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A LOCAL FAITH COMMUNITY RESPONDS TO HIV/AIDS EPIDEMIC

An Effective AIDS Witness in Decatur, Georgia

By

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of
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ABSTRACT

An AIDS Ministry with a Black Church in Decatur, Georgia: An Effective Witness

The purpose and focus of this work is to seek practical means by which local African-American congregations can minister to persons living with AIDS (PLWAs), and to institute an educational awareness model which emphasizes prevention of the HIV virus.

The impetus for the study was a pastoral clinical education program which brought the researcher in contact with HIV/AIDS patients and their families. The study and resulting model for ministry is designed to inspire clergy and laity to institute sharing and caring ministries for PLWAs. Members of the faith community are challenged to respond to the Biblical mandate of Jesus Christ by developing compassionate outreach programs in their local communities.

Having studied the literature, the time has come to demonstrate the practice of this ministry issue at the Antioch African Methodist Episcopal Church (A.M.E.C.) in Decatur, Georgia.

DEDICATION

To my wife, Constance Belin Wicker, and to our children, Valencia and Lauren, for their patience and support during this period of study and practice.

Also, to my father, Dan Wicker, and my mother, Mandy C. Wicker, who have always been there for me. Further, to Bishop Donald George Kenneth Ming of the African Methodist Episcopal Church, who discovered my gifts and gave me challenging opportunities to serve the African Methodist Episcopal Church. Finally, to my church family, the Antioch African Methodist Episcopal Church, which made many sacrifices during this process. **Press On!**

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FOREWORD

While Black America has been challenged by forces from within as well as without, unity has prevailed at important junctures during its history. The Black church has provided the forum in which Black Americans could openly and candidly discuss the struggles and issues which impacted their local and larger communities.

> The black church has no challenger as the cultural womb of the Black community. Not only did it give birth to new institutions such as schools, banks, insurance companies, and low income housing, it provided an academy and an arena for political activities, and nurtured young talents for musical, dramatic and artistic development.[1]

The church remains the most viable, stable, and dominant entity in the African-American community. It was through the church that most institutions and movements which profited Blacks had their beginnings. Therefore, in the midst of the current health crisis, the church has the potential to rise to the forefront of efforts to combat the HIV/AIDS crisis by mounting programs of education and prevention.

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CHAPTER I

THE RESEARCH STATEMENT

The search for better health care in the Black community is reachable and reasonable. Public health programs and health information programs which have been initiated and administered external to the Black community have yielded minimal effectiveness when introduced to Black America. Conversely, "organized programs for preventive medical care based in or affiliated with Black churches have operated effectively throughout the United States for more than twenty years. These programs have had greater impact on attitudes and behaviors of Black Americans because of the Black church's central role in the Black community. Community medicine programs in the Black church have been of several types: primary care delivery, community mental health, health promotion, disease prevention, and health policy."[1]

This study represents a local church's response to a health problem which has ascended to international epidemic status. Programs for the prevention and treatment of AIDS (Acquired Immunodeficiency Syndrome) have met with resistance because of such cultural issues as mistrust and suspicion, gender role expectations, and economic necessities which impact the problem of AIDS among African-Americans. The specific objective of this study is to distill findings from the research base in order to develop a model for a comprehensive AIDS ministry in the Antioch African Methodist Episcopal (A.M.E.) Church, Decatur, Georgia. While the cultural issues addressed in this model for ministry are common among churches in the African-American tradition, the model was designed within the administrative framework of the local A.M.E. Church. Therefore, the model can be adopted and executed in other A.M.E. churches, but it has more limited applicability to other denominations within the African-American tradition.

Locus of the Study

The context and locus of the study include key segments of the Atlanta, Georgia metropolitan community, specifically the City of Atlanta and the adjacent suburb of DeKalb County. The City of Atlanta is the locus of the largest African-American population in the metropolitan area, and DeKalb County ranks second. Thus, the City of Atlanta and DeKalb County constitute prime areas for an examination of community responses to HIV/AIDS as a problem among African-Americans. Additionally, the A.M.E. Church has a major presence in the metro-Atlanta area, primarily in the City of Atlanta and in DeKalb County. DeKalb County is the location of my own pastorate, Antioch A.M.E. Church, which is located in the rapidly growing Decatur-South DeKalb area.

Community Responses to HIV/AIDS Epidemic

In examining the community's response to AIDS among African-Americans, the roles and activities of four major institutions in the city of Atlanta-South DeKalb County community are examined: (1) The Centers for Disease Control (CDC); (2) AIDS Atlanta; (3) Grady Memorial Hospital; (4) Open Hands Ministries and Common Ground Ministries.

The activities of the CDC reflect the response of the federal government to the problem of AIDS in Black America. More specifically, the CDC has recently embarked on several new initiatives directed towards improving the health of the African-American community. The CDC is concerned with education and prevention of disease, while also serving the key role of being a major repository of data on the extent of AIDS in various population groups.

AIDS Atlanta, Inc., is a volunteer-based agency that exists to foster and participate in a broad, compassionate response to the Human Immunodeficiency Virus (HIV) epidemic through advocacy, service and education. They promote protection against HIV infection through abstinence or safe-sex practices; access to health care services without fear of discrimination, humiliation, recrimination or breach of confidentiality; voluntary HIV testing and counseling on an anonymous or confidential basis; prevention of HIV infection through

education as the only effective strategy for reducing the spread of HIV in the absence of an effective treatment or cure.

Grady Memorial Hospital is the major health care facility which has primary responsibility for serving the needs of the indigent population of the metro-Atlanta area. It is jointly supported by the City of Atlanta/Fulton County and DeKalb County. In serving the indigent population of these jurisdictions, by definition, it serves a predominantly African-American population. For poor people with disease and with inadequate insurance coverage, Grady Memorial Hospital is the primary health care provider. Moreover, Grady offers an extensive and unique program of assistance to AIDS patients, and thus, represents the key response of local social service agencies to the problem of AIDS.

The *Common Ground Ministries* is representative of the role and response of charitable agencies in the community to the AIDS problem. *Common Ground's* mission is to function as the vehicle which fosters an integrated working relationship among congregations in metro-Atlanta. More specifically, their objective is to provide daytime facilities for *persons living with AIDS* (PLWAs) or HIV victims. Congregations join by membership fee, and their participation includes the provision of time, talents, and treasures by its members.

The *Open Hands Ministries* receives food and financial contributions from the community in order to minister to PLWAs. The provision of services includes delivering prepared meals to PLWAs who are no longer able to work and provide for themselves. Financial assistance for food, utilities, child care services, medicine, household goods, are among other services available through this organization.

HIV/AIDS program efforts in the African-American community have suffered because governmental entities have failed to adequately comprehend the impact of the cultural complexities of the African-American community. The model for the HIV/AIDS ministry developed and implemented in the Antioch A.M.E. Church community demonstrates the need for incorporating sociological, attitudinal, behavioral, and gender-relevant data into programs introduced into African-American communities.

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CHAPTER II

SCOPE OF THE PROBLEM

AIDS Defined

AIDS (Acquired Immunodeficiency Syndrome) is caused by the HIV (human immunodeficiency infection) virus which attacks and destroys T-cell lymphocytes. T-cell lymphocytes are while blood cells that protect the body against infections. When they are present in insufficient numbers, the body's ability to overcome bacterial, viral, or other harmful invaders is diminished.[1]

AIDS is transmitted through exchange of body fluids during sexual contact or by direct contact with blood from infected persons. Initial cases were identified in male homosexuals; however, some cases occur from ordinary heterosexual contacts. Other cases are found among intravenous drug users who use unsterile needles or who share a needle with someone infected with the virus. Now that donor blood is tested for the AIDS antibodies before being used, cases of transmission via transfusion have been virtually eliminated. Perhaps most disconcerting among known transmittal possibilities, the AIDS virus can be transmitted by an infected mother to her offspring during pregnancy, even if the mother is not ill.[2]

Historical Development of AIDS

There has been a dramatic increase in the number of AIDS cases over the past few years. This phenomenon can be attributed to a number of possible causes:

1. Many hitherto unreported cases are now being reported;
2. Many people who were infected with the virus during past years, are not exhibiting active symptoms of the disease;
3. Drug addiction has not diminished significantly.[3]

The CDC reported in its February 1993 issue, *The Scope of the HIV/AIDS Epidemic*, approximately one million people are currently infected with HIV in this country. The first case of HIV/AIDS in the United States was in New York City in 1977. It was a white male homosexual who had participated in the AIDS laced hepatitis-B vaccine program. In 1979, there were eight known cases of AIDS reported. It was in 1981 that AIDS was first described in the United States.[4]

> In June of 1981, the Black-to-white ratios of HIV/AIDS steadily increased from 3.0% to 3.7% infection by 1990. A recent study found the rate of potential life lost from AIDS in 1989 was 11.1 per 1000 Black men; the rate of white men was 3.9. Among Black women, the rate was 2.8, as compared with 0.3 for white women.[5]

Further, in the CDC reports:

> African-Americans are disproportionately impacted by HIV/AIDS in that they represent 12% of the population and account for 30% of all cases of HIV/AIDS. The Black men account for 26% of AIDS cases among adult men; the Black women account for 53% of all cases among adult women and the children account for 54% of all pediatric cases.[6]

A study of African-Americans and AIDS was initiated by Bakeman *et al.* They reported:

> As of October 1992, there were 242,146 cases of AIDS reported in the United States. Of these cases, 29.7% are among African-Americans. African-Americans are 35 times more likely to contract AIDS than are whites. Black women are 13.8 times more likely to contract AIDS than white women. Black children are 12.8 times more likely to contract AIDS than white children.[7]

In 1993, *The Atlanta Constitution* reported . . . more than 200,000 AIDS deaths, with no cure in sight. Half of the 200,000 victims died in the two preceding years, and another 130,000 to 185,000 were expected to die in the succeeding 14 months.[8] Baker, who serves on the CDC's committee monitoring the HIV/AIDS epidemic, was quoted as saying that researchers need to change their surveillance systems if they want to combat the deadly virus's spread. The article also reported the greatest percentage of AIDS cases came from the Black population.[9]

President Clinton marked World AIDS Day (December 1, 1993) with stamps (*Appendix 1*), speeches, and symbolic gestures--visiting AIDS patients in a hospital--and pledging to fight an epidemic that has brought out the best and the worst in America. Clinton, in his speech, said:

> "In a funny way, this whole disease is bringing out the best and worst in America. It's exposing some of our prejudice in ways that are self-defeating, since every family and child is now at risk. Any yet it's also showing us the courage, the self-determination, the incredible capacity of the American people to give and to love."[10]

Current State of Problem

According to statistics released by the CDC, racial and ethnic minority populations have been disproportionately affected by HIV and AIDS since the early days of the epidemic in the United States. Through June 1996, the CDC had received reports of 548,102 cases of AIDS among persons in the United States. The reported cases were as follows (*Appendixes 2-10*):

*189,004 cases among Blacks

*96,613 cases among Hispanics

*3,826 cases among Asians/Pacific Islanders

*1,439 cases among American Indians/Alaskan Natives

Non-Hispanic Blacks represent 33% of reported AIDS cases in the United States, but make up only an estimated 13% of the United States population. Additional data are as follows:

* Of adult and adolescent Blacks reported with AIDS in the United States, 78% are men.

* HIV/AIDS has been the leading cause of death for Black United States men aged 25-44 since 1990, accounting for 20% of all deaths in this group.

* While the number of AIDS cases reported among white gay men each year has leveled off, it is continuing to rise among Black gay men.

* Of adult and adolescent Blacks reported with AIDS in the United States, 22% are female.

* In 1996, of reported cases in adults/adolescents, 18% occurred among women; of these cases, more than three-fourths (77%) occurred among Blacks and Hispanics.

* Black women accounted for over half (55.4%) of all deaths in women with AIDS reported through 1996.

* More than half (56%) of United States. children with perinatally acquired AIDS are Black. More than 3,000 AIDS cases have been reported among Black United States children under the age of 13, and 95% of these children acquired HIV infection from their mothers during pregnancy or at birth.[11]

HIV/AIDS Prevention and Cure

At present, AIDS remains incurable. Treatment consists only of combating the infections as they arise. While some researchers are optimistic regarding discovery of an effective vaccination against or treatment for the AIDS virus, this has not yet been realized. In the absence of an effective treatment and cure, the key to combating the current epidemic is education toward prevention.

Researchers and health care providers are consistent in recommendations to reduce the risk potential for contracting the deadly HIV virus: limit sexual contacts; use a condom to minimize exchange of body fluids; avoid sexual contacts with people who are at a high risk for AIDS (*e.g.*, drug addicts).

Motivation for Research

Despite the mass media education campaigns and widespread concern regarding HIV/AIDS infection and safe-sex practices, many Americans still engage in life-style choices and practices which place their health, and ultimately their lives, at risk. These unhealthy choices are mirrored in the Antioch A.M.E. Church community (Decatur, Georgia). Consequently, an increase in HIV/AIDS cases is evident in this community.

As one of the five metro-Atlanta counties, DeKalb is growing and attracting families from around the world. Like many American communities, DeKalb County and the City of Decatur have experienced demographic shifts during the last thirty years. The inner-city's composition has changed from predominantly African-American to predominantly white. Conversely, suburban Decatur has shifted from predominantly white to a predominantly African-American racial composition.

To many young African-Americans, metro-Atlanta represents a haven of opportunity. The area is particularly desirable in the areas of education, employment, culture, and business. This led the writer to the Decatur community of DeKalb County, Georgia, relocating from Baton Rouge, Louisiana, in June 1987, with the primary objective to matriculate at The Interdenominational Theological Center. In 1992 after completing seminary and resigning a position with Kroger Food Stores, Inc., the writer became a full-time pastor for the Antioch A.M.E. Church.

The Antioch congregation has always been an upwardly mobile African-American congregation. They are proud of their church, their families, their businesses (family-owned), and their community. The congregation has not been greatly affected by the ills of the Black communities in the United States, such as unemployment, underemployment, crime, drugs, divorce, teenage pregnancy, etc. However, the Antioch congregation has been affected by the health ills of the Black community, such as hypertension, heart disease, arthritis, and HIV/AIDS, etc.

The AIDS education Task Force of the DeKalb Medical Center reports:

FACT: AIDS IS A TOTALLY PREVENTABLE DISEASE.

FACT: AIDS is the number one killer of people in the United States 25 to 44 years of age; one of every five people now living with the disease contracted it in adolescence.

FACT: The Youth Risk Behavior Survey (1993) indicates that 66% of Georgia teens are sexually active and that 62% of this group identify unsafe sexual behavior or drug abuse as a risk factor.

FACT: Georgia is the eighth highest state in the number of AIDS cases; Atlanta the tenth highest metropolitan city in the number of AIDS cases (*Appendix 11*).

FACT: DeKalb County ranks second highest to Fulton County for AIDS reported cased in Georgia (*Appendix 12*).

FACT: The 30032 Zip Code [in which my ministry is located] records one of the highest incidence of AIDS cases in metro-Atlanta (*Appendix 13*).

Personal Background that Informs the Question

Since 1991, following a summer chaplain's position with Grady Memorial Hospital, the writer became very interested and involved in HIV/AIDS-related issues. As a result of his work in the HIV/AIDS area, he developed a close relationship with two HIV/AIDS patients--one, a young man, approximately 27 years of age; and the other, a young baby boy. Both of these patients died with the disease.

The baby's parents both tested positive for the HIV virus. They watched the baby die with the same disease which will ultimately claim their lives. The writer became angry with himself, the parents, the doctors and the hospital, because he thought all of us had failed in saving the life of this little boy.

The parents were both less than 30 years old. The writer saw many, many young people, particularly African-American men, suffering until death without family or friends. The turning point for the writer was the point at which he became personally convicted about his future involvement in the HIV/AIDS cause, resulted after two events:

1. The death of the baby boy;

2. The confession of one patient, "I don't want to die alone, is my last request." He died while the writer was not at the hospital; he knew then that something must be done, and that he could help.

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[4]McAshan, 45.

[5]Ibid., 46.

[6]Centers for Disease Control and Prevention Facts Sheet, 1-4.

[7]Ibid., 141.

[8]Atlanta Constitution, *More Than 200,000 AIDS Deaths With No Cure in Sight*. (November 15, 1993), A1.

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[10]_____, *World AIDS Day*, (December 1, 1993), D1.

[11]See Appendixes 2-10.

CHAPTER III

AIDS IN BLACK AMERICA

Historically, the African-American (Black) community has suffered larger increases in incidence of HIV/AIDS than any other population in the United States. Correlatively, the public health programs and health information programs in the African-American community have yielded less than positive results. Beginning with the early 1900s to the 1960s, public health activities were often directed **at** the Black community, rather than **by** the Black community. The programs were administered from Washington or other centralized governmental structures. It was not until 1986 that a commitment developed to use facts and findings to implement public health efforts with the Black community as partners.[1]

The failure of many public health initiatives can be attributed to the lack of ability of health care providers to identify with health care recipients. Large percentages of health care providers in the Black community share no common bond or experiences with the Black community. Consequently, the lack of cultural relativity and identity leads to the unavoidable reliance on traditional assumptions regarding groups of people. The inevitable and lamentable consequence is the alienation of people from services which might otherwise improve the quality (and quantity) of their lives. The literature supports the premise that social, behavioral, economical and cultural identification must be shared if the service directed to the community is to be performed effectively. David McBride states, "The Black community faces behavioral, cultural, and demographic factors that make community-based mobilization against the spread of AIDS particularly difficult."[2]

There is a critical need for whole communities to be mobilized and made a part of community health prevention and education programs. Such concerted efforts could result in

the empowerment of other Black organizations to serve as role models for young Blacks in more global health education.

Health education as a vehicle for social change should include community organizations, coalition building, education and lobbying public health officials on behalf of public health. It is important that the church and any other institution desiring to do HIV prevention work in the African-American community understands the cultural diversity which is evident in the different languages, cultural practices, and religious beliefs. These cultural differences affect attitudes regarding illness and health-seeking behavior.

Suspicion and mistrust of mainstream medical institutions make it harder to mount an effective communal response to the HIV/AIDS epidemic. There is such widespread fear and suspicion of government institutions and white doctors among African-Americans, that they will resort to almost any alternative rather than conventional medical treatment. The pattern of development and spread of HIV/AIDS provides a scenario in which the unthinkable becomes possible in the minds of a community.

During the early 1980s, AIDS became a national and worldwide public health issue. Within a few years, the concentration of AIDS cases in the United States began to shift from mostly white male homosexuals to urban Blacks. The disparate nature of the initial development and subsequent escalation of the HIV/AIDS problem provided fertile ground for conjecture. As the AIDS crisis gained national attention, the idea of a possible African racial connection to greater susceptibility for AIDS emerged throughout health care systems in the United States. Conspiracy and duplicity against people of color were emerging themes in both formal and informal settings.

Institutions in the Black community have been active in providing information and education for community-based health programs. This practice is significant for a number of reasons. Perhaps most significant is the propensity for a people to ignore prevention messages if they do not perceive the messenger to be credible. As noted earlier, the potential effectiveness of AIDS/HIV education can be mitigated if it is viewed as being imposed on

African-American communities. If imposed, the disease and the persons or institutions providing the information may be viewed with skepticism and mistrust. This tendency is dramatically illustrated in the theory that the HIV/AIDS epidemic is a form of *genocide* (an attempt by white society to eliminate the Black race).

Although the genocide theory may have no basis in fact, educational interventions that seek to alter behavior in order to reduce HIV risk may not be effective without also addressing underlying concerns about possible racist determinants of the AIDS epidemic. The credibility of public health officials among African-Americans is not good. Many Blacks and Latinos will likely listen more carefully to a prevention message from people of color than they will to one from white male, middle-class authorities who are government officials. It is important to understand how the term *genocide* is interpreted within a community, and to understand how the positive impact of an AIDS education prevention program can be negated in a community that believed the government is trying to kill them.

The Nation of Islam disseminated literature describing AIDS as a form of genocide.[3] However, it is very difficult to assess the impact of this media campaign in the shaping of public opinion. Because the organization is perceived by many to be racist, literature may be viewed with skepticism, and its credibility may be questioned.

A study conducted by the SCLC to determine HIV education needs among 1056 Black church members in five cities (Atlanta, Georgia; Charlotte, North Carolina; Detroit, Michigan, Kansas City, Missouri; and Tuscaloosa, Alabama) revealed the following information: 35% believed AIDS is a form of genocide; 30% were unsure; 35% did not believe AIDS to be a form of genocide.[4]

There is one study whose credibility is virtually unchallenged, and thus acts as an historical marker for the legitimate discontent of Blacks with the public health system. The cryptic legacy of the Tuskegee syphilis study, with its failure to educate the participants and treat them adequately, helped to lay the foundation for the pervasive sense of distrust some Black Americans harbor for public health authorities today. Even in the absence of

overwhelming corroborative data, this quintessential example of deception and deceit will linger as a potent reminder of the duplicity of governmental/health agencies whose primary goal should be education, prevention and cure. Stephen Thomas says, "Tuskegee has taken on a life of its own as a disaster myth. It has transcended being a historical event and turned into an urban legend, a personification of medical abuses and racism."[5]

The issue of origin of HIV is a recurring theme with many Blacks. The focus of inquiry revolves around three issues:

1. Whether the virus originated in Africa;

2. Whether the virus was invented as a conspiracy to reduce the Black population;

3. Whether a cure for the virus has been discovered but withheld.[6]

With the hypothesis that the HIV virus originated in Africa, some Blacks fear that persons of African descent will be held culpable for the resulting epidemic. African-Americans and native Africans ask angrily why the rest of the world wants to blame Africa for everything negative and bad, particularly concerning diseases. Samuel V. Duh offers an historical explanation to the query into the role of Africa in the HIV/AIDS origin. Duh's theory states,

> The belief that AIDS originated in Africa has to do with the discovery in the early 1980s of retroviruses in Green monkeys from Africa. When AIDS was recognized as being caused by a retrovirus, questions arose of its origin. . . . During the immediate post-independent years (the early 1960s), many countries in Central and East Africa required expert knowledge; the experts who came included Haitians. The Haitian experts (mostly men) had sex with African women who were infected with the HIV virus. They returned to Haiti and spread the virus in heterosexual and bisexual populations. Homosexuals from San Francisco went to Haiti on vacation, had sex with infected bisexuals, and contracted the virus. They brought it to San Francisco. Meanwhile, some of the European experts also had sex with infected African women and similarly spread the virus to the homosexual population in Europe. The virus spread from homosexual and heterosexual IV drug users, and then it finally spread to the rest of the population.[7]

As Duh offers his own theory of the origins of HIV, he maintains that HIV is not a new virus, and it did not result from the mutation of a monkey virus. He further states, "the view I have espoused on the origin of HIV is not based on hard data. . . ." He concludes, "the spread of AIDS was through travel, tourism, and prostitution."[8]

Ron Simmons of the *Us Helping Us: People into Living*, (the only group founded by gay Black men in Washington, D.C.), states, "My thinking is they're (whites) killing black and brown folks, and the reason they gave it to white folks first is because it was too soon after the Atlanta child murders in 1978, and there would have been riots."[9]

The issue of *race* itself would be irrelevant to the HIV/AIDS epidemic if as a nation we ascribed no special meaning to it or people of all races were treated equally. However, racial inequality in the United States is preeminent among the festering social problems that HIV highlights and upon which the epidemic feeds. Therefore, the cultural issues of specific populations are crucial considerations in any programs designed to alter the course of the epidemic.

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CHAPTER IV

THEOLOGICAL AND MINISTRY ISSUES

The Biblical Perspectives on AIDS

This chapter will examine the biblical precepts which inform the study of HIV/AIDS as a church ministry. First, it will examine several age-old questions which form recurring themes and create fervent debate in local congregations concerning suffering and disease. Second, it explores the crucial and perplexing question concerning God's action and justice as related to suffering and disease. Third, the focus shifts to the practical and biblical views of Jesus' response to leprosy in the Old Testament and how those responses serve as a model for the church's action in the New Testament times. Finally, a statement which informs the Christian church's understanding of its role and mandate in ministering to PLWAs.

Question #1: Is AIDS God's Judgment?

Some in the Christian church espouse the idea that AIDS is a punishment (plague) from God which is based on three assumptions: (1) homosexual acts are sinful; (2) God causes suffering; and (3) God punishes sin with disease.

First, *are homosexual acts sinful*? The Bible contains a number of passages which have been traditionally understood to condemn homosexual acts. However, there is disagreement among modern biblical theologians as to the appropriate interpretation of scripture. For example, the story of Sodom and Gomorrah (Genesis 10) deals with rape, not with loving, consenting gay relationships. There are many ancient and modern scholars who think that the sin of Sodom had nothing to do with sodomy (an English term for homosexual acts), but rather with breaking an ancient near-eastern mandate to provide hospitality to strangers.

According to Dr. T. J. Mafico,

> The Leviticus passages (18:22; 20:13) do condemn homosexual acts, but must be understood in their cultural and historical context. The laws of Leviticus deal with health, avoidance of idolatry, and sacrificial practices. Their purpose was also to separate the Israelites from the pagan nations and their ritual, sexual, dietary, and cultural practices. Many modern Christians and Jews interpret the Levitical prohibition against homosexuality as belonging only to the historical context of the rest of the Levitical laws.[1]

In the *New Testament*, there are three principal passages which are traditionally quoted as describing homosexuality as sinful: Romans 1:27; I Corinthians 6:9-10; and I Timothy 1:9-10.

> Many modern biblical and linguistic scholars strongly question whether these passages even deal with homosexuality at all; or whether they deal instead with sexuality of any kind that is simply **lust for lust's sake**. In fact, none of these four [three] biblical references deals at all with loving, nurturing, mutually beneficial same-sex relationships.[2]

Question #2: Does God Cause Suffering?

