



5-3-2011

HIV/AIDS Disparity between African-American and Caucasian Men Who Have Sex with Men: Intervention Strategies for the Black Church

William Allen Hill

Clea McNeely

Follow this and additional works at: http://trace.tennessee.edu/utk_blackmaj

Recommended Citation

Hill, William Allen and McNeely, Clea, "HIV/AIDS Disparity between African-American and Caucasian Men Who Have Sex with Men: Intervention Strategies for the Black Church" (2011). *Major Studies and Reports*.
http://trace.tennessee.edu/utk_blackmaj/3

This Article is brought to you for free and open access by the Commission for Blacks at Trace: Tennessee Research and Creative Exchange. It has been accepted for inclusion in Major Studies and Reports by an authorized administrator of Trace: Tennessee Research and Creative Exchange. For more information, please contact trace@utk.edu.

HIV/AIDS Disparity between African-American and Caucasian Men Who Have Sex with Men: Intervention Strategies for the Black Church

William Allen Hill · Clea McNeely

© Springer Science+Business Media, LLC 2011

Abstract This manuscript examines the HIV/AIDS health disparity among African-American (AA) men who have sex with men (MSM) as compared to non-Hispanic White (NHW) MSM, and proposes faith-based intervention strategies as a means of reducing the disparity. Effective faith-based HIV/AIDS intervention programs to encompass AA MSM must include community-based participatory research; engage the faith community through data sharing; specifically target and equip church leaders in addition to laity; involve effective collaboration and compromise between public health practitioners and faith leaders; emphasize spirituality and compassion; utilize popular opinion leaders; and be intergenerational.

Keywords Men who have sex with men (MSM) · HIV/AIDS · Faith-based intervention

Almost 30 years into the epidemic, acquired immune deficiency syndrome (AIDS) and its viral precursor, human immunodeficiency virus (HIV), continue to impose a tremendous burden on the US health care system. Although HIV/AIDS adversely affects all segments of the US population, according to the CDC (2009a), men who have sex with men (MSM) continue to be the risk group most severely affected. In this manuscript, the term MSM is used to describe all homosexually and bisexually active men, regardless of their sexual identity. Moreover, MSM account for nearly half of the more than one million persons living with HIV in the United States as well as more than half of all new US HIV infections annually (CDC 2009a). While HIV incidence has declined among heterosexuals and intravenous drug users in recent years, MSM is the only US risk group in which HIV incidence has increased—a trend observable since the early 1990s (CDC 2009a). More

W. A. Hill (✉)

Department of Comparative Medicine, The University of Tennessee Institute of Agriculture,
2431 Joe Johnson Drive, 336 Ellington Plant Science, Knoxville, TN 37996, USA
e-mail: wahill@utk.edu

C. McNeely

Department of Public Health, The University of Tennessee, Knoxville, TN 37996, USA

than 274,000 MSM have succumbed to AIDS-related deaths since the beginning of the epidemic (CDC 2009a).

The aforementioned statistics underscore the urgent need to expand access to HIV prevention programs for MSM. However, when these data are stratified by race, we begin to more clearly appreciate the devastating impact of HIV/AIDS on African-American MSM. A representative study of 1,767 MSM in 5 US cities found that 46% of African-American men sampled were HIV positive (Voelker 2008). By comparison, 21% of non-Hispanic Whites in the study were HIV positive. In the 5 cities cited by Voelker (2008), African-American MSM (AA MSM) men were 2.19 times more likely than non-Hispanic White MSM (NHW MSM) to be HIV positive. As evidence of a national trend and a domestic public health crisis, Peterson and Jones (2009) stated that AA MSM now experience rates of HIV infection that rival those among the general population in the developing world. According to the CDC (2008), the HIV prevalence rate for African-American men (2,388.2 per 100,000 population) was six times the rate for White men (394.6 per 100,000). Moreover, Peterson and Jones (2009) cited that AA MSM have the highest rates of unrecognized HIV infections and the highest proportion of AIDS mortality than any other MSM racial or ethnic group.

This manuscript will examine the HIV/AIDS health disparity among AA MSM as compared to NHW MSM and propose faith-based intervention strategies as a means of reducing the disparity. Behavioral risk factors for HIV infection, such as frequency of sexual intercourse and number of sexual partners, do not explain elevated HIV rates among AA MSM as compared to NHW MSM. Consequently, we propose a conceptual framework that highlights the social factors present in the lives of AA MSM that diminish or preclude their access to HIV prevention resources. Peterson and Jones (2009) highlighted the need for the work presented here when they commented that HIV prevention research has not typically focused on minority men within the general MSM population. It is hoped that the work reported here will be used to develop faith-based HIV prevention programs inclusive of AA MSM and thus reverse the devastating effect of HIV/AIDS.

