HIV care and addictive disorder treatment services was best accomplished through capacity building efforts among faith-based and 12-step peer-led transitional housing programs. We continue to grow our relationships with the aforementioned organizations resulting in an increase in access to this much needed service. This capacity building strategy carries over into other services as well. We reduced a barrier associated with a lack

of transportation when a coalition member provided use of one of their vans for client transportation to and from medical and other appointments, which further demonstrated the value of partnering with churches when developing services that benefit substance users living with or at risk for HIV infection.

We were able to work most effectively with churches that had congregations of 300 to 1,600 members. During the two year period covered in this case study, ten Atlanta-based African-American churches hosted at least one rapid testing initiative. Of the ten churches, six are charter members of our “Faith-based Coalition,” responsible for spearheading and sustaining our rapid HIV testing program. Congregation sizes for coalition members were smaller than many Atlanta area churches. For example, two Atlanta-based mega churches have memberships exceeding 20,000 each.

Member churches are located in either DeKalb or Fulton County and cover east and west Atlanta communities with high prevalence rates of substance use and HIV-infection. One church has approximately 1,600 members, another approximately 1,000 members, but the others have only 300–600 members each. The majority of our larger testing initiatives (120–200 persons tested in one day, 15–20 preliminary HIV-infected individuals, and 10–15 previously undiagnosed cases) occurred at the sites of the smaller churches. They (the smaller churches) are also the venues where we test the largest percentage of IDUs. One church, which has an average membership of approximately 300, is located in a community known for its heterosexual, same sex gender, and transgender commercial sex workers (prostitutes). At this site, we tested between 50 and 100 inner-city substance users per initiative, many of whom were commercial sex workers. The HIV positivity rate at this venue ranged between three and four percent.

Partnering around rapid HIV testing was an excellent strategy for engaging churches in substance use and HIV prevention. We found churches that were uncertain about or lacking the technical background to provide direct HIV prevention services but willing to provide their church as a venue for testing. Some later also agreed to provide temporary shelter in church owned property for HIV-infected persons while they waited to be linked with services. Because rapid testing has both a social science and public health focus, we discovered that professionals with multiple backgrounds in faith, public health, and social work could play key roles in bringing together different groups, which enhances our capacity for the delivery of services. The fact that one of the RCA, Inc. staff members is an ordained minister with a local African-American church may have helped congregations overcome suspicions, noted by previous authors about public health (Markens, Fox, Taub, & Gilbert, 2002).

A final barrier to accessing services for participants is the importance they place on having their basic needs met (e.g., medical attention, a hot meal, and shower) before they can focus on accessing substance use and/or HIV care. Ironically, the venues where we test the fewest participants are

the churches with the two largest memberships. However, these coalition members provide resources to the coalition that many of the smaller churches cannot afford. These additional resources include food baskets for participants, access to credentialed congregants who serve as volunteer educators and counselors, vans for transportation, and financial assistance and furniture donations to our peer-led transitional housing program. The local church is a trusted resource in the African-American community which can lend credibility to social services and public health efforts. The success of this program hinged upon the churches' ability to reach people and understand community needs.

Guidelines for adhering to established legal boundaries had to be clearly understood and followed. Churches were chosen because of their strategic location in communities with high rates of substance use and HIV infection and because of their commitment to addressing these issues in a manner that does not conflict with established legal boundaries. Other churches expressed strong desires for becoming members of the coalition but struggled with adhering to the federal mandate prohibiting proselytizing. They insisted on having as a primary pinnacle of the coalition the right to use "religious conversion" or other practices, including the purchase or distribution of "Christian-specific literature" as methods for reaching out to individuals impacted by addiction and/or HIV infection. Though these interventions are viewed as pragmatic and successful by many, including members of our current coalition, they are clearly prohibited practices for federally funded or other government funded projects.

## DISCUSSION

Members of Atlanta's inner-city African-American communities are at high risk for continued HIV transmission. During the 18 months that we conducted HIV testing, 72 of the 1,947 individuals tested were determined to be previously undiagnosed HIV positive cases. This is an extremely high positivity rate of 3.7%. While these programmatic data were not designed for rigorous statistical analyses, they do demonstrate how, with relatively limited funding and resources, innovative partnerships such as those with African-American churches can be useful tools in identifying and reaching high-risk people. There is a high risk of HIV transmission from HIV-infected individuals in this population who may not know they are infected. When HIV-infected people know their status, they are more likely to protect their partners from infection than they are when unaware of their infection (Celentano, Munoz, Cohn, Nelson, & Vlahov, 1994; Weinhardt, Carey, Johnson, & Bickham, 1999). However, in our logistic regression model, the strongest risk factor for HIV was history of sex with someone who was HIV-infected. This demonstrates that there is also a need for HIV prevention efforts with those known to be

HIV-infected. The strategies identified here could be useful in conjunction with CDC's national Advancing HIV Prevention Initiative and SAMHSA's Rapid Testing Initiative. These initiatives use rapid HIV testing and HIV counseling, education, and referral services to overcome barriers to early diagnosis of HIV infection, and to enhance access to high quality medical care, treatment, and prevention services for HIV-infected individuals (CDC, 2003; SAMHSA News, 2004).

A history of sexual assault was common among women. Future faith-based, social work, and public health efforts should further investigate ways to address the spiritual and mental health needs specific to women in this community. As a strategy for addressing this reality, RCA, Inc. co-sponsors an annual one and a half day event entitled "Victorious Lady Seminar" for more than 300 African American women in early addiction recovery. This event raises awareness of HIV infection through education and rapid testing, and provides social and emotional support for the many women in addiction recovery suffering from undiagnosed and untreated trauma related to sexual, physical, and emotional assault.

There were a number of practical lessons resulting from the development of this model. We found that linking HIV-infected individuals to medical care, and HIV and addictive disorder treatment services was a major challenge, as was the lack of affordable and therapeutic peer-led "addiction-recovery" transitional housing services. Partnering with small-to medium-sized churches, focusing on rapid HIV testing, recognizing the churches' ability to reach people and understand felt needs, and establishing and following guidelines for keeping church and state separate were all important components in the success of our program.

Our findings have some limitations. Participants may not be representative of others in the community because they were recruited as a convenience sample. Risk categories were self-reported and could be subject to bias. Our findings were specific to our population (mostly inner-city African American substance users) and may not reflect other populations.

Partnership with African-American churches is a promising means of reaching high-risk persons for substance use treatment and HIV prevention. Our findings suggest further study of these types of partnerships should be considered.

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