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ORIGINAL PAPER

A Review of Faith-Based HIV Prevention Programs

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Abstract HIV disproportionately affects people of color, suggesting a need for innovative prevention programs and collaborations as part of prevention efforts. African Americans have close ties to the church and faith-based organizations. African American faith communities were slow to address HIV prevention, but in recent years, they have become more involved in such activities. This study reviews the empirical literature on faith-based HIV prevention programs among African American populations. Several successful faith-based/public health collaborations are identified, and the limitations and strengths of faith-based prevention programs are discussed. Recommendations are provided for developing effective faith-based/public health collaborations.

Keywords HIV/AIDS · Faith-based · Substance abuse · Prevention · Education · Churches

Introduction

The increasing incidence of HIV and AIDS in the African American community is a source of great concern within the public health community. At all stages, from initial HIV infection to death from AIDS, African Americans are disproportionately affected compared to non-African American populations. Due to the severity of HIV in the African American community, it is vital to explore using non-traditional intervention methods and partners. 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 key prevention messages. This review discusses the significance of the

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church in the African American community and examines successful faith-based HIV and substance abuse prevention programs and their outcomes.

Role of the Church in the African American Community

Traditionally, churches have occupied a special place in the African American experience. Empirical research has consistently found that substantial proportions of African Americans report church attendance and/or strong ties to spirituality (Lincoln 1984; Pattillo-McCoy 1998). In many instances, the church served as a house of worship, a meeting place for social action organizations, and a locus of community. The African American preacher has been a teacher, a preacher, a politician, and, more recently, a change agent for health (Levin 1984).

African American churches are no stranger to health promotion programs. The African American church continues to take the lead in addressing the health of African Americans, which is especially important given the large amount of evidence that African Americans are victims of neglect by the medical establishment and face large health disparities (Levin 1984; Kaplan et al. 2006).

Health-related programs in African American churches have addressed diverse topics such as assessing attitudes and beliefs about church-based health promotion activities, heart disease prevention, and breast cancer awareness (Hatch et al. 1980; Thomas et al. 1994; Stolley and Koenig 1997; Sanders 1997). There are many reasons why the African American church would be an advantageous venue for HIV/AIDS prevention programs. For example, the church has social networks and support systems that provide opportunities for health promotion programing (Thomas et al. 1994). In addition, the African American church population and leadership tend to have a strong relationship based on mutual trust. As a result, advice on health issues communicated from the pulpit gets members' attention; the church leadership is often viewed as a reliable source of information and may have linkages to disenfranchised groups (Levin 1984; Smith et al. 2005). These factors make the African American church a natural venue to facilitate health awareness. Historically, public health and medical professionals have worked with the African American church to gain access to populations that are hard to reach through mainstream systems. With the rising incidence of HIV/AIDS in the African American community, the church may again be a venue for preventive education.

The African American Church's Role in HIV Prevention

Historically, negative religious and moral attitudes have been a typical part of the social response to infectious diseases and to the people who suffer from them. Initially, the church's response to HIV/AIDS was that it was caused by homosexuality and social decay (Mertz 1997).

Although the African American community was slow to respond to HIV/AIDS, the severity of the HIV problem means that churches and faith-based organizations can no longer be silent. Many churches have a captive audience of youth and adults and are often focal points of the African American community. The Institute of African Studies at the University of Nairobi in Kenya conducted interviews with 26 diverse organizations, including interfaith, Islamic and Christian faith-based organization, academic research institutions, and leading PLWA organization (Nyamongo and Savosnick 2002). Nearly all

interviewees felt that faith-based organizations are essential in the fight against HIV/AIDS. Many said faith-based organizations (FBOs) have a duty to be involved, because their mission is to reach out and provide moral and compassionate support to the most vulnerable and disenfranchised (Nyamongo and Savosnick 2002).

Although previous research supports using faith-based settings to provide HIV/AIDS prevention, there is little empirical work on the types of faith-based HIV prevention programs that are currently being implemented and/or have been implemented effectively in faith-based settings (Coyne-Beasley and Schoenback 2000; Smith et al. 2005; Agate et al. 2005). Therefore, this study seeks to review faith-based HIV/AIDS prevention programs and to provide recommendations for developing partnerships with faith-based organizations to provide HIV/AIDS prevention education.