Our world is full of human suffering caused by hunger, disease, poverty, and many forms of oppression and injustice.

> When these things happen, does this mean they are God's will and, therefore, that God wants us to suffer? While AIDS is certainly a devastating evil, it is not of God's will. . . . In his ministry, Jesus never punished people with sickness. He healed them. AIDS is a tragedy, and God suffers with all who are victimized by it or who lose loved ones because of it.[3]

However, it should be indicated that God heals sometimes through physical restoration, at other times with strength sufficient to grow in the midst of suffering (I Corinthians 12:0). Even when the injustice of tragedy invades our lives, God's compassionate love can bring good in the form of healing and growth.

Question #3: Is Sin Punished with Disease?

Each time some mysterious malady befalls a nation, or an identified segment of the community, there is the rush to see if God did it, and if so, why?

> If God creates illness as punishment, what about other modern afflictions? Are all women with toxic shock syndrome victims of God's wrath? or Blacks with sickle cell anemia? or Jews with Tay-Sachs disease? What kind of justice would it be to visit hereditary illness or birth defects on those yet unborn, those who have not yet lived to sin?[4]

People had similar questions during the time of Jesus. Then as now, many assumed that suffering is a direct result of sin (and that prosperity is a reward for being right). But Jesus challenged that assumption. As Jesus walked alone, he saw a man who had been blind from birth. His disciples asked him: "Rabbi, was it his sin or that of his parents that caused him to be blind?" "Neither, " answered Jesus, "it was no sin, either of this man or of his parents. Rather, it was to let God's work show forth in him." (John 9:1-3).

Question #4: Is God Just?

Regarding the question of the justice of God, Dr. T. J. Mafico offers clarity to the text utilizing Genesis 18:23-26. Mafico states:

> "The entire dialogue takes a question and answer format and surprisingly enough, Abraham takes the leading part and initiates every move. The issue of the dialogue is provoked by the fate of Sodom, the city in which Abraham hypothetically assumed to dwell both wicked majority and the righteous few. At stake is the principle of reward for the righteous and punishment for the wicked, which is enshrined in the concept of the justice of God.[5]

> Gerhard Von Rad believed Abraham did not react simply because Yahweh mentioned Sodom, but he reacted because of an issue which was terrible and alarming. Abraham was shocked not by the word **rasa** (guilty or godless) but by Yahweh's mention of the phrase--*the outcry of Sodom*."[6]

Professor Mafico differed with Von Rad on this issue, and stated:

> There is much biblical evidence to establish that once the outcry of the oppressed reached God, God's response was swift and dire consequences on the offender were immediate and unavoidable. Abraham therefore realized that the distress signal had sounded in Sodom and God's reaction would mean grave consequences on the city. Seeing the destruction of Sodom hanging in the balance, Abraham immediately sought an answer from God on the ethical problem posed by indiscriminate destruction.[7]

> The question which should be asked is: *Since God promised to spare Sodom for the sake of the few righteous ones, why did he then burn it (the city) completely*? The point which is missed by scholars is that Lot and his household were not the people of the land but sojourners. With no citizenship, Lot had no influence.[8]

> Yahweh did not violate his divine principle of justice by removing Lot and his household before setting the whole city in a conflagration. God's terse reply in v. 26 assured Abraham of God's absolute justice in his dealings with men.[9]

Mafico concludes, "man is nothing but dust and ashes in God's sight."[10] Also, we conclude that God is a just God.

An important issue which informs this discussion concerns leprosy in the Bible, Jesus' response to the disease, and his response to persons afflicted by the disease. The parallel between leprosy and HIV/AIDS disease has contributed to rich debate.

Biblical Understanding of Leprosy/Leper

During the Old Testament community of faith (the church) a person sick with leprosy under the Levitical law was most scrutinized, feared, hopeless and shunned than any other. A study of Leviticus Chapters 13 and 14 shows that the skin condition and the disease was cared for by priestly functions. The priest is important in performing *observational tests* in a manner of care. The leper offered his or her head, hands and feet through the gate of the *holy place* for an examination. However, modern scholars argue and believe that the priestly function, *diagnosis*, would also include in its tests, non-leprous diseases such as ringworm.

The basic issue with the laws has to do with clean versus unclean, and living with the unclean. This was the challenge to that community of faith, and it remains with the community of faith even today. As priests performed their *diagnosis*, there were specific procedures which were to be followed in the detection of symptoms of disease. The laws and rituals indicate that lepers were considered dead, unclean and smitten by God. The guidelines as established in Leviticus 13:44-46 were as follows:

1. The priest announced the leper only after examination;
2. The leper is then segregated from the community;
3. The leper is demanded to wear torn clothing;
4. The leper is demanded to cover lower parts of the face;
5. The leper allowed the hair to hang loose from the head;
6. The leper appears dead and cries out, "I'm unclean," when anyone came near.[11]

It is clear the leper was shunned by the community of faith in the Old Testament. The disease undermined the health status and was a stepping-stone to death. The condition carried with it a sense of defilement, inevitability and finality. Likewise, they were treated with contempt and disdain, and were ultimately ostracized by the community of faith in the Old Testament.

Despite the dire tone, the lack of compassion, and the severity of treatment reserved for lepers, Leviticus Chapter 14 provides a note of relief and hope as it outlines *three levels of purification* following the healing of leprosy:

1. Purification by washing and shaving unclean hair;
2. Purification by releasing a bird while killing another;
3. Purification by burnt/cereal offering for guilt (atonement offering with goats).[12]

New Testament Understanding: Mark 1:40-45

The New Testament community of faith relationship to a leper can best be understood from the Markan text (Mark 1:4-45). It is important to investigate how Jesus communicated with a leper, and how this model speaks to the modern day church.

The Leviticus 13 and 14 chapters allow us to understand the leper's position with the community-at-large in the Old Testament community of faith. Yet, Jesus did not respond according to the ritual mandate prohibiting conversation, proximity and intimacy with a leper. The word which allows the Markan text preference in this paper is *compassion.* The Greek word for compassion found in verse 41 is *splanknisthesis*, which is translated in various ways;

feeling sorry for him; in warm indignation;

being filled with compassion;

being moved with pity;

being filled with pity.[13]

It is important to note that the Markan passage is the only one that used the word compassion. While Matthew and Luke passages state that He *put out His hand and touched him*, to imply compassion, the actual word is never explicitly stated.

> There is a discrepancy raised among scholars in v. 41 of the Markan passage, concerning the word *compassion*, because some of the original language texts do not use the word *splanknisthesis* but *orgisthesis*, which can be translated, *filled with anger or filled with warm indignation*, as in the NEB translation. The writer argues that a scribe perhaps misunderstood anger and compassion in the light of Jesus' personality style and recopied the word as *compassion.* Furthermore, Jesus' actions for suffering humanity can easily be understood for compassion rather than anger. Jesus experienced compassion as one having an affection to stand in solidarity with or accompany another through pains in life.[14]

Compassion does cost as it did Jesus in the Markan passage. Jesus could no longer move freely into cities and synagogues. The cost to Jesus for His compassion was isolation, retirement, misunderstood motives. Eventually, acts of this kind cost Jesus His life.

The Mandate . . . The Charge

We are still left with the fact that each passage in the New Testament states that Jesus reached out and actually touched this leper, an action which took tremendous courage and compassion. This model learned from Jesus is our challenge to be Christ-like. In order to truly follow Christ, one must be willing to take the risk, in spite of the potential consequences. The real challenge for the church is, *can we do ministry with PLWAs in the Jesus model of compassion.*

The African-American church can cry out (petition) to God on behalf of the PLWAs in their community. The church is needed in the streets of our towns and cities to bring awareness to citizens who are high risk to HIV/AIDS. The church cannot allow itself to reject or allow others to reject PLWAs. All of God's people have a right to the kingdom of God.

Until the Christian church fully understands the biblical mandate from Jesus Christ, the church will never embrace its responsibility to do ministry to PLWAs or people with any other disease. It is important to be Bible-based to do ministry to sick people; we have attempted to examine both the Old and New Testaments to address the biblical perspectives for doing ministry to PLWAs.

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CHAPTER V

THE THEOLOGY OF SEXUALITY

An approach to the theology of sexuality relating to AIDS must have working definitions. For the purpose of this discussion, the following definitions are presented:

Theology is the study of God and His relationship with humankind and the universe.

Sexuality is an act of having sexual character, possession, powers or capability of sexual feelings.

As stated earlier, AIDS (Acquired Immunodeficiency Syndrome) is a disease caused by the HIV (human Immunodeficiency infection) virus which attacks and destroys T-cell lymphocytes. T-cell lymphocytes are white blood cells that protect the body against infections. When they are present in insufficient numbers, the body's ability to overcome bacterial, viral, or other harmful invaders is diminished.[1]

Our sexaulity is intimately tied to whom we are as spiritual persons. The spiritual life enhances sexuality and gives it direction. Our sexuality gives an earthly wholeness to our spirituality. Our spirituality and our sexuality come into a working harmony in the life of the Kingdom of God.

The parameters for this discussion will be from an approach of a pastoral theology of sexuality. Inherent in the concept is the assumption of legitimacy as well as importance for a congregation to engage in such discussion. The writer contends that the pastor is change agent and enabler for establishing a climate in the congregation which is conducive to a discussion of sexuality. The pastor is spiritual leader of a spiritual people. Thus, the pastor must lead the congregation into open and honest dialogue about sexuality and its role in the life of a spiritual person.

Families are constantly challenged and confronted with issues of sexuality concerning children, the children's peer groups, and the married couple of the family. There are times when the family does not respond to this issue as it related to theology or religion. When the response comes forth, it is often negative and un-Christian in character. "Sexuality and spirituality are not enemies but friends," says Donald Goergen.[2] Therefore, it is critical for the church to maintain positive and supportive relationships with families of the church as they contend with issues of sexuality in the family.

God, Sexuality and Spirituality

Goergen credits Karl Barth with establishing relationship between human sexuality and spirituality.

> Karl Barth was the first major theologian to help us understand human sexuality in the light of spirituality. He helped us understand that the relationship between male and female is the human expression of our relationship with God. So God created man in His own image, in the image of God He created him: male and female He created them.[3]

The Biblical stress upon relationship enlarges our understanding of human sexuality. Our sexualness, our capacity to love and be loved is related to our creation in the image of God. The magnificent biblical scene--*naked and not ashamed--and the man (Adam) and his wife (Eve) were both naked and were not ashamed.* (Genesis *2:25*). There are two principles of understanding that make this a beautiful picture.

1. *There was no shame because there was a state of wholeness. There was an organic unity within themselves and with the rest of creation.*

2. *Their differences also united them; they are male and female, but also one flesh.*

They recognized their masculinity and femininity as the handiwork of God.

The tragic conclusion to the story is how the man and woman rejected God's way. It ruptured the relationship between God and Adam and Eve; it also tarnished the marriage

relationship. We must be reminded of the language of Genesis 3:16--. . . shall rule over you -- is a result of the fall not a part of God's good creation.

That which was originally created to exemplify and glorify a pure, unblemished, and holy relationship has often been distorted, exploited, and tarnished to the point of perversion. Sexuality has been made trivial and banal with the sensationalism of topless bars, pornographic literature, and vivid expressions of sex on television. The unhealthy and unspiritual conceptualization of sex and sexuality has resulted in attitudes and behaviors which lack censure and bounds. The corrupted and depraved views that contemporary society has adopted have resulted in uncontrolled, unrestrained behavior. The natural and unfortunate consequence of morally bankrupt behavior is devastation, in some form. The scourge of HIV/AIDS is the result of a breach in the fidelity and integrity of a relationship which should be characterized by virtue and spirituality.

Jesus: Sexuality and Spirituality

The doctrine of Christ is not an added difficulty for the doctrine of God but the only way in which it can be expressed. It is the work of Christ that gives us the key to the nature of Christ.[4] We cannot separate the person and work of Christ--they are a unity. Our attention to Jesus' attitude toward sexuality must be considered in talking about a theology of sexuality relating to AIDS.

We have very little direct teaching from Jesus on sexuality. However, what we do have underscores Jesus' high view of sex and of marriage. Jesus saw beyond the externalities of law to the internal spirit in which people live. 'I say to you that every one who looks at a woman lustfully has already committed adultery with her in his heart'. (Matthew 5:28).

The inference drawn from this text is that Jesus viewed sex as too good, too high, and too holy to be defiled by impure and improper thoughts. Jesus' condemnation of lust can be understood when one recognizes that the sacredness of the context in which sexuality was created is diminished when it is actualized as lust. Thus, the essential nature and value of the act is desecrated.

Foster contends that when lust is of primal concern, the essential element of relationship is denied. In such cases, the person is no longer viewed in totality as a spiritual being, but is viewed merely as an object, a thing, a nonperson.[5]

> Sin has distorted sexuality in many ways. Pornograhy is a distortion of sexuality. In pornography, we see a truncated sexuality concerned only with the physical as an activity of lust and a dehumanizing exercise of power over others. Lust is also a distortion of sexuality. Lust is runaway, uncontrolled sexual passion. Fulfilling the desires of the human flesh is lust.[6]

Jesus Christ is both human and divine. Christ in human flesh had to be influnced by sex in order to be totally experienced in the human condition. Jesus Christ in human condition was attracted to and by the opposite sex; otherwise, He was not truly a fleshly human man. Thomas asserts, "The final fulfillment of God's covenant promise in a new age of blessedness is seen as taking place through a human agent, Jesus Christ ."[7]

God's ultimate plan for humanity from the beginning of time was made flesh and enacted in human history in the man Jesus. Jesus responded in perfect obedience to His calling and election from God. In the fulfillment of God's plan for humanity, Jesus assumed the nature of a real human being involved in all the relationships of human life.[8]

Sexuality and sex are words often understood in the light of the word love or intimate love. Love must be directly related to sex and sexuality to afford shame and disgrace concerning human action called lust. "Perfect love casts out all fear," says St. John in his first letter. Signs of this perfection show the possibility of a spiritual movement out of the house of fear into the house of love. Henri J. M. Nouwen states, "the house of love is the house of Christ, the place where we can think, speak, and act in the way of God."[9] "The house of love is not simply a place in the afterlife, a place in heaven beyond this world. Jesus offers us this house even in the midst of our anxious world."[10]

Humankind failed God in His ultimate plan by moving away from responsible living and caring in building positive relationships. The secular world's focus is on the pain rather

than the building of a relationship. Lewis Smedes has noted, "Here a person is not feeling pain within a sexual relationship but is experiencing pain as a substitute for a sexual relationship."[11]

Sex and sexuality are the very things that were created to give joy and life, yet they have been twisted and used to bring misery and death. Even that which is essentially and potentially good can become distorted and produce evil. The distortion of human sexuality has resulted in actions and consequences which can be perceived as demonic, indeed. Sin is real; evil is real. The powers and principalities are real and can lead us to the very brink of hell itself.[12]

The Holy Spirit: Sexuality and Sex

There must be a biblical vision of human sexuality and sex. That vision is driven by the Holy Spirit [as teacher], in order that we can know better how to bring our lives into conformity with the ways of [holiness] God.[13]

God is self-revealed as holy, as the holy one. In the Bible, holiness is almost a synonym for diety; it is the essential deity or goodness of God. The first meaning of holy in the Bible is separate or distinct. God's holiness is, in the first instance, that which separates and distinguishes God from profanation by contact with anything else. Holiness is the unapproachable character of God (Exodus 19:21). God alone is holy in Himself. Since no church, no doctrine, no saint, no instittuuion, and no rite is holy in itself, every man and everything and every group is profance in itself. Each is sacred only in so far as it becomes a symbol of the divine holiness.[14] God makes the church holy by the presence of the Holy Spirit. The Holy Sirit is that agent who draws all people into communion with God.

The mission of the church in sexuality and sex can help us by providing a context for happy and satisfying friendships to develop. Donald Goergen has noted that feelings are meant to be felt, and sexual feelings are no exception. When we try to deny these feelings, we cut outselves off from our humanity. Sexual feelings are not to control us; we are to control them.[15]

In Ephesians, Paul quotes the one flesh to urge husbands to love their wives, because he who loves his wife loves himself. (Ephesians 5:28) The point is simple: Marriage creates such a bonded union that to do violence or harm to one's spouse is to do violence to oneself. In essence, we do not have a body, we are a body; we do not have a spirit, we are a spirit. What touches the body deeply, touches the spirit as well.[16]

Even in our bad moments, we can confess with Paul, "It is no longer I that do it, but sin which dwells within me." (Romans 7:17). In such moments, we know that a deeper experience of obedience is coming. Our condition is mitigated by faith, as we proclaim with victory, ". . . by the grace of God and in the timing of God I shall be rid of it."[17]

When people who are seeking to follow Jesus Christ succumb to evil, they are doing precisely that which they abhor. Conversely, when bad people yield to evil, they do so with no consideration of Holiness. The church's ministry must be inclusive enought to provide shelter and renewal for those in fallen conditions of humanness. When in the course of our human frailties our sexuality-gone-awry results in some form of brokenness, (e.g., HIV/AIDS), the grace of God can flow into the wounded spirit, healing and restoring. In the context of a wholesome, caring ministry, our sexuality can develop whole and full and pure.

Understanding the Church in Sexuality and Sex

The faith community gathers under the mandate of love. Foster offers a compassionate view of the Christian church's mission:

> We must be slow to condemn and quick to listen to all who are plagued by lust. The temptations are great in our sex-soaked culture. The distortion of our sexuality into lust can take a very tangled, twisted route. Only by the grace of God and the living support of the Christian fellowship can our lust-inflamed sexuality be straightened upright again.[18]

Karl Barth has called the Song of Solomon an expanded commentary upon Genesis 2:25--and the man and his wife were both naked, and were not ashamed. In Foster's book, *The Challenge of the Disciplined Life*, there are four great themes that should be celebrated

by the church: (1) love's intensity, (2) love's restraint, (3) love's mutuality, and (4) love's permanence; all of which are marvelous windows into human sexuality.[19]

When Jesus says, "make your home in Me as I make Mine in you, He offers us an intimate place that we can truly call home. We live in a society shocked into fear by HIV/AIDS. There is no cure and no place to turn as many succumb to death as a consequence of HIV/AIDS.

> Home is that place or space where we do not have to be afraid but can let go of our defenses and be free, free from worries, free from tensions, free from pressures. Home is where we can laugh and cry, embrace and dance, sleep long and dream quietly, eat, read, play, watch the fire, listen to music, and be with a friend. Home is where we can rest and be healed. The world home gathers a wide range of feelings and emotions up into one image, the image of a house where it is good to be: the house of love."[20]

It is humanity's challenge to create this home within the fellowship of the faith community: the church.

The New Testament authors interpret the church in a variety of ways: the congregation of the faithful, the body of Christ, the fellowship of the spirit, and the community of hope. The church has the unique compulsion and position to offer a compassionate community which destroys barriers that distort sexuality. Even in the Old Testament community, women were often treated as property to be protected and disposed of at male discretion. The church, as a compassionate and healing agent, rejects the notion of female inferiority as a false and soul-destroying doctrine. Thus, if we reject the inherent inferiority of the woman, we must also reject the inherent subordination of the woman.[21]

The Community: Sexuality and Spirituality

Each of us is resurrected only as we enter into the network of relationships called community, a network that embraces not only living persons but people who have died. . . .[22]

> Sex is like a great river that is rich and deep and good as long as it stays within its proper channel. The moment a river overflows its banks, it becomes destructive, and the moment sex overflows its God-given banks, it too becomes destructive. Our task is to define as clearly as possible the

> boundaries place upon our sexuality and to do all within our power to direct our sexual responses into that deep, rich current.[23]

The challenge for the community of faith, as well as the community-at-large, is to promote help and healing wherever needs may exist. The issues of homosexuality, HIV and AIDS, have created fear and alienation in times when compassion and understanding are mandated and essential. Foster asserts,

> The community and the community of faith are challenged with the matter of homosexuality and the level of suffering and hurt . . . [I]f anything can be said that would be helpful--perhaps even healing--it would be well worth any risk involved. All who are caught in the cultural and ecclesiastical chaos over homosexuality need our compassion and understanding.[24]

HIV/AIDS is a result of human sex and sexuality operating outside the boundaries of God's will for humankind. Foster concludes, ". . . although homosexuals are not responsible for their homosexuality, they are responsible for what they do. Choices must be made, and for Christians who find themselves with a homosexual orientation, those choices must be made in the light of God's truth and God's grace."[25]

AIDS is a result of our choices. Social scientists tell us that about five percent of all males and about half that percentage of all females have a confirmed sexual drive toward persons of their own sex.[26] The challenge of the Christian community is to stand with persons in need through times of frustration, discouragement and failure.

A persons continues to have moral responsibilities even when driven to engage in an activity that is less than the best. As Christians, we can neither condone the choice of homosexual practice, nor can we abandon the person who has made the choice. Instead, we stand with the person, always ready to help, always ready to pick up the pieces if things fall apart. Above all, always ready to bring God's acceptance and forgiveness.[27]

Thomas surmises that the church is not fully what it is essentially.[28] It must be understood in the light of what it is called to be, in the ligiht of the good toward which it presses in hope. (*See* 1 John 3:2; Romans 8:23.)

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CHAPTER VI

OVERVIEW OF LITERATURE

There is general agreement in the literature that structural factors are the primary barriers to HIV prevention efforts in African-American communities. De La Cancela argues that intervention methodologies cannot be applied without understanding a group's varied social, economic, educational, and political experiences.[1] Nickens proposes that because of pre-existing health and social ills, the infra-structure we build must be developed with a broader view in mind.[2] Quimby asserts that public health in Black communities is a socioeconomic and political issue.[3] It is important to consider the environments in which people live in order to understand their sociological behaviors.

Governmental, Political, Public Policy Perspectives

The world reacted to AIDS with fear. The November 30, 1993, evening issue of *The Atlanta Constitution* headline read: "It's Time . . . For a Concerted Attack on This Killer" and stated:

> The Clinton administration is recruiting top AIDS experts from government, industry and academia for a new effort to speed the discovery of drugs to stop the epidemic that is killing 92 Americans daily. It's really significant. It represents a level of commitment that we haven't seen yet from the federal government.
>
> Only three antiviral drugs have been approved for patients with the human immunodeficiency virus: AZT, DDI and DDC. The Clinton administration and Congress this year boosted the AIDS research budget at NH by 21 percent to $1.3 billion. But the sad fact remains that not a single new drug application for an antiretroviral drug is currently before the Food and Drug Administration.[4]

The state of Georgia and many state and local governments are responding to AIDS. All three levels of government (local, state, federal) joined forces in the City of Atlanta, Georgia, to open one of its largest AIDS services in the southeastern United States.

Unofficially open since August 9, 1993, the Grady Clinic occupies 40,000 square feet--with room to double in size--at 341 Ponce De Leon Avenue. Under one roof is almost every service doctors and patients need, including counseling, dentistry, research, education, pharmacy, and clinics for women, and adolescents.[5]

Just a couple of years ago, an uninsured person with the AIDS virus had only one place to go for services in North Georgia--Grady Memorial Hospital's cramped, under-staffed clinic. This was a much needed service for the community, the state and the southeastern United States. As reported in *The Atlanta Constitution*

> About 9,000 Georgians have contracted full-blown AIDS. About 50,000 are HIV-positive and may or may not know it. More than 5,000 people have died from AIDS-related causes since the disease was named. The state's 1993 infection rate of 32.4 cases per 100,000 people ranks 11th in the nation."[6]

Increased federal funding has made the difference. Although the Grady Clinic is partially funded by Fulton and DeKalb County taxes, most of the operating expenses are covered by state and federal funds.

The local governments across the United States are taking stands on issues that are related to AIDS. Cobb County, in suburban Atlanta, Georgia, voted to sever the government's financial ties to local arts groups. The controversy began after a complaint to the Cobb County Commission about the gay references in a theater's production of *Lips Together, Feet Apart*, a play about the homosexual lifestyle. This resolution brought national attention to the debate because Cobb County declared *the gay lifestyle* incompatible with community standards.[7]

Cobb County Commissioners said taxpayers overwhelmingly supported their decision. At first, commissioners proposed continuing arts subsidies only for groups that supported strong community, family-oriented values. Commissioner Gordon Wysong, who sponsored the anti-gay resolution said "This takes us out of a business we didn't belong in anyway."[8]

Members of local churches praised the commissioners for taking a stand against homosexuality. Alicia Little of Kennesaw, Georgia, said, "Art is an important thing, but if we have to include homosexual art in Cobb County in our subsidies, I don't think we need art that desperately."[9]

Others from various walks of life have indicated that Cobb County government made a tremendous mistake by linking homosexuality and the arts, by introducing the resolution and funding issue at the same time and by alleging that two plays produced by theater welcomed nudity and homosexual activities. This story was headlined for several days in local metro-Atlanta newspapers.

