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Faith Communities and HIV/AIDS Prevention in New York State: Results of a Statewide Survey

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SYNOPSIS

Objectives. The authors surveyed religious congregations in New York State to document the extent to which HIV/AIDS-related education and prevention services were being offered; to identify barriers to offering services; and to assess respondents' willingness to meet with HIV/AIDS service providers in their communities.

Methods. In October 1997, a questionnaire was mailed to all congregations in New York State. Due to an initially poor response rate, follow-up telephone interviews were made to a random sample of non-respondents. Survey responses were weighted to represent all congregations across New York State.

Results. Just 16.7% of congregations provided or facilitated HIV/AIDS-related prevention services. Respondents cited both attitudinal and resource-related reasons for not offering services. There was a striking discordance between respondents' perceptions of the need for HIV/AIDS prevention services in their communities and an objective measure of need created by the Health Department. Approximately half of survey respondents expressed willingness to meet with HIV/AIDS service providers.

Conclusion. Follow-up efforts to increase the number of religious congregations providing, facilitating, or offering referrals to HIV/AIDS-related education and prevention services are warranted.

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A number of factors make churches, synagogues, mosques, and other religious institutions ideal settings for HIV/AIDS education and prevention activities. Religious organizations exist in virtually all communities, influencing the lives of some of the hardest–to-reach populations. Clergy are often respected as credible sources of information and guidance.[1] In addition, religion is an important socializing force in America; this is especially true in many minority communities.[2] Norris points to the historical role of the African American church as a catalyst for gains in educational opportunity, voter registration, and economic advancement.[3] Mertz has noted the potential for African American and Hispanic faith communities to play a similarly powerful role in the fight against HIV/AIDS.[4]

To some extent this potential is being realized, not just for minority populations. Most mainline denominations have issued resolutions to address the AIDS crisis, and many have established AIDS ministries.[5] In fact, there are wide networks of religious denominations dedicated to HIV/AIDS prevention. One example is the AIDS National Interfaith Network (ANIN), a nonprofit organization created in 1988, made up of approximately 2,000 AIDS ministries. ANIN worked with other faith-based AIDS organizations, such as the Council of National Religious AIDS Networks, to support the efforts of community-based AIDS ministries; to educate the public about HIV/AIDS, and to play an advocacy role with regard to federal AIDS policies.[6]

A variety of resources have been developed by or for faith communities that specifically address the issue of HIV/AIDS prevention. For example, the Centers for Disease Control and Prevention (CDC) has developed a Faith Initiative to educate religious groups about HIV/AIDS resources and to foster the creation of faith-based HIV/AIDS services. As part of this initiative, CDC has published a resource guide that includes a list of educational materials such as curricula, meditations, prayers, and liturgies; a list of national religious organizations that provide information, assistance, and referrals; and a list of periodicals and websites related to the issue of HIV/AIDS and faith communities.[5]

Community-level action. There have been few attempts to gauge the extent to which individual churches, synagogues, and other religious entities are providing HIV/AIDS-related education and prevention services to their communities.

In an effort to determine how responsive the black church is to the health-related needs of African American youth, Rubin et al. surveyed 635 churches in the northern United States with predominantly black congregations and with black senior ministers, finding that health-related services and AIDS support services for young people were seldom offered. In addition, substance abuse programs, including drug and alcohol counseling and prevention seminars, were offered by just 4% of all responding churches. The authors concluded that "some of the most prominent issues facing black adolescents are not being adequately addressed by black churches."[7]

Study objectives. In 1994, the New York State Department of Health AIDS Institute established the New York State HIV Prevention Planning Group (PPG). The primary responsibilities of the PPG are to determine HIV prevention priorities and to develop an annual HIV prevention plan for the state.

Several of the authors of the present study have been affiliated with the PPG's Racial/Ethnic Committee. The main impetus for the present study was the Racial/Ethnic Committee's interest in establishing linkages with faith-based organizations to expand New York State's HIV prevention efforts. The Racial/Ethnic Committee helped identify the following study objectives: (*a*) to document the extent to which HIV/AIDS-related education and prevention activities were being offered by or through local congregations; (*b*) to identify barriers to offering HIV/AIDS services or referrals; and (*c*) to assess the willingness of congregations to work with local HIV/AIDS education and prevention specialists to develop or enhance the HIV/AIDS-related services available to community residents.

Terminology. Because we sampled from the full range of religious groups in the state, we had considerable difficulty coming up with a term to adequately represent each individual survey respondent. For convenience, we use the term *congregation* in this report to refer to the individual church, chapel, synagogue, mosque, tabernacle, basilica, or other entity responding to the survey.

METHODS

Because a long-term objective was to establish linkages between religious congregations in New York State and local HIV/AIDS prevention specialists, we decided to survey the widest possible range of congregations in the

state. In October 1997, we mailed questionnaires to a commercial mailing list of religious groups that had been compiled from Yellow Page listings as of January 1997.

After two months, we had received back just 15% of the 12,650 questionnaires. Because it was unlikely that following up by mail would produce an acceptable response rate,[8,9] an alternative protocol for follow-up of non-respondents was necessary. This consisted of telephone calls to non-respondents to administer an abbreviated version of the survey instrument. We selected more than 1,800 follow-up respondents at random across eight Health Department–defined geographic regions of New York State. Congregations within each region were selected with enough frequency to ensure that the proportion offering services in each region could be estimated within five percentage points and with 95% confidence.