Method

A literature search was conducted using the Medline and PsychInfo search engines. The terms identified in Table 1 were used to create a list of relevant references. We reviewed approximately 500 articles, briefs, and peer-reviewed manuscripts that fell within the keyword searches. Of those articles, four peer-reviewed manuscripts focused on faith-based HIV prevention programs. Table 2 shows the target population, behaviors addressed, topics covered, and evaluation/outcomes of the reviewed faith-based HIV prevention programs.

Results—Summary of Programs

In the following section we describe the types of HIV/AIDS faith-based programs that have been described in peer-reviewed journals.

Program #1—Churches United to Stop HIV

The Churches United to Stop HIV (CUSH) program is a collaborative effort between the Broward County (FL) Health Department and local community faith-based organizations. CUSH, established in 1999, aims to train faith-based leaders and congregations to develop HIV educational programs, outreach and referral services, and support programs for infected individuals and others affected by HIV (Agate et al. 2005). To fulfill these

Table 1 Literature search keywords

Keywords	Number of citations
Religion and HIV prevention	321
Church-based HIV programs	26
Church-based and HIV prevention	27
Religiosity and HIV prevention	11
Black churches and HIV	13
Black churches and HIV prevention	8
Churches and HIV prevention	46
Faith-based HIV prevention	25

Table 2 Summary of faith-based HIV prevention programs targeting African Americans

Target population	Behaviors/Topics addressed	Evaluation/outcomes
Faith-based leaders	(a) Training FBL and congregations to develop HIV education programs, outreach and referral services, support programs for infected and affected individuals	(1) Trained over 2850 leaders
		(2) Completed over 1,000 risk assessment
		(3) Provided HIV testing and counseling to over 825 people
		(4) Provided technical assistance for 48 churches
Adult substance users	(a) HIV risk behaviors	(1) Measures risk behaviors
	(b) Substance use treatment	(2) Entry into treatment
	(c) Case management	(3) Measures psychosocial functioning
	(d) Mental health services Integrates spirituality and cultural competency	(4) Successful in reducing substance use and HIV/AIDS risk behaviors
Adolescents	TAP program	(a) Not well defined
	(a) Church-based HIV/AIDS peer educator programs for adolescents	(b) Program has been implemented in 10+ states
	(b) Adolescents are trained in Values Clarification, HIV/AIDS facts and vocabulary, HIV transmission, condom information, communication skills and other topics	(c) Effective with African American and Latino youth
Adolescents	(a) Substance use and HIV/AIDS risk reduction for adolescents in a faith-based setting	(a) Focus groups with parents, teens, and teachers provided supplemental program assessments
		(b) Measures risk behaviors
		(c) Measures knowledge

objectives, the CUSH staff created a training manual, brochures, and palm cards. Since the program's inception, over 120 churches have joined a consortium for planning and implementing program objectives.

CUSH has been very successful in the South Florida community. The program has provided HIV prevention to over 32,000 people; trained over 2,850 faith leaders; provided risk assessments to over 1,000 people; counseled and tested over 800 people; and provided technical assistance to almost 50 churches. The program has received support from fraternities and sororities and other volunteer agencies. Even though the organization has limited funding, it is able to reach a community that is at high risk for HIV infection.

Program #2—Teens for AIDS Prevention

Teens for AIDS Prevention (TAP) are an example of a prevention education program for adolescents conducted in a religious setting and within a religious context (Mertz 1997). TAP was developed by the AIDS Ministries Program of Connecticut Inc., whose mission is to minister to those affected by HIV/AIDS through care, education, and advocacy (Mertz 1997). Since 1987, the AIDS Ministries Program has helped congregations to embrace a compassionate and informed response to the AIDS epidemic. The TAP program is a church-based program that trains youth-group members as peer HIV/AIDS educators who

then present HIV/AIDS prevention programs to other teens throughout the community. The program's curriculum was developed by Advocates for Youth, a well-known youth advocacy organization based in Washington, DC. The TAP program has been successfully replicated in at least 10 sites, including Texas and Hawaii, and the program has been used effectively with both Latino and African American youth (Mertz 1997).

