Faith-Based HIV Care and Prevention in Chinese Immigrant Communities: Rhetoric or Reality?

Ezer Kang
Wheaton College
John J. Chin and Elana Behar
Hunter College, City University of New York

Ethnic churches attended by first generation Chinese immigrants are uniquely positioned to address emerging HIV prevention and care needs within the Chinese community at-large. Efforts to develop faith-based HIV programs necessitate identifying how HIV intersects with the sinicization of Christianity within Chinese churches. This article will review the process of contextualizing HIV within theological and cultural frameworks that are meaningful for ethnic Chinese church leaders and members. The authors specifically propose two points of integration between public health and ecclesial functions: (1) HIV stigma-mitigation initiatives as informed by Christo-centric teachings of compassion and justice, and (2) HIV prevention and care reframed as social responsibility and informed by the Christian tradition of evangelism. Systems and practices that hinder and promote the involvement of Chinese churches in HIV prevention, care, and stigma-reduction will be discussed.

Immigration is a "theologizing moment" (Carnes, 2004), and ethnic churches in the United States (US) have historically played a pivotal role in helping immigrants navigate a new and often unforgiving terrain. Ethnic churches within Chinese enclaves have largely safeguarded and preserved

cultural traditions while helping to facilitate immigrants' assimilation to their new environments. These efforts are often contextualized and informed by theological and ecclesial tenets. Given their standing in the community, ethnic Chinese churches are uniquely poised to play a crucial role in HIV prevention and care targeted to the communities they serve. However, mobilizing them to do so has been challenging for several reasons. First, discourses about HIV generally consider matters related to sexuality, morality, and substance use—issues that many churches are less inclined to address and integrate with their teachings (Adogame, 2007). Second, HIV involvement potentially compromises the church's perceived moral standing and authority within their community and may alienate them from their constituents (Chin, Mantell, Weiss, Bhagavan, & Luo, 2005). Third, church leaders and members alike have minimal knowledge about HIV and regard the epidemic as less relevant and beyond the scope of their ecclesiastical mission. This article argues that efforts to address these formidable barriers must contextualize HIV epidemiology, prevention, and care within theological and cultural frameworks that are meaningful for ethnic Chinese church leaders and members. Stated differently, the importance of deriving theologically-competent HIV prevention and care models for Chinese churches are on par with ensuring linguistic competence and cultural relevancy of HIV programming that target Asian and Pacific Islander (A&PI) communities.

Recent studies have underscored the potential role of immigrant churches in HIV prevention and care initiatives, given their visibility and authority within ethnic and mainstream communities (Guest, 2003; Chin et al., 2005; Chin, Neilands, Weiss, & Mantell, 2008). The religious and cultural norms that often alienate groups living with or perceived to

be at risk for HIV from the church may concurrently guide engagement with these very same groups, because "the caring facet of religious doctrine override[s] their exclusionary dictates with respect to persons living with HIV/AIDS" (Takshashi, 1997). Chin et al. (2005) framed the conflict between theological directives and responsiveness to community as "conservative innovation"—as church leaders are torn between the responsibilities to preserve and uphold tradition (conservative impulse), and the imperative to respond with timeliness to the felt and actual needs of their community, even at the risk of challenging orthodoxy (innovation impulse).

Much can be borrowed from a growing body of studies from sub-Saharan Africa calling for African churches to assert leadership in a vast region where 67% of all persons living with HIV globally reside (UNAIDS, 2008). HIV has been a defining moment, in particular, for southern African churches to address the exclusion of persons living with HIV, marginalization of women who are at highest risk for HIV infection, and prevention of HIV transmission, as an act of solidarity with the exploited and oppressed (Haddad, 2005; 2006). Southern African churches are largely mobilized by the sheer magnitude of the epidemic's devastation, which obligates an ecclesial response. In contrast, the relatively low HIV prevalence among Chinese Americans coupled with churches who position themselves as theologically and socially conservative, pose a different and unique set of challenges when engaging ethnic churches in Chinese immigrant enclaves in the US.

Formative research to date on church-based health programs (CBHP) in the US has focused on African American communities with few examining other ethnic groups (DeHaven, Hunter, Wilder, Walton, & Berry, 2004). This is unsurprising, given the church's prominence in the history and politics of African Americans. The triumvirate roles of the pastor as "preacher, politician, and teacher" coupled with the church's connection with disenfranchised social groups, have uniquely positioned the African American church to be actively involved in public health initiatives (Francis & Liverpool, 2009). In a systematic review of published literature on faith-based health programs between 1990 and 2000, 91% of faith-placed interventions, where health professions established the church as an intervention site, targeted African Americans (DeHaven et al., 2004).

METHOD

This article explores the potential role of Chinese churches in HIV prevention and care efforts targeting Chinese immigrant communities. The authors draw largely from their work with several Chinese churches in New York City (NYC) to develop and implement a pilot curriculum that integrates HIV prevention and care with the traditional tenets of evangelical Chinese churches. Specifically, this article was based on individual qualitative interviews with two English speaking Chinese pastors who were recruited to participate in a larger study of HIV involvement among religious institutions in NYC including Buddhist temples and mosques. The interviews focused on congregational perception of HIV prevention and care in the Chinese community, potential integration of HIV service with overall church mission, and barriers to HIV involvement. Themes from these interviews were integrated with recommendations drawn from two community advisory board meetings to develop a 2½ hour HIV-curriculum tailored to Chinese Christian churches. The objectives of the HIV curriculum were to: (1) highlight theological and biblical underpinnings for faith-based HIV prevention and care programs; (2) raise awareness of how the epidemic affects marginalized Chinese immigrants in NYC; (3) enhance understanding of HIV transmission and treatment and correct misinformation about transmission and treatment; and to (4) promote discussion of practical opportunities for faith-based involvement in HIV prevention and care among first generation Chinese congregants of ethnic churches.