We implemented the follow-up telephone survey in January 1998. Refusal to participate was low, with refusal rates ranging from 2% to 7% across regions. Failure to reach congregations after a minimum of five telephone calls accounted for the majority of non-responders in each region. Overall, 72% of congregations selected for follow-up participated in the survey. In more than 90% of follow-up telephone interviews, the individual responsible for the delivery of religious services for the congregation was interviewed.

Table 1. Characteristics of congregations responding to survey (*N* = 3,197)

Variable	*Weighted number*	*Weighted percent*
Religious affiliation		
Protestant	1,910	64.6
Catholic	569	19.3
Jewish	194	6.6
Other	281	9.5
	2,954	100.0
Racial/ethnic composition of congregation		
>50% white	2,476	81.2
>50% African American	292	9.6
>50% Hispanic	71	2.3
>50% Asian/Pacific Islander	68	2.2
Other[a]	142	4.7
	3,049	100.0
Number of members in 1996		
1–499	2,143	78.4
≥500	590	21.6
	2,733	100.0
Location		
New York City	516	16.2
New York City vicinity	768	24.0
Rest of state	1,913	59.8
	3,197	100.0
CNI rating		
Low need	1,646	52.7
Medium need	615	19.7
High need	861	27.6
	3,122	100.0

[a]"Other" consisted of congregations in which no single racial/ethnic group accounted for more than 50% of members.

CNI = Community Need Index

Weighting of cases. We received a total of 3,197 responses: 1,878 to the original mailed survey, and 1,319 to the follow-up telephone survey. These 3,197 congregations represented 25% of the 12,650 congregations in New York State. Because response rates to the mailed survey differed by region of the state and because a disproportionate sampling strategy was employed during the follow-up telephone survey, we weighted survey responses to adjust for these factors. Weighting was necessary to ensure that survey results would be generalizable within regions and across the state. Note that the weighting process did not alter the total number of surveys in the analysis (N = 3,197).

For example: In the Northeastern region of the state, 262 of 1,312 congregations responded to the original mailed-in version of the survey, and an additional 209 were interviewed by telephone. Since the telephone respondents needed to represent all 1,050 original non-responders to the mailed survey, the telephone responses were weighted more heavily than the mailed-in responses. This involved assigning weights in a way that (*a*) would maintain the ratio of non-respondents to respondents in the region and (*b*) would not change the total number of responses in the region. The weights that accomplished these two objectives were 0.359 for the mailed-in responses and 1.803 for the telephone responses.

Excluded cases. We dropped Jehovah's Witnesses congregations from the data analysis because a single questionnaire was submitted to represent all Jehovah's Wit-

nesses congregations in the state. Assigning one set of responses to all congregations would have violated the independence assumption necessary to make statistical inferences based on the data. The single questionnaire reported that HIV/AIDS-related education or prevention services were not being provided or facilitated, although HIV/AIDS-related topics were sometimes discussed in the international Jehovah's Witnesses newsmagazine *Awake!* This survey response also indicated that, compared to other services offered, HIV/AIDS-related services were a low priority, both organizationally and among the community of worshipers.

Coding of independent variables. The independent variables in this study were religious affiliation, racial/ethnic composition of the congregation, organizational size, location within New York State, and a measure of the need for HIV/AIDS prevention services, the Community Need Index (CNI).

Religious affiliation. We asked respondents about the congregation's religious affiliation. Respondents were given 16 pre-coded choices and instructed to choose the most appropriate category. Respondents also had the opportunity to provide open-ended responses to this question.

Racial/ethnic composition. We asked respondents to estimate the racial/ethnic distribution of their congregations. Because we were working with the Racial/Ethnic Committee of the PPG, and because minority congregations are located in some of the communities most affected by HIV/AIDS, we were particularly interested in identifying minority congregations, defined as those in which more than 50% of its members represented a specific nonwhite racial/ethnic group.

Size of membership. Rubin et al. found the provision of community-based services to adolescents by religious groups to be positively correlated with organizational capacity, including congregation size.[7] The number of members served is one simple way to measure organizational capacity. We distinguished between those with fewer than 500 members and those with 500 or more members in 1996.

Location. Eight geographic regions were used for sampling and initial data analysis. Preliminary analyses suggested that we could combine these eight regions into three regions for purposes of this study. Combining regions had the advantage of reducing the amount of information being reported, and these regions also matched the geographic distinctions used in other Health Department research, including studies involving a measure of the need for HIV services, the Community Need Index.

CNI rating. The CNI was developed by the New York State Department of Health to assist in identifying communities in need of HIV prevention-related services.[10] The CNI is a multivariate measure that takes into account rates of AIDS cases, newborn seroprevalence, HIV hospital discharge rates, and indicators of high risk behaviors including rates of low birthweight, teenage pregnancy, sexually transmitted diseases, and drug-related hospital discharges. To avoid comparing urban ZIP Codes to rural ones, the CNI is computed separately for New York City counties, New York City area counties, and the rest of New York State.

We classified the 20% of ZIP Codes in each region with the highest scores on the CNI as "high need" ZIP Codes, while the next 20% of ZIP Codes were classified as "medium need," and the remaining 60% of ZIP Codes as "low need." In order to preserve the reliability of the CNI score, and to avoid inadvertent disclosure of confidential data, CNI scores are suppressed for ZIP Codes with fewer than 300 residents and when any one of the indicator variables is based on fewer than six cases. Just over 2% of congregations were located in ZIP Codes for which CNI scores were suppressed.

