On the Battlefield: The Black Church, Public Health, and the Fight against HIV among African American Gay and Bisexual Men

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Abstract HIV affects African American gay and bisexual men (AAGBM) more disproportionately than any other group in the USA. The Black Church, which has been a historic mainstay for African American empowerment and well-being, has the potential to be a public health partner for HIV prevention with AAGBM. Public health partnerships with the Black Church can strengthen HIV prevention efforts with AAGBM by [1] adapting church-based prevention strategies developed for other African American subgroups [2], providing prevention and referral services [3], considering how scripture supports prevention efforts, and [4] emphasizing the tenets of liberation theology. Public health should consider how thoughtful engagement, research, and interventions can support these approaches. Developing partnerships with the Black Church and African American clergy can promote effective HIV prevention efforts for AAGBM.

Keywords African Americans · Gay and bisexual men · HIV · Church · Religion

Introduction

Effective HIV prevention efforts for African American gay and bisexual men (AAGBM) continue to remain elusive. These men compose less than 1% of the US population, but in 2015, they accounted for 26.1% of all HIV diagnoses and 59.9% of diagnoses among African Americans [1]. HIV appears to be worsening among AAGBM. During 2005–2014, HIV diagnoses in this population increased by 22.4% [2]. The Centers for Disease Control and Prevention (CDC) has estimated that if current diagnosis rates continue, one half of AAGBM will be diagnosed with HIV during their lifetimes [3]. Particularly troubling is that a recent meta-analysis found that AAGBM have a 4.2% annual HIV incidence rate—a rate twice that of White GBM—which could result in 60.7% of AAGBM acquiring HIV infection by the time they are 40 years old [4]. These data beg for innovative HIV prevention approaches that exceed other approaches for AAGBM.

One largely untapped prevention resource is the Black Church. This institution—which refers to the collective body of diverse Christian congregations with which African Americans are connected [5]—has long provided a platform for African American civic engagement on social injustices [6]. Since slavery, the Black Church has provided social support to cope with myriad forms of racism [7]. Its preaching, prayer, and music have sparked community-level actions to meet African Americans' physical and mental health needs [8]. The Black Church undergirds high levels of religiosity among African Americans. Most report a religious affiliation (87.2% are Christian) and

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pray every day (82.8%) [9], and African Americans express greater religiosity (e.g., church attendance) than other racial/ethnic groups [10]. The Black Church's influence is so strong that African Americans with no religious affiliation report believing in God with absolute certainty about as often as individuals who report being Catholic or mainline Protestant (70% vs. 72% vs. 73%, respectively) [11]. This suggests that the Black Church has considerable potential to influence how African Americans think about and address health problems [5].

Because the Black Church and public health share some core values, we posit that the Black Church can be a formidable partner in HIV prevention for AAGBM. Both of these institutions emphasize the importance of serving others, addressing determinants of health disparities, utilizing holistic approaches for health promotion, and fighting for social and economic justice for oppressed communities [12]. The Black Church and public health seek to leverage community resources to protect the health of vulnerable populations [13]. Moreover, both entities use education and social marketing techniques to empower individuals to make healthy choices [13]. These values could be conducive to partnerships that address HIV among AAGBM.

The Black Church's Limited Attention to HIV among AAGBM

Despite the Black Church's potential, it has devoted little attention to HIV among African Americans, with attention to AAGBM being extremely rare [14–18]. A 2006–2007 nationally representative survey of US congregations revealed that only 4% of Black congregations had conducted activities to serve persons living with HIV [19]. The vast majority of these congregations (96%) had no doctrinal statement welcoming sexual minorities, and this was associated with an even lower likelihood of conducting HIV prevention activities. Most importantly, as described below, we have identified no Black Church-based HIV prevention efforts specifically developed or adapted for AAGBM (Table 1).