The curriculum was pilot-tested with a senior pastor and nine English-speaking members of a non-denominational Chinese church, initially established in 1944 as a community center to provide residents in Chinatown with immigration, legal, and language services. Approximately 350 English and Cantonese speaking congregants attend two weekly Sunday worship services. The field notes from this pilot session were integrated with a select review of literature on Chinese evangelical churches and faith-based HIV programs in North America to guide the formulation of this article. Rather than focusing on institutional barriers, the authors examine specific theological and cultural underpinnings of conservative Chinese immigrant churches that facilitate or hinder involvement in HIV prevention, care, and advocacy
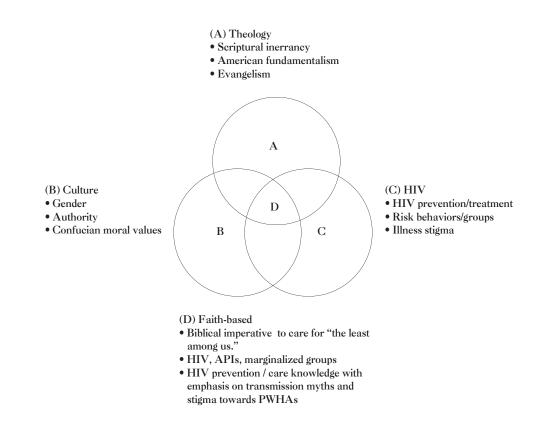
Figure 1. Contextualization of HIV within the theology and culture of Chinese ethnic churches

(A) Theology
• Scriptural inerrancy
• American fundamentalism
• Evangelism

(B) Culture
• Gender
• Authority
• Confucian moral values

(C) HIV
• HIV prevention/treatment
• Risk behaviors/groups
• Illness stigma

(D) Faith-based
• Biblical imperative to care for "the least
   among us."
• HIV, APIs, marginalized groups
• HIV prevention / care knowledge with
   emphasis on transmission myths and
   stigma towards PWHAs

within the Chinese community at-large. The authors will argue first for the importance of considering how Chinese churches uniquely contribute to HIV prevention and care efforts in the Chinese immigrant community at-large. Second, the authors will propose that the integration of select theological, cultural, and public health interests is essential in developing a faith based HIV program for the Chinese immigrant community. Such a program can be graphically represented by area D (Figure 1) which is based on contextualizing dimensions of HIV prevention, treatment, and stigma among A&PIs (circle C) with specific theological (circle A) and cultural frameworks (circle B) that provide meaning for ethnic Chinese churches.

Chinese Immigrants in New York City

By 2006, the number of Chinese immigrants in the US increased nearly fivefold, making them the third largest immigrant group following Mexicans and Filipinos (Terrazas & Devani, 2008). Based on 2000 US Census data, the largest Chinese population resided in the New York metropolitan area, and NYC was home to 85 percent of the New York State's Chinese residents.[1] Seventy-five percent of NYC's Chinese population in 2000 was foreign-born, of which the majority immigrated to the US in the last 20 years. Chinese residents in NYC had less schooling than the general population in NYC - 42% of Chinese adults (25 years old and older) did not complete high school versus 28% of the general population. Most Chinese New Yorkers are foreign-born (75%), with twice the foreign-born rate of all New Yorkers (36%). A large proportion of NYC's foreign-born Chinese are relatively recent immigrants, with 43% having immigrated between 1990 and 2000, as of the 2000 Census.

[1]Data derived from analysis by the Asian American Federation Census Information Center www.aafyn.org/cic/

While there is a substantial migration stream of highly educated and skilled Chinese to NYC, the Chinese ethnic economic system in NYC encourages a substantial and continual influx of poorly educated and often undocumented Chinese (Kwong, 1996). As a result, the overall profile of Chinese in NYC is far different from that of the stereotypical model minority. Of Chinese adults in NYC (259,702), 42% had not graduated from high school, compared to 28% for all adults city-wide. Thirty-one percent had less than a ninth-grade education, more than double the 15% rate for all adults in NYC. The majority of Chinese in NYC (63%) have limited English proficiency, compared to 24% for all New Yorkers. The poverty rate for Chinese New Yorkers is 22%, slightly higher than the overall city rate of 21% (Asian American Federation, 2008). This socioeconomic profile largely explains why countless Chinese in NYC are reliant on ethnic community organizations for information and support.

Since the 1960s, changes in immigration law have resulted in an influx of Chinese from Hong Kong, Taiwan, Vietnam, and since 1979, Chinese intellectuals from the People's Republic of China (PRC; Yang, 1999). In the US, 90 % of Chinese churches have been established by post-1965 immigrants, well educated from China and Southeast Asia (Yang, 2004). Socioeconomic class, diasporic history, education, language, and theological positioning of the church significantly influence the sinicization of Christianity or the rendering of Christianity to reflect the traditions and practices of the Chinese culture (Muse, 2005). As such the implications drawn from this article are limited to the potential role ethnic Chinese churches play in HIV programs tailored to first generation Chinese immigrants.

HIV in A&PI Communities

From 2003 through 2006, the estimated number of A&PIs living with HIV/AIDS in 33 states with name-based HIV reporting increased from 2,234 to 3,187 (CDC, 2007). Moreover, the estimated annual percentage increase in HIV/AIDS diagnosis rates reported between 2001 and 2004 was 8.1% for A&PI males and 14.3% for A&PI females, whereas the estimated annual percentage change for African Americans/Blacks was negative, decreasing during the same period (-4.4 for males and -6.8 for females; MMWR, 2006). In fact, A&PIs were the only racial group with a statistically significant percentage

increase in annual HIV/AIDS diagnosis rates in that period—a finding overlooked by the Center for Disease Control (CDC) in the Mortality Morbidity Weekly report (MMWR) article which published this analysis (Chin, Leung, Sheth, & Rodriguez, 2007). Although the rates of HIV/AIDS cases among A&PIs remain low, Chin and his colleagues (2007) argued that the alarming increase in diagnosis rates may be accounted for by delays in HIV testing and treatment (Huang, Wong, De Leon, & Park, 2008), poor community acknowledgement of illness and inadequate knowledge of transmission, and bidirectional migration between US and Asia where HIV transmission rates have steadily increased.