Analyses. The outcome indicators for this study included whether congregations reported providing, facilitating, or offering referrals to HIV/AIDS-related education and prevention services, the types of services provided, respondents' perceptions of the need for HIV/AIDS-related education and prevention services in their communities, and the willingness of respondents to meet with HIV/AIDS service providers to explore the possibility of offering or enhancing services. In addition, those respondents completing the mail survey were asked about the reasons congregations were not providing, facilitating, or offering referrals to services, if they were not.

We used SPSS (Version 8.0) to enter, code, clean, and produce the frequencies and cross-tabulations reported in the study.

We used SAS (Version 6.1) to perform multinomial logistic regression analyses predicting the trichotomous dependent variables of HIV/AIDS service provision and

Table 2. Responses to the question: "Does your organization currently provide or facilitate the provision of HIV/AIDS-related education/prevention services to community members? If not, are referrals offered so these services can be accessed elsewhere?"

Variable	Yes, services provided or facilitated	No, but referrals offered	No, and no referrals offered	Multivariate analysis[a]			
				Likelihood of providing or facilitating services[b]		Likelihood of offering referrals for services[b]	
	Weighted percent	Weighted percent	Weighted percent	OR	95% CI	OR	95% CI
Total (N = 3,147)	16.7	48.6	34.7	—	—	—	—
Religious affiliation							
Protestant (n = 1,878)	16.7	50.6	32.7	2.3	1.4, 3.8	2.7	1.9, 4.0
Catholic (n = 557)	21.2	50.1	28.7	3.0	1.7, 5.1	3.0	2.0, 4.6
Jewish (n = 194)	10.8	25.3	63.9	Reference	—	Reference	—
Other (n = 282)	13.1	52.5	34.4	NS	—	2.8	1.8, 4.4
Racial/ethnic composition of congregation							
>50% white (n = 2,438)	14.4	51.6	34.0	Reference	—	Reference	—
>50% African American (n = 286)	22.4	39.2	38.5	NS	—	NS	—
>50% Hispanic (n = 71)	36.6	29.6	33.8	2.7	1.4, 6.0	NS	—
>50% Asian/Pacific Islander (n = 67)	17.9	26.9	55.2	NS	—	NS	—
Other (n = 142)[c]	24.6	48.6	26.8	2.2	1.3, 3.6	NS	—
Number of members in 1996							
1–499 (n = 2,112)	14.2	50.3	35.6	Reference	—	Reference	—
≥500 (n = 586)	20.3	46.2	33.4	1.4	1.0, 1.9	NS	—
Location							
New York City (n = 506)	20.8	30.0	49.2	Reference	—	Reference	—
New York City vicinity (n = 758)	17.3	40.1	42.6	NS	—	1.5	1.2, 2.1
Rest of state (n = 1,883)	15.4	57.0	27.6	1.8	1.3, 2.6	3.1	2.3, 4.1
CNI rating							
Low need (n = 1,625)	14.0	49.7	36.2	Reference	—	Reference	—
Medium need (n = 601)	15.3	50.7	33.9	NS	—	NS	—
High need (n = 844)	22.6	44.7	32.7	1.6	1.2, 2.0	NS	—

NOTE: The total number of respondents for each independent variable may not equal 3,147 due to missing data.

[a]Adjusted for the other independent variables shown in the table and for an additional "missing data" variable that was included to control for missing data on religious affiliation, racial/ethnic composition, number of members, and CNI rating.

[b]Comparison group was congregations not providing, facilitating, or offering referrals for services.

[c]"Other" consisted of congregations in which no single racial/ethnic group accounted for more than 50% of members.

OR = odds ratio
CI = confidence interval
NS = not significant
CNI = Community Need Index

perceived need for services. Multinomial logistic regression avoids the problems associated with estimating sets of binary logistic regression equations to deal with trichotomous dependent variables. This is done by estimating two equations simultaneously, with each accounting for the effects of the other.[11] We chose reference groups for the multivariate analyses based on patterns observed in the bivariate analyses, selecting the reference groups that were most likely to produce positive odds ratios (ORs) in multivariate analyses.

We also used SAS (Version 6.1) to perform a logistic regression analysis predicting the dichotomous variable of whether religious organizations would be willing to meet with local HIV/AIDS prevention specialists.

RESULTS

It is important to note that the large number of respondents resulted in many statistically significant differences, despite small absolute differences on some outcome measures. In what follows, we emphasize large differences and consistent patterns or trends, while smaller differences and isolated or contrary findings are not stressed.

Note also that, except as noted, all data reported here are weighted, and the denominators used in calculating percentages are the number of congregations responding to the given question.

Composition of sample. Nearly 65% of congregations indicated a Protestant affiliation, while 19.3% were Catholic and 6.6% Jewish (see Table 1). In an open-ended response section of the questionnaire, 9.5% of respondents to this question specified another religious affiliation. However, with the exception of "Non-denominational," none of these other religious affiliations accounted for more than 20 total responses. Finally, 243 respondents provided no information on religious affiliation (not shown in table).