Conceptual Framework

Figure 1 presents a conceptual framework of the determinants responsible for HIV infection in NHW and AA MSM. The framework posits that multiple factors explain the relationship between race and HIV infection among MSM including social constructs,

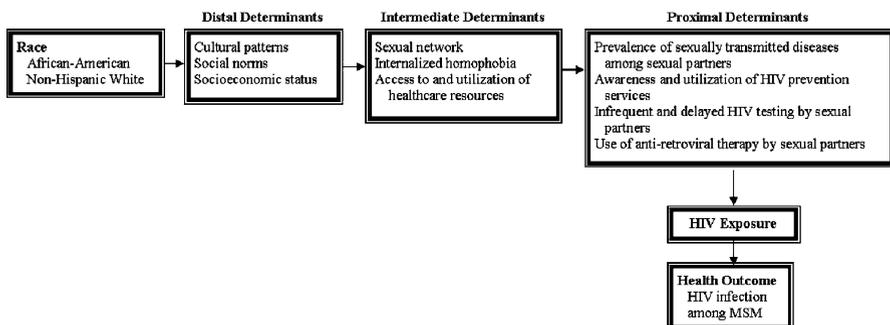


Fig. 1 Causal pathway of HIV infection among MSM

human behavior, microbial interaction, and prevention and treatment access and utilization. For simplicity, we have grouped various factors into distal, intermediate, and proximal determinants.

Race

Understanding why AA MSM experience a disproportionate burden of HIV infection remains a central public health priority (Voelker 2008). In a comprehensive review of the literature, Millett et al. (2006) identified 12 hypotheses purported to explain greater HIV prevalence among AA MSM. Of these hypotheses, Millett et al. (2006) concluded that only two are evidence-based while others likely originate from stereotypes or misinformed beliefs about the lives of AA MSM. Our literature review further corroborated the findings of Millett et al. (2006) and provided the basis for the proposed structural framework.

Racial differences in HIV infection rates among MSM likely depend on factors other than behavioral risks (Millett et al. 2007). The studies reviewed by Millett et al. (2006), particularly those conducted in the past decade, failed to support the hypothesis that AA MSM engage in more sexual risk taking than other MSM. Moreover, several studies have found greater HIV prevalence among AA MSM despite comparable or lower rates of unprotected anal intercourse than MSM of other races or ethnicities (Millett et al. 2007; Malebranche 2003). Greater injection drug use and sexual activity while under the influence of substances by AA MSM have also been hypothesized as factors contributing to the racial differences in HIV prevalence (Millett et al. 2006). After review of the literature, Millett et al. (2006) concluded that AA MSM are no more likely than other MSM to report drug or alcohol use; crack cocaine is the only illicit drug that AA MSM report using more often than other MSM. Gay identity and acculturation have been associated with lower HIV-related risk behavior, and AA MSM are less likely than NHW MSM to identify as gay (Millett et al. 2007). As a result, lack of gay identity has been hypothesized to increase HIV risk behavior among AA MSM. This is yet another unsupported hypothesis and likely represents an additional stereotypical categorization of the lives of AA MSM. As cited by Millett et al. (2007), non gay-identified or non disclosing MSM have fewer male sex partners than gay-identified or “out” MSM and having fewer sex partners, being non gay-identified, and nondisclosure of sexuality are also each associated with a lower likelihood of HIV. Further illuminating the AA MSM HIV health paradox, Raymond and McFarland (2009) cited that AA MSM engage in less commercial sex work than MSM of other race/ethnicities.

In the model presented here, race affects cultural patterns, social norms, and socioeconomic status, and collectively, these three determinants are posited as the chief explanatory variables for the association between race and HIV among MSM. The aforementioned variables are hypothesized to be distal determinants of HIV infection among MSM and will be described in detail below.

Distal Determinants

Cultural Patterns

Culture refers to shared patterns of thought and behavior that characterize a social group, which are learned through socialization processes and persist over time. We posit that cultural patterns are a direct determinant of the sexual networks of MSM. Additionally, cultural patterns may determine what discussions are acceptable during sexual decision

making within sexual networks (Eaton et al. 2010). In a cross-sectional survey of MSM in San Francisco during 2007–2008, Raymond and McFarland (2009) determined that AA MSM had a threefold higher level of same-race sexual partnering than would be expected by chance alone. Raymond and McFarland posited the following reasons for the aforementioned occurrence:

- 1) AA MSM are the least preferred as sexual partners by other MSM; 2) AA MSM are perceived to be at higher risk for HIV compared to other partners, which may lead to MSM of other races avoiding AA MSM as sexual partners; 3) AA MSM are ranked as the least easy to meet by other MSM; and 4) AA MSM are perceived to be less welcome in common venues for socializing among MSM. (p. 635)

Moreover, Raymond and McFarland (2009) determined that NHW MSM were significantly less likely to have sexual partners of non-White race/ethnicities. Admittedly, the aforementioned study may contain sample bias as all respondents resided in the same large urban city. However, if the results can be generalized, cultural patterns of non-Black MSM, result in sexual networks that are less likely to include AA MSM. We suggest that cultural patterns determine sexual network selection. We further hypothesize sexual network selection is directly related to the prevalence of sexually transmitted diseases (STDs) including HIV among AA MSM, as explained below.