This inattention is paradoxical, and it exists alongside institutionalized mistreatment of AAGBM. Throughout slavery and Jim Crow segregation, the Black Church met the spiritual, social, economic, and physical needs of African Americans by providing resources (e.g., social support) that were systematically denied to them as an oppressed group [20]. It did so with inspiration from

the New Testament of the Bible [21], which emphasizes care for socially disadvantaged persons (Matthew 25:40) and unconditional acceptance of all (Revelation 22:17). However, many Black denominations and religious leaders have vehemently condemned AAGBM for being sexual minorities [17, 22–24]. AAGBM often report experiencing high levels of religious ostracism and vitriol (e.g., anti-gay slandering), even when they hold key leadership positions within their congregations [16, 17, 24–28]. These actions create contexts of discrimination toward and stigmatization of AAGBM, which make it difficult for HIV prevention and other support services to benefit AAGBM [24]. The Black Church's unjust treatment of AAGBM exacerbates the intersecting social oppressions of racism, stigma, heterosexism, and poverty that AAGBM endure in society at-large [29]. Such occurrences are contrary to the Black Church's mission to provide non-judgmental service to socially marginalized populations [30, 31].

Nevertheless, partnerships with the Black Church have the potential to benefit AAGBM. One reason is that, despite homophobic treatment that they commonly experience in church settings, AAGBM frequently attend church and participate in church activities [25–27, 32]. A 2014 study found that young AAGBM were significantly more likely than young Latino and White GBM to attend religious services at least monthly (65.9% vs. 10.6% vs. 15.2%, respectively) and report that religion was very or fairly important to them (64.6% vs. 15.2% vs. 10.7%, respectively) [32]. Second, research among AAGBM and other high-risk populations suggests that church-based support may promote improved mental health [16, 27, 33] and decreased HIV-related risk behaviors [32, 34–39]. This research complements a large body of research on the benefits of religious support for health behaviors and life expectancy [40]. Third, the Black Church has provided leadership conducive to interventions for improving other health conditions: fasting glucose levels [41], diabetes self-management [42], physical activity [43], and mammography utilization [44]. Partnerships arguably could yield similar HIV prevention benefits for among AAGBM. Most importantly, recent years have brought about the rise of gay-affirming Black Christian ministries and clergy—even some with ties to relatively conservative Black denominations—demonstrating their dedication to the health of AAGBM [30, 31, 45]. Collectively, these factors suggest that the public health landscape is ripe for collaborative partnerships that

Table 1 Published faith-based HIV prevention intervention strategies for African Americans, United States, 2005–2015

Approach	Target population	Objective(s)	Core components of intervention approach	Findings	Major conclusions ^a
Churches United to Stop HIV (Agate et al. 2005) [57]	African American residents of Broward County, Florida ($N = 48$ churches; $N > 32,000$ persons receiving prevention information; $N > 2850$ faith leaders using curriculum)	–Train faith leaders and congregations to develop HIV educational programs, outreach, and referral services –Support existing programs for HIV-infected and HIV-affected individuals	County health department, community-based organizations, and faith-based organizations collaborated on the production of materials to promote HIV education and training: a. training manual b. brochures c. palm cards	Post-intervention: –Technical assistance provided to 48 churches –HIV prevention education, outreach, or referrals provided to $>32,000$ persons – >2850 faith leaders trained to use curriculum –HIV risk assessments completed for >1000 persons –HIV counseling and testing provided to >825 persons Post-intervention: –6 churches successfully partnered with a community-based organization to test 1114 African American women for HIV, resulting in 55 new diagnoses (positivity = 4.9%) –Churches served as host sites for SISTA and provided church vans for transportation of participants –Qualitative data suggest that participants acquired more knowledge related to HIV prevention, substance use, and domestic violence	–Partnerships between faith-based organizations and public health partners can help prevent HIV transmission –Churches should have strong commitment to fight HIV and lead the project –Partnership with health department facilitated success –Authors provided no major conclusions
SAVED SISTA Project (Collins et al. 2007) [48]	Women in or seeking recovery from drug and alcohol addiction in Atlanta, Georgia (HIV Testing $N = 1114$ persons; Intervention $N = 59$ persons)	–Reduce HIV risk behavior by promoting self-esteem, gender pride, and resilience via an adaptation of SISTA	6 small-group sessions in churches discussed: a. ethnic and gender pride b. basic HIV education c. assertiveness skills d. behavioral self-management (i.e., correct and consistent condom use) e. coping with life adversity		
Metropolitan Community AIDS Network (MacMaster et al. 2007) [53] ^b	Substance users in Nashville, Tennessee ($N = 163$ persons)	–Provide outreach, HIV/STI testing, case management, HIV risk reduction interventions, substance use treatment, and health services from a faith-based perspective	Via multiple complementary approaches, participants “learn about and begin to identify how spirituality operates in their own lives and its relationship to life challenges”: a. street outreach and risk reduction b. HIV/STI counseling and testing c. alcohol and drug coordination services leading	Baseline to 12 months: –Significant decreases in mean # of sex partners, # times had condomless sex, trading sex for drugs ^b (past 30 d) –Significant increases in # days paid for employment, amount of money made through employment ^b (past 30 d) –Significant decreases in amount of money spent on	–“Emphasizing spirituality...may be beneficial in reducing substance use and high-risk sexual behaviors” p. 236