Table 1 shows that a large majority (81.2%) of respondents reported that their congregations were more than 50% white, while nearly 10% were more than 50% African American. Hispanic and Asian/Pacific Islander majority congregations together accounted for just 4.5% of congregations. Seventy-five percent of Hispanic and Asian/Pacific Islander majority congregations were located in New York City (not shown in table). Finally, the majority of congregations in the "other" category indicated that no single racial/ethnic group accounted for more than 50% of their members. The racial/ethnic composition information was missing for 148 survey respondents (not shown in table).

Table 1 indicates that 21.6% of congregations reported memberships of 500 or more. Initial analyses included a more refined ordinal measure of congregation size; however, those analyses suggested the dichotomous measure to be the most parsimonious way to summarize the data. Data on organizational size were missing for 464 respondents.

Congregations in New York City accounted for 16.2% of survey responses. Those near New York City (in Nassau and Suffolk counties) accounted for 24.0% of survey responses, and 59.8% were located in the remainder of New York State.

According to CNI scores, 27.6% of congregations were located in high need ZIP Codes, while 19.7% were located in medium need and 52.7% in low need ZIP Codes (Table 1).

Provision of services. We asked survey respondents whether their congregations either directly provided or facilitated (by allowing HIV/AIDS service providers to come on-site) HIV/AIDS-related education and prevention services. For those that did not provide or facilitate services, we asked whether they offered referrals to services. Table 2 shows that 16.7% of congregations directly provided or facilitated services, while another 48.6% offered referrals for services. More than one-third (34.7%) of congregations did not provide, facilitate, or offer referrals for services.

Jewish congregations were less likely than Protestant or Catholic congregations to provide, facilitate, or offer referrals for services. In fact, the odds of providing or facilitating HIV/AIDS-related services were 2.3 times as high for Protestant congregations as for Jewish congregations, and 3.0 times as high for Catholic congregations as for Jewish congregations. Similarly, the odds of offering referrals for services were 2.7 times as high for Protestant congregations as for Jewish congregations, and 3.0 times as high for Catholic congregations as for Jewish congregations.

Congregations with Hispanic majorities were significantly more likely than those with white majorities to provide services (OR = 2.7). No differences were seen by racial/ethnic composition, however, with regard to the offering of referrals for services, when the effects of the other study variables were controlled for.

Congregations with 500 or more members were somewhat more likely than those with fewer than 500

Table 3. Responses to the question: "What is the need for HIV/AIDS, related education/prevention services in your community?"

Variable	Low need Weighted percent	Moderate need Weighted percent	High need Weighted percent	Multivariate analysis[a] Likelihood of perceiving a high need for services[b] OR	95% CI	Likelihood of perceiving a moderate need for services[b] OR	95% CI
Total (N = 3,080)	51.0	33.6	15.5	—	—	—	—
Religious affiliation							
Protestant (n = 1,848)	46.2	36.7	17.2	3.4	1.7, 6.7	6.4	3.8, 11.0
Catholic (n = 534)	52.6	32.8	14.6	2.4	1.2, 4.9	4.2	2.4, 7.3
Jewish (n = 191)	85.3	8.9	5.8	Reference	—	Reference	—
Other (n = 271)	50.2	33.2	16.6	2.6	1.2, 5.6	5.3	2.9, 9.7
Racial/ethnic composition of congregation							
>50% white (n = 2,388)	56.2	32.3	11.5	Reference	—	Reference	—
>50% African American (n = 287)	23.7	42.9	33.4	4.5	3.0, 6.7	2.5	1.8, 3.5
>50% Hispanic (n = 69)	24.6	40.6	34.8	3.8	1.8, 7.9	2.4	1.3, 4.7
>50% Asian/Pacific Islander (n = 62)	54.8	32.3	12.9	NS	—	NS	—
Other (n = 137)[c]	35.0	35.8	29.2	2.8	1.7, 4.6	1.5	1.0, 2.4
Number of members in 1996							
1–499 (n = 2,112)	51.6	33.5	14.9	Reference	—	Reference	—
≥500 (n = 586)	47.0	38.1	14.9	NS	—	NS	—
Location							
New York City (n = 506)	48.4	30.1	21.5	Reference	—	Reference	—
New York City vicinity (n = 758)	52.9	31.9	15.2	NS	—	NS	—
Rest of state (n = 1,883)	50.9	35.2	13.9	NS	—	NS	—
CNI rating							
Low need (n = 1,625)	56.6	31.4	11.9	Reference	—	Reference	—
Medium need (n = 601)	46.7	38.2	15.1	NS	—	1.4	1.1, 1.7
High need (n = 844)	41.1	35.7	23.2	1.9	1.4, 2.4	1.3	1.1, 1.6
HIV/AIDS services							
Provided or facilitated services (n = 502)	30.3	37.8	31.9	9.8	6.9, 14.0	2.5	1.9, 3.3
Did not provide or facilitate services but offered referrals (n = 1,488)	49.5	34.3	16.3	3.5	2.6, 4.8	1.4	1.2, 1.7
Did not provide or facilitate services and did not offer referrals (n = 1,040)	63.4	30.2	6.4	Reference	—	Reference	—

NOTE: The total number of respondents for each independent variable may not equal 3,080 due to missing data.

[a]Adjusted for the other independent variables shown in the table and for an additional "missing data" variable that was included to control for missing data on religious affiliation, racial/ethnic composition, number of members, and CNI rating.