Social Norms

Social norms are customary rules of behavior that coordinate one's interactions with others. Moreover, norms impose uniformity of behavior within a given social group, but often vary substantially between groups. In a qualitative study of 745 racially and ethnic diverse undergraduates attending a large Midwestern university, Calzo and Ward (2009) determined that parents of African-American participants discussed homosexuality more frequently than the parents of other respondents. In an analyses of the values communicated, Calzo and Ward (2009) reported that Black parents offered greater indication that homosexuality is perverse and unnatural. Additionally, the authors found that friends of Black participants provided significantly more conservative messages about homosexuality than did the friends of White participants. These data suggest that both parents and friends of African-Americans may be more likely to communicate that homosexuality is a moral issue and that it is perverse. Further corroborating these findings, Peterson and Jones (2009) reported that AA MSM were more likely than NHW MSM to perceive that their friends and neighbors disapprove of homosexuality.

Regarding the prevailing view of homosexuality in the African-American community, Pitt (2010) reported:

The Black community believes that “real men” are gainfully employed, provide for and maintain leadership in their homes, and in other ways are able to exhibit control over their own destiny. Black manhood, then, depends on men's ability to be provider, progenitor, and protector. But, as the Black male performance of parts of this script is thwarted by racism and capitalist patriarchy, the performance of Black masculinity becomes predicated on a particular performance of Black sexuality and avoidance of weakness and femininity. If sexuality remains one of the few ways that Black men can recapture a masculinity withheld from them in the marketplace, endorsing Black homosexuality subverts the cultural project of reinscribing masculinity within the Black community. (p. 40)

As a result, African-Americans perceived as homosexuals are categorized as a threat to the perception of African-American masculinity and are shunned by large portions of Black culture. We argue that social norms within the African-American community regarding homosexuality contribute to greater internalized homophobia in AA MSM, as explained below.

Socioeconomic Status

Public health professionals have long recognized the relationship between socioeconomic status (SES) and positive health outcomes. SES is one of the strongest and most consistent predictors of morbidity and premature mortality (Adler and Newman 2002). In a study of 4,868 MSM, Madison et al. (2003) found that compared to NHW MSM, AA MSM were more likely to have lower socioeconomic status. Madison et al. (2003) reported that 21% of the AA MSM surveyed had no college education, whereas only 8% of NHW MSM surveyed lacked a college education. Sixty three percent (63%) of AA MSM respondents reported an income of <\$29,000, while only 35% of NHW MSM respondents reported a similar income (Madison et al. 2003). From these data, it is unclear how many respondents reported earnings below the US Federal Poverty Guidelines. It is clear however, that poverty and low SES have been associated with insufficient health coverage and limited quality of care (Peterson and Jones 2009). Our model posits that SES impacts access to and utilization of health care resources among MSM.

Intermediate Determinants

Sexual Networks

As discussed above, cultural patterns among MSM determine their sexual networks. The combination of attitudes on the part of non-Black MSM, and the environments found in gay venues serve to separate AA MSM from other MSM populations (Raymond and McFarland 2009). This separation results in sexual networks of AA MSM that are constrained to smaller numbers and are therefore potentially more highly interconnected than other MSM groups. It is plausible that once HIV enters such a tightly connected network, it is likely to spread rapidly if network members fail to utilize proven HIV prevention strategies. Studies performed during the first decade of the HIV/AIDS epidemic reported high rates of unprotected anal intercourse among AA MSM (Millett et al. 2007). Similarly, high HIV prevalence among black gay and bisexual men was being reported by the Centers for Disease Control and Prevention for the same time period (Millett et al. 2007). Since AA MSM tend to have sex with other AA MSM (Raymond and McFarland 2009), greater rates of unprotected anal intercourse early in the epidemic may have increased the background prevalence of HIV among AA MSM, which has continued to rise to the disproportionately high HIV rates observed today despite comparable rates of unprotected anal intercourse as NHW MSM since the 1990s (Millett et al. 2007).