The program includes a 17-module curriculum that can be implemented during a weekend retreat. The curriculum combines generic material for teens on HIV/AIDS prevention with specific religious material developed by AIDS Ministries, and it covers topics such as Values' Clarification, HIV/AIDS Facts and Vocabulary, HIV Transmission, and Role-Playing on Communication Skills, to name a few (Mertz 1997). Existing youth groups are the most likely site within churches for the TAP program. The program supports the idea that a faith-based setting could be a potential forum for providing sexuality and HIV prevention education.

Program #3—METRO CAN

The Metropolitan Community AIDS Network (Metro CAN) is affiliated with the Metropolitan Interdenominational Church in Nashville, TN. Metro CAN was developed in response to the growing number of African American substance users who are at risk for HIV/AIDS (MacMaster et al. 2007). The program incorporates spirituality, viewed as the totality of what it means to be human, and encompasses an individual's biological, physical, mental, and social aspects. The program uses a culturally relevant model of service delivery and is based on the extensively evaluated National AIDS Demonstration Research program and the National Institute on Drug Abuse (NIDA) Cooperative Agreement for AIDS Community-Based Outreach Intervention Research Program (NIDA/NADR Outreach Model), which is regarded as the best-practice model for reaching out of treatment substance users (MacMaster et al. 2007). Metro CAN's primary goal is to serve the target population (African American substance users) through the provision of a coordinated continuum of outreach, HIV/STD testing, case management, HIV risk-reduction interventions, substance abuse treatment, and health or mental health services from a faith-based perspective.

The program's components include street outreach and risk reduction, HIV/STD test and counseling, alcohol and drug coordination services that transition participants to treatment, ongoing long-term intensive case management, support groups, and spiritual nurturing activities. One innovation of the Metro CAN program is that it integrates spirituality and the delivery of culturally competent services. The program is grounded in the principles of love and spirituality, and it stresses creating a community environment where participants are not judged or condemned. Program staff serve participants' needs by providing support, nurturing, and positive affirmations to help them choose life-enhancing behaviors (MacMaster et al. 2007).

The study used a single group design with repeated measures of program outcome indicators at baseline, 6 and 12 months post-intake, to examine changes over the course of the program participation. Over the course of 3 years, a total of 13,230 outreach contacts were made. Of those contacts, 193 individuals were provided with additional services beyond street outreach, with 163 completing the initial intake process; 116 received ongoing case management; and 51 completed additional follow-up evaluations at 6 and 12 months. Results indicated that this program reduced substance use and HIV/AIDS risk behaviors, increased life-enhancing behaviors such as housing stability and employment, and decreased involvement in illegal activity. The program appears to be particularly

effective for African American women, who saw the largest decrease in the number of sexual partners between baseline and 6 months post-intake. The program data support the idea that using a faith-based approach that emphasizes spirituality rather than aggressive and authoritarian techniques may be an effective approach for reducing substance use and high-risk sexual behaviors among this population.

Program #4—Project BRIDGE

Project BRIDGE is a community-based participatory research project that focuses on designing, implementing, and evaluating a faith-based substance abuse and HIV/AIDS prevention program for African American adolescents. The 3-year, federally funded program was a collaborative effort between the faith-based community and university-based investigators. The study team used community-based participatory methods to engage the faith-based community and the target population—adolescents—in the development of the program. The study team partnered with a local African American congregation in Houston, TX. The church was already a dynamic part of the community with over 14,000 members. It had an active community outreach program addressing a wide variety of health-related topics relevant to the African American community (Marcus et al. 2004).