Table 1 (continued)

Approach	Target population	Objective(s)	Core components of intervention approach	Findings	Major conclusions ^a
Columbia-Union Faith-Based Adolescent STI/HIV Prevention Project (Baldwin et al. 2008) [50]	African American youth aged 13–19 years in Columbia and Union Counties, Florida ($N = 43$ churches; $N = 101$ youth participating in the intervention)	<ul style="list-style-type: none"> –Educate African American adolescents on basic facts about HIV/STIs –Assess and compare effectiveness of peer- and adult-led faith-based HIV educational outreach programs 	<p>to substance abuse treatment d. intensive case management e. support groups f. spiritual nurture activities</p> <p>Churches partnered with community-based organization to educate youth via adult-led and peer-led interventions. Materials included local, state, and national HIV data; group discussions; interactive games; and short educational videos. Primary components included: a. surveying pastors about their beliefs regarding HIV/STI training for adolescents and HIV/STI programs in their churches b. training adolescents in faith-based institutions to become HIV/STI peer educators c. implementing a peer-led HIV/STI prevention educational program</p>	<p>alcohol, # of days of alcohol, cocaine, heroin, and marijuana use^b (past 30 d)</p> <p>At baseline: –All pastors chose to deliver an abstinence-based (vs. more comprehensive) curriculum Post-intervention: Adult-led youth ($n = 61$) were more likely than peer-led youth ($n = 40$) to provide correct post-test answers to the following statements (all $ps < .05$): –HIV is curable (91.8% vs. 75.0%) –HIV testing is completely confidential and may be anonymous (91.8% vs. 75.0%) –HIV can be acquired by shaking hands with an infected person (96.7% vs. 82.5%) –Condom use is a measure to prevent HIV acquisition (90.2% vs. 57.5%) –When sexually active, latex condoms provide the best protection against sexual transmission of HIV (80.3% vs. 45.0%) –Teen girls can prevent pregnancy, STIs, and HIV by not having sex (95.1% vs. 67.5%)</p>	<ul style="list-style-type: none"> –Adult intervention leaders may have been more experienced and knowledgeable regarding HIV/STIs and more effective in conveying knowledge than peer leaders –Findings suggest that risk perceptions are more accurately adjusted even after a brief intervention–Support of pastors and other church leaders must be gained by reconciling their values and needs with the simultaneous need to conduct rigorous process and outcome evaluation of preventive interventions
Faith Communities Project (Tyrell et al.		<ul style="list-style-type: none"> –Increase involvement of faith communities in 	<p>a. Annual “meeting on common ground” involving faith</p>	<p>At baseline, for churches participating in the project:</p>	

Table 1 (continued)