As reported by Harawa et al. (2004), AA MSM are more likely than other MSM to have partners of a different age than themselves or to initiate their homosexual activity with an older man. Because older gay cohorts have a higher HIV prevalence, older partners are more likely to be infected; hence the partner pool for young, AA MSM likely has high background HIV prevalence (Harawa et al. 2004). This hypothesis is supported by recent data that reported most new HIV infections among Black MSM occur among young Black

MSM; moreover, there are more reported new HIV infections among young Black MSM (aged 13–29) than among any other age and racial group of MSM (CDC 2009a).

Intraracial and intergenerational components of AA MSM sexual networks may contribute to the faster spread and higher prevalence of HIV by creating more highly interconnected partnerships and linkages from lower to higher HIV prevalence between age groups (Bohl et al. 2009). An additional component of sexual networks is concurrency, or the degree to which individuals have more than one sexual relationship at the same time. In a study of 521 MSM in San Francisco, Bohl et al. (2009) determined that although AA MSM tended to have fewer sexual partners overall, when they did have multiple partners, they were more likely than non-Black MSM to have all of their partnerships overlap or be very close to each other in time. Individuals with concurrent partners have a greater probability of being exposed to an acute HIV infection and thus are at greater risk for contracting HIV. The interconnectivity that results from a high degree of partner overlap is a biologically feasible mechanism for expansion and maintenance of the HIV epidemic among AA MSM (Bohl et al. 2009). All of the above findings substantiate our hypothesis that HIV risk emanates from sexual networks rather than individual behaviors. Factors including a higher amount of intragroup partnering, a higher amount of intergenerational partnerships, and a higher degree of complete overlap or close intervals between partners coupled with a high background prevalence of HIV in AA MSM, likely lead to higher HIV exposure and infection among AA MSM.

Internalized Homophobia

Internalized homophobia is defined as the lesbian, gay, or bisexual individual's inward direction of society's homophobic attitudes (Meyer 1995). The construct includes negative attitudes toward homosexuality, discomfort with disclosure of sexual orientation, disconnectedness from other homosexuals, and discomfort with same-sex sexual activity (Newcomb and Mustanski 2010). AA MSM have been observed to have high levels of internalized homophobia and are less likely to disclose homosexual orientation than MSM or other racial or ethnic groups (Peterson and Jones 2009). We posit that social norms regarding homosexuality within the African-American community lead to increased internalized homophobia for AA MSM. As suggested by Peterson and Jones (2009), we concur that internalized homophobia among AA MSM may reflect the enduring influence of organized religion in their lives. As reported by Peterson and Jones (2009), AA MSM tended to be more involved with religious communities than NHW MSM. In many Black churches, the messages preached by pastors and inscribed in the doctrines of the church are at the very least heterosexist, but are more likely to be stridently critical of homosexuality (Pitt 2010). Pitt (2010) suggested that threats to homosexual identity persist because some AA MSM continue to participate in religious communities in which the religious identity is strengthened, while the sexual identity is stigmatized and condemned as reprehensible. We argue that internal battles between racial, sexual, and religious identities lead to psychological distress and subsequent internalized homophobia among AA MSM. Peterson and Jones (2009) posited that greater internalized homophobia was associated with lower awareness and utilization of HIV prevention services.

Access to and Utilization of Health Care Resources

As reported by Peterson and Jones (2009), barriers to access and use of health care resources constitute structural disadvantages that pose overwhelming problems for AA

MSM. As previously stated, access to and utilization of health care resources among MSM is impacted by SES. According to Peterson and Jones (2009):

Among HIV-positive MSM, Blacks are less likely than other MSM to have access to private clinics, to express HIV-related health concerns to their medical providers, to use outpatient health services, to report satisfaction with medical personnel in outpatient settings, to report an absence of nondiscriminatory practices among medical staff, to trust the quality and competence of outpatient medical services, and to trust physicians. (p. 977)

All HIV treatment and most HIV testing require an individual to enter the health care system. If the entrance of AA MSM into the health care system is negatively impacted by SES or distrust of medical providers, it is likely that early medical interventions aimed at identifying or slowing HIV infection are inaccessible or underutilized by AA MSM. The interrelatedness of AA MSM sexual networks and the inaccessibility or underutilization of health care resources places AA MSM and their sexual partners at higher risk for HIV infection. We posit that access to and utilization of health care resources directly impacts the frequency of HIV testing, stage of infection at testing, and the use of antiretroviral therapy.

Proximal Determinants

Prevalence of Sexually Transmitted Diseases among Partners

Sexually transmitted diseases (STDs) increase vulnerability to and transmissibility of HIV infection (Millett et al. 2006). AA MSM are more likely than other MSM to report ever having had an STD or currently having an STD. In a study of several thousand MSM in New York City who were tested for HIV, HIV-positive AA MSM were significantly more likely to be coinfecting with gonorrhea, syphilis, or nongonococcal urethritis than HIV-positive White MSM (60% vs. 18%) (Millett et al. 2006). We posit that the prevalence of STDs in the intraracial, intergenerational sexual networks of AA MSM contributes to the observed racial HIV infection disparity.