Whatever the results of this local government's action, their action in effect provided one model for other local governments who must confront a similar issue in the future. As one Cobb County resident said to Gordon Wysong, "Thank you for drawing the line my county commissioners wouldn't draw fourteen years ago." "Homosexuality," she said, "is a sin." A week later, *The Atlanta Constitution* reported that the City of Decatur's mayor, Mike Mears, offers an open door policy to Cobb County residents who are oppressed to come on down to his city of inclusion. "We in Decatur officially recognize same-sex families, single-parent families, everyone."[10]

Conversely, Doug Marshall, head of the DeKalb Christian Coalition said: "If the domestic partnership issue comes up, we'll come out against it because we don't want our tax money going for everybody and funding junk."[11]

The Clayton County school system canceled a student newspaper which addressed issues such as AIDS and homosexuality. The school system took this away because an article affirmed homosexual behavior if that was the person's preference. All local public school systems should have publications, classes, workshops, and support community causes in every community concerning drugs and sexual behavior. Children are teaching themselves about these behaviors and society isn't involved. The government forced public prayer out of school

systems, but refuses to replace it with another vehicle of checking moral character and behavior. For this, the church must be guardian.[12]

The Christian Recorder of the African Methodist Episcopal Church published an article which stated, "President Clinton told twenty-five religious leaders to call upon their parishioners to see the relationship between faith and responsible citizenship."[13]

Quoting from *The Culture of Disbelief*, Mr. Clinton asserted that since becoming president, he has been surprised by how secular American society has become. Leading our society from a deeper separation of the sacred. The government will not be effective in the Black community without the church.[14]

The National Commission on AIDS recommended:

> Federal, state and local governments should join forces with the private sector in providing long-term support to community-based organizations serving communities of color. As part of this effort, the U. S. Public Health Service should expand and promote comprehensive and integrated programs for technical assistance to and capacity building in these communities. Often the assistance from federal government is handled by state and local governments which fail to deliver the federal goods and services to the adequate places and people in the African-American communities.[15]

We are at a moment in the history of our nation, and in the history of our churches, when we need transforming Christian actions. For generations the Black church has been concerned about health care and about the welfare of all people. The government and the church must come together to seek a common ground for the common good as we work together with an uncommon disease called AIDS. No matter who introduces the service, it remains a fact in the Black community, the family and the church are the two primary components of any health education and health care program.

Sociological and Behavioral Perspectives

There are several studies of male and female sexual behavior as it relates to the sociological issue of condom use in the African-American community. The task of

understanding the behaviors and attitudes related to condom use among Black males and females is extremely important because of the high incidence of sexually transmitted diseases (STDs) among the Black population.

One study by a group of scholars led by Dr. Ernest H. Johnson examines Black males who always use condoms. This study had three objectives: (1) To determine the attitudes and knowledge about condom use among a subgroup of young Black adult males. (2) To determine whether knowledge about AIDS, drug use, angry reactions related to condom use, STDs, and risky sexual behavior (*e.g.*, anal intercourse and sex with prostitutes) varied with the steady use of condoms.

For this study, 106 black males completed a questionnaire concerning attitudes and knowledge about the use of condoms and AIDS. Of the 106 males in the study, 27 (26%) reported that they **always** use condoms, 31 (29%) did not use condoms and had low intentions of using them, and 48 (45%) reported high intentions to use condoms.[16]

The results of all three groups of Black males indicated their knowledge about AIDS was exceptional. The Black males with low intentions to use condoms reported negative attitudes about condom-use and reacted with anger when their partners asked about previous sexual contacts. A significantly larger percentage of low-intenders were treated for gonorrhea, syphilis, herpes and genital warts than other males. Also, a larger percentage of Black males in the low-intenders group reported experiences with anal intercourse and sex with a prostitute, but considered themselves at low risk for HIV/AIDS. However, the most striking finding was that marijuana is used more often by Black males of the low-intenders group. Given the nature of Johnson's measure, it was not possible to determine whether marijuana use was associated with sexual intercourse or the failure to use condoms during sex.

In Johnson's investigation, three important factors were discovered that may help to explain why such a low percentage of young adult Black males use condoms with their partners:

1. Black males with multiple sexual partners, who do not use condoms are well aware of AIDS and how it is transmitted.

The large majority knows that using condoms is an effective means of reducing the chances of being exposed to HIV infection. What remains a big puzzle, is why roughly two-thirds of this sample of young, well-educated Black males do not use condoms with their partners. It is clear, knowledge about AIDS is not an important part of the answer, it could be the issue of behavior rather than knowledge.

2. The Black males with low intentions to use condoms were more likely to perceive condoms as inconvenient and unacceptable, would avoid using them if at all possible, and would voice strong objections if their partners suggested using condoms.

3. This inquiry involved the angry reaction associated with the use of condoms. Black males in the steady-user group reacted with greater anger. It was also observed that Black males with low intentions to use condoms react with more intense anger to a number of important situations such as:

When condoms interrupt foreplay,

When condoms interfere with sexual pleasure,

When a partner refuses sex unless a condom is used; and

When he thinks a partner will reject him if he asks about previous sexual behavior.[17]

Statistics released by the National Commission on HIV/AIDS suggest that Black men and women have the highest incidence of infection among any group with HIV.[18] It cannot be denied that the number of women and children infected with HIV, particularly within the communities of color, continues to grow dramatically. Even in the fact of staggering statistics, denial and apathy still characterize the behavior of persons who are potentially at highest risk levels.

Research conducted by Dr. Denese O. Shervington of Louisiana State University in New Orleans led her to conclude that the majority of African-American women neither perceive themselves to be at risk, nor perceive the need to engage in safe-sex practices. A premarketing study of the female condom, *Reality*, provided an opportunity to assess not only

acceptance and relevance of the product, but also knowledge, attitudes and practices among a group of African-American women in New Orleans.[19]

Shervington's study, *Acceptability of the Female Condom Among Low-Income African-American Women*, yielded significant findings. One of the main findings suggested that cultural norms of female submission in sexual negotiation is a major barrier to preventive actions among these women. The second finding from the research study was that women favor the female condom because they felt this allowed them control over safe-sex practices without having to challenge the power of their male partners.

Shervington reported that the discussions by the women in all three of her study groups indicated that they were aware of the transmission of the HIV virus and knowledgeable about mechanisms to protect themselves from HIV disease by the use of condoms. Third, the discussions indicated that the fear of relationship loss is more important to the majority of African-American women than fear of the deadly virus. In fact, some women equated wellness as maintaining a relationship.

> It was also found that group dynamics of universality and interpersonal learning is present in these groups. Group participation seems to have afforded the women the opportunity to clarify for themselves and each other the value of good health. It also allowed them to help each other recognize their own power in assuming more responsibility for protecting themselves from disease. The liking of the female condom was particularly pronounced in those women who had friends or family members who were dying or had died of AIDS.[20]

The enthusiastic acceptance of the female condom is in stark contrast to the general negative acceptance of the male condom. The female condom allows women the ability to assume responsibility for their sexual health without having to challenge their male partner's need to dominate the negotiation of this sexual issue. If the degree of acceptance in the general public mirrors that of the study group, the female condom holds promise in the battle to combat the spread of HIV within the African-American community.

Issues of education, knowledge, and resulting responses to HIV/AIDS prevention efforts are complex and enigmatic. Even among populations which might be expected to act in responsible and enlightened ways, the magnitude of the HIV/AIDS crisis does not seem to be internalized. *The Atlanta Journal* reported on an AIDS symposium held at Spelman College in Atlanta, Georgia, for the purpose of educating college students about this disease which is spreading rapidly in the minority community among the college-age group. Spelman is a member institution of the Atlanta University Center. More than 10,000 students attend the six institutions that make up the Atlanta University Center, but only about 30 students attended the SCLC/Women's World AIDS Day Education and Prevention Symposium at Spelman.[21]

Attending the Spelman symposium was Dr. Louis Sullivan, former United States Secretary of Health and Human Services. Sullivan reported that more than half of the reported AIDS cases in 1993 were among African-Americans or Hispanics. While officials listed the grim facts regarding the spread of AIDS in the Black community, the college auditorium was half-full for much of the symposium. Half the audience included SCLC staff and supporters, Atlanta University Center officials and staff, and a few student representatives from colleges throughout Georgia. The attendance seems to indicate that many college students are ignoring the problem.

Gerry White, a 27-year old Clark-Atlanta University student attending the conference said he knows what will wake up students--"someone close to them suffering with AIDS." It was a friend's death that gave him the wake-up call. He said further, "I saw him (his friend) laying on his death bed, eyes sunken in, warts all over his body, and I watched him struggle to open his eyes."[22]

While responses to education campaigns such as the one at Spelman are often dismally low, the outlook is not totally bleak. Dr. Robert Staples, an associate professor of Sociology at the University of California in San Francisco offered some positive data on Black human sexuality:

> The most popular myth is that Black sexuality has always been and continues to be unrestrained and unrestricted, but in reality Blacks are very, very conservative in their attitudes and practices toward sex. For example, in a study that concentrated on the ethnic and cultural differences in women's sexual behavior, 74 percent of white women and only 26 percent of Black Women in Los Angeles County, California, between the ages of 18 and 36 had 13 or more sexual partners. This survey revealed that 69 percent of white women and only 31 percent of Black women had four to seven one night stands since age 18. The data on men is just as revealing. Researchers at the Battelle Human Affairs Research Center in Seattle were looking for sexual behavior that might influence the spread of AIDS and other sexually transmitted diseases when they surveyed men across the nation in their 20's and 30's.[23]

The sociological environmental facts show some low-income urban African-Americans living conditions can influence AIDS prevention efforts. According to De La Cancela:

1. A person may engage in unprotected sexual behavior for economic motivations;

2. Lack of access to health care due to economic status is conducive to the transmission of AIDS for the following reasons:
   a. poor minority individuals with already compromised immune systems may not receive adequate care;
   b. disease prevention information is received late;
   c. individuals with STDs like herpes, syphilis, or chlamydia may forego treatment;
   d. those addicted to substances do not receive care or detoxification.

3. A history of racism, ethnocentrism and classism in governmental and medical/scientific planning and policy may make minorities distrustful of such bodies and therefore less likely to listen to messages they deliver.

4. Over-representation of minorities with substance abuse and in jail places them in circumstances in which they are likely to participate in a culture of sharing drug paraphernalia and engage in homosexual activities.

The impact of homosexuality on the spread of HIV/AIDS in the Black community is a difficult and sensitive issue. *The Atlanta Journal* reported Duncan Teague of the African-American Lesbian/Gay Alliance (AALGA) of Atlanta, Georgia, stated,

> It doesn't make sense to ask for your liberation as a person who is part of a sexual minority when you're being murdered because of your

> color. Alienated from the black church and the community as a whole, black gays become a dual minority: discriminated against by white and black people alike. Most openly gay black men can relate stories of being attacked, either verbally or physically, by other black men. Such hostility, black gays say, is common. Much of this hostility come from the history of oppression of black people.[25]

Stung by AIDS and persistent hostility within the black community, the AALGA have formed their own political organizations, magazine, unofficial churches and athletic leagues. In summary, the Black gay community, both male and female alike, have organized in Atlanta and in major cities around the United States to become socially acceptable.

The sociological issues surrounding HIV prevention in the African-American community are summarized in the studies of De La Cancela, Nickens and Quimby. However, the real issue stated here is condom use as an acceptable prevention method among both male and female cohort groups. The growing edge for the community-based prevention programs is reaching the college campus population in the United States. The cutting-edge for the Black community and the Black church is gay/lesbian acceptance as a reality and not a myth, as we face the turn of the century.

The Ethnographic and Cultural Perspectives

Cultural differences affect health status and outcomes and, therefore, health programs must be developed to address such differences. Cultural social norms and values of the African-American community should be incorporated into HIV education/prevention efforts. An effort to bring theoretical clarity to human phenomena must be informed by an understanding of the socio-cultural context in which the phenomena occur.

There are four areas of the African-American world view that play a significant role in understanding the ethnographic approach to an effective HIV/AIDS ministry: holism, harmony, spirituality, and communalism, as stated by Randolph and Banks.

> "The Holism value-system emphasizes all aspects of a person's thinking, feelings, and behavior. The black individual and the black family make sense of their world and their experience as it determines which

> events are meaningful and which are not. Value system provides the process by which those events are made with their lives."[26]

HIV/AIDS facts must be placed within the appropriate cultural, social, and historical context and be made personally and communally relevant to persons of African descent. The American Red Cross, in its African-American HIV/AIDS prevention program, has a proverb poster that reads, *The ruin of a nation begins in the homes of its people*. The African-American community now has a population that has AIDS related to life-style, and there is a need for approaches to incorporate the African principles of *interconnectedness* (It takes a whole village to raise a child) and collaborations (A single bracelet does not jingle).

The next Africentric dimension that must also be considered in AIDS/HIV activities is *harmony*. This is when one must overcome the fear of being identified as having the virus as well as condoning the life-styles. The most aggressive approach to HIV/AIDS ministry in the African-American community may be to show how the Christian ministry relates to one's total life experience with the community.

The more traditional dimensions of the African world view will enhance a Christian ministry program in the areas of spirituality and communalism. In most cases, the spiritual nature of people may suggest that the church can be useful in a ministry to PLWAs but the church has been slow to respond on the basis of moral reasons or contradictions with church teachings. At the same time, the church has not been a vehicle to address issues of human sexuality and to openly talk about drug addiction, except from a negative perspective.

The next African world view is *communalism*; it is the understanding of the collective self. This is a theory to motivate a person toward safe sex practices such as using a condom which runs counter to the value of children and collective survival for all humanity.

Airhibenbuwa, *et al*, state that HIV prevention efforts aimed at African-Americans must recognize the power differential called *gender roles*. Gender roles define the nature and type of activities pursued by men and women. For example,

> One reason why many women do not use condoms or do not negotiate condom use is related to sex-role socialization and social class

> issues. While it might seem that inability of women to use or negotiate condoms contributes to the maintenance of the imbalance in the male-female relationship. In a larger context, female powerlessness is better understood in the context of economic security. The role of sex may be seen as a barter in exchange for the financial support of a male partner. A woman may place more value on securing food and shelter for herself and her children than on practicing safer sex, particularly from an indigent African-American woman's perspective.[27]

The African-American cultural views must be viewed in the context of the black family and the black church according to the facts and findings for an effective HIV/AIDS community-based church program ministry. There are several cultural characteristics that should be understood before doing ministry with any community; only a few will be considered here.

Culturally, the Black family must be at least understood before the work of AIDS ministry can begin. "The African-American cultural values state the extended family belief system states all the aunts and uncles are responsible parents of all their nieces and nephews, the belief in collectivism as opposed to individualism and respect for age."[28]

The strengths and weaknesses of the Black family unit must be understood.

> The studies of E. Franklin Frazier and Daniel P. Moynihan have culminated in the adaptation of social policies predicated on the assumption that the black family is unstable, disorganized, and unable to provide its members with the social and psychological support and development needed to assimilate fully into the American society.[29]

In short, HIV/AIDS prevention and education programs for African-Americans should be culturally relevant to the Black family. There must be cultural education not only for the Black family, but for the knowledge of community culture as well. Beyond 1973, it seemed as if culture for African-Americans was experienced in community; since that time our youth seem to easily forget cultural values and norms. Cultural education is important as the issue of HIV/AIDS and African-Americans is discussed.

> Culture represents a set or sets of shared behaviors and ideas which are symbolic, systematic, cumulative, and transmitted from generation to

> generation which provide a group or nation of people with a general design for living and patterns for interpreting reality.[30]

Psychological Perspective

There are psychological facts, findings and data that must be considered in the African-American community prior to doing HIV/AIDS preventive education ministry. The literature suggests that in the Black community, health prevention programs such as HIV/AIDS can best be implemented by persons or institutions which are a part of the community, such as the church. However, there are psychological, congregational and public fears about HIV/AIDS that should be considered for a ministry with PLWAs.

The Atlanta Journal-Constitution reported the psychological fears of some small town communities. Ellen and her husband, who also has AIDS, have left the sting of the ignorance that breeds fear, even hatred. Garbage has been thrown in their yard. They've received anonymous phone calls. They had to hire a lawyer to get their five year-old son in school because they have the virus.[31]

There is much information, education and improving media coverage on this issue, that by now, great improvements should be made for PLWAs. Until now, the PLWAs faced with great injustices in all segments of society because of fear, ignorance and prejudices. Barbara J. George of Ecumenical Ministries of Oregon, has developed a chart comparing six congregational attitudes towards AIDS which she had observed in popular opinion when the disease first became a public issue. She gives names to the categories of opinion; *plague, not me, wrath of God, conspiracy, public health, and human dilemma.* However, the first four here are negative, counterproductive attitudes and interfere with a responsible approach to the problem.[32]

In the *plague* mentality, PLWAs were viewed as leper-like people and the average person would want to avoid places where a PLWA might be found. In this state of thought, persons worry as individuals, but expect the general public to find the cause and cure. However, the extreme of this view is to suggest that all persons infected with HIV be isolated

into quarantine camps so that they would not be free to walk about in public. This is based upon inadequate knowledge of the congregation about HIV and AIDS.

The *not me* approach states that PLWAs are *somebody else* (IV drug users and homosexuals) in which persons use denial and bad humor about PLWAs. An earlier community level to this approach was *those people* would eventually infect each other and die off and end the problem. Closely related to this view was the conspiracy approach which is stated several times in this work about AIDS was brought to our community by an enemy faction. This is the frame of reference until AIDS come to church and finds our members and their families.

The *punishment of God* mentality is voiced loudest from the religious community. The PLWA is looked upon as a *sinner*, that reflects divine punishment from God for bad behavior. The only way the church with this mentality responds is confined to the mandate of abstaining as the way of solving the problem. For example, in 1988 the Southern Baptist Convention took this position by stating AIDS is a punishment of God.

The last two of the George attitudinal categories about AIDS are ones with which the church could be identified. The first one is *public health*, where the PLWA is not an outcast or a sinner, but a patient. The final approach, the *human dilemma* view is where the PLWAs are identified as our brothers and sisters in trouble.

The *public health* view is a commendable one for the community of faith because of its openness toward PLWAs, and a more neutral rather than judgmental attitude toward the virus and its concern for personal and community education. But better is the *human dilemma* approach because it encompasses compassion and solidarity with the PLWAs, which is where the Christian needs to be. Compassion is the unique ingredient which separates the *human dilemma* approach from all the others.

Churches are moving to a more compassionate approach--away from the idea that AIDS is a punishment of God, or somebody else's problem or a conspiracy or a plague out of control. In each congregation there will be persons who will have many fears with which to

deal, and who will adhere to one or another of the destructive points of view. It becomes the task of those experienced in the public health field to help persons to deal with their fears and to move the congregation toward a compassionate, Christian response.

The psychological views and issues that face the African-American community and their congregations must always struggle to overcome the fears that hinder us to do an effective HIV/AIDS ministry. In many instances the Black clergy has fed the psychological paranoia. When a clean-needles program was first proposed in New York City in 1989, the minister of Abyssinian Baptist church decreed he was not in favor of cooperating with the devil. Also, the minister who presides over the Plymouth Congregational Church in Washington stated in 1994 "the white establishment pushes drugs into the communities, they cripple the community politically and economically with drugs. They send the Black males to jail."[33]

The cultural item that must be understood in the African-American community is the aforementioned theme of suspicion and mistrust. The feelings of suspicion and mistrust experienced by many African-Americans whenever whites express a sudden interest in their well-being has hindered progress in this health crisis. As a result, it is more expedient for the African-American community to offer its own models for HIV prevention and caretaker programs.

Another issue in the African-American community is the perception that AIDS education is being *imposed* on the Black community by the white majority culture. HIV prevention programs targeted towards the Black community must foster trust and respect in order to gain acceptance. The program must also take into account the needs of this culture, especially as it reflects the African-American experiences within the context of American culture.

Hanna Rosin writes of a middle-aged Black man, Otis, who found out he was HIV-positive in 1986. When he confided in his minister, the man pointed at him the next day in church and preached about the sins of bad living. Otis won't go to an AIDS clinic, even for a

prescription. "Nope. That's you know . . . a homo place, and your mama or your cousin or anybody could see you go in and then you're branded for life.[34]

The shame surrounding AIDS in Black America makes prevention almost impossible, and treatment widely refused. Thus, the infection continues on an increasingly upward curve. There are some people who would rather not know; one reason being the homosexual connotation closely associated with the disease.

The HIV/AIDS epidemic brings psychological fears to all. *The Washington Post* offered the following scenario:

> You run to a car accident scene and discover a well-dressed 30 year-old man suffered a heart attack; a bit of blood is dripping from his forehead. Would you administer mouth-to-mouth resuscitation? If you're a doctor, nurse or resident at a large Los Angeles teaching hospital, the answer is likely to be "NO".[35]

Clearly, the federal, state, and local governments face significant problems with this public health issue. Public health officials are challenged to ensure that effective and equitable HIV policy, programs, and funding efforts are administered effectively and equitable in all communities of America.

Summary

Documented examples of health education programs and health care programs to assist communities are evidenced at national, state and local levels of government. However, our particular concern here is the African-American community as it relates to government involvement. Collaborative efforts between public health officials, researchers, health professionals, and community-based service providers are critical to effectiveness of education and prevention programs. Such collaboration can enhance understanding of the role of cultural and socioeconomic factors in the transmission of HIV, the disease process, and access to health care. Information gleaned from these efforts should be taken into account in designing HIV prevention messages, services, programs, and in providing expanded treatment opportunities.

A distillation of appropriate cultural information illuminates the need for the Black church to be a vehicle for providing compassionate, community-based health programs with education/prevention as the focus of congregational responses and actions.

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CHAPTER VII

THE PRACTICE OF AN HIV/AIDS MINISTRY AT THE ANTIOCH AFRICAN METHODIST EPISCOPAL CHURCH

Limitations of the Model

Persons who have high church involvement were most likely affected by the education/prevention intervention efforts of this project. Such was the case because these persons were more receptive to the message, and they did not present a threat to the volunteers. Conversely, persons who have low to no church involvement were less likely to be impacted. The para-organized (unofficial) groups in the community such as gangs, drug-dealers, prostitutes, street corner inner-circles, bar room patrons, and homeless persons were not directly reached in this model. While there may be unintentional effects to such persons who are part of extended family and friends circles, they were not direct recipients of the ministry.

The model has broad generalizability to other A.M.E. churches. However, because it was developed with the episcopal structure of African Methodism, it has more limited applicability to other African-American churches. The review of literature will be informative and useful in all denominations.

The oral tradition is strong and has a dominant presence in the African-American community. Therefore, there is a dearth in the operational component of the literature (preaching, teaching, administration). Additionally, African-American congregations have limited involvement in HIV/AIDS ministries; that which does exist, has not been well-documented.

The Episcopal Framework for Ministry

The Role of the Pastor. In the episcopal structure of African Methodism, the pastor serves as chairperson for all organized boards. As such, he/she is the catalyst for innovation and progress in local congregations. Additionally, he/she serves as the official worship leader; he/she sets the tone and creates an environment which is intentionally inviting and conducive to worship and fellowship. The order of worship should inspire, inform, empower, and maintain theological relevance to all hearers. When embarking upon a ministry as sensitive and potentially controversial as an HIV/AIDS ministry, a strong pastoral presence is essential.

In the tradition of African Methodism, the Antioch A.M.E. Church is a pastor-led congregation. There is a strong expectation that important projects and initiatives will receive more than tacit endorsement at the pastoral level. Therefore, with the initiation of the HIV/AIDS ministry instituted at Antioch, the pastor was visible and prominent as primary researcher and advocate for the project. High pastoral visibility and active involvement helped to increase congregational receptivity to the ministry issue. Because the project included a community component, the pastor's role included creating linkages with other churches and community organizations having an interest or existing involvement in HIV/AIDS ministry.

Recognizing that the power vested in the office of pastor is insufficient to ensure the acceptance and institutionalization of innovations, the pastor sought to epitomize effective leadership. Good leadership is characterized by an unusual duality. While it is almost universally recognizable, it has an element of mystery about it. Bishop Rueben P. Job asserts, "Ask any local congregation and they will tell you when they see it and when they don't."[1]

He continues by attributing much of the success of effective leaders to intuition, flare, risk-taking, and sometimes even theatrical ability. In such a scenario, judgment, feeling, sense and values emerge in primacy and in total contrast to such generally revered qualities, as efforts, education or experience.[2]

The Official Board. This official governing board of the local A.M.E. church consists of the leadership from all component parts of the local church organization. The pastor

convenes regular sessions of the official board of the Antioch A.M.E. Church once per month; special sessions are called when necessary for the transaction of church business during interim periods.[3]

In the A.M.E. tradition, a new idea or new ministry is presented to the pastor and the official board of the local church for approval. The pastor appealed to the official board for acceptance of the HIV/AIDS ministry as a new ministry undertaking for the Antioch Church. The appeal included a request for financial and spiritual support of the new ministry. All persons who were selected by the pastor for the small group ministry were present at the official board meeting to give credence and support to the ministry.

A pretest was conducted to assess the existing level of knowledge board members possessed concerning HIV/AIDS (*Appendix 14*). To orient board members to the proposed ministry, literature was disseminated for further reading. Each board member was telephoned as a follow-up and reminder to read the hand-out before the next month's official board meeting.

Second Official Board Meeting. A congregational HIV/AIDS policy and mission statement received approval during the third session of the ministry's introduction to the board. The policy was signed by each member of the board and ministry team who was present at the meeting. The board voted to present this ministry issue to the congregation.

The Church Conference. The church conference is a meeting of all members who are in good and regular standing with the local church business.[4]

The HIV/AIDS ministry was presented to the church conference following approval by the official board (*Appendix 15*). The church conference was scheduled approximately three weeks following the official board meeting. The process of presentation and approval was a condensed version of the orientation the official board received during the preceding three sessions of the approval process.