Approach	Target population	Objective(s)	Core components of intervention approach	Findings	Major conclusions ^a
2008) [58]	Faith community representatives in New York state (<i>N</i> = 201 persons)	HIV prevention and health care by fostering partnerships between faith communities and HIV service providers	leaders, AIDS service organizations, prevention planning group members, state health department staff persons, and persons living with HIV; forum discusses the role of faith communities in HIV prevention b. regional activities (e.g., prayer breakfasts) within the state to increase HIV-related awareness and foster collaboration between faith communities and community-based organizations c. state health department provides technical assistance, primarily via workshops, to faith-based organizations and community-based organizations	<ul style="list-style-type: none"> –79.3% reported being “very” or “somewhat” prepared to provide HIV information –31.0% currently provided HIV education to the community –50.5% expressed willingness to meet with community-based providers Perceived barriers to providing HIV prevention services: <ul style="list-style-type: none"> –Lack of money (49.1%) –Lack of qualified staff (48.2%) –HIV not perceived as part of church’s mission (45.0%) –Clergy lack experience or ability to provide HIV prevention (35.8%) –Opposition to homosexuality (23.6%) –Lack of HIV knowledge (21.8%) –Opposition to condom use (20.9%) –Opposition to drugs and alcohol (20.2%) 	<ul style="list-style-type: none"> –Involving faith leaders in planning and implementation increased community buy-in –Establishing “common ground” during implementation fostered participation throughout the project –Scheduling activities regularly helped to sustain partnerships between faith communities and HIV service providers
Taking It to the Pews (Berkley-Patton et al. 2010) [54]	Faith community members in Kansas City, Missouri (<i>N</i> = 221 church members who completed surveys assessing intervention exposure; <i>N</i> = an estimated 3400 persons reached by intervention)	<ul style="list-style-type: none"> –Engage churches individually and collectively in delivering an HIV intervention directly to church members 	<ul style="list-style-type: none"> a. religiously tailored toolkit containing materials that can easily be included with the flow of existing church activities (e.g., responsive readings) b. using trained pastors and church liaisons to implement intervention components (e.g., discussion of HIV within sermons) c. process evaluation to collect pastors’ and church members’ feedback on churches’ involvement in HIV prevention 	<ul style="list-style-type: none"> Post-intervention (qualitative): <ul style="list-style-type: none"> –Church liaisons believed intervention tools were easy to use –Church members appreciated hearing about how HIV affects African Americans –Concerns included challenges dealing with “some of the more difficult HIV-related issues” (e.g., homosexuality) Post-intervention (quantitative): Most church members (<i>N</i> = 221) surveyed reported exposure to 	<ul style="list-style-type: none"> –Implementing HIV interventions in Black church is achievable –Including church leaders (i.e., pastors) in planning, development phase, and ongoing processes fostered HIV awareness –Meeting churches “at their level of readiness” promoted discussions of “controversial” HIV prevention issues (e.g., condom use, homosexuality)

Table 1 (continued)

Approach	Target population	Objective(s)	Core components of intervention approach	Findings	Major conclusions ^a
YOUR Blessed Health (Griffith et al. 2010) [51]	Youth aged 11–19 years in Flint, Michigan; parents and church leaders also reached by intervention ($N = 1833$ persons directly reached by intervention components)	<ul style="list-style-type: none"> –Increase capacity of faith-based institutions and faith leaders to address HIV/STIs among youth –Change churches' norms to be more open for youth and adults to discuss HIV/STIs 	<p>a. 10-h, 5-session youth training on basics of HIV/STIs, sexual knowledge, communication skills, and individualized risk-reduction plans</p> <p>b. 10-h, 5-session adult training program on HIV/STI knowledge</p> <p>c. initial (16-h) and ongoing training and support for pastors, pastors' spouses, and other church leaders conducting youth and adult trainings d. church-wide activities (e.g., sermons) to promote HIV awareness and reduce HIV stigma e. community-wide events (e.g., health fairs) that educate and increase HIV awareness</p>	<p>intervention components at church</p> <ul style="list-style-type: none"> –Information (91.0%) –Sermon (83.7%) –Responsive readings (83.9%) –Bulletin board (80.4%) –Resource table (79.3%) –Projection screen (69.2%) –Group discussion (66.4%) –Health fair offering HIV testing (56.5%) <p>Post-intervention:</p> <ul style="list-style-type: none"> –12 churches delivered program to 245 youth (7 of these churches delivered program to 151 adults) –662 persons participated in church services in which faith leaders presented HIV-related information –8 community-wide events reached 720 individuals and prompted dialog on sexuality and safer sex –Youth “seemed to internalize information about HIV transmission” –Sessions helped youth understand the complexity of sexual relationships 	<ul style="list-style-type: none"> –Faith-based HIV prevention programs are feasible if they [1] respect church doctrines and pastors' visions; [2] engage pastors' spouses and other leaders; and [3] build on church leadership's understanding of appropriate messages –Churches can balance moral and spiritual missions while addressing HIV
SISTA Adaptation in a Church Setting (Wingood et al. 2011) [49]	Women aged 18–29 years who had condomless sex in past 6 mo. in Lithonia, Georgia ($N = 44$ persons)	<ul style="list-style-type: none"> –Develop a gender-specific, culturally tailored, theoretically derived faith-based HIV intervention 	Facilitators connected religious and spiritual values to intervention activities (e.g., wisdom → correct and consistent condom use). Two small-group sessions in the church discussed: a. gender awareness	<p>At baseline:</p> <ul style="list-style-type: none"> –26.3% used condoms inconsistently (past 6 mo.) –34.6% did not use a condom at most recent sexual encounter 	<ul style="list-style-type: none"> –Adapting SISTA to a church setting was feasible –Community-based participatory research principles helped to enhance university-church collaboration