[b]Comparison group was congregations perceiving a low need for service.

[c]"Other" consisted of congregations in which no single racial/ethnic group accounted for more than 50% of members.

OR = odds ratio
CI = confidence interval
NS = not significant
CNI = Community Need Index

members to provide HIV/AIDS-related education and prevention services (OR =1.4). Larger congregations were no more likely than smaller ones to offer referrals for services.

One of the more interesting findings is that nearly half of New York City congregations neither provided nor offered referrals for services. This compares with 42.6% of those in the New York City vicinity and 27.6 % in the rest of New York State (Table 2). These findings held up in multivariate analyses, with three of the four odds ratios reaching statistical significance. We conducted additional analyses to isolate congregations in four other large cities in New York State (Albany, Buffalo, Rochester, and Syracuse). The results (not shown) indicated that there were lower percentages of congregations failing to provide, facilitate, or offer referrals for services in these four cities than in New York City, with rates ranging from 10% in Rochester to 31% in Syracuse.

We had anticipated finding a strong relationship between CNI score (our measure of service need) and the provision of services. However, as can be seen in Table 2, we found only a weak relationship between CNI score and the likelihood of providing or facilitating services in analyses adjusted for the effects of the other study variables. Congregations in high need areas were somewhat more likely than those in low need areas to report providing or facilitating services (OR =1.6); however, none of the other odds ratios was statistically significant.

Type of HIV/AIDS-related services offered. Figure 1 shows the types of HIV/AIDS-related education and prevention services being offered by those congregations directly providing or facilitating services (n = 525). Literature distribution (51% of congregations) and HIV/AIDS education (48%) were the most commonly offered services. Other commonly offered services included HIV/AIDS support groups, HIV/AIDS education taking place off-site but facilitated by the congregation, HIV/AIDS counseling, and human sexuality classes. Less commonly offered services included parenting classes, referrals for HIV testing, information about needles/syringes, and condom distribution. While some of these services are not specifically centered on HIV/AIDS issues (for example, parenting classes), survey respondents indicated that HIV/AIDS prevention-related topics were being discussed in the context of these other services.

We also looked for associations between the type of HIV/AIDS-related services offered and the study's independent variables. However, because these analyses were based on the subset of congregations that directly provided or facilitated services, many findings were based on small numbers of cases and consistent patterns were not apparent.

Perceived need for services. We asked respondents to indicate whether there was a "low," "moderate," or "high" need for HIV/AIDS-related education and prevention services in their communities. Although we posed no a priori hypotheses, we were particularly interested in comparing respondents' self-perception of the need for services to our measure of community need, the CNI.

About half (51.0%) of congregations indicated that the need for HIV/AIDS-related services in their community was "low," while 33.6% indicated a "moderate" need for services and just 15.5% of respondents believed that the need for services was "high" (Table 3).

Perceived need for HIV/AIDS-related services varied considerably. For example, responses from Jewish groups contrasted greatly with those from other religious affiliations: 85.3% of respondents from Jewish congregations indicated that there was a low need for services in their communities, compared with about half of respondents from each of the other religious affiliations. These differences were maintained in multivariate analyses (see Table 3).

Table 3 also shows that, compared to predominately white congregations, those with African American and Hispanic majorities were more likely to report a high need for services in their communities and were also more likely to report a moderate need for services. For example, respondents from African American majority congregations were 4.5 times as likely as those from white majority congregations to perceive the need for services in their communities to be high, and 2.5 times as likely to perceive a moderate need for services. Similar effects were observed for predominantly Hispanic congregations (odds ratio of 3.8 for high need and 2.4 for moderate need). Congregations in the "other" category were also more likely than majority white congregations to perceive both high (OR = 2.8) and moderate (OR = 1.5) needs for HIV/AIDS services. Perceived need for HIV/AIDS-related services did not differ significantly by congregation size or location.

The relationship between CNI score and the perceived need for HIV/AIDS-related education and prevention services compares a more objective measure of need with a more subjective one. The relationship between

Table 4. Responses to the question: "Would your organization be willing to meet with community-based HIV/AIDS providers to explore the possibility of offering these services in the future?"

	Weighted percent willing to meet	Multivariate analysis[a]	
		OR	95% CI
Total (N = 3,140)	49.8		
Religious affiliation			
Jewish (n = 192)	20.8	Reference	—
Protestant (n = 1,878)	54.0	3.1	2.1, 4.5
Catholic (n = 557)	44.3	2.4	1.6, 3.7
Other (n = 276)	51.8	3.0	1.9, 4.6
Racial/ethnic composition of congregation			
>50% white (n = 2,434)	45.9	Reference	—
>50% African American (n = 289)	73.7	3.1	2.3, 4.3
>50% Hispanic (n = 68)	60.3	2.0	1.2, 3.4
>50% Asian/Pacific Islander (n = 68)	80.9	6.6	3.5, 13.2
Other (n = 141)[b]	51.1	NS	—
Number of members in 1996			
1–499 (n = 2,115)	50.9	Reference	—
≥500 (n = 573)	46.4	NS	—
Location			
New York City (n = 507)	49.3	Reference	—
New York City vicinity (n = 754	48.9	1.4	1.1, 1.8
Rest of state (n = 1,879)	50.2	1.4	1.1, 1.9
CNI rating			
Low need (n = 1,621)	46.4	Reference	—
Medium need (n = 599)	53.8	1.2	1.0, 1.5
High need (n = 846)	54.1	NS	—
HIV/AIDS services			
Provided or facilitated services (n = 507)	55.2	1.5	1.2, 1.8
Did not provide or facilitate services but offered referrals (n = 1,513)	52.1	1.4	1.1, 1.6
Did not provide or facilitate services and did not offer referrals (n = 1,074)	44.0	Reference	—

NOTE: The total number of respondents for each independent variable may not equal 3,140 due to missing data.