Creating a Climate for Ministry

In order for an HIV/AIDS ministry to achieve maximum potential, it must be instituted in a caring and supportive climate. The church must be viewed as the *community of the compassionate*, which in the eyes of most African-Americans is central to the biblical mandate of the church. Persons and families living with HIV/AIDS must have a general feel that the pastor is a compassionate person in a welcoming church. Compassion as defined by Messer means "to suffer with other people, to enter into places of pain, and to share in our common weaknesses, fears, confusions and anguish."[5]

God's grace works through the minister and the ministry for many sick and hurting persons. To effectively minister to PLWAs or to people most likely affected, the minister must project an image as the wounded healer in a community of the compassionate, as described by Donald E. Messer in his book, *Contemporary Images of Christian Ministry*.[6] He must be viewed as a person who is professional (pastoral counseling) and a person who cares (pastoral care). Edward P. Wimberly in his book, *Pastoral Counseling and Spiritual Values: A Black Point of View*, says:

> "Pastoral counseling is a dimension of the liberation ministry of the church: first, to help free people from those internal, interpersonal and family shackles that prevent them from moving toward their full potential as children of God. Pastoral counseling is a dimension or extension of pastoral care, focusing on issues the pastor and counselee can agree on by open contract.[7]

He continues by stating, "The pastor and the congregation take the initiative because they recognize the need; however, in responding to that need, other needs may emerge that are recognized not only by the pastor but also by the parishioner."[8]

The lay workers must feel that the pastor is caring, and both pastor and laity must have a bonding people-oriented and people-centered relationship. When this is achieved, people and their needs become the primary concerns of the church leadership, and ministry effectiveness is maximized.

Formulating Ministry Teams

In the Antioch model, the pastor selected the laity trainees who would serve on the ministry team. As Weems said of leadership, "so it is in the selection of laity to serve for this ministry issue . . . it involves intuition, risk-taking, judgment and feeling."[9]

Individual Pastoral Care Sessions. The individual sessions focused on the selection of persons to join the HIV/AIDS ministry at Antioch. The pastor relied on intuition and personal knowledge of members to identify persons who might have an interest in the HIV/AIDS ministry. After six weeks of interviews and individual sessions, ten persons were selected, all of whom had been affected by the illness in some way.

The pastor used the individual sessions to discern each candidate's temperament for this ministry issue. The pastor, as interviewer, guided the conversation from a general discussion of social problems, to a more specific focus on the issue of disease, particularly AIDS. The following guidelines for recruiting project trainees were successful in the Antioch model.

1. Get to know people in the congregation whose lives have been touched by AIDS, or who have encountered others with it. If the pastor is able to create an inviting atmosphere and to project sincerity, compassion and professionalism, people will generally respond by volunteering their time to the ministry issue.

2. Form prayer partners to teams consisting of family and friends who are living with or know a person living with AIDS. Five prayer partner couples were formed for the Antioch project.[10]

These partners/teams were constituted from members of the congregation who had been touched by AIDS. The pastor, as primary researcher, served as leader of the team during initial stages. This role and involvement was critical to creating a climate in which the pastor's vision for the ministry could be shared, focus could be developed, and cohesion and bonding could be effected among members of the teams. Additionally, the pastor is acutely aware of the stresses involved in ministering to others on a continual basis. Because of his

active involvement in the training of the teams, he is able to detect early signs of discouragement, disinterest and impending disaster for trainees who may not be suited to this particular ministry.

Small Group Ministry. After the individual pastoral care sessions and the selection of the ten trainees (this phase of the project can be called *recruitment*), a small group was formed to plan for the work of the group. A group leader was selected to facilitate the work of the pastor as trainer. The criteria for selection were commitment to the HIV/AIDS ministry, ability to share the pastor's vision for this ministry in the local church, and willingness to follow-up on the training. After four-to-six weeks of meetings, the individual level of commitment was discernible for each of the project participants.

The Training Module

Consistent with the overall goal of the project, the training was designed to build upon the best knowledge and practice currently utilized in the health education community, and to make optimal use of the untapped human and cultural resources in the African-American community at large. By merging these two components, an element of cultural competence heretofore absent in health education/prevention programs targeted to African-American communities, was introduced. *Culturally competent*,[11] in the context of this project, suggests effective use of skill resources and knowledge that are responsive to the cultural values and norms, strengths and needs that relate to the prevention of HIV in the African-American community.

The ten persons selected for training spent four-to-six weeks meeting in two-hour sessions each week. The sessions were designed to increase the knowledge and awareness of HIV/AIDS-related illnesses, to help allay any fears and apprehensions trainees harbored, and to promote a more positive attitude about PLWAs. An additional goal was to provide a forum in which trainees might seek the spiritual renewal necessary to sustain them during this ministry.

The pastor was the lead-trainer of those selected to serve; he served also as a member of the training class. Professional community trainers and support persons were invited to sessions during the four-to-six weeks training period. Trainers and support persons came from the local AIDS Atlanta, Inc.; the American Red Cross; Common Ground, Inc.; Emory University; Morehouse School of Medicine; Sisters in Love, Inc.; and the SCLC, Inc. An on-site training component was conducted at Grady Memorial Hospital.

The members of the group shared articles which highlighted HIV/AIDS from an African-American perspective; they visited the DeKalb County Board of Health to gather additional data on this ministry issue. The group members continued to discuss the impact of HIV/AIDS on their personal lives. They sought to discover ways in which the congregation might be motivated to share in this ministry.

The goal of this segment of training was to heighten awareness regarding the AIDS illness, and to discover opportunities for AIDS ministry in the church. A 10-minute discussion of the problem was presented by the pastor, followed by a 3-minute appeal from two of the members of the small group. The follow-up activity included an HIV/AIDS awareness survey. (*Appendix 16*)

The Antioch congregation financially supported its volunteers with transportation to the training sites and fed the volunteers one meal per training day. These six sites were approved by the pastor. The training sites were as follows:

1. The Grady Memorial Hospital Health Care System
2. AIDS Atlanta, Inc.
3 The AIDS Network at Emory University
4. The Southern Christian Leadership Conference Headquarters.
5. The Morehouse School of Medicine
6. The Antioch A.M.E. Church.

Each site was located in the metro-Atlanta area, and each offered various approaches to HIV/AIDS prevention and care. Each training site received correspondence outlining

intent and expectations six weeks before the training date. Letters of reminder were sent to each volunteer two weeks before the starting date for the training, and a telephone call of reminder two days before the starting date for the training. The training period was eight weeks for community volunteers who were recruited by the Antioch volunteers.

The Antioch volunteers set forth specific guidelines for the training program. Foster, in an article published by the *Journal of Black Psychology*, gives four key philosophical principles for an HIV/AIDS training program in an African-American context. The principles were adopted for use in this project:

1. *Harmony*: a belief in a spiritual force that acts as a connective link to all life and beings. That same spiritual force lends direction, purpose and energy to human endeavor.

2. *Interconnectedness*: the belief in the individual, group, family, community, and all animate and inanimate entities are viewed as integral parts of a larger interdependent system.

3. *Authenticity*: the highest value lies in person-to-person interactions and relations. It is the capacity to be true to ourselves; even in our relationships with others, that brings fulfillment.

4. *Balance*: the principle of an ongoing process of mediating competitive or opposing forces.[12] The training objectives were helpful for the initial training of the Antioch volunteers, and subsequently, the community volunteers. The training component for Foster's study, *An Africentric Model for AIDS Education, Prevention . . . within the African-American Community*, was adopted for the Antioch model. The primary objectives of the training were as follows:

1. To provide a base level of information regarding AIDS and its impact on the African-American community;

2. To increase awareness and to sensitize program participants (volunteers) to the plight of HIV/AIDS sufferers and their loved ones;

3. To increase understanding of and sensitivity to the dynamics and cultural realities of African-Americans who are HIV positive;

4. To enhance each volunteer's ability to provide culturally competent AIDS educational workshops.

An introductory course was held at each of the work sites. These workshop sessions had four primary objectives:

1. To increase the knowledge-base of the volunteers regarding the HIV virus;

2. To facilitate the development of culturally competent knowledge and skills as they relate to HIV prevention, education and intervention in the African-American community;

3. To provide opportunities for trainees to develop supportive relationships with other concerned persons in the community;

4. To assist each trainee in developing a strategy relevant to their respective local needs, with emphasis placed on the need to educate local constituents and network with existing congregational service providers.[13]

Church Involvement

Memorial Sunday Observance. A memorial Sunday is observed each year during the weekend of the national Memorial Day celebration in the United States. During the worship service, names of the departed members of the local church are recognized and their memories honored at Antioch. It is significant for parishioners to hear the names of their deceased loved ones and to know that their lives are memorialized. As PLWAs die from their illness and the families move forward with the healing process, the church and congregation are viewed as *the community of the compassionate*. Carl J. Scherzer in his book, *Ministering to the Dying,* says:

> "This service is a chance for the minister to tell his people about the scriptural implications regarding immortality and man's preparation for the eternal life. It affords the minister an opportunity to share the significance of the sick, and to renew understanding of how our religious virtues may help us meet our spiritual needs in time of sickness and death."[14]

From time to time the minister is asked to address various church classes and organizations. These are excellent opportunities to explain the significance of the pastoral care for the sick.

Scherzer further states that pastoral letters written by the minister, from time to time, are instructive about the sick list and those in the hospitals, at home, and in the nursing home, enabling the congregation to be *compassionate* in community ministry. The concept of pastoral letters has been a tradition at Antioch for a number of years. As pastor, this writer transformed the practice in order to personalize the act and to make it an integral part of the HIV/AIDS ministry.

The Worship Service: Altar Meditation (Call). In the order of worship for the African Methodist Episcopal Church, there is no designated section for altar call. However, like many other churches in the A.M.E. tradition, the practice is a part of the Antioch order of worship. This is the time a worshiper can come before the public assembly with other worshipers, kneel at the chancel rail before the alter, and enter into prayer. While this is a public act, it possesses a very private and spiritual aura.

Shelp and Sunderland in their book *AIDS and the Church - The Second Dacade*, say:

> "Pastors can heighten a congregation's awareness of the sufferings, needs, and opportunities for ministry that people with HIV/AIDS present by referring to them in intercessory prayers and (periods of meditation). Pastors are to remind the congregation that they are called to be a servant--people serving a servant Lord. Pastors can proclaim that at the center of the gospel there is a divine call for reconciliation between God and humanity and between mutually estranged human beings. [15]

The Antioch family had several members dying with AIDS. The first time the congregation was challenged about AIDS and PLWAs was during a meditation period led by the pastor. The public reaction to this event was minimal, but a few telephone calls from older parishioners indicated that there were still persons in the church and community who were unfamiliar with the epidemic.

The Worship Service: Sermons. The sermon is the focal point of the worship service. This component of the service allows the pastor to lead the congregation in a study of Scripture, thereby hoping to discover fresh words of encouragement and strength for the

faithful. The capacity and power of the scriptures to provide spiritual renewal for wounded souls is critical in all areas of ministry, including ministry to PLWAs.

The sermons designed to minister to PLWAs and their families focused on the issue of compassionate love and Biblical mandates for the church to do ministry in this area of human suffering and need. Such proclamation preaching necessitated careful preparation to protect the anonymity and confidentiality of PLWAs, as well as to ensure that the integrity of this sacred act was not compromised. McCalep summarizes these issues as thus:

> Preaching is the most powerful tool God has ordained. The pulpit becomes powerful when God's anointed messenger or vessel delivers God's anointed word. Depending on the experience and skills of the pastor, the time required to prepare a 20-40 minute sermon can vary from 20-40 hours.[16]

When preaching a sermon which ministers to PLWAs in the context of the African-American church tradition, Henry H. Mitchell provides an effective sermon outline (Appendix 17). He promotes the development of sermons about the life situation of the hearers. The challenge is to draw the hearers into the experiences of Biblical characters. This occurs because of a kind of self-recognition induced by the vividness and living relevance of the description of Biblical characters and their activities. Self-recognition promotes growth as the hearer creates parallels between the scriptural events and current life experiences.[17]

The sermon text is where every sermon is born; the sermon purpose should embody the action demanded by the text. A fitting marriage of Biblical text and behavioral purpose must precede the birth of every sermon. When text and purpose are well-matched, the flow and movement of the sermon is facilitated.[18]

The sermon's behavioral purpose is second only to the scriptural text which provides impetus for development. It is often difficult to decide what a proper purpose for a given sermon might be. However, it should reflect the preacher's intuition and spiritual discernment of the hearer's need. The purpose most often deals with the hearer's dependence on and trust in God's power or love.[19]

The body of a sermon, composed of homiletic moves, will emerge naturally when text and purpose are in synergy. The homiletic moves are intentional combinations of exegesis and exposition, with additional materials to help in the formation in consciousness of the images and truths of the word. The flow itself will be stated in principal stages of action, like acts of play, which now are often referred to as moves. The goal of each move within the sermon is to help the gospel to form in consciousness.[20]

The sermon celebration is ecstatic reinforcement filled with the good news. The surprising good news is the best way to motivate people to do the will of God. The body of the sermon is often best written after it becomes clear how the celebration will relate the text and purpose. The task of the celebration demands the free flow of joyous emotion. This joyous emotion is the preacher's own spirit, facial expression, and tonal qualities, which serve as vehicles for contagious celebration.[21]

Laity Involvement

The Laity of the church can give new life and meaning to the Christian ministry by becoming an active human resource for Kingdom-building on earth. The laity is not an ordained ministry, but without it the church would not survive. The laity ministry of the church enables the church to train and communicate the goals of the leadership through the life of the congregation. The organized lay ministry in the A.M.E. Church has connectional, episcopal, conference, district, and local levels of organization in the denomination. The selected lay group (volunteers) offers its service at no payroll expense to the Antioch local church. The lay volunteers were trained utilizing the same strategies employed in the training model.

The purpose of the Antioch volunteer group was to foster HIV/AIDS awareness in the congregation, while maintaining the least intrusive presence. Formal meetings and group settings were minimized. Evangelistic enlistment was not the focus of their mission. Shelps and Sutherland say,

> "To view evangelism as the primary objective of ministry to people with AIDS is to misunderstand ministry and probably will be counter-productive with the targeted audience. Thus, the purpose for all ministry, including AIDS ministry is to represent God's love for all humanity, without condition, and to embody and express that love in all human relationships.[22]

It was important to create a team identity among the ten persons initially selected and trained for this ministry. The persons became a community within the community of the congregation. Evelyn E. Whitehead and James D. Whitehead put it simply: "Community is a gathering of people who support one another's performance. . . . Community is the place where we learn how to hold one another."[23]

This team served to nourish a group of volunteers which was bonded by the common cause of HIV/AIDS awareness/prevention and offered spiritual enablement. Volunteers do not need contracts so much as they need covenants and for them, relationships always count more than structures.[24]

Lovett H. Weems, Jr., states ways to foster team building for most causes:

1. Treat everyone with respect on the team.

2. Involve each team member in developing cooperative goals, planning, and problem-solving; it will pay rich dividends.

3. Collaboration is the task of making sure the people in the group who have the knowledge and the people who can make change happen are working together.

4. Allow the laity more power by entrusting them with projects; as a result, they will grant the influence and power to the church leadership.

5. The laity is the information grapevine in a local church. This can be accomplished by surveys, focus groups, neighborhood group meetings, staff, discussions and comments among themselves.

6. The laity must be recognized from the church leadership for their volunteer service in ministry projects.

7. The laity in ministry projects such as HIV/AIDS must love the people and not the issues. The volunteers must have a heartfelt love for people.[25]

As the Antioch laity embarked on this ministry, they decided it was not evangelism, but rather, a communication activity. The goal was to communicate HIV/AIDS awareness to the congregation and community, while offering a ministry of support, nurture and consolation to PLWAs. The laity at Antioch A.M.E. Church communicated their HIV/AIDS ministry story utilizing the following activities: a public announcement series, the Sunday School ministry, a word-of-mouth campaign, and a door-to-door campaign.

Public Announcements. Information is the key to educating an information-age people. The DeKalb County Board of Health provides information on AIDS-related deaths. The Anioch A.M.E. Church utilizes this data to disseminate information on deaths among PLWAs in South DeKalb County (the location of the Antioch A.M.E. Church). The information is printed in the public announcement section of the Sunday morning Antioch worship bulletin on a periodic basis. The announcements generated interest among lay workers in the congregation. This was evidenced by the telephone calls received through the administrative offices of Antioch from persons volunteering to join the ministry group.

Radio announcements were another component of this campaign. A local radio station allots free time for church announcements submitted within their deadline. To ensure adequate lead-time, the announcements for this project were submitted three weeks in advance. Several calls to the Antioch Church resulted from this media effort.

Sunday School Ministry. Dr. Jonathan Jackson says, "Christian education is that ministry which undergirds all the other ministries of the church."[26] The Sunday School is probably one of the most conducive venues for Christian education in the A.M.E. Church. As a teaching arm of the church, it provides an excellent opportunity for the laity to become involved in an AIDS ministry. The Sunday School superintendent was active from the beginning of this ministry.

The Sunday School at Antioch decided to undertake this study in a two-pronged approach. The first area of education is awareness/prevention of the disease; the second

general area of study is behavior that places people at risk for HIV infection. The pastor met with the Sunday School staff to prepare for an open forum during the Sunday School hour.

The area of education included information on the HIV virus. its means of transmission, rate and demographics of infection, preventive measures, physiological test for infection, symptoms of infection, secondary complications, and precautions to take when ministering to infected persons.

The exciting experience led to creative ways to involve and educate parishioners through the Sunday School. To bring the issues to life, there were role-playing episodes by teenagers in the congregation. The adult leadership of the church identified the issues and the appropriate responses from the church. These scenarios depicted the various circumstances in which the disease is transmitted in society. The true context must be shared about the disease as it is transmitted. One participant focused on an AIDS patient who was homosexual; the next one focused on an IV drug user; the next one focused on some who contracted the disease through blood transfusions; another on a newborn baby and its parents. The most poignant scenarios revolved around parents whose children have AIDS. These role-play activities created the kind of lasting impressions that no other dialogue had been able to achieve during this ministry campaign.

The Laity Word-of-Mouth Campaign. The Antioch word-of-mouth campaign enlisted the assistance of each volunteer member to talk with at least ten persons in the congregation and in the community concerning the HIV/AIDS disease.

A list of names was developed from the membership roll and disseminated among team members. The goal was to talk with each person on the list within a two-week period. At the conclusion of the two-week period, a meeting was scheduled on a week-day afternoon for debriefing.

The meeting lasted one hour and focused on the information gathered. It was discovered that volunteer members used a variety of settings to reach the persons on their lists: telephone calls, choir rehearsals, Bible study class, community club and church meetings.

The volunteers indicated that most persons seemed unknowledgeable about detailed information concerning HIV/AIDS. However, their findings indicated that all the persons had heard of the disease. Several persons indicated that their first introduction to the disease was through the Antioch church ministry. When asked whether the persons would volunteer time to an HIV/AIDS ministry, the responses were mixed.

The volunteers discussed appropriate successive steps in their ministry campaign. In an effort to reach more people with the message of awareness and prevention, a neighborhood door-to-door campaign was planned. The pretest instrument (*Appendix 14*) was used in this campaign during the telephone calls and the Bible study class.

The Door-to-Door Campaign. The door-to-door campaign in the neighborhood was to be accomplished in four weeks. Each volunteer was given an opportunity to share a strategy for launching this campaign. During the sharing, the volunteer team accepted the idea of placing door-knob-hangers on front-door entrances of neighborhood residences (*Appendix 18*). The hanger only gave general information about HIV/AIDS, the Antioch Church name, address, telephone number, and HIV/AIDS hotline telephone numbers.

There were six adult volunteers who trained nine teenagers, mostly family members of the volunteers, for this phase of the campaign. The youths were directed to place the hanger on the door (not to ring the doorbell), what to say if approached by a homeowner, how to dress, how to speak and information on the sponsoring group--the Antioch A.M.E. Church.

This campaign was effective for a number of reasons: (1) the teenagers were afforded an opportunity to participate in a meaningful church ministry; (2) they increased their personal awareness of HIV/AIDS; (3) they became potential resources for educating other teenagers regarding risk factors associated with sex and drug-related behaviors.

The volunteers began their door-to-door campaigns each Saturday morning at nine o'clock; their activities ended at two o'clock in the afternoon. Afterwards, they gathered at the church for lunch, discussed the work of the day and generated ideas for future efforts. Each session was closed with devotion. The pastor shared insights and information with the

volunteers and provided words of encouragement. He maintained a visible presence during this phase of the project by serving as an adult worker two of the four weeks the campaign was conducted.

Several families responded to the campaign because of personal encounters with AIDS in their families. Some persons began to visit the church, others joined the church, and still others joined the team of volunteers.

In a very positive and unanticipated response, two persons called the pastor and invited the volunteer team to do a home discussion session. A home discussion session entails an individual or individuals offering their home as a forum for the discussion of a specific issue. The Antioch volunteers were available to provide information on HIV/AIDS; others discussed their fears, concerns, and feelings about working with the Antioch team. Handouts were obtained from the office of the local CDC.

The efforts of the laity volunteers were helpful in disseminating information to the church and surrounding community. Each component activity was successful as a distinct entity, and important to the collective impact of the ministry. The activities increased awareness among a large segment of South DeKalb County citizens, created interest in outreach ministry efforts within the Antioch congregation, and increased interest in the Antioch ministries within the community. The volunteers served to empower the church and community to minister to PLWAs, their families and the community at large.

Community Involvement

After the pastor and laity of the local church are committed to a ministry issue, it can only achieve a real-life dimension when it reaches the people for whom the ministry was designed. Following the mobilization of the laity of Antioch, the third component of the project was initiated. The Antioch volunteer group, in consultation with the pastor, decided the group would be most effective in its awareness/prevention campaign by networking with other organized functioning groups in the City of Decatur and the South DeKalb County community.

During the earlier phases of the project, it was discovered that large segments of the African-American community were unaware of the impact of HIV/AIDS on the community. Approximately ten approaches were utilized in the Antioch community component of this project to foster awareness, education and prevention with grass-roots segment of the population:

1. Training seminars
2. Volunteer program
3. YMCA/YWCA programs
4. Community club meetings/parties
5. Family/friends/class/community reunions
6. Senior adult programs
7. Neighborhood clubs
8. Public housing tenants associations
9. Churches (intra-interdenominational)
10. Community car-give-away campaign

The Volunteers Program. Shelp and Sunderland, in *AIDS and the Church: Second Decade*, highlight significant obstacles encountered when attempting sensitive ministry issues:

> "Ministering to people touched by HIV/AIDS differs in several ways from ministering to people with other illnesses. The fears evoked by the disease and the negative attitudes toward people whose behaviors place them at risk can combine to become a significant barrier to ministry. Some will hesitate to become involved, and some may refuse because of a concern not to offend people who oppose this ministry and to protect important relationships that might be jeopardized by unsympathetic friends.[27]

The Antioch volunteers hosted a pot-luck dinner as an opportunity for ministry. Representatives from community organizations such as AIDS Atlanta, Sisters Love and Common Ground were invited to attend the dinner. The volunteers were unaware that three persons were present who were infected by AIDS. The pastor shared this information with the volunteers during their next meeting. Following the revelation, some volunteers reconsidered their participation in the project because of fear. While the withdrawal of volunteers did not have pronounced effects on the remaining volunteers, it did affect the

morale in perceptible ways. Shelp and Sutherland provide additional insight into the problem of their writings:

> "The possible strain on fellowship may intensify as people with HIV/AIDS remain or become part of the corporate life of the congregation. Embracing people who are generally feared and disliked may be less threatening to fellowship as long as it is an activity outside the physical structure of the church. If an AIDS ministry is to have maximum integrity, it would seem to require a willingness to include in the multifaceted life of the congregation the people to whom ministry is offered.[28]

It was clear to the researcher that in this project, volunteers often did not make a commitment to the issue, but to a group or friend. Thus, the connection they maintained with the project was tenuous.

The community component of the program began with the ten persons initially trained by the pastor, and the six recruited by the Antioch volunteers. They participated in training at several of the training sites. A bond developed between the volunteers that allowed them to rely on each other during stressful times. As the volunteers grew in numbers, they were separated into teams. The theory was to increase the number of volunteers, but to maintain control of the size of the group.

The YMCA/YWCA. The administrators of the local Young Men's Christian Association (YMCA) and the Young Women's Christian Association (YWCA) were asked to sponsor a community AIDS training workshop for young men and women of the Antioch volunteers and the community volunteers.

Youth and adults from other churches and the community schools came together on a Saturday from 10:00 A.M. until 2:00 P.M. The volunteers of Antioch sponsored a cookout on the church grounds for the event. Persons affected by the illness were present. Parents and children of the YMCA/YWCA talked about HIV prevention. The speaker for the occasion was a staff member from the local YMCA/YWCA. The presentation was concluded by a question and answer period. This format was extremely successful for generating involvement among the youth.

> Opening the doors of the church to people touched by HIV/AIDS may involve opening the doors to the sanctuary, the clergy offices, the church Sunday School rooms and (church) members' homes. Living in solidarity with people touched by HIV/AIDS may require more than adult participation.[29]

The counselors from the YMCA/YWCA allowed the youth to openly engage in dialogue, raise questions, concerns and comments regarding HIV/AIDS issues. Youth leaders recognized that the youth participants might feel inhibited and apprehensive, therefore, parents and adult members of the Antioch congregation were excluded from the session. This arrangement allowed the youth to speak candidly regarding HIV/AIDS.

Some of the most positive responses to the session came from young men who had been in denial about the disease's potential for affecting their lives. In spite of previous education/awareness efforts, some of the young men refused to believe that they might become victims of this deadly disease. However, following the dialogue with PLWAs and counselors who are actively involved in HIV/AIDS counseling, they were more accepting of the possibilities. Also, they were more cognizant of how their own lifestyle choices can either increase or decrease the likelihood of infection.

Community Club Meetings/Parties/School Class Reunions. Relationships among African-Americans in the City of Decatur community are characterized by a discernible closeness. As a result, many of these relationships have been formally organized into clubs or small groups. Several of Antioch's members are affiliated with some of these clubs. Other club members are associated with various other community churches.

A number of groups and clubs have emerged from high school class reunions. For example, *Class Act of 1980* is comprised of members of the Decatur High School 1980 graduation class. They organized for the purpose of maintaining contact and developing community activities to foster unity and identity for the City of Decatur community, school and descendants.