Table 1 (continued)

Approach	Target population	Objective(s)	Core components of intervention approach	Findings	Major conclusions ^a
Facilitating Awareness to Increase Testing for HIV (FAITH; Derose et al. 2014) [55]	African American and Latino churches in Los Angeles County, California (<i>N</i> = 5 churches)	–Reduce HIV stigma in partnership with African American and Latino churches	and ethnic pride; norms supporting healthy relationships; and awareness of HIV risk b. enhancing communication and condom use skills a. congregation-based HIV testing b. HIV education workshops to promote HIV awareness, increase HIV knowledge, and engender empathy toward persons affected by HIV c. optional peer leader workshops to apply HIV education workshops' concepts in a personal and interactive way d. pastor-delivered sermons that challenge stigma, encourage positive attitudes toward persons living with HIV, and promote HIV testing	–19% reported having male sex partners (past 6 mo.) –11.5% tested positive for Chlamydia Post-intervention: –Community involvement in participatory research was invaluable in designing and modifying intervention –Churches connected with local health department, an atypical community partner –Pre-testing intervention components in English and Spanish provided important feedback from clergy and public health partners –Congregation-based HIV testing had to be adapted from health department community testing protocol to make testing convenient for parishioners	–Women liked the intervention –FAITH is a multifaceted HIV stigma reduction intervention that Protestant and Catholic African American and Latino churches can implement
Focus on Youth with Informed Parents and Children Together (FOY + ImPACT adapted for faith settings; Lightfoot et al. 2014) [52]	Church-going youth aged 12–14 years and their parents in Wake County, North Carolina (<i>N</i> = 51)	–Increase sexual health knowledge and skills –Build HIV awareness –Improve decision-making skills –Increase youth-parent communication	a. intervention conducted with friendship groups (parallel to church youth groups) b. ImPACT fosters parent-child communication around sexual risk reduction c. condom demonstration d. community-based participatory research provides model for implementation	Post-intervention: –Church settings facilitated trust among youth and parents –Condom discussions sometimes perceived as contradictory to church teachings; however, teaching condom use provided information youth needed –Overt inclusion of faith tools (e.g., prayer) would make intervention more suitable to a church setting	–Engaging faith communities in adapting and implementing HIV prevention could reduce racial HIV disparities –Allowing faith leaders to support and promote HIV prevention within churches and church networks is important
Project Fostering AIDS Initiatives That Heal (Abara et al. 2014) [52]	Churches that received HIV prevention funding during 3 years in South Carolina	–Reduce HIV stigma –Dispel HIV-related myths	a. technical assistance to promote program sustainability b. trainings on	Post-intervention: –Churches reported increased HIV knowledge,	–Partnering with churches is beneficial for addressing HIV

Table 1 (continued)

Approach	Target population	Objective(s)	Core components of intervention approach	Findings	Major conclusions ^a
et al. 2015) [56]	(year 1: $N = 24$; year 2: $N = 34$; year 3: $N = 39$)	–Help churches prevent HIV	budgeting, grant-writing, and the Health Insurance Portability and Accountability Act c. 8-h, 4-session intervention training on HIV knowledge, effective communication with participants, and non-judgmental, interactive environments d. pastor-delivered HIV messages in sermons e. church leaders tested for HIV during worship services	partnerships, and prevention capacity –HIV stigma decreased in congregations –Churches benefitted from technical assistance, funding, evaluations, carefully crafted HIV messages, and church leaders who demonstrated non-stigmatizing attitudes	–Churches can address HIV stigma and promote knowledge about HIV testing and safer sex

All intervention approaches that we selected included process and/or outcome evaluation data

HIV human immunodeficiency virus, *STI* sexually transmitted infection

^a Authors' statements in the abstract or discussion section provided the basis for conclusions

^b MacMaster et al. reported that findings were significant, but they did not provide p values

include the Black Church as an HIV prevention partner for AAGBM.

Potential Church-Based Approaches to Addressing HIV among AAGBM

The purpose of this article is to describe the Black Church's potential role as an HIV prevention partner for AAGBM. We acknowledge that the Black Church has limitations, notably its history of homophobic treatment of AAGBM, that challenge public health efforts to engage it in work needed for AAGBM. However, the Black Church's aforementioned history of human service, willingness to address HIV in some congregations, use of scripture, and embrace of theology that affirms all human beings provide unique opportunities for progress. We present four non-mutually exclusive approaches that could strengthen HIV prevention efforts with AAGBM.