[a]Adjusted for the other independent variables shown in the table and for an additional "missing data" variable that was included to control for missing data on religious affiliation, racial/ethnic composition, number of members, CNI rating, and provision of HIV/AIDS services.

[b]"Other" consisted of congregations in which no single racial/ethnic group accounted for more than 50% of members.

OR = odds ratio
CI = confidence interval
NS = not significant
CNI = Community Need Index

these two variables was not particularly strong (Table 3). In fact, the discordance between the two measures is the more striking observation: 41% of respondents in high need areas as defined by the CNI perceived a low need for HIV/AIDS-related services in their communities, while just 23% described a high need for services.

As expected, provision of HIV/AIDS-related education and prevention services was related to perceived

need for such services (Table 3). Congregations providing services were significantly more likely than those not providing services to perceive the need for services to be high (OR = 9.8) or moderate (OR = 2.5). Similarly, there were significant differences in perceived need between congregations providing and not providing referrals for services.

Willingness to meet with education and prevention service providers. We asked respondents whether their organizations would be willing to meet with local HIV/AIDS service providers to explore the possibility of offering (or enhancing their already existing) HIV/AIDS-related education and prevention services. We asked respondents that were willing to meet to provide a contact name and telephone number for future follow-up. About half (49.8%) of survey respondents stated a willingness to meet with HIV/AIDS service providers to explore offering or enhancing services (Table 4).

Representatives from Jewish congregations were least likely to indicate a willingness to meet with providers: only 20.8% of respondents from Jewish congregations indicated a willingness to meet, compared with from 44.3% to 54.0% of respondents from each of the other religious denominations. These differences were maintained in the multivariate analysis (Table 4).

Respondents from predominately white congregations were significantly less likely to indicate willingness to meet with HIV/AIDS service providers than respondents from African American, Hispanic, or Asian/Pacific Islander majority congregations; these differences remained in the multivariate regression analysis (Table 4).

Willingness of respondents to meet with local HIV/AIDS education and prevention providers was not related to congregation size, but it did vary by geographic region (Table 4). Congregations in the New York City vicinity and those in the rest of New York State were more likely than those in New York City to express a willingness to meet, with an odds ratio of 1.4 observed for each in the multivariate analysis.

Finally, provision of HIV/AIDS-related education and prevention services was only weakly associated with willingness to meet with providers (Table 4): 44.0% of congregations not providing, facilitating, or offering referrals for services agreed to meet with HIV/AIDS service providers, compared with 55.2% of those providing or facilitating services and 52.1% of those offering referrals for services.

Barriers to offering HIV/AIDS-related services or referrals. One of our study objectives was to identify the reasons why religious groups were not involved in HIV/AIDS-related education and prevention activities. On the written questionnaire, we asked those congregations that were not providing, facilitating, or offering referrals for services to indicate the barriers to doing so. Respondents were given a set of pre-coded reasons and were also allowed to indicate additional reasons in an open-ended section of the questionnaire.

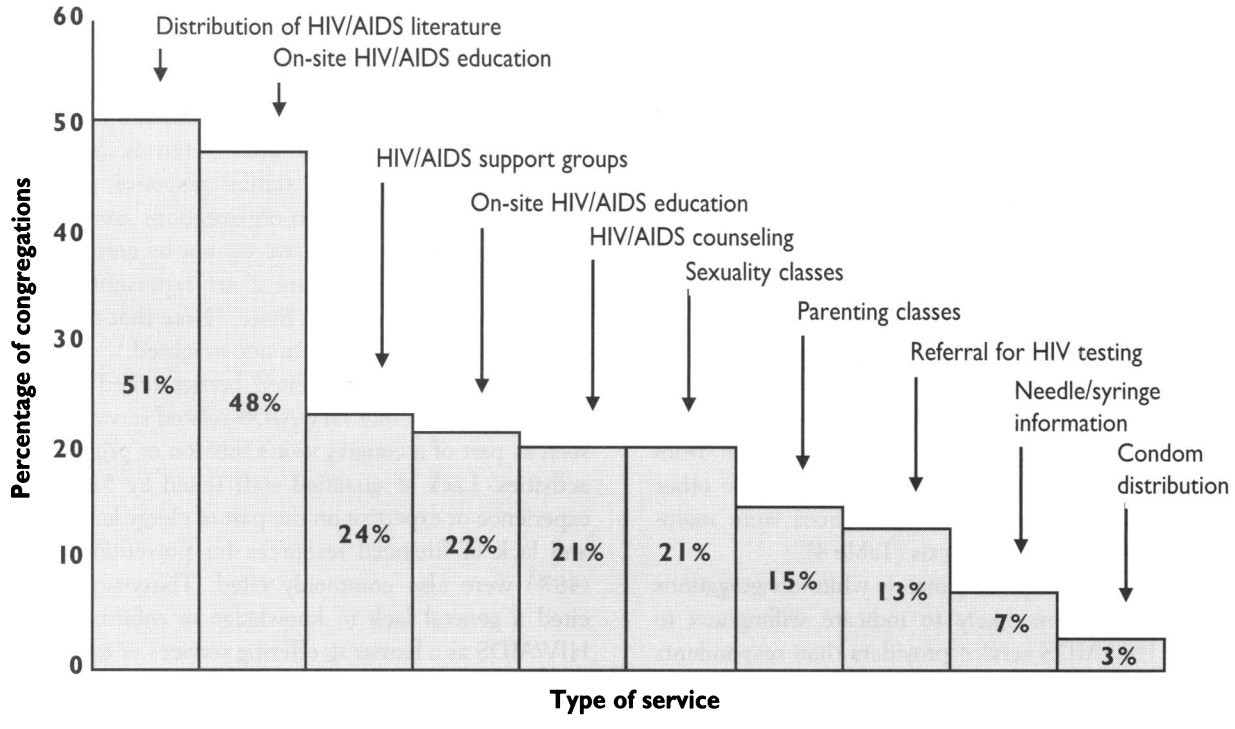
It is important to note that, because we needed to shorten the telephone version of the survey, we did not ask telephone respondents this question. As a result, the reasons presented in Figure 2 reflect only those congregations reporting on the mailed questionnaire that they did not provide, facilitate, or offer referrals for services. Although we found very similar response patterns on other survey items between organizations completing the two versions of the survey, we cannot be certain that the reasons presented in Figure 2 are representative of all congregations in New York State. (Note that the percentages reported in Figure 2 are not weighted.)