In China for example, an estimated 700,000 HIV infections were reported as of October 2007, an 8% increase since 2006. It is estimated that 44.7% of new infections in 2007 were transmitted through heterosexual contact, 12.2% through male homosexual contact, 42% through injection drug use (Wang et al., 2009). Between 2005 and 2007, case reports indicate that HIV transmission through heterosexual contact increased from 10.7% to 37.3% and through homosexual contact, 0.4% to 3.3% (Wang et al., 2009). Moreover, the proportion of women infected doubled over the past decade, 90% of whom are of child bearing age (15-44 years old), which is likely to result in more mother to infant transmission of HIV (China, 2007; Lu et al., 2008).

HIV Stigma and Culture

Many Chinese immigrants living with HIV regard themselves as socially unacceptable and harbor deep shame and self-blame for contracting the virus. Scrambler & Hopkins (1990) defined this self-perception as felt stigma or the fear of being rejected if others knew of their illness. A&PIs' fear of being shunned is largely shaped and reinforced by firmly held views of HIV within the Asian immigrant community. Specifically, collective beliefs of casual contagion and discriminatory attitudes towards homosexuals, intravenous drug users, and undocumented immigrants shape A&PIs' experiences of their illness and trigger fears of being overtly ostracized. As such, HIV-related stigma carries long-term detrimental mental health consequences (Kang, Rapkin, & DeAlmeida, 2006). Fear of disclosing their HIV serostatus, in particular, becomes an acute stressor and concealing one's HIV status entailed continual vigilance, which Strauss & Glaser (1975) termed as "work." The stress that accompanied

living a double life becomes emotionally draining and deprive A&PIs of social support from family and friends (Chin et al., 2007; Kang, Rapkin, Springer, & Kim, 2003).

Engaging Religious Institutions in HIV Prevention & Care

Collaborative partnerships between churches and public health institutions are conceptualized as faith-based or faith-placed (Campbell et al., 2007). Faith-based interventions take into account the religious culture and beliefs of targeted individuals and communities, while faith-placed interventions view the religious organization more simply as a location for delivering interventions, regardless of their religious content. Similarly, emic approaches to health promotion programs incorporate understandings of existing needs within the church congregation or the community served by the church as defined by the church leaders and members themselves. In contrast, etic approaches are initiated from outside the church, often with minimal understanding of the point of view of targeted individuals. DeHaven et al. (2004) found that 25% of health-promotion programs from 1990 to 2000 were faith-based and 40% faith-placed.

Within the context of cardiovascular disease prevention, Lasater et al. (1997) proposed four levels of collaborative relationship between health educators and churches. Level I involvement utilized the church as a recruitment site for health promotion activities. Level II included programs conducted on church premises. Level III programs intentionally included congregation members in the delivery of the intervention. Lay health educators were trained to implement the program protocol developed by the researcher. Level IV programs integrated public health issues with scriptural themes. Lasater and colleagues argued that Level III and IV programs best utilized the distinctive contributions of faith-based organizations in public health. However, collaborations between pubic health institutions and faith communities were largely influenced by competing institutional perspectives, priorities, and values (Francis & Liverpool, 2009; Israel, Schultz, Parker, & Becker, 1998). The importance of sensitivity towards and embracing different priorities were highlighted by Resnicow, Baranowski, Ahluwalia, & Braithwaite (1999) who distinguished between surface and deep cultural sensitivity in health promotion interven-

tions. The surface dimension of cultural sensitivity accounted for the environmental and social contexts in which behavior occurred. The deep structural dimension accounted for theological, cultural, and social nuances that influenced how a congregation perceived the cause, prevention, and treatment of illnesses (Campbell et al., 2007).

Our pilot HIV curriculum for Chinese churches largely reflected Lasater et al.'s (1997) Level IV approach and Campbell et al.'s (2007) "deep" contextualization of HIV prevention and care with select theological and cultural frameworks. Developing the curriculum in this manner required grappling with potentially difficult compromises between what religious leaders and congregants would accept and what public health research deemed as most effective. For example, an abstinence-only curriculum may be considered in keeping with a conservative Chinese church's theological tenets, while providing timely education on condom use to reduce HIV risk, as recommended by best practices in public health, may be considered unacceptable in such churches. Religious leaders may prefer that their congregants obtain this information elsewhere, despite how difficult it may be to access this information due to language and cultural barriers. A Chinese pastor interviewed for this project recommended that the curriculum should "mention the principles [of HIV prevention] but [should not] emphasize ways of prevention …" Instead, the curriculum should encourage participants to "abstain from having sex before marriage and from having sex outside of marriage." He felt that "condoms are accessible—people can get them themselves. We don't have to tell them about condoms." As noted by the pastor himself, many of the compromises involved questions of emphasis rather than complete dismissal of basic information.

In accounting for deep cultural sensitivity in ethnic Chinese churches, it is important to consider the influence of American fundamentalism in shaping their theological tenets, which include the authority of Scripture, salvation and eternal life based on Christ's redemptive work, centrality of evangelism and missions, and importance of a spiritually transformed life (Marsden, 1991). Moreover, Chinese churches reflect the socio-cultural values commonly upheld by immigrant families. What are these cultural values and how are they integrated with the tenets of American fundamentalism?