The BRIDGE project provided a structured program for youth in grades 6–8 one evening per week during the school year. The intervention included four components: Life Skills Training, Spreading the Word, Choosing the Best (an abstinence-based curriculum), and a faith component. The faith component was woven in throughout the program. Focus groups with parents, students, and teachers provided supplemental assessments of BRIDGE. During year 1, the Life Skills training curriculum was implemented over a 15-week period. Each lesson was accompanied by an appropriate scripture reading. Recreational time, e.g., trips to the beach, bowling or sports activities, was scheduled as part of the program but took place on other days (Marcus et al. 2004). During the second year, a unique Afro-centric component of the program focused on risk prevention alternatives, "Spreading the Word," was implemented (Marcus et al. 2004). Second-year participants were given the opportunity to design media, write, produce plays, compose music, and gather grandparent life histories. An esteemed local playwright was hired to guide the drama segments, which incorporated prevention messages from the Life Skills training curriculum. In the third year, the focus was on sexuality and providing in-depth information about substance abuse. The Choosing the Best curriculum was selected because it was in keeping with the church's teachings (Marcus et al. 2004). The research team and additional volunteers were trained in this curriculum, and a team member who was a college drug prevention counselor facilitated the more in-depth discussion around substance abuse (Marcus et al. 2004). Cultural sensitivity was addressed by ongoing team interaction as the project was implemented. Church members, who were predominantly African American, met regularly with the university team members, who were primarily Anglo-American, to create a common understanding related to cultural issues (Marcus et al. 2004).

Based on the focus group feedback, adolescent participants recommended that the research team provide more opportunities for them to lead activities; they were very interested in sharing what they learned with others outside of the church setting. As a result, the project team added peer education as a regular feature of Project BRIDGE.

To improve retention and recruitment, incentives such as movie passes, free T-shirts, rallies, awards, and other activities were added. Youth in BRIDGE recruited friends and other adolescents from all over Houston to participate in youth rallies where HIV/AIDS

and substance abuse messages were featured along with dancing, music, and refreshments (Marcus et al. 2004).

The study design included a comparison group of African American adolescents from another large church in Houston with a comparable youth ministry. The comparison group was given incentives for their participation and the comparison churches' staff and volunteers were offered training to implement BRIDGE in their own setting.

Findings from the BRIDGE program support the use of faith-based HIV and substance abuse prevention programs. Adolescents who participated in the BRIDGE program reported significantly less marijuana and other drug use and had more fear of AIDS compared to adolescents who did not participate in the program. Based on the program's success, it became part of the church's ministry and has been extended to others in the community, with over 40 volunteers trained to deliver the curriculum and assist with the program's implementation. However, the sample size was relatively small ($N = 34$), and it is possible that youth could have been influenced by external and internal factors. However, this project provides support for public health/faith-based collaboration.

Discussion

These programs indicate that the public health and faith-based communities can partner and develop successful collaborations. Some of the key elements for successful collaboration that were identified across programs include (1) involving the faith-based community and the target population in design, implementation, and program evaluation, (2) recognizing that the senior pastor/pastoral staff may have time constraints, requiring a liaison who is committed to HIV-related initiatives, (3) incorporating spirituality and compassion into prevention efforts instead of authoritarian and judgmental opinions and attitudes, (4) making sure the program is culturally appropriate for the target audience, and (5) creating a sense of ownership by the faith-based organization to ensure wider program distribution and participation (Mertz 1997; MacMaster et al. 2007; Agate et al. 2005; Marcus et al. 2004).

Many churches struggle with moral issues related to sexual and drug behaviors at the root of health problems such as substance abuse, HIV/AIDS, and violence. Some of these subjects are key topics for HIV/AIDS prevention education (vaginal, anal, and oral sex). The inability to provide comprehensive information to all people is a limitation when dealing with some faith-based organizations. If this scenario is present, the "sensitive" topics may have to be deleted from the program to respect the leader's wishes and still provide much-needed education to adolescents. For example, in Project BRIDGE, an abstinence-only sexuality curriculum was selected in keeping with the church's tenets. Adolescents who participated in this program learned about HIV prevention from this perspective rather than a comprehensive approach; this may be a limitation of working with adolescents in a faith-based setting. Findings indicated that adolescents were more afraid of HIV/AIDS than youth who did not participate in this program. Previous empirical findings have shown a "fear-based" approach to sexuality education is less effective than comprehensive sexual education (CSE), which instead stresses abstinence and includes age-appropriate, medically accurate information about contraception (Forrest 2008). CSE also provides developmentally appropriate information about relationships, decision making, assertiveness, and skill building to resist social/peer pressure (McKeon 2006). But there are approaches for discussing sensitive issues in faith-based settings. When a controversial issue arises that conflicts with an institution's tenets the following strategies may

be implemented: (1) Secular agencies may provide appropriate resources on how to begin a discussion; (2) public health professionals may be able to assist with the discussion, while the faith-based leader frames the topic in a biblical manner; or (3) if secular agencies provide additional resources and address the issue, the faith-based institution can be free to focus on services that are more congruent with its mission (Thomas et al. 1994).