The most commonly cited barrier (cited by 66% of respondents) was that HIV/AIDS-related services were not seen as part of a congregation's mission or primary service activities. Lack of qualified staff (cited by 52%), lack of experience or expertise on the part of clergy leaders (50%), and lack of financial resources for prevention programs (48%) were also commonly cited. Thirty-seven percent cited a general lack of knowledge or information about HIV/AIDS as a barrier to offering services or referrals.

Forty-one percent of respondents cited opposition to homosexuality/bisexuality, drugs and alcohol, or condom use. About a third (35%) of congregations not providing services or referrals indicated that HIV/AIDS was not considered a serious problem in their communities. Respondents were less likely to state specific biases against people with HIV/AIDS as barriers to providing services, although such responses did occur: 10% of respondents indicated "fear of HIV/AIDS" as a reason for not offering services or referrals, while 9% cited negative attitudes toward people at risk or infected with HIV.

We reclassified the barriers shown in Figure 2 into two general categories: lack of resources and attitudinal barriers. Resource-related reasons consisted of: (*a*) lack of qualified staff; (*b*) lack of clergy experience or ability; (*c*) lack of financial resources for prevention programs; and (*d*) lack of knowledge/information about HIV/AIDS. The remaining six reasons were considered attitudinal barriers. Eighty-seven percent of respondents reported one or more attitudinal barriers, while 68% cited one or more resource-related barriers. A cross-tabulation of these two variables (not shown) indicated that 55% of

Figure 1. Types of HIV/AIDS-related education and prevention services provided or facilitated (*n* = 525 congregations)



respondents gave both resource- and attitudinal-related reasons for not offering services or referrals, while 28% listed attitudinal barriers only and 13% specified resource-related barriers only.