Awareness and Utilization of HIV Prevention Services

As a consequence of internalized homophobia, we hypothesize that AA MSM have less awareness and decreased utilization of HIV prevention services including counseling, education, and outreach. Moreover, many HIV intervention programs aimed at MSM occur in gay environments which may be unavailable or unappealing to AA MSM. Equally problematic is the dearth of culturally appropriate prevention programming specifically designed for AA MSM. Currently, only 1 program (Many Men, Many Voices) specifically targeting AA MSM is listed as a best evidence intervention in the CDC Compendium of Evidence-Based HIV Prevention Interventions (2009b). Due to cultural patterns among MSM and social norms within African-American communities, traditional MSM prevention services will likely continue to be under utilized by AA MSM. The need to develop and implement effective interventions inclusive of AA MSM has never been more urgent.

Infrequent or Delayed HIV Testing by Partners

Although AA MSM are as likely as other MSM to have ever been tested for HIV, AA MSM are tested less frequently and later in their HIV infection than other MSM (Millett et al. 2006). As a result, Millett et al. (2007) concluded that AA MSM were seven times more likely than NHW MSM to have an unrecognized HIV infection. High rates of unrecognized HIV infection among Black MSM increase the odds of HIV transmission to sexual partners. Due to the impact of cultural patterns on the sexual network of AA MSM, these partners are likely to be other AA MSM.

Use of Antiretroviral Therapy by Partners

HIV-positive Black MSM are less likely than other MSM to be on highly active antiretroviral therapy (Halkitis et al. 2003). It has been demonstrated that antiretroviral therapy decreases viral load, which lowers HIV infectivity (Millett et al. 2007). HIV-positive individuals who are not on antiretroviral therapy are more likely to transmit HIV to uninfected sex partners during unprotected episodes than are individuals who are taking therapy. If the framework we posit is valid, the lower rate of use of antiretroviral therapy by AA MSM has a significant impact on the observed racial differences in HIV disease prevalence due to the interconnectivity of the sexual networks of AA MSM.

Public Health Implications

Mays et al. (2004) argued that the essence of HIV prevention in MSM is about influencing human behaviors and those human behaviors are ultimately a function of the interpersonal and social context. We unequivocally agree. To effectively address HIV/AIDS among AA MSM, we must meet them where they are and provide culturally relevant information. While others (Malebranche 2003; Peterson and Jones 2009) have advocated for AA MSM targeted interventions, we argue that such approaches are inherently limited due to internalized homophobia among AA MSM. Jones et al. (2008), authors of the seminal work describing a HIV prevention program adapted specifically for AA MSM, readily concluded their successes were not generalizable to all AA MSM as results were based on convenience samples recruited at nightclubs. Gay venues may be unavailable or unattractive to the majority of AA MSM. While we do not argue against AA MSM targeted approaches, we strongly advocate that community and faith-based interventions designed specifically for African-Americans be offered in tandem with such targeted approaches. Providing community level, culturally appropriate, faith-based HIV/AIDS intervention for African-Americans and thus AA MSM, will directly impact many of the determinants we describe. A community level, culturally relevant, HIV/AIDS prevention program can be easily sustained through effective partnerships between public health practitioners and faith leaders.

Approach

Churches have traditionally occupied a special place in the African-American experience (Francis and Liverpool 2009). As stated by Griffin (2006):

The Black church has functioned as the center of Black people's lives from its origins as an invisible institution during chattel slavery to its present day as a highly

visible institution. Being one of the few institutions owned by Black people for Black people, the Black church, at its best, has not only served as a house of worship, but has also provided social status, hope, and stability for the millions of Africans who have lived in America. (p. 55)

Despite the institution's importance, few intervention programs consider the role of the church and spirituality in HIV prevention for AA MSM, and notwithstanding condemnation of homosexuality by many African-American religious leaders, church and spirituality play a pivotal role in the lives of many AA MSM (Malebranche 2003). As stated by Dyson (2004):

One of the most painful scenarios of Black church life is repeated Sunday after Sunday with little notice or collective outrage. A Black minister will preach a sermon railing against sexual ills, especially homosexuality. At the close of the sermon, a soloist, who everybody knows is gay, will rise to perform a moving number, as the preacher extends an invitation to visitors to join the church. The soloist is, in effect, being asked to sing, and to sing his theological death sentence. His presence at the end of such a sermon symbolizes a silent endorsement of the preacher's message. (p. 235)

In a qualitative study of 34 Black gay men, Pitt (2010) determined that most participants attended church regularly and many were involved in a full range of roles and activities in church including pulpit ministry, service ministry, performing arts ministry, and other support areas. Due to the institution's elevated social standing within African-American social communities and its importance in the lives of many AA MSM, the Black church represents a logical, yet untapped venue for HIV intervention programming.