The Antioch volunteers were allowed to discuss HIV/AIDS awareness and prevention in club meetings. A VHS tape distributed by the local Red Cross was also shown. It was not

uncommon to find that several families in any given club had already been touched by this disease. Of great concern to many of the groups was the mode of transmission of the HIV virus.

Financial donations were made to the volunteer group by the various clubs. When it was discovered through discussion that four members of *Class Act of 1980* had died from AIDS-related illness, the group made a sizable donation to the Antioch HIV/AIDS ministry. Other kinds of support included personal visits to PLWAs in their homes and at the hospitals. At the 1994 class reunion of *Class Act*, the Antioch volunteers were allowed to give literature about HIV/AIDS to all the reunion participants.

Senior Adult Programs. The senior adult programs sponsored by local congregations are in great numbers in South DeKalb County. The Antioch Seniors' Program is a member of the *Reaching Out to Senior Adults (R.O.S.A.) Program* in Dekalb County. The Antioch AIDS volunteers invited the senior adults of Antioch to the city-wide AIDS walk-a-thon. Those who were able, walked with other senior adults across Piedmont Park in the City of Atlanta, Georgia. T-shirts were given at the end of the day, food was served, and literature about HIV/AIDS was distributed.

Two weeks later. a film was shown at the Antioch Church to the senior adults concerning HIV/AIDS prevention. The senior adults decided to sponsor a Jambalaya dinner party for graduating seniors at Decatur High School to share information about HIV/AIDS. The AIDS Atlanta organization joined the senior group by presenting the information to these youth. The invitations were initiated through the school counselor's office; final approval was secured from the principal and the class officers.

Again, the youth indicated that their awareness was heightened by the interactions. They were very happy that the senior adults cared about their future welfare. The church received several thank-you notes from the students, parents, grandparents, school counselor and the principal.

The most astonishing information discovered by the senior adults was that AIDS cases are increasing in the middle-aged population.

> From 1988 to 1993, AIDS cases among people 45 to 49 years old have increased five-fold--from 6,274 to 30,279, according to the Centers for Disease Control and Prevention. Since 1985, AIDS cases among those 50 years and older has jumped from 1,498 to 40,361. For example, there's the 53-year-old grandmother from Forest Park, the 50-year-old divorcee from Snellville and the 62-year-old gay man from Atlanta.
>
> What is driving the increase in divorce and widowhood. People are re-entering the dating scene after 20, 30, even 50 years of marriage. Many aren't using condoms.[30]

Neighborhood Clubs/Public Housing Tenants Associations. There are several neighborhood watch organizations and public housing facilities in the downtown Decatur area (Zip Code 30032). For various reasons there were only a few neighborhoods that chose to participate in this project. The Antioch volunteers targeted their activities to two housing projects.

The Rosewalk Neighborhood Association meets at the Antioch Church every four months. This gave the Antioch volunteers direct contact with the residents. However, this neighborhood is comprised primarily of young European-American families; most of the families have direct knowledge of the HIV/AIDS epidemic. The president of the association gave the volunteers an opportunity to share information about the Antioch AIDS project. In spite of their knowledge of the epidemic, many persons did not realize that AIDS is the second leading killer of young people between ages 25 - 44.

As a result of this meeting, a pot-luck dinner was planned with Antioch, a nearby Quaker group, and the Rosewalk Subdivision residents. The dinner was held at the Antioch Church, with approximately 275 persons in attendance. The church fellowship area and lawn were opened as areas for eating and mingling. The entire session lasted approximately two hours. Approximately 45 minutes was devoted to dialogue focused on the topic, *The Local*

Congregations in AIDS Ministry: A Christian Mandate. HIV/AIDS literature was distributed to those in attendance.

The group decided to target two public housing complexes with HIV/AIDS information. Permission was secured to display posters in the laundry rooms, game rooms, mail rooms and the main offices of each public housing complex. The Antioch Church's telephone number was one of several listed as contact numbers for follow-up information. Several calls were received over a period of months. The church vans were used on several occasions to provide persons with transportation to hospitals. In most cases, these persons were already experiencing AIDS-related illness. Sometimes neighborhood club members would help as volunteers for specific projects, such as going to the hospital with a sick person. However, these persons never formally joined the Antioch volunteers group. What seemed most unfortunate, as observed during this ministry experience, was that the people affected most by HIV/AIDS (youth and young adults) showed the least interest and participation.

Intra/Interdenominational Congregations. There are several organizations in metro-Atlanta, Georgia which focus efforts on the HIV/AIDS problem. The Antioch volunteers joined one such organization, *Common Ground.* As previously mentioned *Common Ground's* mission is to be the vehicle which fosters an inter-working relationship among congregations in metro-Atlanta. It provides daytime facilities for PLWAs or HIV victims.

The congregations join by membership fee and participate by providing time, talents, and treasures of its members. Antioch provided a lunch at the *Common Ground* headquarters located in Atlanta. The food was prepared and served to the participants by the Antioch volunteers. Other congregations made similar contributions during the year.

Participation in the *Common Ground* ministry afforded the Antioch volunteers opportunities to share and gain knowledge from other congregations that were involved in AIDS ministry. This was an invaluable resource providing strength and fresh insights about AIDS ministry. Particular benefits were derived during times when the Antioch volunteers

suffered stress and potential burn-out. Prayer vigils, healing services, and prayer breakfasts with other congregations were included among the activities.

A Community Car Give-Away Campaign. The volunteer group wrote a proposal letter (*Appendix 19*) to car dealerships in the metro-Atlanta area. They shared their purpose of promoting HIV/AIDS awareness, education and prevention in the Decatur area. Twenty-three letters were sent out; three responses were received. One dealership donated a 1994 Toyota Tercel car; the other two dealerships made cash donations.

The volunteers decided to sponsor a community car give-away campaign. The idea received the endorsement of the pastor and was taken to the official board of the Antioch Church. The campaign was accepted with some excitement, concerns and reservations. However, the feedback was more positive than negative. The official board voted to present the campaign idea to the church conference as a church project. It was approved. This gave the volunteers more human resources that were much needed.

The volunteers went to merchants and business persons in the Decatur community to get approval to display the car to the public. Locations targeted for the display were high-volume-customer stores. The following accepted the proposal and participated:

Kroger Food Store, Inc.
Cub Food Store, Inc.
Fred's General Foods, Inc.
Chevron Service Gas Station
BP Service Gas Station
Racetrac Service Gas Station
Hardee's Fast Food Restaurants

A letter of thanks was mailed to each business participating in the campaign.

To stimulate interest in the HIV/AIDS awareness, education and prevention project, tickets were sold for the car give-away. The tickets included local HIV/AIDS contact telephone numbers printed on the back (*Appendix 20*). In order to project an air of professionalism and to give credence to the campaign, a dress code was developed for volunteers participating in the ticket sales. The approved attire was a T-shirt; dark pants or

skirt; and dark, low-heeled shoes. The T-shirt bore the Antioch A.M.E. Church name, along with the words *Fight the Killer: AIDS.*

There were approximately sixty responses/calls to the church office requesting additional information. Some callers were interested in the campaign and the church's involvement in the initiative. The names, telephone numbers and addresses from the ticket stubs were used as a future mailing list for the church and for the AIDS ministry.

This campaign provided a tremendous opportunity for the membership of Antioch and the project volunteers to promote the AIDS ministry. Banners, flyers, radio announcements, and word-of-mouth were included among the other advertisement media. Approximately 8,000 contacts were made in the City of Decatur and South DeKalb communities, and information was disseminated to persons who might not otherwise have received it.

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CHAPTER VIII

EVALUATION

The failure of many HIV/AIDS education and prevention programs to produce desired effects can be attributed to various cultural, social, political and economic antecedents. As we approach a new millennium, it is incumbent upon churches to maximize their status and position to initiate change, to oversee innovation, and to achieve results where other institutions have failed. The need, the challenge, and the window of opportunity for providing effective and relevant HIV/AIDS programs to the African-American community are present. The efficacy of this project shall be evaluated on the degree of effectiveness in filling this void.

Project Goal: To promote HIV/AIDS awareness and education among the Antioch African Methodist Episcopal Church parishioners and community.

Project Objective: To develop an effective, practical, culturally-sensitive model for an HIV/AIDS education and prevention ministry which ultimately leads to decreased incidence of the disease in the Antioch community.

Project Effects/Outcomes

1. To improve the visibility and availability of the Antioch A.M.E. Church as a community resource for HIV/AIDS education, by actively promoting collaborative relationships between the church and the community agencies.

Effort: Approximately thirty clock hours were devoted to identifying churches within the ecumenical faith community, and other community agencies/organizations which were involved in HIV/AIDS education and prevention. For three weeks, the researcher and lay volunteer devoted two hours per day to contact-identification and contact-initiation strategies.

Week 1: Telephone calls to community agencies/organizations which identified HIV/AIDS concerns in their yellow-page telephone advertisements.

Week 2: The researcher and volunteer worked out of the CDC office to identify churches and agencies who were known to have an HIV/AIDS focus.

Week 3: Churches and agencies identified during the initial two-week period were contacted by telephone. The list of prospective collaborators was reduced to five churches and agencies.

Performance: The targeted organizations and churches were contacted for interviews. During the dialogue, the researcher and lay volunteer shared the focus of the Antioch project and enlisted the cooperation and inclusion of the groups in the Antioch initiative. This initial phase of the project was very successful, as evidenced by the participation of the groups in subsequent phases of the project. Also, the number of rebound referrals received during the project is indicative of the success and effectiveness of the Antioch participation in this collaborative effort toward education and prevention.

In addition to the contacts initiated and the information obtained during this process, brochures and other literature available through the various organizations were collected for strengthening the referral network established for the project.

Adequacy: Through the efforts of this project, the pastor and lay volunteer became better informed about existing programs and resources in the Decatur community. Additionally, other churches and organizations/agencies became aware of Antioch's involvement with the HIV/AIDS crisis in the Decatur community. It was acutely evident that too few resources, both human and material, are dedicated to systematic and comprehensive HIV/AIDS education and prevention programs in the Decatur community. Additionally, the existing programs are missing critical age groups (*i.e.*, teens and young adults) in the education and prevention process. There still remains a staggering lack of awareness of the impact the epidemic is having among this cohort group.

Efficiency: This was the most effective strategy to involve the Antioch congregation with the existing network of churches and organizations experienced in the HIV/AIDS education and prevention ministry. The congregation had limited human and financial

resources; therefore, this approach created a network for referrals, and developed exposure to other programs and services offered throughout the community.

Process: The factors contributing to the success of this endeavor were the concentrated blocks of time, and the professional and collaborative support given by the churches and agencies. The liberality in sharing information by other local congregations provided additional insight for the information of the Antioch ministry. Personal witness and involvement with persons of other faiths added a very necessary spiritual dimension to the development of this project.

The primary limitation in working with a number of churches and agencies is maintaining the involvement, interest and momentum necessary to sustain the collaborative power of the project. Establishing means for combining existing resources for mutual and maximal benefit was an ongoing challenge for persons located in different communities. The typical profile for church worker(s) involved with the HIV/AIDS ministry is a person with a part-time commitment and allocation of time between this and other ministries/responsibilities.

2. ***To improve the relationship between the church and the community by providing positive programs/interventions which have life-sustaining, life-altering and life-saving potential.***

Effort: Dissemination of information in order to increase awareness and to effect changes in behavior was the focus of the Antioch project. Education awareness and prevention workshops were initially hosted at Antioch, with other church and agency representatives participating. The workshops were moved from church to church on a monthly basis. Each congregation hosting the workshop was required to have present the pastor, the local church leadership, members of the church and their families, visitors and community leaders. The lead persons for the congregation were advised by Antioch on how to set up their invitations and rally for strong attendance. Telephone calls, written communications, and meetings with other agencies were scheduled to promote development of the workshops.

Performance: The distribution of printed materials was a critical component of the Antioch project. The Antioch Church made financial contributions to offset costs of materials used during the workshops. Additionally, Antioch's Sunday worship bulletins contained inserts which served an informational function. The door-to-door campaign and the car campaign reached large audiences in the Decatur community with HIV/AIDS literature. The radio spots provided an additional medium for information and education. Approximately 8,000 persons in the Decatur community were affected by the education campaign strategies.

Space, human and financial resources were donated by local churches to Antioch and to other community-based organizations engaged in HIV/AIDS education and prevention services.

Adequacy: The workshops were perfected in their professional approach and personalized to win people to the cause. The volunteers involved in the community component of the project were successful in reaching large numbers of persons. A degree of success was experienced as evidenced by the 57 telephone inquiries received by the Antioch Church following the community activities. However, persons who are not a part of the *mainstream culture*, and who are most likely to exhibit combinations of at-risk behaviors, were least impacted by the HIV/AIDS education and prevention campaign.

Efficiency: The strategies utilized in this phase of the project were effective, to the extent and scope of their development. Ideally, basic HIV/AIDS awareness and prevention education should be expanded to include human sexuality education and substance abuse education. These issues can be addressed through the existing auxiliary units of the church's administration. The workshops could also include congregational representation from Sunday School classes, youth departments, missionary departments, married couples ministries, and other small group ministries in the local congregation.

Strategies designed to reach intact groups were a part of the Antioch project. Further identification of such groups could yield widespread contact with larger communities of persons.

Process: The mobile nature of the workshop component of the project made it possible to reach persons outside the immediate Antioch community. Rotating the location of the workshops to the member churches of the collaborative provided opportunities to extend the HIV/AIDS project to various geographic sectors of the Decatur community.

The project was enhanced by the design and structure of the A.M.E. Church. The organizational structure, with its component auxiliaries, was particularly conducive to the delivery of the HIV/AIDS education and prevention program within the church family and the community.

3. ***To promote coordination, integration, and articulation between HIV/AIDS service-providers in order to achieve better service.***

Effort: Several schools, community-based organizations, hospitals, housing programs for PLWAs, and public health agencies, that have HIV/AIDS education and prevention programs and services were identified by the lay volunteer worker and the pastor. Antioch A.M.E. Church was placed on the mailing list of each agency. The pastor visited each site and spent approximately 90 minutes with the site supervisor or administrator. The lay and community volunteers visited several of the sites as well.

Performance: These HIV/AIDS services organizations were identified and offered the service and involvement of church members as volunteers in their programs and activities. The church offered to provide support and assistance from committed members in any area of need and capability. Some agencies allowed members of the congregation to help with sensitive issues, offering spiritual support to PLWAs and their families. The researcher shared a pastoral perspective at other agency workshops and worship services having an HIV/AIDS focus.

Adequacy: Social service and health organizations are becoming increasingly aware of the importance of the spiritual element in physical and emotional well-being. When dealing with the myriad familial and social issues accompanying this devastating disease, the benefits of spiritual support are widely recognized and sought. Because of the credibility of the

program developed through this project, Antioch received many counseling referrals from other organizations. Additionally, the church became recognized for its non-judgmental, unconditional acceptance of PLWAs and their families into the fellowship. Conversely, the Antioch volunteers were able to make referrals to medical and social agencies as the needs of the contacts were dictated.

Efficiency: Becoming an AIDS advocate for equal access to services for PLWAs in minority communities around metro-Atlanta was an important component of the project. By seeking out service-providing agencies and by reciprocating in offering services, the strategies employed by the Antioch project was very successful.

Process: The element of cultural sensitivity infused throughout the program aided in the success of the project. The general lack of trust in the government by the minority populace, made such a program welcomed and accepted. The willingness of the Antioch group to coordinate resources for better services in the Black communities gained acceptance among service providers as well.

4. To enable volunteers to complete training together as cohorts in order to promote collegiality, professionalism and mentoring support among one another and program contacts.

Effort: Training of volunteers was accomplished in three stages: (1) the pastor's training, (2) community involvement training, and (3) the professional agency training. Hours of training were required at each stage.

The ministry teams were to view one another as spiritual partners during the project. Their meetings together included 4-to-6 weeks of training conducted by the researcher and agency experts, with 2-hour sessions each week. Community volunteers who were trained by the Antioch ministry group participated in 8-week sessions.

Performance: The training principles of harmony, interconnectedness, authenticity and balance provided the necessary undergirding to promote collegiality in the group. In learning about sensitivity as it relates to ministering to PLWAs and the community, volunteers

learned to relate to one another with heightened sensitivity. They learned to communicate in non-judgmental ways, and to offer support, nurture and consolation to other volunteers, as well as PLWAs. This kind of support was particularly important during the stressful and emotionally-draining times which confronted the volunteers.

Adequacy: A strong sense of camaraderie was developed within the initially trained group of volunteers. The group was bonded to the degree that they were able to regulate behaviors of others, to ensure performance consistent and compatible with the goals of the project.

Efficiency: This outreach ministry allowed training participants to understand HIV/AIDS at a personal and compassionate level. The collegiality which developed during the training phase enabled volunteers to openly discuss among themselves issues which surfaced during the project. This was particularly critical when they interacted with PLWAs in the community who shared their personal crises with the volunteers. The professionalism which was exhibited during the debriefing sessions attested to the commitment and understanding which volunteers had developed regarding the project issues.

Process: Concepts of team-building were incorporated into the training component of the project. Team identity and the sense of community-within-community of the congregation developed among the Antioch volunteers. Allowing participants to develop and direct the focus of the group, particularly during debriefing, enhanced the commitment and ownership that participants felt. In addition to developing the sense of community, participants also developed a sense of responsibility for the success of the project and the well-being of members of the cohort. However, some volunteers were lost during the training as well as the implementation phase of the project. This can be attributed to the fact that the commitment was sometimes directed toward other individuals in the group, rather than to the cause itself.

5. To generate a research focus in local church ministry which informs future study in the area of health education in African-American communities.

Effort: The church's involvement in this HIV/AIDS education ministry enabled the participants and the larger church congregation to see that such endeavors need not be burdensome. There is a vast amount of scientifically precise, explicit, clear, and appropriate literature available through the American Red Cross, local health departments, state HIV/AIDS prevention programs, the CDC and other community-based prevention organizations and agencies which receive support from public funds.

Throughout the course of the project, the researcher highlighted the importance of this and future efforts in advancing the cause of research and practice, as well as the condition and well-being of the community. The researcher discussed characteristics and conditions of previous efforts directed toward HIV/AIDS education in the Black community. Particular emphasis was placed on the various sociological, psychological, political, and economic issues which impeded the success of the efforts. The focus of the discussion embraced a concept of the faith community's responsibility for effecting the course of future research and practice in order to fulfill and actualize their mission.

Performance: The researcher shared liberally from articles, books, pamphlets and other print media. The resources led the congregation to a realization of the need to get information to non-traditional audiences. A community health care educational seminar was held with other community-based operations, including such groups as the senior citizens. The seminars were conducted through the mobile community workshop strategy.

Adequacy: This project afforded an opportunity for the entire congregation to find a helping, ministering role outside the traditional preaching and teaching venue of the church. Project volunteers could be heard in open dialogue with one another and with other parishioners concerning the relevance of the project, and the need for future involvement. The vision emerged of the church assuming a more visible and responsible role in issues which impact the well-being of the community. Of equal importance, parishioners recognized the

need for the church to be more accessible to the community, particularly in terms of re-casting itself as a community of the compassionate.

Efficiency: Because the researcher selected the initial participants based on their overall ability to conceptualize a broader view of the mission and role of the church, it maximized support for the project at the most critical point in the process. The project was designed to increase levels of participation and widen the circles of inclusion; therefore, persons were drawn into participation as their awareness and commitment developed. While this was not the only way education could be accomplished, it was most effective for this congregation.

Process: A primary factor which contributed to the success of this element of the project was the visible collaboration with other community organizations/agencies. The attendance at several community health fairs by the leadership, volunteers, and membership of the Antioch Church contributed to their sense of importance in the project. The emphasis that other organizations placed on the involvement of the faith community in such projects added further validation to the researcher's contention that there is a valuable role for the church in developing a focus for the future.

CHAPTER IX

SUMMARY

Racial and ethnic minority populations have been disproportionately affected by HIV and AIDS since the identification and development of the epidemic in the United States. Additionally, these cases are not evenly distributed throughout the nation. This geographical variation and distribution of AIDS among African-Americans suggests that there are forces in society that impact African-American communities in different ways. Thus, alternative models for conceptualizing AIDS as a disease are required. These models must be formed within the context of factors which are peculiar to the African-American community.

The HIV infection is experiencing growth in African-American women at an alarming rate. An understanding of gender roles and expectations in the African-American community has a bearing on the understanding of perceptions of risk and implications for program effectiveness. Consequently, models for risk-reduction and prevention must begin by identifying facilitators and barriers to risk-reducing behaviors.

Ethnographic studies of prevention have informed the development of alternative models to health education which are both culturally and socially sensitive. The concept of AIDS as a behavioral problem which is influenced by race and ethnicity has created new venues for research and progress in the fight against the disease.

The Black church is uniquely community-based, and African-Americans are generally in regular attendance for church-sponsored activities. Utilizing the church as a change agent for health-related behavior capitalized on the position the church has maintained in the African-American community. A church-community action model holds promise for providing a culturally sensitive element for health intervention and health promotion programs which have been heretofore lacking in traditional models.

The data compiled by the CDC indicate growing increases in HIV/AIDS incidence in the Antioch community. *(Appendix 13)* Consequently, the pastor/researcher developed a vision to fulfill the church's mission of providing holistic ministries for the congregation and the community. The Antioch model for HIV/AIDS education and prevention was designed to meet a growing need, and to address the defects in existing models.

Lessons Learned: Pastoral Perspective

1. Selection of volunteers for this ministry should include scrutiny to ensure respect for confidentiality of program participants;

2. The pastor should maintain psychological and professional distance from the ministry team volunteers. Because a close working relationship is necessitated, establishing a clear dimension of discretion is necessary.

3. Following the pastor's initial training of volunteers, subsequent training should be delegated to team leaders. This allows the volunteers to develop ownership for the ministry, and it allows the pastor to devote adequate time to other phases of his total ministry.

4. Provide clear rewards, both tangible and intangible, for project volunteers. Plaques and a luncheon were utilized in this project. Cards, certificates of recognition and public acknowledgments are also effective.

Lessons Learned: Laity Perspective

1. Training should occur in an environment which promotes feelings of comfort and security for the volunteers. For this study, volunteers performed at optimum levels when the training was conducted on-site at the church. Outcomes were less positive when volunteers were trained at other training sites (*e.g.*, Grady Memorial Hospital, Common Ground).

2. Other community organizations (*e.g.*, sororities, fraternities) should be included in the training in order to increase the volunteer pool.

3. Create a rotation system for volunteers and trainees.

4. Expand the ministry to target gangs, drug dealers, and prostitutes. These populations are at higher levels of risk, but are less likely to hear mainstream messages of prevention and education.

Lessons Learned: Community Perspective

1. Seek additional ways to link community organizations to the project.

2. Give careful consideration to promotional strategies which might impugn the integrity and moral character of the church. The car give-away was perceived by some persons as gambling, rather than a means of promoting HIV/AIDS awareness and education.

3. The church's role in ministries such as HIV/AIDS is not always accepted. The church may be perceived as creating involvement in non-spiritual matters.

Conclusions

The success of this project can be measured in terms of responses to the various educational awareness activities sponsored throughout the community. Inquiries received through the telephone hotline created opportunities for Antioch volunteers to make referrals to other social service and medical agencies. Similarly, community agencies made rebound referrals (*i.e.*, creating a network in which clients are referred back-and-forth between service providers) to Antioch for clients who needed spiritual support during periods of crisis.

The lasting effects of the project are evidenced in the congregation's receptivity to high-risk persons (*e.g.*, homosexuals and drug users) who attend public worship. The congregation has assumed a bold posture in proclaiming their involvement in a ministry as controversial as HIV/AIDS. The work in this area has created an open forum for dialogue to develop among parishioners.

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APPENDIX

APPENDIXES

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APPENDIX 1

Stamp Design © 1993 United States Postal Service

TIME TO ACT!

WORLD AIDS DAY • 1 DECEMBER, 1993

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FACT SHEET
1 July 1996

Joint United Nations Programme on HIV/AIDS

UNAIDS AND WHO

The HIV/AIDS situation in mid 1996
Global and regional highlights

Estimates as of 1 July 1996*

People living with HIV/AIDS	Adults	21 million
	male	12.2 million
	female	8.8 million
	Children	800,000
	Total	**21.8 million**
HIV/AIDS-associated deaths in 1995	Adults	1 million
	male	600,000
	female	400,000
	Children	300,000
	Total	**1.3 million**
Cumulative HIV infections	Adults	25.5 million
	male	14.9 million
	female	10.5 million
	Children	2.4 million
	Total	**27.9 million**
Cumulative AIDS cases	Adults	6.1 million
	male	3.5 million
	female	2.6 million
	Children	1.6 million
	Total	**7.7 million**
Cumulative HIV/AIDS deaths	Adults	4.5 million
	male	2.6 million
	female	1.9 million
	Children	1.3 million
	Total	**5.8 million**

* Because of rounding, figures may not tally.