Chinese Churches: Formation of Culture and Theology

Ethnic churches have been influential in American Chinatowns since 1952 (Cao, 2005). Sociologists have long argued that Christian conversion among new Chinese immigrants was spurred by a desire to assimilate to dominant Western culture, "where core American values are funneled through the socialization of religion" (Ng, 2002). Some argued that church membership facilitated the gain of material resources ("rice-bowl Christians"), reinforced a perception of becoming more American, and fulfilled a social need for ethnic identification. Others such as Yang (1998), attributed the growth of ethnic Chinese churches to dramatic social and cultural transitions in China that have positioned Christianity as a viable belief system for those in search of meaning and order. Moreover, conservative ethnic churches have provided an absolute and assertive Biblical ethos in response to the perceived trappings of modernity—an ethos to which new immigrants are known to be particularly susceptible (Yang, 1998). Ethnic churches also helped to facilitate the integration of Chinese and Christian identities, a growing need among middle class immigrant families in which both *Chineseness* and Christianity are seen as important. Cao (2005) aptly described the church as a "Chinese family where the notions of Chineseness are celebrated" (p. 192).

Rather than framing conversion to Christianity as furthering ethnic identification or assimilation, Ng (2002) framed conversion as a process of reidentification whereby Chinese Christians recast Christianity into a faith that reflected their cultural mores and values. In doing so, Chinese immigrants developed a "local faith" that was deeply intertwined with their own culture, and "absorbs the nourishment of Chinese culture and is suited to the spirit and psychology of the Chinese" (p. 23; Lam, 1980) For example, in her study of an evangelical Chinese church in Boston, Muse (2005) argued that "Christianity is not a form of assimilation to contemporary western society, but rather to a historically constructed view of the ancient Hebrew culture of the Bible. Christianity is appropriated to enhance Chinese culture, not replace it" (p. 27). Yang (1999) further argued that many Chinese Christians "selectively preserve certain aspects of Chinese culture with transformative reinterpretation" of the Christian faith (p. 133). As such, churches were more inclined to embrace traditional Confucianism values that were more ideologically aligned with conservative Christian doctrine such as loyalty, faithfulness, and duty. Conversion to Christianity, for example, was less motivated by acknowledgement of personal sin or Christ's redemptive and reconciliatory act on the cross. Rather, conversion was largely propelled by recognition of one's limitations in a foreign land and acceptance of God as their guardian and provider (Ng, 2002).

The doctrine of Scriptural inerrancy, in particular, informed much of the church's traditional views on gender roles, sexuality, and authority (Yang, 1999). The centrality of Scripture as the inspired and unerring word of God, "profitable for teaching, for reproof, for correction, for instruction which is in righteousness" (2 Timothy 3:16-17) has been held without compromise by many Chinese evangelical churches as it provides church members with a coherent and consistent framework from which to create meaning about the world. Dialogue about the relevancy of addressing HIV by the church necessitates contextualizing it within Scriptural texts. The Chinese pastors interviewed for this project, for example, highlighted scriptural texts related to indiscriminate compassion for the poor and physically ill, caring and honoring one's body, along with proscriptions against premarital sex and marital infidelity. It was noteworthy that pastors interviewed in this study referenced Scriptural texts that addressed both individual (risky sexual behavior) and structural dimensions (poverty) of HIV.

Although selective Scriptural proof texting (e.g. Romans 1:26-27) has led to a rhetoric of condemnation for persons with HIV, it has also provided imperatives for compassion to "the least of these"—those despised and downtrodden—as an act of devotion to God (Matthew 25:31-46).[2] Abel (2006) observed in his study of a northeastern Chinese church that Christians' generosity, counterintuitive to many first generation Chinese immigrants, was a decisive factor in their conversion. Framing indiscriminate compassion towards "widow, orphan, stranger and the poor" as an act of dispensing true justice and expression of obedience to God, was

---

[2]Christ's reference to "the least of these" admonished those who intentionally ignored others *in times* of their hunger, thirst, loneliness, illness, or imprisonment. In referencing this text in the context of HIV, the authors argued for the importance of applying this teaching to persons with HIV during their times of need. This term does not imply nor suggest that persons with HIV are bestowed less worth and in need of charity or sympathy.

consistent with Muse's (2005) characterization of Chinese churches as "countercultural" to the traditional model ethnic minority goals of upward mobility and self-determinism to secure economic improvement and honor to the family (p. 111). This was evident by a response from a Chinese pastor asked by authors whether HIV prevention and care programs reflected his church's mission:

Getting involved with HIV education and prevention fits in with our organization's mission because in general we believe that we are called to love all people. That is, those who are poor, victimized, marginalized in society. Assuming the disease is because of bad actions, we still try to love the person, share the gospel, and change the person.

Scriptural mandates for compassion and justice, however, have not sufficiently mobilized Chinese churches to act because of interpretations of competing scriptural texts. Given their literal reading of the Bible, Chinese immigrant churches for example uphold their mission to evangelize–"to go and make disciples of all nations" (Matthew 28:16-20)–which is measured by the number of adult converts who are baptized (Yang, 1999). Collective responses to social concerns have been considered secular, modern, and distractions from inculcating the importance of personal piety and evangelism. Moreover, many conservative Christians associated social activism with the Three-Self-related churches, religious institutions officially recognized by the Communist party in the People's Republic of China, but discredited by Chinese Christians in the US as theologically questionable (Guest, 2003).

Consideration of HIV-related issues could also explicitly or tacitly challenge core values and theological positions deemed critical in preserving order and solidarity within the institution (Chin et al., 2008). The stigma associated with HIV and groups marginalized as "at-risk" (e.g. homosexuals, those engaging in non-marital sex, injecting drug users) within the Chinese community (Chin et al., 2007; Kang et al., 2003) potentially jeopardize the church's moral credibility among the Chinese community at-large. As noted by a Chinese pastor in this study, "it's difficult to get people to come to an [HIV] workshop. People will not come unless it affects them personally–like their career." There is safety in preserving institutional and personal status quo as highlighted by a passage from a co-author's field notes taken during a pilot-workshop with leaders from a Chinese church: "The pastor commented that it's perhaps common for Chinese churches to be 'self-preserving.' This keeps them

from participating. The Asian mentality is more 'inward.' People generally take care of themselves before they take care of others."