The authors are aware of the obstacles inherent in faith-based HIV interventions—especially related to AA MSM populations. Overall, the Black church maintains a conservative theological approach to issues of gender, sexuality, and sexual expression (Griffin 2006). Moreover, most mainline Black denominations promote a theological view that homosexuality is sinful and that the only legitimate sexual expression is toward the opposite sex in marriage (Griffin 2006). Despite such formidable obstacles, immense opportunity exists. As stated by Francis and Liverpool (2009), faith-based organizations, through their broad presence in African-American communities, have access to a wide audience, making them a significant asset that can be used to disseminate HIV prevention messages. A respected cornerstone in African-American communities, the Black church can ill-afford to opt for complacency or silence with regard to the HIV/AIDS epidemic. In this particular case, the silence is deadly.

We suggest that community-based participatory research (CBPR) will be required to effectively mobilize the Black church against HIV/AIDS. CBPR requires the active involvement of community members in community assessment, and empowers and democratizes program planning and evaluation by putting community members in control of the questions asked and the issues investigated (Bryant 2010). CBPR will ensure the cultural and theological appropriateness of faith-based HIV/AIDS prevention messages. Moreover, CBPR builds trust and creates stakeholders which are pivotal for successful outreach to minority populations. CBPR will create adaptable and relevant approaches designed to meet African-American clergy and parishioners where they are and offer public health solutions and actions that are compatible with the congregations' theological views and constraints. In the approach we propose here, CBPR will have to be conducted with each target congregation as theological beliefs and practices may vary between congregations.

Intervention Components

Churches are essential partners in the effort to reduce the numerous health disparities that exist between African-Americans and other racial groups (Baskin et al. 2001) and HIV/AIDS is no exception. Moreover, the Black church provides a captive audience of AA MSM. Effective faith-based HIV/AIDS intervention programs to encompass AA MSM must (1) include community-based participatory research and social marketing strategies, (2) engage the faith community through data sharing, (3) specifically target and equip church leaders in addition to laity, (4) involve effective collaboration and compromise between public health practitioners and faith leaders, (5) emphasize spirituality and compassion, (6) utilize popular opinion leaders, and (7) be intergenerational.

In a review of faith-based HIV prevention programs, Francis and Liverpool (2009) identified only 4 peer reviewed manuscripts that focused on programs targeting African-Americans. One such program, Churches United to Stop HIV (CUSH) is a collaborative effort between the Broward County, Florida Health Department and local faith-based organizations. Since 1999, CUSH has provided HIV prevention to over 32,000 people; trained over 2,850 faith leaders; provided risk assessments to over 1,000 people; and counseled and tested over 800 people (Francis and Liverpool 2009). Notable characteristics of CUSH which should be incorporated into other faith-based HIV/AIDS intervention programs include effective partnering between public health practitioners and clergy and capacity building among religious leaders. Moreover, providing faith leaders with community-specific reports describing the health attributes of individuals who live in the surrounding area has been shown to empower African-American churches to act as a conduit for health-related information and health promotion at a local level (Kruger et al. 2009). Through data sharing, the public health practitioner begins the engagement process which may initiate collaborative relationships between practitioner and clergy. Moreover, the CDC (2006) recognized that faith leaders are generally in agreement on their responsibility to the community to address HIV/AIDS, yet leaders are not always equipped to fulfill that role. CUSH specifically targeted church leaders and provided such leaders with background guidance, education, and training, and appropriate resources to disseminate HIV prevention information. While not specifically designed for AA MSM, CUSH provides an excellent model for delivery of culturally appropriate HIV/AIDS prevention services to AA MSM who serve and are served by the Black church.

Teens for AIDS prevention (TAP) is another faith-based HIV prevention program targeting African-Americans. Specifically designed for adolescents, TAP is a church-based program that trains popular opinion leaders (POL), peer HIV/AIDS educators who then present prevention programs to other community teens (Francis and Liverpool 2009). POL interventions have been shown to reduce HIV risk behavior in both MSM (Kelly et al. 1991) and AA MSM (Jones et al. 2008). With respect to target audience, programs such as TAP may provide prevention information to potentially vulnerable populations of young, Black MSM which currently have the highest incidence of HIV infection among MSM. Furthermore, we posit that POL interventions would likely be successful for adult, African-American parishioners. Again, while not specifically designed for AA MSM, we hypothesize that faith-based POL interventions will inevitably reach AA MSM due to the importance of spirituality in their lives and the constraints of their social and sexual networks.