Figure 3. Male adult/adolescent AIDS cases reported July 1995 through June 1996, United States

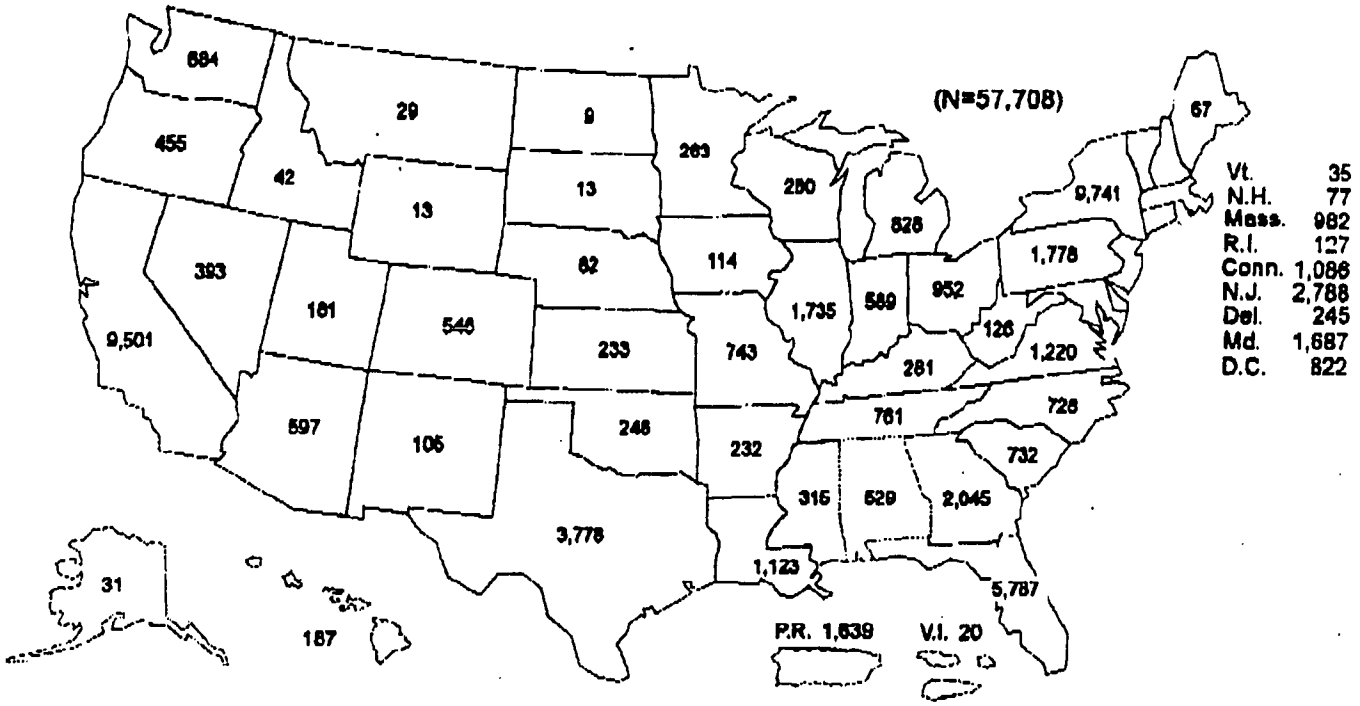


Figure 4. Female adult/adolescent AIDS cases reported July 1995 through June 1996, United States

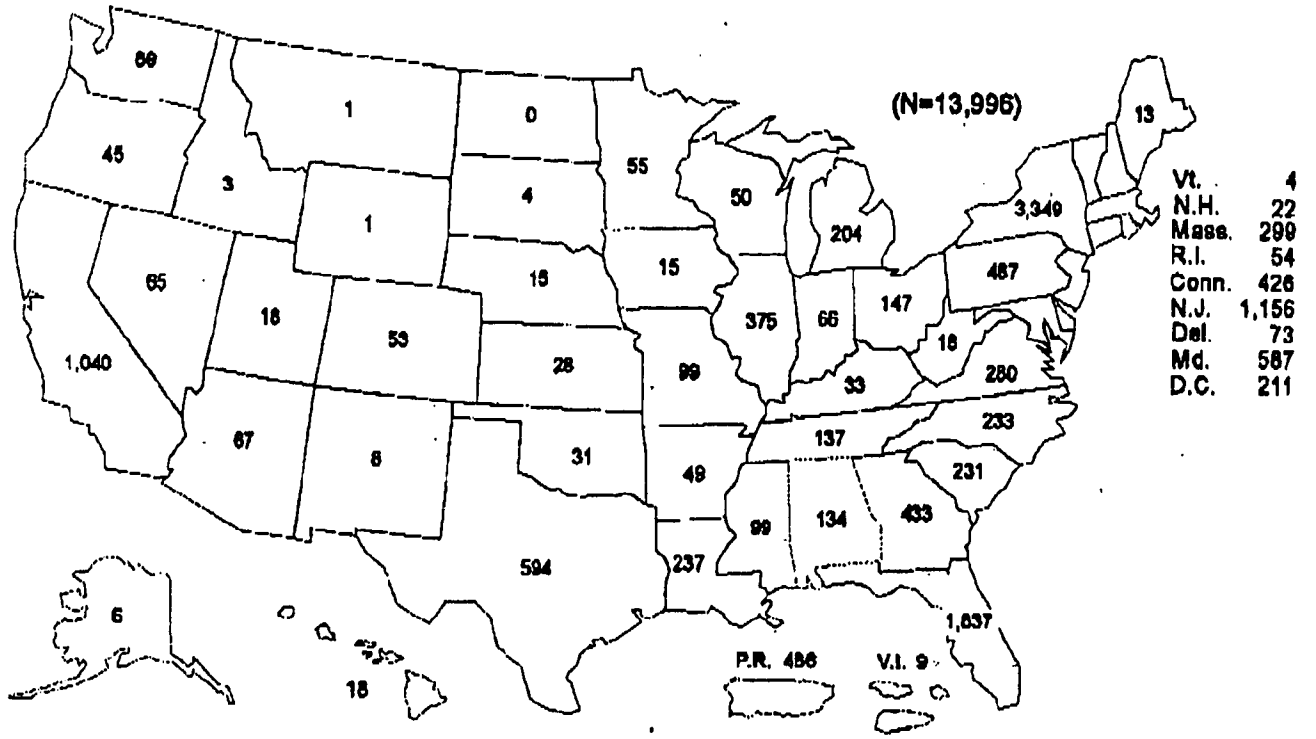


Table 1. AIDS cases and annual rates per 100,000 population, by state, reported July 1994 through June 1995, July 1995 through June 1996;[1] and cumulative totals, by state and age group, through June 1996, United States[2]

U.S. state of residence	July 1994 - June 1995		July 1995 - June 1996		Cumulative totals		
	No.	Rate	No.	Rate	Adults/ adolescents	Children <13 years old	Total
Alabama	565	13.4	696	16.7	3,928	55	3,983
Alaska	79	13.1	37	6.1	337	4	341
Arizona	559	13.7	664	16.7	4,717	19	4,736
Arkansas	287	11.7	286	11.6	2,003	30	2,033
California	10,981	34.9	10,589	33.5	93,240	509	93,749
Colorado	717	19.6	600	16.0	5,509	27	5,536
Connecticut	1,059	32.3	1,532	46.8	7,835	159	7,994
Delaware	310	43.8	320	44.6	1,647	13	1,660
District of Columbia	1,216	214.5	1,045	188.5	8,622	126	8,748
Florida	9,305	66.7	7,741	54.6	54,807	1,183	55,990
Georgia	2,293	32.5	2,503	34.8	15,698	168	15,866
Hawaii	264	22.4	208	17.4	1,670	14	1,684
Idaho	57	5.0	45	3.9	348	2	350
Illinois	2,766	23.5	2,149	18.2	17,374	210	17,584
Indiana	519	9.0	659	11.4	4,187	32	4,219
Iowa	146	5.1	129	4.5	924	8	932
Kansas	264	10.3	263	10.3	1,731	11	1,742
Kentucky	311	8.1	315	8.2	1,984	14	1,998
Louisiana	1,113	25.8	1,374	31.6	8,346	106	8,452
Maine	139	11.2	80	6.4	724	6	730
Maryland	2,915	58.3	2,296	45.5	13,837	245	14,082
Massachusetts	1,371	22.7	1,295	21.3	11,110	177	11,287
Michigan	1,057	11.1	1,040	10.9	7,741	83	7,824
Minnesota	412	9.0	320	6.9	2,843	19	2,862
Mississippi	413	15.5	415	15.4	2,568	38	2,606
Missouri	685	13.0	850	16.0	6,755	49	6,804
Montana	24	2.8	30	3.4	206	2	208
Nebraska	111	6.8	98	6.0	736	8	744
Nevada	412	28.2	459	30.0	2,823	21	2,844
New Hampshire	112	9.9	99	8.6	655	7	662
New Jersey	4,738	60.0	3,995	50.3	30,475	649	31,124
New Mexico	228	13.8	113	6.7	1,288	4	1,292
New York	12,537	69.1	13,251	73.1	99,191	1,858	101,049
North Carolina	1,017	14.4	975	13.6	6,792	95	6,887
North Dakota	6	0.9	9	1.4	72	–	72
Ohio	1,191	10.7	1,117	10.0	8,133	101	8,234
Oklahoma	268	8.2	278	8.5	2,580	18	2,598
Oregon	506	16.4	501	16.0	3,661	14	3,665
Pennsylvania	2,661	22.1	2,270	18.8	16,052	218	16,270
Rhode Island	288	29.0	182	18.4	1,501	16	1,517
South Carolina	992	27.2	970	26.4	5,786	65	5,851
South Dakota	20	2.8	17	2.3	108	4	112
Tennessee	877	16.9	903	17.2	5,112	42	5,154
Texas	5,108	27.7	4,399	23.5	37,025	295	37,320
Utah	153	8.0	199	10.2	1,273	20	1,293
Vermont	30	5.2	39	6.7	280	3	283
Virginia	1,145	17.5	1,513	22.9	8,319	139	8,458
Washington	925	17.3	777	14.3	7,150	26	7,176
West Virginia	113	6.2	146	8.0	680	8	688
Wisconsin	363	7.1	330	6.4	2,647	23	2,670
Wyoming	14	2.9	14	2.9	136	–	136
Subtotal	73,821	28.3	70,103	26.7	523,056	6,943	529,999
U.S. dependencies, possessions, and associated nations[2]							
Guam	–	–	4	2.8	17	–	17
Pacific Islands, U.S.	–	–	–	–	2	–	2
Puerto Rico	2,548	69.7	2,153	58.4	17,071	341	17,412
Virgin Islands, U.S.	62	59.7	32	30.6	262	12	274
Total[3]	76,289	28.9	72,416	27.1	540,208	7,296	548,102

[1]See Technical Notes for a discussion of the impact of the 1993 AIDS surveillance case definition for adults and adolescents (implemented January 1, 1993) on the number of cases reported annually since 1993.
[2]U.S. totals presented in this report include data from the United States (50 states and the District of Columbia), and from U.S. dependencies, possessions, and independent nations in free association with the United States. See Technical Notes.
[3]Totals include 398 persons whose state of residence is unknown.

Table 4. Male adult/adolescent AIDS cases by exposure category and race/ethnicity, reported July 1995 through June 1996, and cumulative totals, through June 1996, United States

Exposure category	White, not Hispanic				Black, not Hispanic				Hispanic			
	July 1995-June 1996		Cumulative total		July 1995-June 1996		Cumulative total		July 1995-June 1996		Cumulative total	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Men who have sex with men	17,665	(70)	180,294	(76)	6,856	(33)	55,327	(39)	4,297	(39)	34,806	(44)
Injecting drug use	2,783	(11)	20,884	(9)	6,845	(33)	51,143	(36)	3,673	(33)	29,410	(37)
Men who have sex with men and inject drugs	1,614	(6)	16,670	(8)	1,077	(5)	10,869	(8)	459	(4)	5,337	(7)
Hemophilia/coagulation disorder	250	(1)	3,259	(1)	57	(0)	430	(0)	42	(0)	346	(0)
Heterosexual contact:	568	(2)	3,234	(1)	1,765	(8)	8,527	(6)	745	(7)	3,398	(4)
Sex with injecting drug user	*183*		*1,351*		*539*		*3,591*		*236*		*1,167*	
Sex with person with hemophilia	*5*		*20*		*5*		*10*		*1*		*7*	
Sex with transfusion recipient with HIV infection	*8*		*124*		*15*		*104*		*9*		*70*	
Sex with HIV-infected person, risk not specified	*370*		*1,739*		*1,206*		*4,822*		*490*		*2,162*	
Receipt of blood transfusion, blood components, or tissue	172	(1)	2,941	(1)	106	(1)	907	(1)	48	(0)	491	(1)
Risk not reported or identified[1]	2,138	(8)	7,428	(3)	4,095	(20)	14,299	(10)	1,708	(16)	5,040	(6)
Total	25,188	(100)	236,490	(100)	20,801	(100)	141,902	(100)	10,970	(100)	78,926	(100)

Exposure category	Asian/Pacific Islander				American Indian/Alaska Native				Cumulative totals[2]			
	July 1995-June 1996		Cumulative total		July 1995-June 1996		Cumulative total		July 1995-June 1996		Cumulative total	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Men who have sex with men	321	(67)	2,593	(77)	84	(49)	726	(60)	29,260	(51)	274,192	(59)
Injecting drug use	33	(7)	173	(5)	35	(20)	175	(15)	13,386	(23)	101,714	(22)
Men who have sex with men and inject drugs	17	(4)	114	(3)	26	(15)	201	(17)	3,196	(6)	35,218	(8)
Hemophilia/coagulation disorder	7	(1)	55	(2)	2	(1)	26	(2)	360	(1)	4,122	(1)
Heterosexual contact:	19	(4)	78	(2)	5	(3)	21	(2)	3,102	(5)	15,268	(3)
Sex with injecting drug user	*5*		*22*		*2*		*9*		*966*		*6,142*	
Sex with person with hemophilia	–		–		–		–		*11*		*37*	
Sex with transfusion recipient with HIV infection	*3*		*7*		–		*1*		*35*		*307*	
Sex with HIV-infected person, risk not specified	*11*		*49*		*3*		*11*		*2,090*		*8,782*	
Receipt of blood transfusion, blood components, or tissue	8	(2)	96	(3)	–	–	5	(0)	334	(1)	4,449	(1)
Risk not reported or identified	77	(16)	279	(8)	20	(12)	48	(4)	8,068	(14)	27,189	(6)
Total	482	(100)	3,386	(100)	172	(100)	1,202	(100)	57,706	(100)	482,182	(100)

[1]See figure 6.
[2]Includes 644 men whose race/ethnicity is unknown.

Table 5. Female adult/adolescent AIDS cases by exposure category and race/ethnicity, reported July 1995 through June 1996, and cumulative totals, through June 1996, United States

Exposure category	White, not Hispanic				Black, not Hispanic				Hispanic			
	July 1995-June 1996		Cumulative total		July 1995-June 1996		Cumulative total		July 1995-June 1996		Cumulative total	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Injecting drug use	1,205	(39)	8,050	(43)	2,882	(36)	20,745	(48)	901	(33)	7,026	(44)
Hemophilia/coagulation disorder	5	(0)	87	(0)	9	(0)	47	(0)	5	(0)	21	(0)
Heterosexual contact:	1,282	(41)	7,169	(38)	2,934	(37)	15,054	(35)	1,292	(48)	7,197	(45)
Sex with injecting drug user	*472*		*3,162*		*976*		*7,005*		*511*		*3,881*	
Sex with bisexual male	*148*		*1,105*		*150*		*890*		*71*		*368*	
Sex with person with hemophilia	*18*		*231*		*9*		*47*		*7*		*28*	
Sex with transfusion recipient with HIV infection	*25*		*255*		*16*		*126*		*21*		*84*	
Sex with HIV-infected person, risk not specified	*619*		*2,415*		*1,781*		*6,986*		*682*		*2,836*	
Receipt of blood transfusion, blood components, or tissue	83	(3)	1,671	(9)	132	(2)	984	(2)	49	(2)	486	(3)
Risk not reported or identified[1]	547	(18)	1,680	(9)	2,068	(26)	6,471	(15)	471	(17)	1,254	(8)
Total	**3,122**	**(100)**	**18,857**	**(100)**	**8,025**	**(100)**	**43,301**	**(100)**	**2,718**	**(100)**	**15,984**	**(100)**

Exposure category	Asian/Pacific Islander				American Indian/Alaska Native				Cumulative totals[2]			
	July 1995-June 1996		Cumulative total		July 1995-June 1996		Cumulative total		July 1995-June 1996		Cumulative total	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Injecting drug use	8	(11)	69	(17)	16	(38)	100	(47)	5,016	(36)	36,039	(46)
Hemophilia/coagulation disorder	1	(1)	3	(1)	–	–	–	–	20	(0)	158	(0)
Heterosexual contact:	35	(49)	181	(45)	16	(38)	82	(38)	5,563	(40)	29,712	(38)
Sex with injecting drug user	*7*		*54*		*9*		*47*		*1,976*		*14,165*	
Sex with bisexual male	*5*		*48*		*3*		*11*		*377*		*2,425*	
Sex with person with hemophilia	*1*		*4*		–		*2*		*35*		*312*	
Sex with transfusion recipient with HIV infection	*2*		*16*		–		–		*66*		*482*	
Sex with HIV-infected person, risk not specified	*20*		*59*		*4*		*22*		*3,109*		*12,328*	
Receipt of blood transfusion, blood components, or tissue	11	(15)	82	(21)	–	–	10	(5)	276	(2)	3,235	(4)
Risk not reported or identified	16	(23)	63	(16)	10	(24)	23	(11)	3,121	(22)	9,510	(12)
Total	**71**	**(100)**	**398**	**(100)**	**42**	**(100)**	**215**	**(100)**	**13,996**	**(100)**	**78,854**	**(100)**

[1]See figure 6.
[2]Includes 99 women whose race/ethnicity is unknown.

Table 6. Pediatric AIDS cases by exposure category and race/ethnicity, reported July 1995 through June 1996, and cumulative totals, through June 1996, United States

Exposure category	White, not Hispanic				Black, not Hispanic				Hispanic			
	July 1995-June 1996		Cumulative total		July 1995-June 1996		Cumulative total		July 1995-June 1996		Cumulative total	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Hemophilia/coagulation disorder	–	–	158	(12)	1	(0)	33	(1)	1	(1)	35	(2)
Mother with/at risk for HIV infection:	91	(93)	959	(73)	415	(92)	4,007	(95)	142	(91)	1,557	(91)
Injecting drug use	32		411		115		1,634		38		649	
Sex with injecting drug user	17		185		49		601		34		432	
Sex with bisexual male	5		53		4		50		1		35	
Sex with person with hemophilia	–		15		–		5		1		5	
Sex with transfusion recipient with HIV infection	–		10		–		8		–		7	
Sex with HIV-infected person, risk not specified	20		104		67		547		29		182	
Receipt of blood transfusion, blood components, or tissue	–		40		2		73		2		29	
Has HIV infection, risk not specified	17		141		178		1,089		37		218	
Receipt of blood transfusion, blood components, or tissue	4	(4)	182	(14)	3	(1)	83	(2)	4	(3)	92	(5)
Risk not reported or identified[1]	3	(3)	17	(1)	32	(7)	78	(2)	9	(6)	19	(1)
Total	98	(100)	1,314	(100)	451	(100)	4,201	(100)	156	(100)	1,703	(100)

Exposure category	Asian/Pacific Islander				American Indian/Alaska Native				Cumulative totals[2]			
	July 1995-June 1996		Cumulative total		July 1995-June 1996		Cumulative total		July 1995-June 1996		Cumulative total	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Hemophilia/coagulation disorder	–	–	3	(8)	–	–	1	(5)	2	(0)	228	(3)
Mother with/at risk for HIV infection:	2	(100)	27	(68)	1	(100)	21	(95)	655	(92)	6,586	(90)
Injecting drug use	–		4		–		11		185		2,714	
Sex with injecting drug user	–		4		–		4		100		1,228	
Sex with bisexual male	–		2		–		–		10		140	
Sex with person with hemophilia	–		–		–		–		1		25	
Sex with transfusion recipient with HIV infection	–		–		–		–		–		25	
Sex with HIV-infected person, risk not specified	1		7		–		1		117		844	
Receipt of blood transfusion, blood components, or tissue	–		1		–		–		4		143	
Has HIV infection, risk not specified	1		9		1		5		238		1,467	
Receipt of blood transfusion, blood components, or tissue	–	–	9	(23)	–	–	–	–	11	(2)	367	(5)
Risk not reported or identified	–	–	1	(3)	–	–	–	–	44	(6)	115	(2)
Total	2	(100)	40	(100)	1	(100)	22	(100)	712	(100)	7,286	(100)

[1]See figure 6, footnote 1.
[2]Includes 16 children whose race/ethnicity is unknown.

Table 7. AIDS cases in adolescents and adults under age 25, by sex and exposure category, reported July 1994 through June 1995, July 1995 through June 1996;[1] and cumulative totals through June 1996, United States

	13-19 years old						20-24 years old					
	July 1994-June 1995		July 1995-June 1996		Cumulative total		July 1994-June 1995		July 1995-June 1996		Cumulative total	
Male exposure category	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Men who have sex with men	87	(34)	66	(32)	543	(33)	1,053	(61)	844	(57)	9,479	(63)
Injecting drug use	18	(7)	12	(6)	109	(7)	209	(12)	174	(12)	1,898	(13)
Men who have sex with men and inject drugs	9	(4)	5	(2)	78	(5)	125	(7)	94	(6)	1,617	(11)
Hemophilia/coagulation disorder	87	(34)	62	(30)	678	(41)	66	(3)	68	(5)	567	(4)
Heterosexual contact:	9	(4)	11	(5)	47	(3)	114	(7)	97	(7)	556	(4)
Sex with injecting drug user	*1*		*3*		*16*		*42*		*19*		*216*	
Sex with person with hemophilia	*1*		–		*1*		–		*3*		*4*	
Sex with transfusion recipient with HIV infection	–		–		–		*1*		–		*10*	
Sex with HIV-infected person, risk not specified	*7*		*8*		*30*		*71*		*75*		*326*	
Receipt of blood transfusion, blood components, or tissue	14	(8)	10	(5)	74	(4)	10	(1)	7	(0)	101	(1)
Risk not reported or identified[2]	29	(11)	39	(19)	118	(7)	152	(9)	208	(14)	843	(6)
Male subtotal	253	(100)	205	(100)	1,647	(100)	1,719	(100)	1,492	(100)	15,061	(100)
Female exposure category												
Injecting drug use	18	(10)	12	(7)	142	(15)	186	(23)	130	(16)	1,498	(30)
Hemophilia/coagulation disorder	4	(2)	–	–	10	(1)	1	(0)	2	(0)	13	(0)
Heterosexual contact	94	(50)	95	(54)	507	(55)	467	(57)	414	(52)	2,576	(52)
Sex with injecting drug user	*28*		*22*		*211*		*152*		*135*		*1,228*	
Sex with bisexual male	*6*		*6*		*29*		*27*		*27*		*201*	
Sex with person with hemophilia	*3*		*1*		*13*		*6*		*4*		*45*	
Sex with transfusion recipient with HIV infection	–		–		*1*		*3*		*4*		*16*	
Sex with HIV-infected person, risk not specified	*57*		*66*		*253*		*279*		*244*		*1,086*	
Receipt of blood transfusion, blood components, or tissue	12	(6)	7	(4)	65	(7)	10	(1)	9	(1)	107	(2)
Risk not reported or identified	59	(32)	62	(35)	203	(22)	161	(20)	239	(30)	742	(15)
Female subtotal	187	(100)	176	(100)	927	(100)	825	(100)	794	(100)	4,936	(100)
Total	**440**		**381**		**2,574**		**2,544**		**2,286**		**19,997**	

[1]See Technical Notes for a discussion of the impact of the 1993 AIDS surveillance case definition for adults and adolescents (implemented January 1, 1993) on the number of cases reported annually since 1993.
[2]See figure 6.

Table 8. AIDS cases by sex, age at diagnosis, and race/ethnicity, reported through June 1996, United States

Male Age at diagnosis (years)	White, not Hispanic No.	(%)	Black, not Hispanic No.	(%)	Hispanic No.	(%)	Asian/Pacific Islander No.	(%)	American Indian/ Alaska Native No.	(%)	Total[1] No.	(%)
Under 5	443	(0)	1,763	(1)	665	(1)	15	(0)	9	(1)	2,899	(1)
5-12	303	(0)	322	(0)	217	(0)	8	(0)	1	(0)	853	(0)
13-19	726	(0)	560	(0)	327	(0)	19	(1)	14	(1)	1,647	(0)
20-24	6,541	(3)	5,216	(4)	3,119	(4)	113	(3)	50	(4)	15,061	(3)
25-29	32,478	(14)	19,120	(13)	12,349	(15)	438	(13)	243	(20)	64,715	(14)
30-34	55,851	(24)	31,102	(22)	19,276	(24)	741	(22)	327	(27)	107,431	(23)
35-39	53,259	(22)	32,876	(23)	17,778	(22)	736	(22)	260	(21)	105,062	(23)
40-44	38,581	(16)	24,637	(17)	12,121	(15)	602	(18)	167	(14)	76,218	(16)
45-49	22,940	(10)	13,285	(9)	6,628	(8)	349	(10)	73	(6)	43,335	(9)
50-54	12,267	(5)	7,027	(5)	3,460	(4)	182	(5)	29	(2)	22,997	(5)
55-59	6,765	(3)	3,800	(3)	1,879	(2)	112	(3)	19	(2)	12,804	(3)
60-64	3,884	(2)	2,094	(1)	1,078	(1)	46	(1)	12	(1)	7,123	(2)
65 or older	3,198	(1)	1,685	(1)	811	(1)	50	(1)	8	(1)	5,759	(1)
Male subtotal	237,236	(100)	143,687	(100)	79,808	(100)	3,411	(100)	1,212	(100)	485,904	(100)
Female **Age at diagnosis (years)**												
Under 5	434	(2)	1,776	(4)	648	(4)	11	(3)	12	(5)	2,888	(4)
5-12	134	(1)	340	(1)	173	(1)	6	(1)	–	–	658	(1)
13-19	169	(1)	605	(1)	145	(1)	6	(1)	1	(0)	927	(1)
20-24	1,171	(6)	2,666	(6)	1,048	(6)	24	(6)	22	(10)	4,936	(6)
25-29	3,316	(17)	6,996	(15)	2,913	(17)	45	(11)	39	(17)	13,316	(16)
30-34	4,461	(23)	10,441	(23)	4,028	(24)	82	(20)	51	(22)	19,092	(23)
35-39	3,685	(19)	9,856	(22)	3,363	(20)	75	(18)	43	(19)	17,158	(21)
40-44	2,324	(12)	6,399	(14)	2,079	(12)	59	(14)	21	(9)	10,892	(13)
45-49	1,200	(6)	2,864	(6)	1,070	(6)	39	(9)	20	(9)	5,199	(6)
50-54	676	(4)	1,489	(3)	602	(4)	21	(5)	8	(4)	2,799	(3)
55-59	502	(3)	845	(2)	373	(2)	11	(3)	5	(2)	1,738	(2)
60-64	359	(2)	536	(1)	188	(1)	17	(4)	3	(1)	1,103	(1)
65 or older	784	(4)	504	(1)	175	(1)	19	(5)	2	(1)	1,496	(2)
Female subtotal	19,225	(100)	45,417	(100)	16,805	(100)	415	(100)	227	(100)	82,198	(100)
Total	**256,461**		**189,004**		**96,613**		**3,826**		**1,439**		**548,102**	

[1]Includes 650 males and 109 females whose race/ethnicity is unknown.