The mandate for compassion is also often tempered by the Confucian worldview and conservative Christian ideology that do not recognize equal gender status. In Confucian culture, a woman's standing in a patriarchal society was aptly described by the adage–a man's talent is considered a virtue, a woman without talent is virtuous (Muse, 2005). Protestant fundamentalism, which abides by a literal reading of select biblical texts which portray women as subservient to men, further reinforced gender conservatism in Chinese churches and has been incorporated into many immigrants' worldview (Yang, 2004).[3] The increasing trend of HIV infection among A&PI women underscores the importance of considering gender conservatism in Chinese churches when addressing the contribution of gender inequality to HIV risk. Recent studies showing the importance of self-efficacy that lead to effective HIV risk reduction practices among A&PI women (Gazabon, Morokoff, Harlow, Ward, & Quina, 2007; Takshashi, Malalong, DeBell, & Fasudhani, 2006) highlight the need to find ways of incorporating women's empowerment into HIV education curricula without overly encroaching upon the church's position on gender conservatism–in the same manner as efforts to identify and reframe cultural scripts and their influences on safe sex practices (Chin, 1999).

Other central values upheld by many conservative Chinese churches were family harmony and the moral upbringing of children. An overwhelming concern among parents, for example, was the extent to which their children were influenced by a sexually-permissive culture–namely one that permits premarital sexual activity, teenage pregnancy, and homosexuality (Yang, 1999). As such separation between the church and the outside world was considered essential in maintaining social-ethical values upheld by Christianity and Chinese cultures (Lam, 1980). Sexuality was inculcated as a requisite dimension of marriage between husband and wife, and sex was regarded as an aspect of a woman's primary duty of procreation (1 Timothy 2:11-15; Genesis 1:28). Premarital sexual relations are regarded not only as a violation of scriptural teaching (sin), but as an act that

---

[3]Hermeneutic studies that argue for gender equality are beyond the scope of this article and have been more thoroughly examined (Kwok, 1992; Lienemann-Perrin, 2004; Webb, 2001).

brings shame and humiliation to one's family within the context of the Confucian notion of "filial impiety" (Muse, 2005). Discussions about sexuality generally draw parallels between the respective relationships between husband-wife and Christ-church. Although a positive view of sexuality has a clear place within Christian theology, church leaders may nevertheless be uncomfortable discussing this aspect of sexuality. For example, Haddad (2006) observed that churches in KwaZulu-Natal often emphasized prohibitions against sexual immorality because they were less comfortable discussing sexuality as God's gift of physical intimacy and sexual discourse remained taboo. Similarly, a Chinese pastor interviewed for the current study explained,

Religious institution would feel uncomfortable discussing sexual transmission openly. Asians are more sympathetic to HIV transmitted through drug use rather than through sexual activity. Because through sexual activity, this means sex outside of marriage. Chinese people put a higher standard on relationships compared to drug use. Sexual activity outside marriage shames the whole family. Relationships are very important.

Selectively framing HIV prevention as an act of honoring the human body created in *imago dei*, and promoting abstinence over condom use may be the preferred approach within evangelical circles. Although this approach clearly represents a limited and possibly counter-productive approach to HIV prevention, depending on the intended target group, it remains unclear whether it still provides much-needed attention to issues of HIV transmission, HIV stigma, and HIV care.

Faith-Based HIV: Integrating Ethnic Identity, Theology, and Public Health

Selectively integrating culture and theology with HIV prevention and care priorities poses a necessary challenge for faith-based programs in Chinese ethnic churches. To address this challenge, Francis & Liverpool (2009) highlighted the importance of compromise over what public health professionals and church leaders deemed as important prevention and care messages. As such, the authors propose two points of integration for faith-based HIV initiatives in Chinese ethnic churches: 1) the compatibility of HIV stigma-reduction and Christian churches' imperative to act with compassion; and 2) the compatibility between promoting HIV awareness as a form of social responsibility that is aligned with the tradition of evangelism.

First, the teachings of transformative grace and unconditional compassion upheld by Chinese churches uniquely position them to address what may be the most challenging aspect of HIV care and prevention—namely the stigma of living with HIV and/or belonging to a perceived HIV-risk group (i.e., injecting drug users, men who have sex with men, blood plasma donors in Asia, commercial sex workers). HIV-based stigmatization leads to the alienation and isolation of persons living with HIV and more generally renders it more difficult to openly and non-judgmentally discuss HIV. Unconditional acceptance and compassion (the biblical concept of "grace") challenges the destructive labeling and discrediting of a person or group. HIV stigma has been found to create and perpetuate feelings of negative self-worth and blame, compromise the quality and utility of interpersonal relationships, and exacerbate fears of marginalization among seropositive A&PIs (Kang et al., 2006; Kang, Rapkin, Remien, Mellins, & Oh, 2005). Generally, stigmatized groups are "pejoratively regarded by the broader society and are devalued, shunned, or otherwise lessened in their life chances" (p. 304; Alonzo & Reynolds, 1995). Experiences of exclusion heightened by one's internalized shame of living with HIV and fear of public ostracism should their serostatus be revealed are particularly common in the narratives of many undocumented Chinese immigrants living with HIV in NYC (Kang et al., 2003).

Volf's (1996) metaphor of "embrace" responds to the problem of exclusion, and challenges Christians to not simply accept others, but to engage and recognize their shared humanity - "the will to give ourselves to others and 'welcome' them, to readjust our identities to make space for them is prior to any judgment about others, except that of identifying them in their humanity" (p. 29). Although few church leaders would disagree with Volf's (1996) concept of "embrace," many would have difficulty with the deed of embrace, as noted by a Chinese pastor interviewed for the current study:

The HIV-positive person needs to be cared for by a leader or pastor so that he/she can be introduced through the pastor—one who has credibility. Otherwise, it's hard to do this. People may have a negative or untrue perspective if they know someone is HIV-positive. There may be a lot of speculation or misinformed ideas.