Approach 1: Adapt Prevention Strategies Developed for Other African American Sub-Groups

Using *HIV, African American, Black, church, faith, and religion*, we searched PubMed and PsycInfo for church-based HIV prevention strategies for African Americans that were published during 2005–2015. Our review began in 2005 because this was when CDC reported very high HIV prevalence (46%) among AAGBM in five cities [46], and it preceded a CDC HIV prevention consultation with faith leaders [47]. We highlight studies that provided process and/or outcome evaluation data, which might inform the development or adaptation of HIV prevention strategies for AAGBM. We consider a broad range of strategies (e.g., knowledge dissemination, HIV testing, behavior change interventions, and sermonology) in light of the diverse public health approaches that exist.

Researchers have disseminated 11 faith-based strategies for African Americans (Table 1). Target populations included women [48, 49], youth [50–52], substance users [53], congregations [54–56], and the African American community at-large [57, 58]. Strategies sought to promote HIV-related knowledge and awareness [50, 51, 54–57], testing for HIV and other sexually transmitted infections (STIs) [49, 53, 55–57], condom use [49–52], safer sex negotiation [48, 49, 51, 52], and reductions in HIV stigma [55, 56]. All strategies used partnerships between public health organizations and

community members, including church leaders. Although none of these were for AAGBM, such strategies might benefit them because AAGBM are at higher risk of acquiring HIV than the populations to whom researchers targeted these strategies.

To facilitate adaptation of prevention strategies, churches can provide settings in which behavior change and other interventions occur. For example, researchers successfully adapted two evidence-based interventions for African American women [48, 49] and youth [52] (*SISTA* and *Focus on Youth*, respectively) by using individual churches as implementation sites. These adaptations are noteworthy because the original efficacy studies for these interventions did not include religion or spirituality as components [59, 60]. However, *d-up: Defend Yourself!* [61] and *Many Men, Many Voices* [62]—the only CDC-supported interventions for AAGBM—both include religious components. Specifically, these interventions encourage AAGBM to discuss religion and spirituality and the impact that these factors can have in promoting or mitigating HIV risk among AAGBM. This makes them adaptable for use in church settings, where many AAGBM already assemble. However, public health partners would need to encourage congregations to be welcoming and affirming of AAGBM in order that these men feel comfortable participating in church-based interventions.

Our review suggests that congregations can create social milieus that facilitate the use of prevention strategies with AAGBM. For example, one congregation used spiritual counseling with substance users, who experienced a decreased number of sex partners, increased condom use, and decreased drug use over time [53]. Moreover, pastors have delivered sermons to counteract HIV stigma to, in turn, promote HIV testing [55]. Strategies like these could benefit AAGBM, who sometimes engage in substance use [63] and commonly experience HIV stigma that precludes them from accessing HIV testing and care [64, 65]. Public health can further support milieus conducive to HIV prevention by encouraging pastors to deliver sermons that counteract homophobia, which underlies AAGBM's high risk for HIV [17].

Approach 2: Provide HIV Prevention and Referral Services

Many congregations have the capacity to directly provide HIV services (e.g., nurses' guilds). The strategies

summarized in Table 1 occurred in large part because churches had health ministries in place or because parishioners simply wanted to provide HIV prevention services [48, 49, 51, 52, 55]. Some congregations with varying attitudes toward homosexuality have begun to provide HIV prevention, care, and referral services to AAGBM. These congregations include those that are openly gay affirming as well as those known to be less progressive. Although programs for AAGBM may not appear in peer-reviewed journals, we recognize several programs as “reputationally strong” efforts that are well-known within the HIV prevention workforce [66]. Public health entities can, in partnership with the Black Church, replicate these programs to increase their population-level effectiveness.

One example is the Metropolitan Interdenominational Church in Nashville, Tennessee. This openly gay-affirming congregation has a clinic that provides HIV testing, HIV medical care, case management, adherence counseling, and re-engagement with HIV care services [67]. Many AAGBM in this congregation and from the community receive HIV prevention and care services here. This church’s pastor argues that his provision of services is successful because the congregation embraces the notion of serving “whosoever,” which can “push us to a place of not being exclusive and not alienating any person as we focus on sexual health and sexuality within the context of the church.” [68].