Metropolitan community AIDS network (Metro CAN) is the third faith-based prevention program targeting African-Americans. Specifically designed for substance users, Metro CAN includes street outreach and risk reduction, HIV/STD counseling, alcohol and drug

coordination services that transition participants to treatment, ongoing case management, support groups, and spiritual nurturing activities (Francis and Liverpool 2009). As cited by Francis and Liverpool (2009), Metro CAN is grounded in the principles of love and spirituality, and stresses creating a community environment where participants are not judged or condemned. Moreover, program staff serve participants' needs by providing support, nurture, and positive affirmation to help them choose life-enhancing behaviors. We posit use of the Metro CAN servanthood model is beneficial in outreach to AA MSM—especially those with HIV/AIDS. Congregations adopting such a model may experience shifts in social norms in addition to providing needed social support to individuals infected with HIV/AIDS.

Lastly, project BRIDGE is a community-based participatory research intervention to reduce substance abuse and HIV/AIDS in African-American adolescents. An official ministry of a Houston, Texas-based church, project BRIDGE represents a collaborative effort between university-based investigators and African-American church stakeholders, and includes four components: life skills training; afrocentric prevention alternatives based on arts, media, communication, music, and physical activity strategies; an abstinence-focused curriculum using real life case studies and small group discussions, and a faith component (Marcus et al. 2004). Project BRIDGE has high potential to reach young AA MSM. Effective partnering between public health academics and church leaders is critical to the success of project BRIDGE and should be mimicked by others planning faith-based HIV/AIDS interventions. Marcus et al. (2004) cited that all participants were committed to recognizing and valuing the different lived experiences, skills, and priorities each of the participants brought to the endeavor. Public health practitioners must respect theological boundaries when planning and implementing faith-based interventions. Furthermore, CDC (2006) noted that faith leaders appeared to welcome a relationship with public health, provided that the relationship remained compatible with their religious perspectives and community obligations.

The benefits of engaging the faith community in the prevention of HIV/AIDS are innumerable. We do not posit that faith-based organizations should serve as the primary source for HIV prevention programs, but we recognize the importance of such programs for AA MSM. Due to factors posited in our model, including African-American social norms and cultural patterns of MSM, the Black church may be the only viable provider of HIV/AIDS prevention services for many AA MSM. The Black church response to HIV/AIDS will require negotiation at multiple levels and that church leaders reconcile their theological perspectives concerning sexuality and their commitment to serve the needs of their congregants and communities (Cunningham et al. 2009).

We posit that faith-based interventions, such as those described above, will increase awareness and utilization of HIV prevention services among AA MSM, one of the proximal determinants of HIV infection among MSM discussed in our model. We readily concede these approaches primarily utilize Black churches as delivery vehicles for education services. Yet, we argue that effective, sustained faith-based HIV interventions may also change social norms of parishioners and decrease internalized homophobia among MSM, which we have identified as distal and intermediate determinants, respectively of HIV infection among MSM.

References

- Adler, N. E., & Newman, K. (2002). Socioeconomic disparities in health: Pathways and policies. *Health Affairs, 21*(2), 60–76.