Table 12. Adult/adolescent AIDS cases by single and multiple exposure categories, reported through June 1996, United States

Exposure category	AIDS cases No.	(%)
Single mode of exposure		
Men who have sex with men	263,499	(49)
Injecting drug use	112,024	(21)
Hemophilia/coagulation disorder	3,418	(1)
Heterosexual contact	43,676	(8)
Receipt of transfusion[1]	7,672	(1)
Receipt of transplant of tissues, organs, or artificial insemination[2]	12	(0)
Other[3]	69	(0)
Single mode of exposure subtotal	430,370	(80)
Multiple modes of exposure		
Men who have sex with men; injecting drug use	30,622	(6)
Men who have sex with men; hemophilia/coagulation disorder	133	(0)
Men who have sex with men; heterosexual contact	7,095	(1)
Men who have sex with men; receipt of transfusion/transplant	3,171	(1)
Injecting drug use; hemophilia/coagulation disorder	173	(0)
Injecting drug use; heterosexual contact	23,194	(4)
Injecting drug use; receipt of transfusion/transplant	1,478	(0)
Hemophilia/coagulation disorder; heterosexual contact	70	(0)
Hemophilia/coagulation disorder; receipt of transfusion/transplant	765	(0)
Heterosexual contact; receipt of transfusion/transplant	1,304	(0)
Men who have sex with men; injecting drug use; hemophilia/coagulation disorder	39	(0)
Men who have sex with men; injecting drug use; heterosexual contact	3,849	(1)
Men who have sex with men; injecting drug use; receipt of transfusion/transplant	546	(0)
Men who have sex with men; hemophilia/coagulation disorder; heterosexual contact	17	(0)
Men who have sex with men; hemophilia/coagulation disorder; receipt of transfusion/transplant	32	(0)
Men who have sex with men; heterosexual contact; receipt of transfusion/transplant	241	(0)
Injecting drug use; hemophilia/coagulation disorder; heterosexual contact	44	(0)
Injecting drug use; hemophilia/coagulation disorder; receipt of transfusion/transplant	31	(0)
Injecting drug use; heterosexual contact; receipt of transfusion/transplant	793	(0)
Hemophilia/coagulation disorder; heterosexual contact; receipt of transfusion/transplant	27	(0)
Men who have sex with men; injecting drug use; hemophilia/coagulation disorder; heterosexual contact	8	(0)
Men who have sex with men; injecting drug use; hemophilia/coagulation disorder; receipt of transfusion/transplant	13	(0)
Men who have sex with men; injecting drug use; heterosexual contact; receipt of transfusion/transplant	139	(0)
Men who have sex with men; hemophilia/coagulation disorder; heterosexual contact; receipt of transfusion/transplant	4	(0)
Injecting drug use; hemophilia/coagulation disorder; heterosexual contact; receipt of transfusion/transplant	16	(0)
Men who have sex with men; injecting drug use; hemophilia/coagulation disorder; heterosexual contact; receipt of transfusion/transplant	2	(0)
Multiple modes of exposure subtotal	73,806	(14)
Risk not reported or identified[4]	36,630	(7)
Total	540,806	(100)

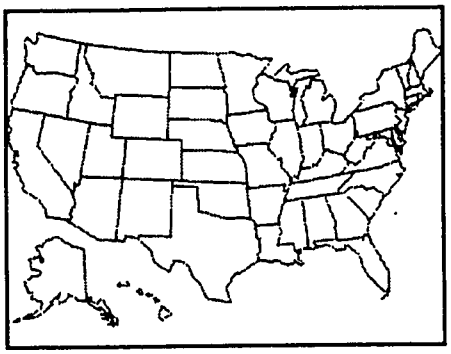
[1]Includes 35 adult/adolescents who developed AIDS after receiving blood screened negative for HIV antibody.
[2]Twelve adults developed AIDS after receiving tissue, organs, or artificial insemination from HIV-infected donors. Four of the 12 received tissue or organs from a donor who was negative for HIV antibody at the time of donation. See *N Engl J Med* 1992;326:726-32.
[3]See table 11 and figure 6 for a discussion of the "other" exposure category. "Other" also includes 39 persons who acquired HIV infection perinatally, but were diagnosed with AIDS after age 13.
[4]See figure 6.

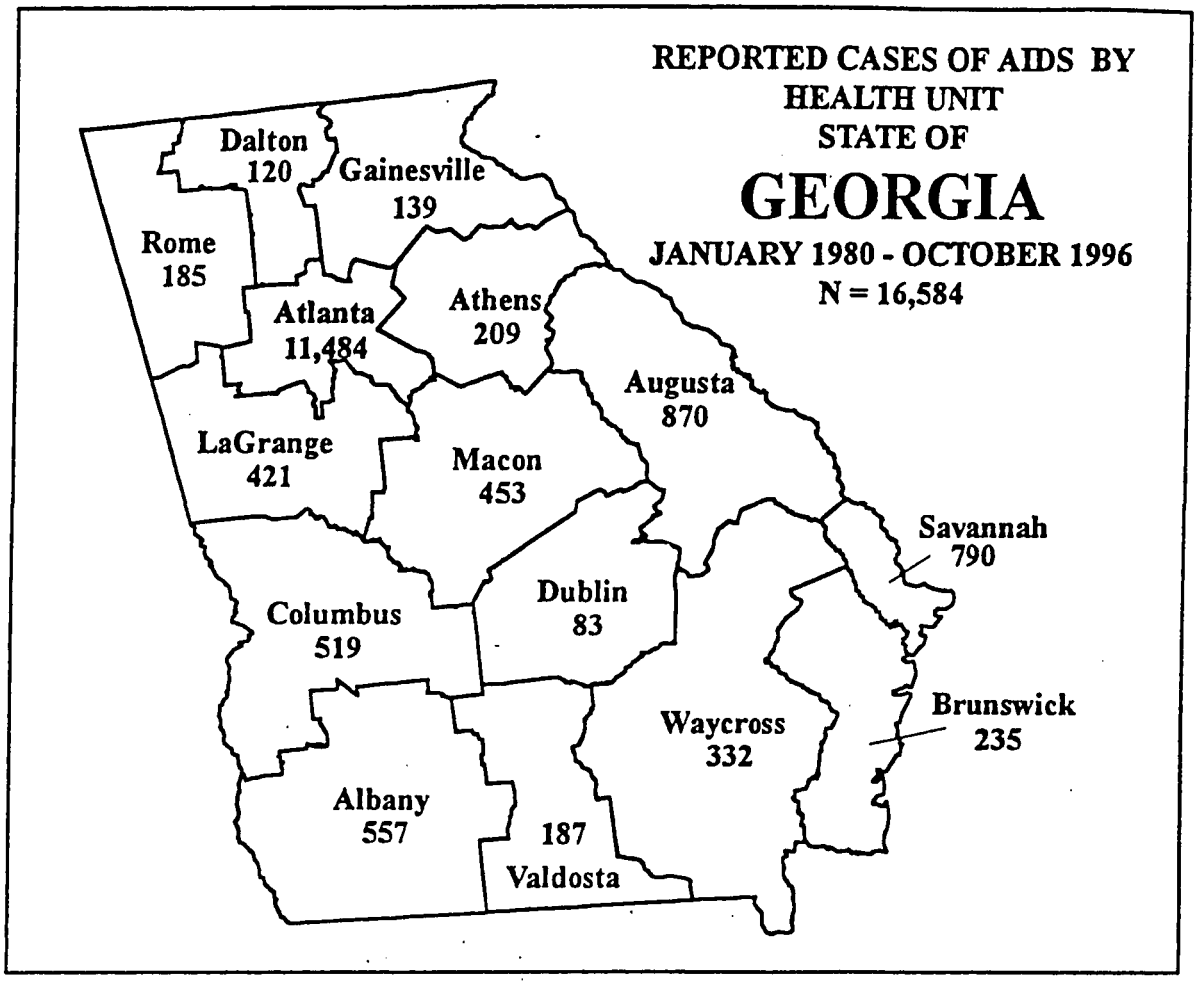
Cumulative Number of Reported AIDS Cases Among the Top Eight Reporting States

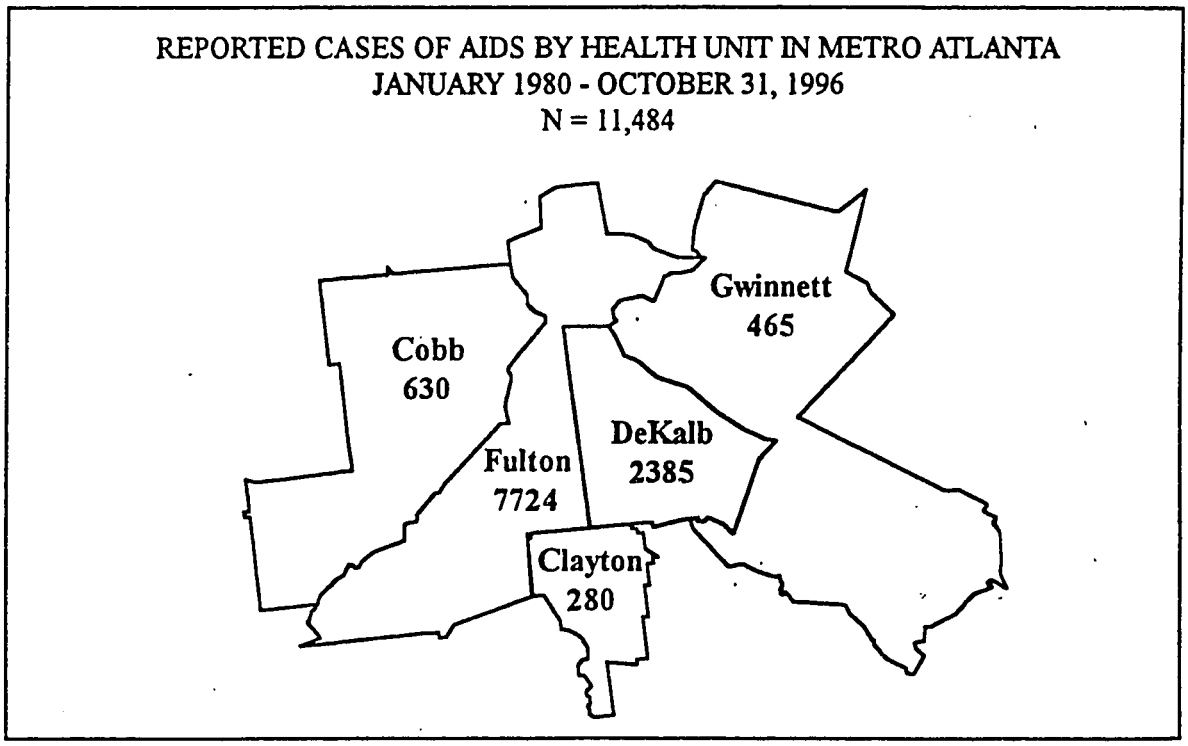
AIDS cases and annual rates per 100,000 population by state, reported July 1994 through June 1995, July 1995 through June 1996 and cumulative totals.

STATE	TOTALS
New York	101,049
California	93,749
Florida	55,690
New Jersey	31,124
Illinois	17,584
Pennsylvania	16,270
Georgia	15,866

This report indicates the State of Georgia is eight highest ranking among AIDS cases in the United States.




REPORTED CASES OF AIDS BY
HEALTH UNIT
STATE OF
GEORGIA
JANUARY 1980 - OCTOBER 1996
N = 16,584
Dalton
120
Gainesville
139
Rome
185
Atlanta
11,484
Athens
209
Augusta
870
LaGrange
421
Macon
453
Savannah
790
Columbus
519
Dublin
83
Brunswick
235
Waycross
332
Albany
557
187
Valdosta


REPORTED CASES OF AIDS BY HEALTH UNIT IN METRO ATLANTA
JANUARY 1980 - OCTOBER 31, 1996
N = 11,484
Gwinnett
465
Cobb
630
DeKalb
2385
Fulton
7724
Clayton
280

State of Georgia Map

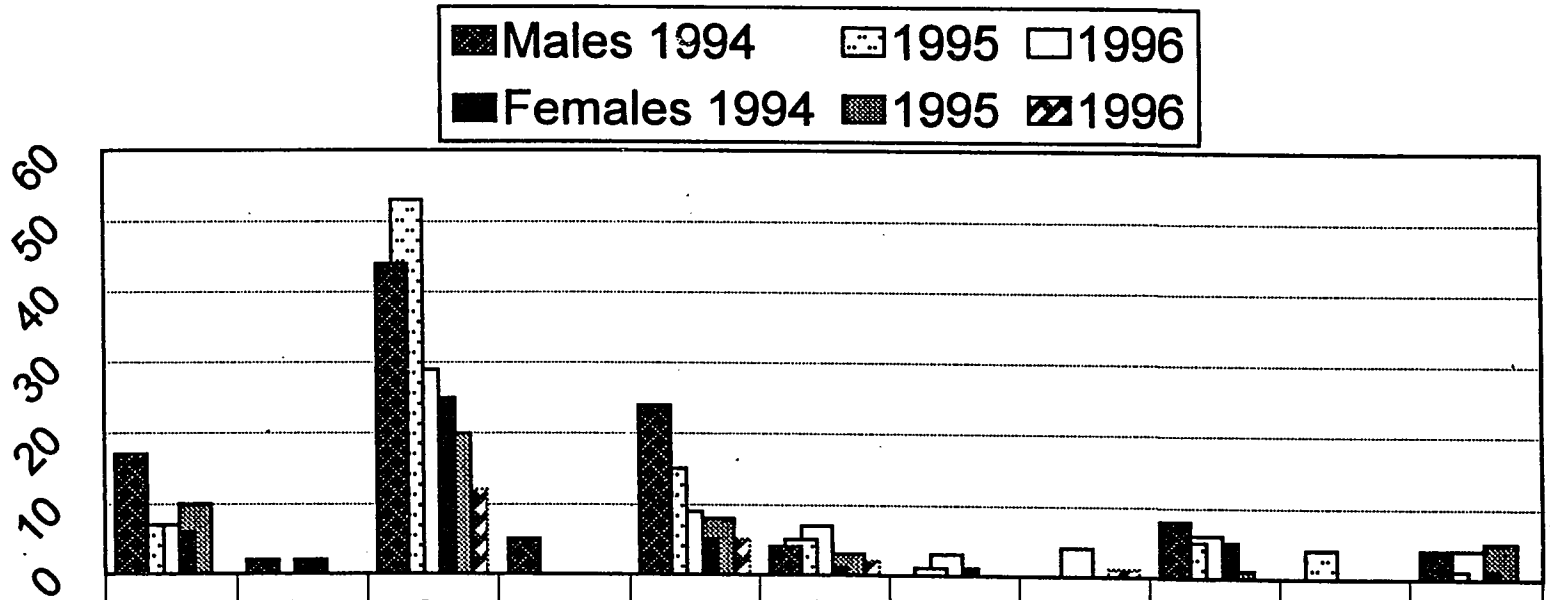
- The State of Georgia Map indicates Atlanta having the largest reported cases of AIDS. Both Fulton and Dekalb Counties are included.

- The Metro Atlanta Map indicates Fulton (7724) and Dekalb (2385) having the largest reported cases.

APPENDIX 12

African American Testing HIV Positive by Zip Codes

In context of study eleven zip codes in South Dekalb County



	30030	30031	30032	30033	30034	30035	30038	30058	30083	30087	30088
Males 1994	17	2	44	5	24	4			8		4
1995	7		53		15	5	1		5	4	1
1996	7		29		9	7	3	4	6		4
Females 1994	6	2	25		5	1	1		5		1
1995	10		20		8	3			1		5
1996			12		5	2		1			

1994 - 1996

APPENDIX 13

PRE/POST HIV/AIDS KNOWLEGE TEST

Put the answers to the questions on the Answer Sheet. Darken the circle: A = TRUE and B = FALSE.

1. Testing positive for HIV means a person has AIDS.
2. You can get AIDS from hugging.
3. AIDS is carried only in blood.
4. If my co-worker has AIDS I should start looking for another job.
5. You can get AIDS by sitting on the toilet seat after someone who is carrying the virus.
6. You can transmit AIDS through vaginal sexual activity.
7. If a kitchen worker has AIDS I have to find another place to eat lunch.
8. A positive test for the AIDS antibody means you have AIDS.
9. AIDS can be gotten only by gays, people who share IV drug needles, or through blood transfusions.
10. If you shake hands with someone with AIDS you have a chance of catching the disease.
11. AIDS is made up of many different diseases.
12. Women have a greater risk of getting the AIDS virus from having sex with men than men do from having sex with women.
13. If my boss has AIDS he is gay.
14. You can transmit AIDS through oral sex.
15. AIDS stands for Acquired Immunodeficiency Syndrome.
16. I am afraid to work with someone with AIDS.

APPENDIX 15

AIDS POLICY STATEMENT

Antioch African Methodist Episcopal Church of Decatur, Georgia
AIDS Policy 1995

Whereas, all persons are children of God and

Whereas, we as members of the Body of Christ are called by Christ to minister to all of creation and

Whereas, the task of the Church is to share the love and grace of God, which is the ultimate hope of all persons and

Whereas, Christ has called us through His example to be in ministry to the sick, including those who are ill with diseases that are sometimes considered socially unacceptable and

Whereas, person with AIDS or any level of HIV infection and their families suffer from fear, grief, isolation, discrimination, violence and are in urgent need of the love and grace of God and a loving, supporting and reconciling ministry from the Church and

Whereas, the Church of Jesus Christ is called to provide the loving support and ministry that is needed by these persons and their families and

Whereas, all current medical information reports that HIV is not spread under social conditions via touching or sharing books, eating utensils, toilets, telephones, drinking fountains or any other casual means; that HIV is spread via sexual contact with infected persons or by spreading IV drug needles with infected persons or by prenatal transmission-- making transmission in a church setting extremely remote

Therefore be it resolved that Antioch African Methodist Episcopal Church of Decatur, Georgia:

1. Continue to be educated about HIV
2. Be a "Caring Congregation" which welcomes person, their loved ones and families into the fellowship of the church at whatever level they are comfortable and able;
3. Treat such persons with dignity and respect;
4. Be sensitive to concerns of HIV infected persons about confidentiality, if they desire it.
5. Offer opportunities for persons interested in ministry to AIDS patients to do so.
6. Make pamphlets and other informational material available.
7. Support its staff networking with other churches and agencies which work with HIV.
8. Be open to the use of our building for HIV-related ministries.

AIDS Awareness

Congregational Survey

1. AIDS can the transmitted by deep kissing. **YES NO**
2. AIDS can be contracted through intravenous drug use. **YES NO**
3. AIDS is a problem exclusive the the medical community. **YES NO**
4. The AIDS virus can be transmitted to newborn babies. **YES NO**
5. Blood transfusions are a major factor in the transmission of the AIDS virus. **YES NO**
6. The AIDS virus is found primarily among the homosexual male population. **YES NO**
7. AIDS can be transmitted through heterosexual contact. **YES NO**
8. AIDS can be transmitted from casual nonsexual contact such as shaking hands or eating with someone who has AIDS. **YES NO**
9. Reliable tests are available to test for the AIDS virus. **YES NO**
10. Most people exposed to the AIDS virus develop the disease. **YES NO**
11. AIDS is a preventable disease. **YES NO**
12. An effective treatment has been found for AIDS. **YES NO**

13. Do you know anyone with AIDS? **YES NO**
14. Do you know anyone who died with AIDS? **YES NO**
15. Are you interested in helping someone with AIDS? **YES NO**

Sermon Outline

***Sermon Title*: "Love is a Splendid Thing"**

***Sermon Text:* John 15:9-17**

Sermon *Behavioral Purpose*: Moving the hearers to love Persons Living with AIDS (PLWA'S) and HIV.

***Sermon Introduction*: Contrast "Agape" with human love. Agape Love(God's Way) is unhesitatingly and unconditionally. Human Love (Our Way) is tentative, limited and conditional.**

***Sermon Move 1*: Agape is a choice.**
Agape goes further than knowledge. Agape can't be achieved on our own. God must empower us. God knows our fears and enable us to love anyway.

***Sermon Move 2:* Loving Persons with AIDS is a test for the church.**
A. Love PLWA's in spite of our fears,
B. Love PLWA's unconditionally.

***Sermon Move 3:* The church is challenged to go bear fruit.**
The church must bear fruit that will last as stated in Galations 5:22 which says the fruit of the spirit is LOVE, joy, peace, patience, kindness, goodness, faithfulness, gentleness and self-control. There is no law against these natural passions and desires.

Sermon Celebration:* When HIV/AIDS come to the Church, choose *Love*. God expects his church to choose *Love* over hate. You cannot have *love* and reject HIV/AIDS when it comes to church. *God's way is "agape" love.

Antioch A.M.E. Church
Pastor Stafford J. Wicker

Door Hanger

HIV/AIDS Go to Church

The leading killer of persons age 24-45 in your community.

Antioch A.M.E. Church
109 Hibernia Ave.
Decatur, Georgia 30032
404-299-3388

HOTLINES

AID Atlanta	**404-872-0600**
Common Ground	**404-847-6425**
Centers for Disease Control (CDC)	**404-639-2076**
Grady Memorial Hospital	**404-616-9809**
Project Open Hand	**404-872-6947**

Note: **Utilized as an instrument in HIV/AIDS awareness campaign.**

Name:
Dealership:
Mailing Address:
City: State: Zip:

Dear :

As leaders in the same community, we are all interested in the well-being of the citizens we serve. The Antioch African Methodist Church has a 126-year history in the city of Decatur. Your business enjoys a rich history in this same community.

The Antioch congregation is engaged in an HIV/AIDS **education-prevention** project. In the Decatur community, HIV/AIDS is the second highest rated killer of persons between 25-44 years of age.

We are seeking a business partner in the project to assist us spread the word about this killer. We have a proposal to present to you at your earliest convenience.

I will call for an appointment within the next seven days.