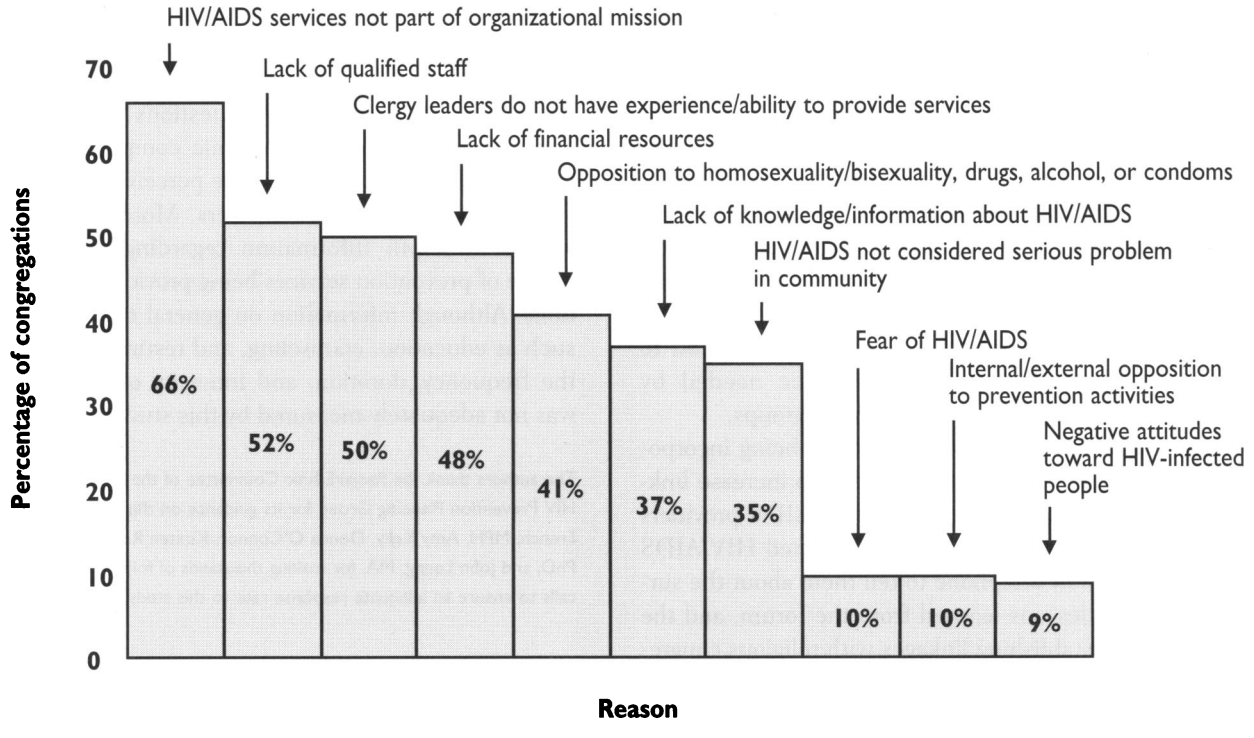
DISCUSSION

We found that 16.7% of congregations were directly providing or facilitating the provision of HIV/AIDS-related education and prevention services. Although an additional 48.6% indicated that they provided referrals for these services, 34.7% reported not providing, facilitating, or offering referrals for services. This finding suggests that macro-level efforts to involve religious organizations in HIV/AIDS prevention, such as nationally-based AIDS ministries and federally sponsored initiatives to foster the creation of faith-based HIV/AIDS services, are not translating into community-level prevention services for many congregations in New York State.

We found that more than half of respondents cited *both* attitudinal and resource-related reasons for not providing services. This finding suggests that HIV/AIDS providers attempting to create linkages with religious groups will need to be ready to address both types of barriers. It is important to emphasize that this study did not address the feasibility (or even desirability) of persuading religious groups to become involved with the provision of HIV/AIDS-related services.

The finding that nearly 50% of New York City congregations did not provide, facilitate, or offer referrals for services is troubling since NYC has the highest rates of HIV infections and AIDS cases in the state.[12] However,

Figure 2. Barriers to providing, facilitating, or offering referrals for HIV/AIDS-related education and prevention services (*n* = 506 congregations)



our finding may simply reflect a perception on the part of respondents that HIV/AIDS education and prevention service needs in New York City were being adequately met by agencies and community-based organizations specifically funded to provide these services.

The most consistent factor affecting the outcome measures of this study was the religious affiliation of the survey respondent. Jewish congregations were, as a group, the least likely to provide services or offer referrals for services, the least likely to perceive a high need for services, and the least willing to meet with service providers to explore the possibility of offering services in the future. Identification of those Jewish congregations willing to meet with providers for capacity-building activities was a step toward making HIV/AIDS-related services more readily accessible through Jewish congregations.

This study uncovered discordance between the Health Department's objective measure of need for HIV/AIDS prevention services and survey respondents' views of the need for such services. There are at least three possible reasons for these differences in perception. First, the CNI does not consider the extent to which HIV/AIDS-related services are being provided in high, medium, or low need areas. The discordance may therefore have been due to an assessment of need on the part of respondents that factored into account the HIV/AIDS-related services already in place locally. It is also possible that respondents to this survey narrowly interpreted this question to apply to the HIV/AIDS-related needs of their members, rather than of the community at large. Finally, the discordance may be indicative of misperceptions on the part of religious leaders regarding the need for HIV/AIDS-related prevention services in their communities.

Follow-up activities. Many respondents expressed a willingness to meet with community-based HIV/AIDS service providers to explore the possibility of offering or enhancing services. Especially encouraging was the finding that many congregations not providing services and not offering referrals for services were interested in meeting with providers. These results have sparked renewed interest in New York State in the role faith communities can play in HIV/AIDS prevention. In June 2000, the AIDS Institute hosted a community forum in the northeastern region of the state, bringing together religious representatives and HIV/AIDS service providers. The objectives of the forum were to introduce HIV/AIDS service providers to local religious groups; to explore strategies for establishing and maintaining linkages between HIV/AIDS service providers and religious groups; to explore the best practices needed to involve religious groups in HIV/AIDS education and prevention; and to define the types of technical assistance needed by HIV/AIDS service providers and religious groups.

Input from the regional forum is now being incorporated into a larger-scale follow-up effort to increase linkages between religious groups and HIV/AIDS providers statewide. The AIDS Institute has contacted HIV/AIDS service providers by telephone to tell them about the survey results, the lessons learned from the forum, and the importance of establishing linkages with religious congregations. Follow-up materials have been sent to providers, including lists of the religious organizations in their service areas willing to meet with them. We will follow up with service providers in three to six months to determine the extent to which new linkages have been established.

Study limitations. The findings of this study are based on self-reported data, some of which were fairly subjective in nature. As a result, responses to some survey questions may have been less valid than responses to others. Particularly vulnerable were questions asking respondents to estimate the racial/ethnic composition of their congregations and to estimate the perceived need for services among community members. More limiting is the lack of in-depth information regarding the type and nature of prevention services being provided by congregations. Although information on general types of services such as education, counseling, and testing was obtained, the frequency, duration, and intensity of these services was not adequately measured by this study.

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