- Baskin, M., Resnicow, K., & Campbell, M. (2001). Conducting health interventions in black churches: A model for building effective partnerships. *Ethnicity and Disease, 11*, 823–833.
- Bohl, D. D., Raymond, H. F., Arnold, M., & McFarland, W. (2009). Concurrent sexual partnerships and racial disparities in HIV infection among men who have sex with men. *Sexual Transmitted Infections, 85*, 367–369.
- Bryant, C. A. (2010). Community-based approaches to health promotion. In J. Coreil (Ed.), *Social and behavioral foundations of public health* (pp. 273–289). Thousand Oaks, CA: Sage Publications.
- Calzo, J. P., & Ward, M. (2009). Contributions of parents, peers, and media to attitudes toward homosexuality: Investigating sex and ethnic differences. *Journal of Homosexuality, 56*, 1101–1116.
- Centers for Disease Control and Prevention. (2006). CDC executive summary: CDC consultation on faith and HIV prevention. Retrieved from <http://www.cdc.gov/hiv/resources/other/PDF/faith.pdf>.
- Centers for Disease Control and Prevention. (2008). HIV prevalence estimates—United States, 2006. *Morbidity and mortality weekly report, 57*(39). Retrieved from <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5739a2.htm>.
- Centers for Disease Control and Prevention. (2009a). HIV and AIDS among gay and bisexual men [Data file]. Retrieved from <http://www.cdc.gov/NCHHSTP/newsroom/docs/FastFacts-MSM-FINAL508COMP.pdf>.
- Centers for Disease Control and Prevention. (2009b). *2009 compendium of evidence-based HIV prevention interventions*. Retrieved from <http://www.cdc.gov/hiv/topics/research/prs/evidence-based-interventions.htm>.
- Cunningham, S. D., Kerrigan, D. L., McNeely, C. A., & Ellen, J. M. (2009). The role of structure versus individual agency in churches' responses to HIV/AIDS: A case study of Baltimore city churches. doi: [10.1007/s10943-009-9281-7](https://doi.org/10.1007/s10943-009-9281-7).
- Dyson, M. (2004). *The Michael Eric Dyson reader*. New York, NY: Basic Civitas Books.
- Eaton, L. A., Kalichman, S. C., & Cherry, C. (2010). Sexual partner selection and HIV risk reduction among black and white men who have sex with men. *American Journal of Public Health, 100*(2), 503–509.
- Francis, S. A., & Liverpool, J. (2009). A review of faith-based HIV prevention programs. *Journal of Religion and Health, 48*, 6–15.
- Griffin, H. L. (2006). *Their own receive them not*. Cleveland, OH: Pilgrim Press.
- Halkitis, P. N., Parsons, J. T., Wolitski, R. J., & Remien, R. H. (2003). Characteristics of HIV anti-retroviral treatments, access and adherence in an ethnically diverse sample of men who have sex with men. *AIDS Care, 15*(1), 89–102.
- Harawa, N. T., Greenland, S., Bingham, T. A., Johnson, D. F., Cochran, S. D., Cunningham, W. E., et al. (2004). Associations of race/ethnicity with HIV prevalence and HIV-related behaviors among young men who have sex with men in 7 urban centers in the United States. *Journal of Acquired Immune Deficiency Syndrome, 35*(5), 526–536.
- Jones, K. T., Gray, P., Whiteside, O., Wang, T., Bost, D., Dunbar, E., et al. (2008). Evaluation of an HIV prevention intervention adapted for black men who have sex with men. *American Journal of Public Health, 98*(6), 1043–1050.
- Kelly, J. A., St. Lawrence, J. S., Diaz, Y. E., Stevenson, L. Y., Hauth, A. C., Brasfield, T. L., et al. (1991). HIV risk behavior reduction following intervention with key opinion leaders of population: An experimental analysis. *American Journal of Public Health, 81*(2), 168–171.
- Kruger, D. J., Lewis, Y., & Schlemmer, E. (2009). Mapping a message for faith leaders: Encouraging community health promotion with local health data. *Health Promotion Practice, 10*. [10.1177/1524839908328995](https://doi.org/10.1177/1524839908328995).
- Madison, M. T., Skinner, J., Mayer, K., & Victorianna, G. (2003). Proceedings from the National HIV Prevention Conference. Atlanta, GA: Go tell it on the mountain: HIV risk and African American MSM within the HIH/DAIDS explore clinical trial.
- Malebranche, D. J. (2003). Black men who have sex with men and the HIV epidemic: Next steps for public health. *American Journal of Public Health, 93*(6), 862–865.
- Marcus, M. T., Walker, T., Swint, J. M., Smith, B. P., Brown, C., Busen, N., et al. (2004). Community-based participatory research to prevent substance abuse and HIV/AIDS in African-American adolescents. *Journal of Interprofessional Care, 18*(4), 347–359.
- Mays, V. M., Cochran, S. D., & Zamudio, A. (2004). HIV prevention research: Are we meeting the needs of African-American men who have sex with men. *Journal of Black Psychology, 30*(1), 78–105.
- Meyer, I. H. (1995). Minority stress and mental health in gay men. *Journal of Health and Social Behavior, 36*(1), 38–56.
- Millett, G. A., Flores, S. A., Peterson, J. L., & Bakeman, R. (2007). Explaining disparities in HIV infection among black and white men who have sex with men: A meta-analysis of HIV risk behaviors. *AIDS, 21*, 2083–2091.

- Millett, G. A., Peterson, J. L., Wolitski, R. J., & Stall, R. (2006). Greater risk for HIV infection of black men who have sex with men: A critical literature review. *American Journal of Public Health, 96*(9), 1007–1019.
- Newcomb, M. E., & Mustanski, B. (2010). Internalized homophobia and internalizing mental health problems: A meta-analytic review. *Clinical Psychology Review, 30*, 1019–1029.
- Peterson, J. L., & Jones, K. T. (2009). HIV prevention for black men who have sex with men in the United States. *American Journal of Public Health, 99*(6), 976–980.
- Pitt, R. N. (2010). “Still looking for my Jonathan”: Gay black men’s management of religious and sexual identity conflicts. *Journal of Homosexuality, 57*, 39–53.
- Raymond, H. F., & McFarland, W. (2009). Racial mixing and HIV risk among men who have sex with men. *AIDS Behavior, 13*, 630–637.
- Voelker, R. (2008). Studies illuminate HIV’s inequalities. *Journal of the American Medical Association, 299*(3). Retrieved from <http://jama.ama-assn.org/cgi/content/full/299/3/269>.