Yours in fulfilling the great commission,

Rev. Stafford J. Wicker, Senior Pastor

Antioch HIV Project
Ticket Design

Front Side

Making A difference in the Community

A Community Car Give-A-Way
1994 Toyota Tercel

Antioch A.M.E. Church
109 Hibernia Street
Dectur, Ga. 30032
Donation$5.00

Winner does not have to be present to win

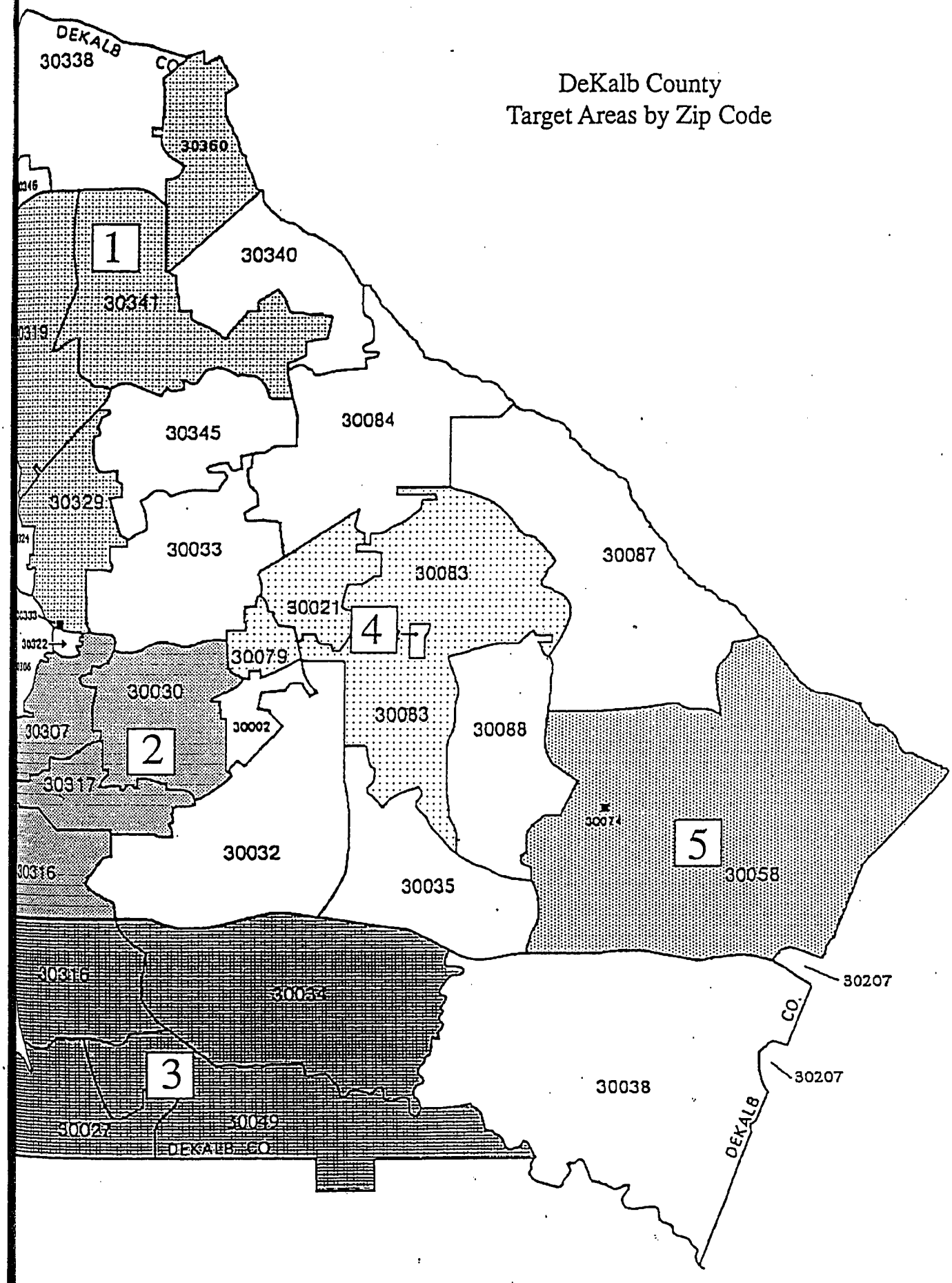
Back Side

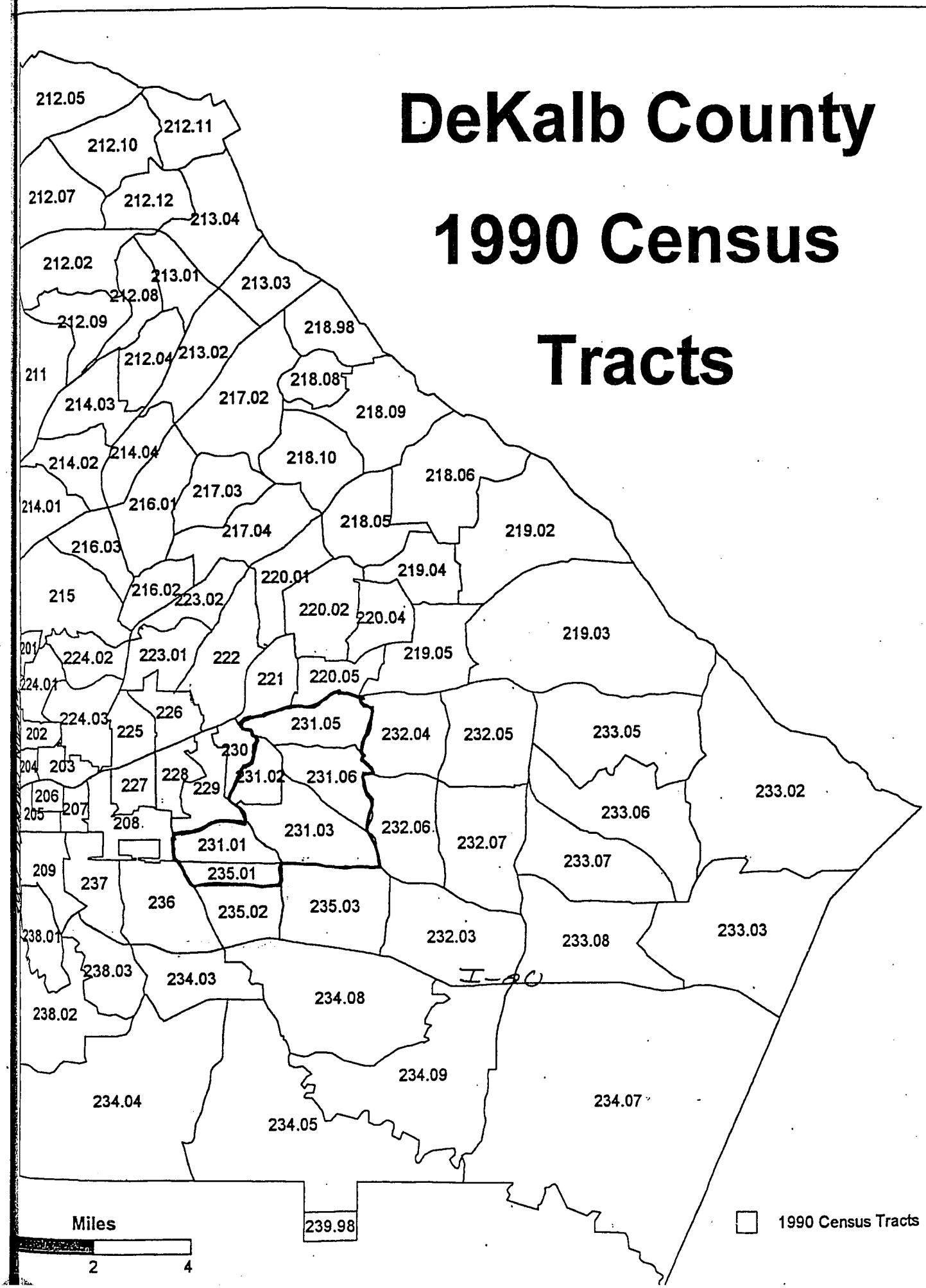
AIDS HOTLINES

National AIDS Hotline	***800-342-AIDS***
Teens AIDS Hotline	**800-440-TEEN**
CDC National Hotline	**800-227-8922**
Antioch A.M.E. Church	**404-299-3388**
The Mothers Initiative	**800-828-3280**
National Association of PLWA'S	**202-898-0414**
AIDS Related Community Service	**800-992-1442**

Antioch A.M.E. Church

APPENDIX 21


DeKalb County
Target Areas by Zip Code
DEKALB CO
30338
30360
1
30340
30341
30345
30084
30329
30033
30087
30083
30021
4
30079
30030
30083
30088
30307
30002
2
30317
30074
5
30032
30058
30316
30035
30316
30034
30207
CO.
3
30038
30207
30027
30049
DEKALB CO
DEKALB


DeKalb County
1990 Census
Tracts
212.05
212.11
212.10
212.07
212.12
213.04
212.02
213.01
213.03
212.08
212.09
218.98
212.04
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211
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201
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231.05
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235.01
237
236
235.02
235.03
238.01
232.03
233.08
233.03
238.03
234.03
I-20
234.08
238.02
234.09
234.04
234.07
234.05
239.98
Miles
2
4
1990 Census Tracts

Table 10C. Age, Race, Sex, April 1, 1990

Census Tract	Age	Total	White	Black and Other	Male	Female	White Male	White Female	Black & Other Male	Black & Other Female
228.00	0-4	242	127	115	115	127	54	73	61	54
	5-14	403	212	191	207	196	111	101	96	95
	15-19	366	232	134	79	287	28	204	51	83
	20-34	929	610	319	342	587	211	399	131	188
	35-59	973	580	393	438	535	270	310	168	225
	60 +	389	253	136	134	255	86	167	48	88
	Total	3302	2014	1288	1315	1987	760	1254	555	733
229.00	0-4	294	87	207	146	148	45	42	101	106
	5-14	540	127	413	266	274	74	53	192	221
	15-19	266	53	213	144	122	26	27	118	95
	20-34	1130	475	655	519	611	223	252	296	359
	35-59	1316	552	764	611	705	266	286	345	419
	60 +	564	381	183	208	356	141	240	67	116
	Total	4110	1675	2435	1894	2216	775	900	1119	1316
230.00	0-4	97	90	7	58	39	55	35	3	4
	5-14	139	118	21	70	69	61	57	9	12
	15-19	71	61	10	36	35	31	30	5	5
	20-34	501	386	115	232	269	173	213	59	56
	35-59	636	569	67	288	348	260	309	28	39
	60 +	532	511	21	204	328	199	312	5	16
	Total	1976	1735	241	888	1088	779	956	109	132
231.01	0-4	523	41	482	248	275	21	20	227	255
	5-14	1014	41	973	504	510	21	20	483	490
	15-19	525	34	491	260	265	12	22	248	243
	20-34	1323	150	1173	572	751	79	71	493	680
	35-59	1555	206	1349	669	886	108	98	561	788
	60 +	546	269	277	217	329	107	162	110	167
	Total	5486	741	4745	2470	3016	348	393	2122	2623
231.02	0-4	218	89	129	112	106	53	36	59	70
	5-14	316	122	194	158	158	60	62	98	96
	15-19	136	52	84	69	67	33	19	36	48
	20-34	1105	331	774	547	558	177	154	370	404
	35-59	905	507	398	406	499	235	272	171	227
	60 +	555	514	41	222	333	208	306	14	27
	Total	3235	1615	1620	1514	1721	766	849	748	872

Table 10C. Age, Race, Sex, April 1, 1990

Census Tract	Age	Total	White	Black and Other	Male	Female	White Male	White Female	Black & Other Male	Black & Other Female
231.03	0-4	921	176	745	466	455	99	77	367	378
	5-14	1684	204	1480	890	794	111	93	779	701
	15-19	793	143	650	387	406	72	71	315	335
	20-34	2540	687	1853	1213	1327	390	297	823	1030
	35-59	2935	979	1956	1297	1638	440	539	857	1099
	60 +	1023	782	241	411	612	321	461	90	151
	Total	9896	2971	6925	4664	5232	1433	1538	3231	3694
231.05	0-4	482	153	329	265	217	89	64	176	153
	5-14	643	177	466	330	313	93	84	237	229
	15-19	429	123	306	267	162	75	48	192	114
	20-34	3044	868	2176	1965	1079	525	343	1440	736
	35-59	1737	901	836	934	803	452	449	482	354
	60 +	478	431	47	189	289	174	257	15	32
	Total	6813	2653	4160	3950	2863	1408	1245	2542	1618
231.06	0-4	450	65	385	238	212	30	35	208	177
	5-14	587	85	502	296	291	39	46	257	245
	15-19	492	100	392	257	235	53	47	204	188
	20-34	2742	540	2202	1366	1376	324	216	1042	1160
	35-59	1426	599	827	664	762	293	306	371	456
	60 +	439	360	79	176	263	149	211	27	52
	Total	6136	1749	4387	2997	3139	888	861	2109	2278
232.03	0-4	457	25	432	232	225	11	14	221	211
	5-14	786	51	735	405	381	27	24	378	357
	15-19	427	45	382	206	221	16	29	190	192
	20-34	1690	223	1467	756	934	125	98	631	836
	35-59	1626	305	1321	739	887	155	150	584	737
	60 +	315	215	100	136	179	99	116	37	63
	Total	5301	864	4437	2474	2827	433	431	2041	2396
232.04	0-4	477	307	170	261	216	170	137	91	79
	5-14	832	521	311	397	435	239	282	158	153
	15-19	459	321	138	257	202	180	141	77	61
	20-34	1425	960	465	696	729	493	467	203	262
	35-59	2287	1798	489	1075	1212	842	956	233	256
	60 +	701	662	39	327	374	311	351	16	23
	Total	6181	4569	1612	3013	3168	2235	2334	778	834

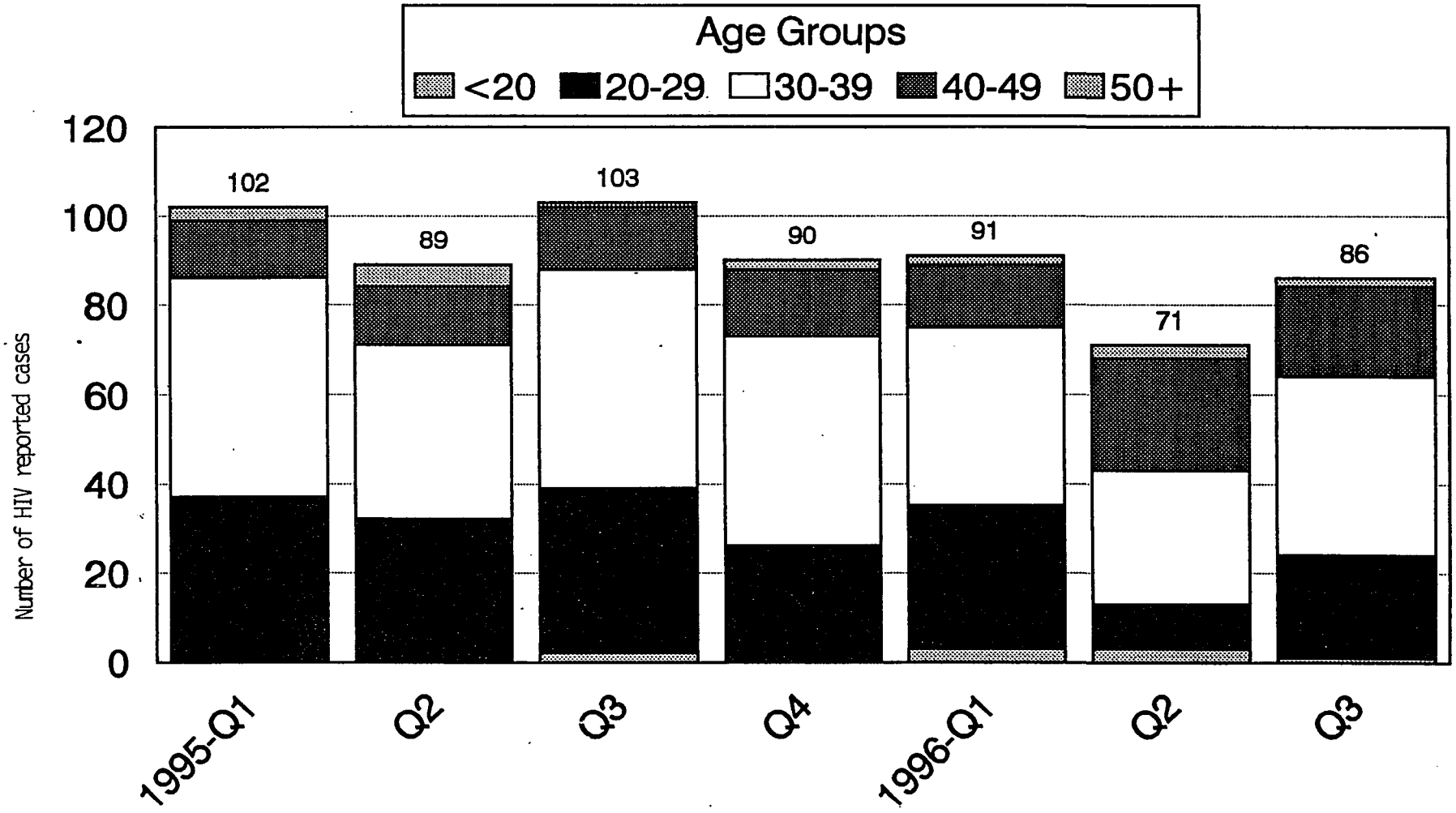
Table 10C. Age, Race, Sex, April 1, 1990

Census Tract	Age	Total	White	Black and Other	Male	Female	White Male	White Female	Black & Other Male	Black & Other Female
235.01	0-4	410	11	399	205	205	5	6	200	199
	5-14	731	21	710	359	372	12	9	347	363
	15-19	379	13	366	177	202	6	7	171	195
	20-34	1031	47	984	467	564	22	25	445	539
	35-59	1246	87	1159	530	716	40	47	490	669
	60 +	372	143	229	140	232	61	82	79	150
	Total	4169	322	3847	1878	2291	146	176	1732	2115
235.02	0-4	690	12	678	352	338	7	5	345	333
	5-14	1507	12	1495	741	766	5	7	736	759
	15-19	880	7	873	451	429	4	3	447	426
	20-34	1938	78	1860	895	1043	44	34	851	1009
	35-59	2758	128	2630	1161	1597	51	77	1110	1520
	60 +	560	216	344	222	338	81	135	141	203
	Total	8333	453	7880	3822	4511	192	261	3630	4250
235.03	0-4	885	69	816	439	446	34	35	405	411
	5-14	2135	101	2034	1100	1035	54	47	1046	988
	15-19	1026	50	976	529	497	25	25	504	472
	20-34	2627	341	2286	1226	1401	195	146	1031	1255
	35-59	4106	526	3580	1859	2247	241	285	1618	1962
	60 +	993	530	463	403	590	223	307	180	283
	Total	11772	1617	10155	5556	6216	772	845	4784	5371
236.00	0-4	792	10	782	378	414	5	5	373	409
	5-14	1796	19	1777	896	900	6	13	890	887
	15-19	995	11	984	502	493	5	6	497	487
	20-34	2583	52	2531	1219	1364	26	26	1193	1338
	35-59	3716	108	3608	1696	2020	58	50	1638	1970
	60 +	882	125	757	362	520	46	79	316	441
	Total	10764	325	10439	5053	5711	146	179	4907	5532
237.00	0-4	567	3	564	271	296	1	2	270	294
	5-14	1057	3	1054	537	520	1	2	536	518
	15-19	508	5	503	243	265	2	3	241	262
	20-34	1464	24	1440	644	820	12	12	632	808
	35-59	1743	52	1691	755	988	33	19	722	969
	60 +	528	60	468	216	312	26	34	190	278
	Total	5867	147	5720	2666	3201	75	72	2591	3129

HIV Testing: DeKalb County Board of Health

All Sites: No. of Positives by Age Groups

In Quarters: January 1990 through September 1996



Age 20-49 is the highest affected group of persons as reported by international, national and local statistics.

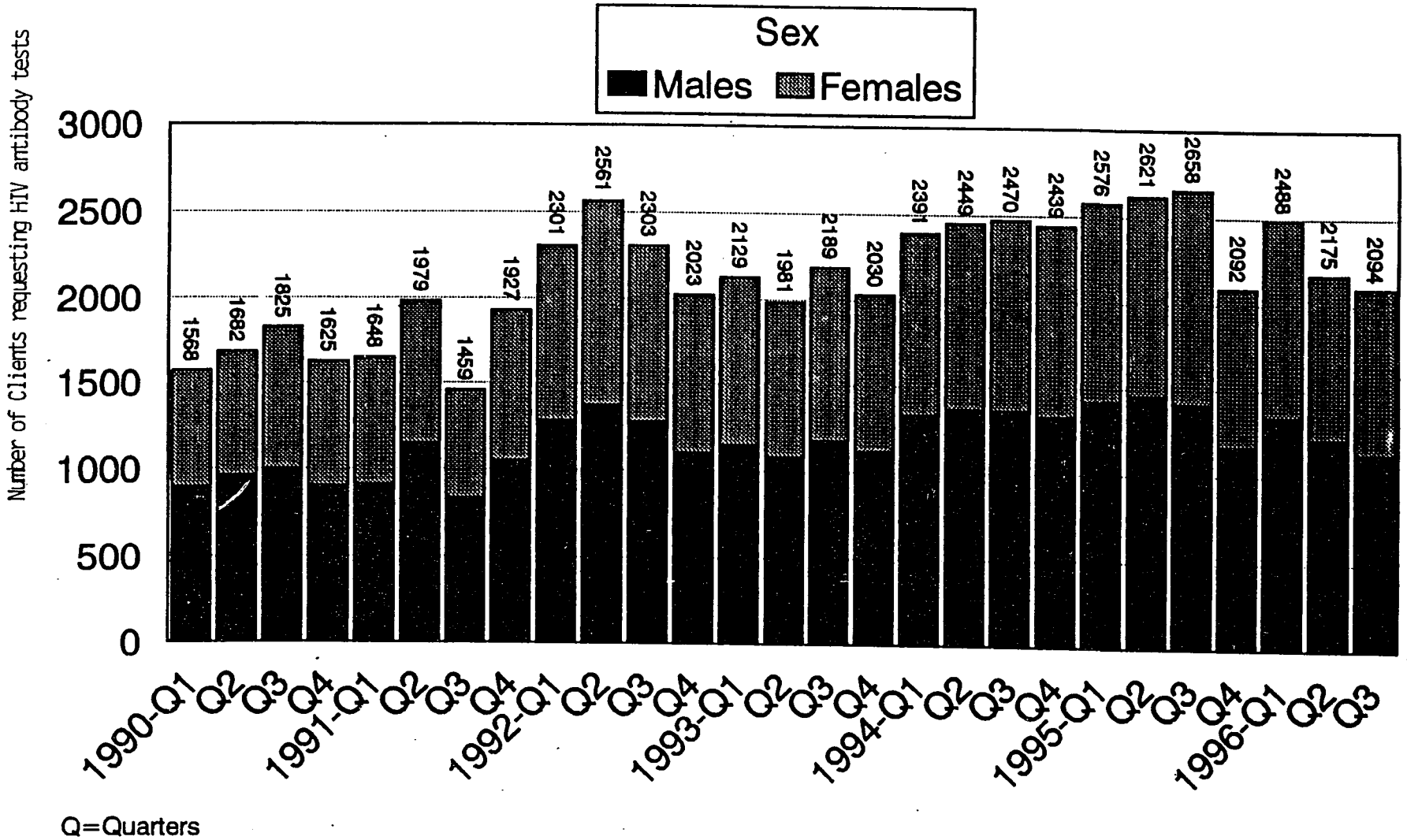
10/96

APPENDIX 22

HIV Testing: DeKalb County Board of Health

All Sites: Number of Tests by Sex

In Quarters: January 1990 through September 1996



Q=Quarters

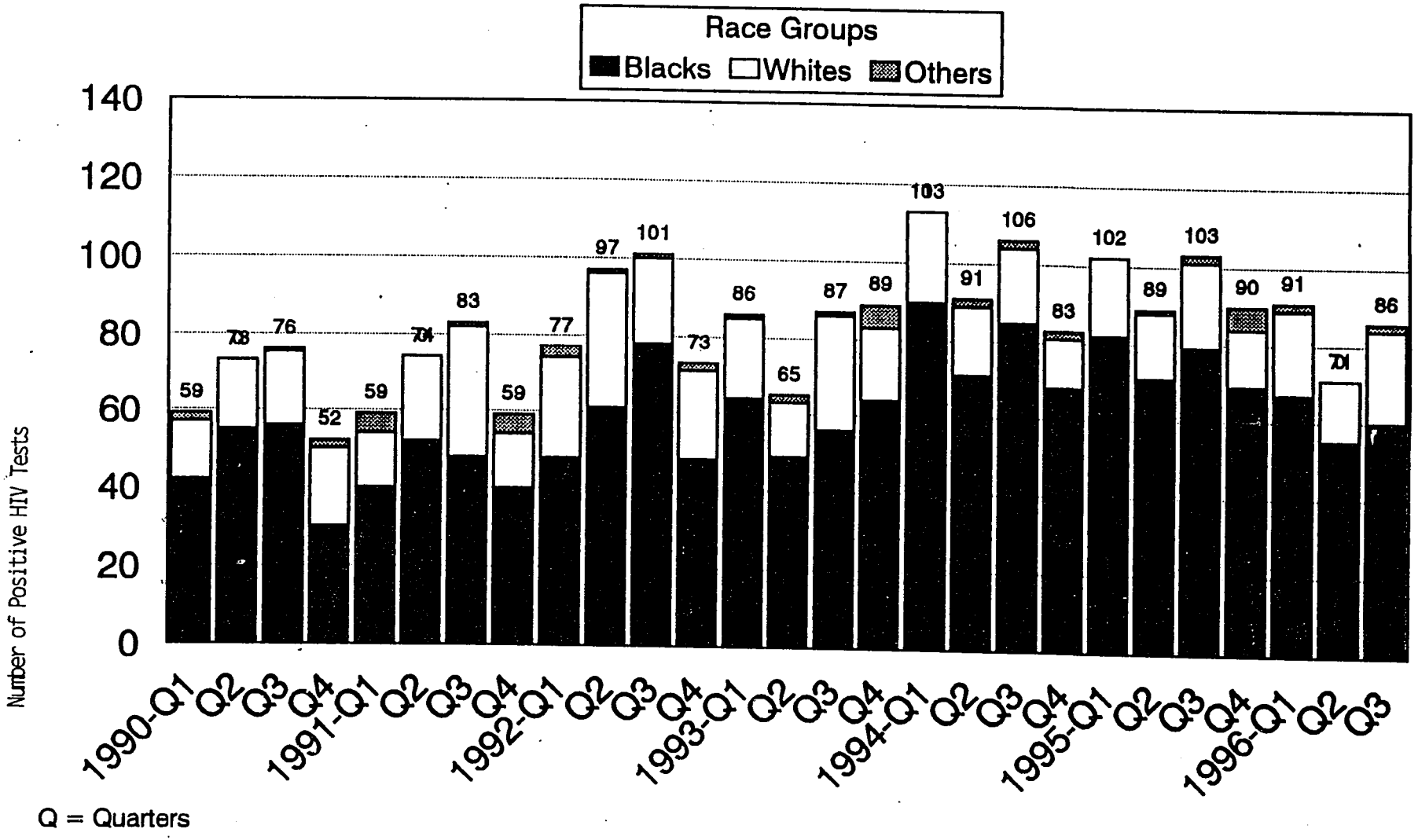
10/96

APPENDIX 23

HIV Testing: DeKalb County Board of Health

All Sites: No. of Positives by Race Groups

In Quarters: January 1990 through September 1996



Q = Quarters

APPENDIX 24