The unquestionable need to address HIV stigma is implied, but the challenges posed to congregation members are clearly stated. The same pastor suggested that fostering personal familiarity with persons

living with HIV/AIDS (PLWHA) and "de-issuing" the epidemic are important first steps—"it's harder to address HIV stigma with a stranger coming in who is HIV-positive. We don't know their background. The main issue is that the level of trust needs to be built up. It's not impossible to care for an HIV-positive person, but it takes time." Church leaders, respected members in the church, or HIV service providers who are Christians (e.g., physicians, nurses, HIV educators, social workers) lend assurance to this unfamiliar process of embracing PLWHAs in church.

In addition to integrating *grace-filled* compassion with addressing HIV stigma, a second point of integration for faith-based HIV programs is recasting HIV education and care as a social mandate to be coupled with the work of evangelism. Conn (1982) argued for the importance for solidarity with diverse listeners without accommodating the evangelistic messages—to "become like all things to all men, so that by all possible means I might save some" (1 Cor. 9:19-23). When isolated from people and the context from which the gospel is communicated and lived, the method of evangelism is called into question. It is beyond the scope of this paper to discuss the relationship between social responsibility and evangelism as stated in the Lausanne Covenant—"in the church's mission of sacrificial service, evangelism is primary." However, Bosch's (1984) interpretation of the Great Commission is noteworthy. He argued that in Christ's instruction to make disciples of all nations by baptizing new converts and "teaching them to observe all that I have commanded you" (Matt 5:17-20), Christ's central commandments were to love and uphold justice. As such, to fulfill the words of the Great Commission is to practice "superior justice" (p. 26). Sider (1975) similarly contends that evangelism cannot be practiced without advocating for justice, stating that "failure to teach prospective believers and new converts that coming to Jesus necessarily involves a costly discipleship that will confront social, economic and political injustice constitutes an heretical neglect of the Great Commission" (p. 266). In facilitating our seminar with Chinese church leaders, it was particularly helpful to broaden their understanding of HIV as an illness that largely affects marginalized groups and heightens the inequities that predate that onset of illness. As noted in a passage from a co-author's field notes,

The co-facilitator also mentioned how HIV encapsulates everything the church does: the church addresses poverty and helps disenfranchised groups, and this is precisely who is affected by HIV the most. It makes HIV different from other chronic illnesses. This was very useful. The group mentioned later that this issue should be discussed more in depth at the start of the workshop.

Misinformation About HIV Prevention, Transmission and Treatment

Misinformation about HIV transmission and preventive practices, coupled with deeply rooted HIV-stigma, remains a public heath challenge in the Chinese community. The "co-occurrence" of correct and incorrect knowledge of HIV transmission highlight the importance of reinforcing knowledge of documented modes of transmission and correcting inaccurate transmission knowledge (Boer & Emons, 2004; London & Robles, 2000). London (2000) argued that "as people 'know' more, they are able to fear more; inaccurate beliefs of HIV transmission emerge when new information is introduced … and assimilated into existing cultural frameworks for understanding contagion and disease" (p. 1277). In addition to imparting accurate information about HIV transmission, prevention programs also need to address cultural scripts that reinforce incorrect HIV transmission beliefs that hinder appropriate preventive practices and heighten discrimination against PLWHAs.[4] Chinese church leaders noted that imparting knowledge did not necessarily alleviate fears about HIV transmission. A Chinese pastor noted that just as the chance of transmitting HIV through saliva was minimal, the chance of winning the lottery was also minimal, and people have won the lottery. The perceived uncertainty and unfamiliarity of HIV prevention dampened the church's efforts to play a more active role in prevention and care efforts.

Conclusion

Chinese churches in the US inculcate a compelling worldview informed by select cultural and theological frameworks that collectively challenge a number of traditional Confucianism values (Muse, 2005). This worldview is informed by *both* select cultural scripts that are aligned with Christian doctrine, and the biblical imperative to love Christ and others as oneself

---

[4]Recent applications of the transtheoretical model of health behavior change (Prochaska, Redding, Harlow, Rossi, & Velicer, 1994) warrant further consideration – particularly as it pertains to how faith-based institutions progress though a series of motivational readiness stages . Of specific relevance is the extent to which individual motivational interviewing approaches could be adapted to foster institutional intention to implement HIV prevention and care programming (Martin & Sihn, 2009).

(Luke 10:27). This sinicization of Christianity particularly among recent Chinese immigrants positions ethnic churches to potentially address misconceptions of HIV transmission and treatment that perpetuate the stigmatization of persons living with HIV or belonging to high-risk groups. Despite doctrinal agreement on the importance of cultivating a spirit of inclusion rather than exclusion of PLWHAs, traditional Chinese churches may not necessarily practice this doctrine because of the priority placed on preserving ethno-theological values. By specifically separating the church from the outside world and regarding HIV as an irrelevant issue deemed less worthy of attention, ethnic churches largely remain at the periphery of HIV prevention and care in Chinese immigrant communities. Notwithstanding these formidable challenges, the influence and authority of ethnic churches within Chinese immigrant communities underscore the importance of creating means to integrate HIV prevention and care with the scriptural mandate to evangelize and demonstrate compassion and uphold justice.

Deserving of careful attention is potential bias against faith-based HIV prevention and care efforts—a bias largely formed by conservative churches' views of HIV/AIDS as divine retribution against homosexuals during the first decade of the epidemic, and its theological pronouncement against homosexuality and pre-marital sex. This has understandably discouraged public health efforts to contextualize HIV in Chinese church settings. However, it would be remiss to disregard or minimize the potential role of Chinese churches in addressing the epidemic as it impacts the immigrant community. Just as HIV prevention and care initiatives have appropriately been tailored to address cultural, socio-economic, and gender differences among communities of color, similar efforts are needed to identify commonalities between public health and theology.