Another noteworthy example is the Bethel African Methodist Episcopal Church in Wilmington, Delaware. Although it is not a gay-affirming ministry, it has an outreach center that provides HIV testing, counseling, linkage to care services, and referrals to social services for persons living with HIV [69]. The pastor has commented on his approach toward serving AAGBM: “I have my own theological and spiritual interpretations of alternative lifestyles, but that does not impact whether or not I will minister...I don’t care how you got the virus. I do care if you live.” [69]. This church demonstrates the potential impact that congregations with less progressive stances toward sexual minorities can have in providing health services that benefit AAGBM.

Although it is not a church, the National Association for the Advancement of Colored People (NAACP) produced two “Social Justice Imperative” HIV prevention manuals for churches [70, 71]. These manuals outline strategies that churches are taking and can take to provide HIV prevention and referral services to AAGBM. These manuals include culturally competent

terminology that churches should use as they seek to better understand and serve all sexual minorities, especially AAGBM. Moreover, these manuals identify gay-friendly clinics in several major cities that provide HIV prevention and treatment services to AAGBM. As the United States’ oldest civil rights organization with historic ties to the Black Church, the NAACP has substantial potential to influence congregations’ provisions of HIV-related services to AAGBM. These examples suggest that African American congregations, in light of their diverse characteristics, can consider multiple options as they begin delivering prevention and referral services.

Approach 3: Use Scripture to Support Prevention

African Americans historically used the Bible to validate themselves as they endured racism stemming from slavery and Jim Crow segregation [20, 21]. For example, they revered the Jewish Exodus story because it illustrated God’s desire to help the oppressed [72]. The Black Church’s commitment to health stems from Biblical passages that emphasize health (e.g., Jeremiah 30:17; Matthew 11:28) [21]. Notwithstanding congregations’ varied use of scripture, their shared history of using the Bible offers promise for preventing HIV among AAGBM [17].

Some public health professionals have capitalized on this history by developing scriptural reference guides for African American churches seeking to combat HIV. These guides include scriptures about health, compassion, and justice [73–75], which are public health principles that are very pertinent to AAGBM [76]. Similarly, the NAACP’s manuals include scriptures that stress love and acceptance of stigmatized persons, and they encourage congregations to use these scriptures in order to combat social oppression and stigma that affect the health of AAGBM [70, 71]. These manuals also reference the high HIV morbidity among AAGBM to increase congregations’ willingness to address HIV in this population.

Some religious groups are beginning to use scripture to directly combat homophobia, which is the lynchpin of the Black Church’s silence around HIV [14, 17, 22, 23]. Black preachers are increasingly evaluating Biblical texts to show that they support the Black Church embracing AAGBM [77, 78]. One general approach has been to use scriptures that discuss the importance of having socially inclusive, diverse religious communities

that embrace AAGBM (e.g., Luke 14:23) [30, 45]. Using these scriptures, some African American congregations have welcomed AAGBM and other sexual minorities as both laity and clergy [30, 31]. A more specific strategy has been to develop church doctrine, sermons, and ministries that acknowledge the humanity of sexual minorities. These efforts stem from religious leaders' use of the New Testament, which emphasizes love (e.g., Matthew 22:39), compassion toward socially marginalized groups (e.g., Luke 4:18), and non-judgmental treatment of others (e.g., John 8:7) [17, 45]. Public health entities can partner with these types of ministries because they may help other congregations to be less homophobic.

Approach 4: Emphasize the Tenets of Liberation Theology

Liberation theology is a practical, faith-based orientation that encourages social action to address human suffering [79]. The Black Church historically embraced liberation theology because it confronted the unjust treatment of African Americans [80]. Well-known examples of the use of liberation theology occurred in the writings and speeches of Dr. Martin Luther King, Jr., who commonly spoke about justice as he fought for racial equality (e.g., Amos 5:24: "But let justice roll down like waters and righteousness like an ever-flowing stream") [81].

Some Black Church leaders have begun to use liberation theology to oppose religion-based homophobia and promote social justice for sexual minorities. They argue that the principles of love, compassion, justice, and equality—which African Americans have long supported as the basis for Black liberation—can support AAGBM's liberation from social oppression and HIV [17, 30, 31, 45, 82–84]. These religious leaders argue that congregations should unconditionally accept AAGBM as valued members of African American churches and communities [30, 31, 82, 84] and fight against homophobia, which places AAGBM at risk for HIV [17, 45].