In contrast, there are faith-based leaders who are concerned and willing to assist with community-wide and/or local church-based efforts; planners must remember to meet the faith of community where they are (Kreninin et al. 1999). Some leaders will allow open discussion on the most controversial issues, such as abortion, condom use, and homosexuality, while others will not want to discuss these issues for biblical reasons. Some leaders may not want to be involved in prevention activities but will only want to focus on their faith-based organization's needs. Each faith-based community has a different starting point. Public health professionals need to be aware of this and be willing to negotiate; they must be open to exchanging ideas regarding program goals and objectives to be addressed due to the philosophical differences between their respective institutions (Jacknik et al. 1984).

We must acknowledge limitations to working with faith-based organizations: (1) leaders may be unwilling to discuss sensitive topics, (2) leaders may want to emphasize abstinence versus comprehensive sex education, (3) leaders may not think their youth are at risk, and (4) leaders may not be interested in addressing this topic. However, there are also numerous strengths to collaborating with faith-based institutions such as (1) they have a captive audience of youth, parents, and potential volunteers, (2) they are respected institutions in the community or have community credibility, (3) research indicates that religious faith and a strong moral sense play important roles in protecting youth from harm, (4) faith-based organizations may offer youth development programs and have the potential to reach youth and adults outside of their communities.

We suggest the following strategies for developing effective faith-based public health HIV and substance abuse prevention programs, (1) public health professionals and faith-based leaders must be willing to compromise over what public health professionals deem as key prevention messages and what faith-based leaders are willing to discuss, (2) if faith-based leaders are reluctant to discuss HIV/AIDS, the issue can be framed as part of broader Christian values in that the church should teach individuals the biblical and theological foundations of sickness and health and emphasize compassion, not condemnation, fear or hostility toward HIV/AIDS prevention and/or people who are HIV infected (Mertz 1997; Francis 2005).

Public health partners may have to discuss why faith-based organizations and leaders should be concerned about HIV/AIDS and substance abuse within their community. For example, they may need to explain why HIV/AIDS risk behaviors are a problem; discuss the consequences; make the problem quantifiable through statistics that show its magnitude in the community; discuss whether the problem is getting better or worse; and discuss the problem's relevance to the particular faith community (Schulenberg et al. 1997).

Finally, organizations can establish an HIV/AIDS planning task force that includes a diverse array of participants (e.g., varied by age, gender, income, and place of residence, and including academics, educators, and social service agency members) who can assist them in organizing prevention efforts; this would allow organizations to pool resources and services.

The benefits of engaging the faith community in both the prevention and treatment of HIV/AIDS and substance abuse cannot be overstated. Faith-based leaders and organizations can play a critical role in fighting the disease in their neighborhoods. Faith-based leaders have a captive audience of African Americans. Therefore, their voices may facilitate the inclusion of those affected by and infected with HIV and help mitigate stigma within the community at large. We are not suggesting that faith-based organizations be the

primary source of HIV and substance abuse prevention initiatives, but we believe they can play an important role in prevention. However, it is critical that prevention efforts continue at the local community, state, and federal level and that community-wide public and private partnerships are developed to address the health needs of those most at risk for the burden of disease.

Innovative prevention programs and collaborations must be established in support of prevention efforts. Future research should not only focus on the development of faith-based HIV and substance abuse prevention programs but should also include funding for rigorous program evaluations, and provide funding to support the development of community-based infrastructure to develop public and private partnerships with faith-based institutions.

According to Baskin et al. (2001), churches are essential partners in the effort to reduce the numerous health disparities that exist between African American and other ethnic groups (Baskin et al. 2001). In addition, there are many valid reasons why one should involve the faith community; faith communities focus on values, have community credibility, have access to young people, parents and potential volunteers, have skills in reducing conflict, and are willing to provide in-kind contribution (Krenin et al. 1999). Furthermore, due to the disproportionate impact that AIDS has on African American communities and that the church plays such a strong role in this community, faith-based leaders can no longer stand by and say that this problem is not within their purview as religious leaders.

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