Faith based HIV prevention and care programs in Chinese evangelical immigrant churches require integration of select aspects of culture, theology and public health agendas. Integration does not necessitate reconciling ideological differences; rather it implies sufficient shared suppositions that guide our efforts to prevent the spread of HIV and ensure the compassionate treatment of persons living with HIV. The authors propose that focusing on HIV stigma mitigation, and framing HIV prevention and care as an opportunity to practice compassion and uphold justice, a mandate on par with evangelism, are timely starting points of integration.

REFERENCES

Abel, A. (2006). Favor fishing and punch-bowl Christians: Ritual and conversion in a Chinese Protestant church. *Sociology of Religion, 67*(2), 161-178.

Adogame, A. (2007). HIV/AIDS support and African Pentecostalism. *Journal of Health Psychology, 12*(3), 475-484.

Alonzo, A. A. and Reynolds, N. R. (1995). Stigma, HIV and AIDS: an exploration and elaboration of a stigma trajectory. *Social Science and Medicine, 41*, 303-315.

Asian American Federation (2008, October). *Working but poor: Asian American poverty in New York City*. New York: Asian American Federation.

Boer, H., & Emons, A. A. (2004). Accurate and inaccurate HIV transmission beliefs, stigmatizing and HIV protection motivation in Northern Thailand. *AIDS Care, 16*(2), 167-176.

Bosch, D. J. (1984). The scope of mission. *International Review of Mission, 73*(289), 17-32.

Campbell, M. K., Hudson, M. A., Resnicow, K., Blakeney, N., Paxton, A., & Baskin, M. (2007). Church-based health promotion interventions: Evidence and lessons learned. *Annual Review of Public Health, 28*, 213-234.

Cao, N. (2005). The church as a surrogate family for working class immigrant Chinese youth: An ethnography of segmented assimilation. *Sociology of Religion, 66*(2), 183-200.

Carnes, T. (2004). Faith, values, and fears of New York City Chinatown seniors. In T. Carnes & F. Yang (Eds.), *Asian American religions: The making an remaking of borders and boundaries* (pp. 223- 244). New York: New York University Press.

Center for Disease Control (2007, June). HIV/AIDS surveillance: General epidemiology (through 2006).

Chin, D. (1999). HIV-related sexual risk assessment among Asian/Pacific Islander American women: An inductive model. *Social Science and Medicine, 49*(1999), 241-251.

Chin, J., Leung, M., Sheth, L., & Rodriguez, T. R. (2007). Let's not ignore a growing HIV problem for Asians and Pacific Islanders in the US. *Journal of Urban Health, 84*(5), 642-647.

Chin, J., Mantell, J. E., Weiss, L., Bhagavan, M., & Luo, X. (2005). Chinese and South Asian religious institutions and HIV prevention in New York City. *AIDS Education and Prevention, 17*(5), 484-502.

Chin, J., Neilands, T. B., Weiss, L., & Mantell, J. E. (2008). Paradigm shifters, professionals, and community sentinels: Immigrant community institutions' roles in shaping places and implications for stigmatized public health initiatives. *Health and Place, 14*(2008), 866-882.

China, State Council AIDS Working Committee Office & UN Theme Group on AIDS in China (2007). *A joint assessment of HIV/AIDS prevention, treatment and care in China.*

Conn, H. M. (1982). *Evangelism: Doing justice and preaching grace*. New Jersey: Presbyterian & Reformed Publishing.

DeHaven, M. J., Hunter, I. B., Wilder, L., Walton, J. W., & Berry, J. (2004). Health programs in faith-based organizations: Are they effective? *American Journal of Public Health, 94*, 1030-1036.

Federation, A. A. (2008, October). *Working but poor: Asian American poverty in New York City*. New York: Asian American Federation.

Francis, S. A., & Liverpool, J. (2009). A review of faith-based HIV prevention programs. *Journal of Religion and Health, 48,* 6-15.

Gazabon, S. A., Morokoff, P. J., Harlow, L. L., Ward, R. M., & Quina, K. (2007). Applying the transtheoretical model to ethnically diverse women at risk for HIV. *Health Education & Behavior, 34,* 297-314.

Guest, K. J. (2003). *God in Chinatown: Religion and survival in New York's evolving immigrant community*. New York: New York University Press.

Haddad, B. (2005). Reflections on the church and HIV/AIDS. *Theology Today, 62*(2005), 29-37.

Haddad, B. (2006). "We pray but we cannot heal": Theological challenges posed by the HIV/AIDS crisis. Journal of Theology for Southern Africa, 125(July 2006), 80-90.

Huang, Z. J., Wong, F. Y., De Leon, J. M., & Park, R. J. (2008). Self-reported HIV testing behaviors among a sample of Southeast Asians in an urban setting in the United States. *AIDS Education and Prevention, 20*(1), 65-77.

Israel, B. A., Schultz, A. J., Parker, E. A., & Becker, A. B. (1998). Review of community-based research: Assessing partnership approaches to improve public health. *Annual Review of Public Health, 19,* 173-202.

Kang, E., Rapkin, B. D., & DeAlmeida, C. (2006). Are psychological consequences of stimga enduring or transitory? A longitudinal study of HIV stigma and psychological distress among Asians and Pacific Islanders living with HIV illness. *AIDS Patient Care and STDs, 20*(10), 712-723.

Kang, E., Rapkin, B. D., Remien, R. H., Mellins, C. A., & Oh, A. (2005). Multiple dimensions of HIV stigma and psychological distress among Asians and Pacific Islanders living with HIV illness. *AIDS & Behavior, 9*(2), 145-154.

Kang, E., Rapkin, B. D., Springer, C., & Kim, H. J. (2003). The "demon plague" and access to care among undocumented Asian immigrants living with HIV disease in New York City. *Journal of Immigrant Health, 5*(2), 49-58.