Some nationally recognized initiatives direct churches in the use of liberation theology. In its manuals, the NAACP defined liberation theology and framed HIV as a social injustice affecting African Americans [70, 71]. These manuals include sermon topics to help pastors disseminate non-stigmatizing health messages. Similarly, The Balm in Gilead, Inc., which is a

public health organization, developed a booklet to help churches understand how homophobia has stymied the response to HIV among all African Americans, especially AAGBM [17]. This booklet and a separate collection of sermons [84] show how renowned, gay-affirming, African American religious leaders (e.g., Professor Cornell West) have encouraged other African American ministers to embrace liberation theology and, ultimately, AAGBM parishioners. The NAACP and The Balm in Gilead, Inc. have published no rigorous evaluations of this work. However, public health entities' widespread dissemination of these products could prompt the Black Church to use liberation theology to combat homophobia in support of HIV prevention among AAGBM.

A Way to Move Forward

Partnerships with the Black Church are feasible, but making partnerships fruitful for AAGBM will require work. Public health entities should consider how engagement, intervention, and research can facilitate use of the approaches we described.

Thoughtful engagement will allow public health to capitalize on the Black Church's existing orientation toward human service. Public health partners can engage congregations in HIV prevention for AAGBM by "meet [ing] them where they are" [74] while simultaneously challenging congregations to be less homophobic and more concerned about the health of AAGBM [24, 84]. Public health should recognize the Black Church's historic fight to promote health, civil rights, and human rights while encouraging the Church to be a compassionate partner for a group that it often views negatively. Public health agencies can support faith leaders who attempt to provide non-judgmental ministry to AAGBM [70]. They can do this by offering workshops [55], social marketing materials [85], and support services that destigmatize homosexuality and bisexuality, while emphasizing the value that AAGBM offer congregations (e.g., music ministry) [27]. Congregations may benefit most from public health engagement that involves ongoing technical assistance, which can promote long-term sustainability of prevention efforts for AAGBM [56].

Consideration of the Black Church's role in the intervention process is paramount. Public health partners can support individual- or group-level intervention strategies by encouraging faith leaders to

develop sermons that affirm AAGBM [17, 45, 83, 84] or host sessions for interventions that discuss religion and spirituality (e.g., *Many Men, Many Voices*) [76]. Community-level interventions might involve interdenominational work on prevention campaigns [86], including those that address homophobia [85], which can mobilize entire communities to tackle HIV among AAGBM. Society-level interventions can include national campaigns regarding HIV and the need to become more accepting of sexual minorities [87]. Public health agencies can help to strengthen national networks of religious leaders so that broader conversations about African American health include AAGBM as a priority population [17, 84]. They can also help the Black Church to address homophobic ideologies (e.g., “love the sinner, hate the sin”) that impede prevention efforts [88]. Because faith leaders encounter multiple health problems (e.g., diabetes) that disproportionately affect African American parishioners, holistic intervention approaches that address HIV alongside other health problems might be warranted [89].

Research can identify best practices for engaging the Black Church and fill important knowledge gaps. Community-based participatory research is one strategy for developing HIV prevention efforts that are both evidence-based and faith-based [49, 52, 54, 55]. Supported by the *National HIV/AIDS Strategy: Updated to 2020* [90], this research can trigger the activism [19], collaboration [91], and mobilization [74] needed to address HIV among AAGBM. Because few public health partnerships with the Black Church exist for AAGBM, public health partners must first develop and strengthen partnerships with this entity to acquire the buy-in needed to support research that could benefit AAGBM [74]. Research could also strengthen the existing knowledge base demonstrating the harmful effects that the Black Church’s homophobic rhetoric and noninvolvement in HIV prevention has had on AAGBM. Perhaps, alongside the aforementioned approaches that we propose, such knowledge could prompt church leaders to alter their actions toward AAGBM.

As HIV continues its unabated spread among AAGBM, public health should diligently work to utilize the largely untapped resources that the Black Church can have for AAGBM. The Black Church has demonstrated its impressive ability to combat innumerable challenges facing African Americans in the past. Extending this institution’s progressive, compassionate

legacy to AAGBM can provide the foundation necessary to support HIV prevention for this population. In doing so, the Black Church will increase its capacity to serve AAGBM and counteract the devastating consequences of HIV.

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