Kwok, P. (1992). Claiming our heritage: Chinese women and Christianity. *International Bulletin of Missionary Research, 16*(4), 150-154.

Kwong, P. (1996). *The new Chinatown*. New York: Hill and Wang.

Lasater, T. M., Becker, D. M., Hill, M. N., & Gans, K. M. (1997). Synthesis of findings and issues from religious-based cardiovascular disease prevention trials. *Annals of Epidemiology, 7*(7), Supp 1, S46-S53.

Lam, W. H. (1980). Patterns of Chinese theology. *Occasional Bulletin of Missionary Research, 4*(1), 20-24.

Lienemann-Perrin, C. (2004). The biblical foundations for a feminist and participatory theology of mission. *International Review of Mission, 93*(368), 17-34.

London, A. S., & Robles, A. (2000). The co-occurence of correct and incorrect HIV transmission knowledge and perceived risk for HIV among women of childbearing age in El Salvador. Social Science and Medicine, 51(2000), 1267-1278.

Lu, L., Jia, M., Ma, Y., Yang, L. H., Chen, Z., Ho, D., et al. (2008). The changing face of HIV in China. *Nature, 455,* 609-611.

Marsden, G. M. (1991). *Understanding fundamentalism and evangelicalism*. Michigan: WM Eerdmans Publishing.

Martin, J. E., & Sihn, E. P. (2009). Motivational interviewing: Applications to Christian therapy and church ministry. *Journal of Psychology and Christianity, 28*(1), 71-77.

MMWR. (2006). Racial/Ethnic Disparities in Diagnoses of HIV/AIDS: 33 States, 2001–2004. *MMWR Morbidity Mortality Weekly Report, 55*(5), 121-125.

Muse, E. A. (2005). *The evangelical church in Boston's Chinatown*. New York: Routledge.

Ng, K. H. (2002). Seeking the Christian tutelage: Agency and culture in Chinese immigrangs' conversion to Christianity. *Sociology of Religion, 63*(2), 195-214.

Prochaska, J. O., Redding, C. A., Harlow, L. L., Rossi, J. S., & Velicer, W. F. (1994). The transtheoretical model of change and HIV prevention: A review. *Health Education Quarterly, 21*(4), 471-486.

Resnicow, K., Baranowski, T., Ahluwalia, J. S., & Braithwaite, R. L. (1999). Cultural sensitivity in public health: Defined and demystified. *Ethnicity and Disease, 9*(1), 10-21.

Scrambler, G., & Hopkins, A. (1990). Generating a model of epileptic stigma: The role of qualitiative analysis. *Social Science and Medicine, 30*(11), 1187.

Sider, R. J. (1975). Evangelism, salvation and social justice: Definitions and interrelationships. *International Review of Mission, 64*(255), 251-267.

Strauss, A., & Glaser, B. (1975). *Chronic illness and the quality of life*. St. Louis: Mosby.

Takshashi, L. M. (1997). Stigmatization, HIV/AIDS, and communities of color: Exploring response to human service facilities. *Health and Place, 3*(3), 187-199.

Takshashi, L. M., Malalong, M. C., DeBell, P., & Fasudhani, A. (2006). HIV and AIDS in suburban Asian and Pacific Islander communities: Factors influencing self-efficacy in HIV risk reduction. *AIDS Education and Prevention, 18*(6), 529-545.

Terrazas, A. M., & Devani, B. (2008). Chinese immigrants in the United States. Retrieved 1/15/09, 2009, from http://www.immigrationinformation.org/USfocus/print.cfm?ID=685

UNAIDS. (2008). *Report on the global AIDS epidemic: Executive summary*.

Volf, M. (1996). *Exclusion and embrace: A theological exploration of identity, otherness, and reconciliation*. Nashville: Abingdon Press.

Wang, L., Wang, N., Wang, L., Li, D., Jia, M., Gao, X., et al. (2009). The 2007 estimates for people at risk for and living with HIV in China: Progress and challenges. *Journal of Acquired Immunodeficiency Syndrome, 50,* 414-418.

Webb, W. J. (2001). *Slaves, women, & homosexuals: Exploring the hermeneutics of cultural analysis*. Downers Grove: InterVarsity Press.

Yang, F. (1998). Chinese conversion to evangelical Christianity: the importance of social and cultural contexts. *Sociology of Religion, 59*(3), 237-257.

Yang, F. (1999). *Chinese Christians in America: Conversion, assimilation, and adhesive identities*. Penn State Press.

Yang, F. (2004). Gender and generation in a Chinese Christian church. In T. Carnes & F. Yang (Eds.), *Asian American religions: The making an remaking of borders and boundaries* (pp. 205-222). New York: New York University Press.

AUTHORS

KANG, EZER. *Address*: 501 College Ave, Wheaton IL 60187. *Title*: Associate Professor of Psychology, Wheaton College. *Degree*: Ph.D., Clinical Psychology, Fuller Theological Seminary. *Areas of specialization*: Mental health and structural interventions for adolescents, Asian immigrants, and the urban poor living with HIV.

CHIN, JOHN J. *Address*: Hunter College, City University of New York. 695 Park Avenue West Building 1611, New York, NY 10065. *Title*: Associate Professor and Director of the Master of Urban Planning Program, Department of Urban Affairs and Planning. *Degree*: Ph.D., Urban Planning, Columbia University. *Areas of specialization*: Urban health and the role of community institutions in the delivery of social and health services.

BEHAR, ELANA. *Address*: Hunter College, City University of New York, 695 Park Avenue West Building 1611, New York, NY 10065. *Title*: Research associate, Department of Urban Affairs and Planning. *Degree*: M.A., Applied Anthropology, Montclair State University. *Areas of specialization*: She is currently Project Director for several studies on Asian immigrant health and the role of community institutions in the delivery of social and health services.