Christianity

Ezer Kang and David Arute

Christianity, a monotheistic religious movement diverse in form and expression and marked by a common commitment to the life and teachings of its founder Jesus of Nazareth, has informed varied faith-based responses to HIV/AIDS since the beginning of the pandemic—from early pronouncements against HIV prevention measures (e.g., condom use and needle exchange) to further marginalization of gay men living with the illness. However, recent initiatives have emerged to stem the tide of the epidemic with prevention and care programs that are aligned with orthodox Christian doctrine. Christian-based HIV programming (CBHP) gained visible momentum during the second decade of the epidemic. This is most notable among churches in urban African-American enclaves in the USA and southern African countries—both regions with disproportionate representations of persons newly infected with HIV and living with AIDS. Moreover, as a result of research identifying a strong link between rising HIV incidence and inequitable socioeconomic conditions, a response to the epidemic began to gain ground, largely influenced by the evangelical social justice movement.

Established CBHP at churches and Christian-based social service organizations have included community education about HIV transmission prevention, church leadership training, HIV-stigma reduction media campaigns, outreach to HIV high-risk groups, promotion of HIV-antibody testing and counseling, and emotional and practical support for people living with HIV (PLHIV). CBHP in the USA are often conceived of and implemented in partnership with external organizations. Collaborative partnerships between churches and public health institutions are conceptualized as faith-based or faith-placed. Faith-based interventions take into account the religious culture and beliefs of targeted individuals and communities,

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E. Kang (✉)
Department of Psychology, Wheaton College, Wheaton, IL, USA
e-mail: ezer.kang@wheaton.edu

D. Arute
Wheaton College, Wheaton, IL, USA

whereas faith-placed interventions view the religious organization as a location for delivering interventions, regardless of their religious content.

Recent scholarship on the development of CBHP has highlighted the important challenge of identifying points of integration between orthodox Christian doctrine, ecclesiastical practices, and response to HIV. For example, some have argued that scriptural teachings of transformative and unconditional compassion as modeled by Jesus Christ uniquely positions CBHP 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. Texts from the Old and New Testaments that consistently referred to the sins of oppression and admonishment of those who unjustly treat those who carry less social power, have challenged Christian institutions to apply these principles to HIV/AIDS. Others have emphasized the important pairing of upholding justice and proclaiming the atoning work of Jesus Christ—a primary task for Christians. Proponents of this approach to Christian evangelism specifically argue that propagating the life and work of Christ is inseparable from teaching the responsibilities of becoming a Christian—that is, confronting social and economic injustices. Threads of liberation theology, for example, that emphasized solidarity with exploited communities have been woven into the responses of many churches in African and South-American countries.

Within Christian subgroups that acknowledge the importance of responding to the epidemic, there are formidable challenges to implementing CBHP in the Americas and southern regions of Africa. First, limited financial and human resources are generally directed towards the needs of congregation members and target constituent groups rendering involvement in HIV programming less feasible. Second, collaborations with external HIV-organizations are frequently stifled by ideological differences about HIV prevention measures, sexual ethics, substance abuse, and harm reduction interventions. Third, there exists a lingering bias against CBHP, one that was largely formed during the first decade of epidemic against fundamentalist churches that viewed HIV/AIDS as divine retribution against homosexuals. Finally, HIV involvement potentially compromises the churches' perceived moral standing and authority within their communities and may alienate the churches from their constituents. This threat of compromised social standing is particularly felt in select African countries where many coexisting churches compete in the religious marketplace for a small group of unaffiliated individuals.

Recent scholarship has focused on how religious institutions such as Christian churches influence broader social milieus within which HIV risk behavior occurs and illness stigma proliferates. The argument follows that diverse Christian traditions play a formidable role in shaping cultural and political scripts that inform social responses to the epidemic. In the USA, this is exemplified among diverse immigrant and African-American churches that weld considerable influence over community norms and values—ones that can facilitate or undermine public health efforts in HIV prevention and treatment. The importance of preserving traditional, moral, and institutional values has rendered active involvement in HIV-related activities a challenge among many ethnic Christian churches. However, researchers have urged strategic approaches to address these institutional barriers by identifying proximal and distal points of integration between HIV prevention and treatment, doctrinal teaching, and cultural faith practices.

Related Topics: Coping, faith community, prevention strategies, religion and spirituality.

Suggested Reading

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.

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*, 866–882.

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.

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

Kang, E., Chin, J., & Behar, E. (2011). Faith-based HIV care and prevention in Asian immigrant communities in New York City. Rhetoric or reality? *Journal of Psychology & Theology, Special Issue "Faith in Practice: Reflections on Community Psychology in Action", 39*, 268–279.

Muñoz-Laboy, M., Garcia, J., Moon-Howard, J., Wilson, P. A., & Parker, R. (2011). Religious responses to HIV and AIDS: Understanding the role of religious cultures and institutions in confronting the epidemic. *Global Public Health, 6*(S2), S127–S131.

Hearn, K. D., O'Sullivan, L. F., El-Bassel, N., & Gilbert, L. (2005). Intimate partner violence and monogamy among women in methadone treatment. *AIDS and Behavior, 9*(2), 177–186.
Mah, T. L., & Shelton, J. D. (2011). Concurrency revisited: Increasing and compelling epidemiological evidence. *Journal of the International AIDS Society, 14*, 33.
Stein, J. A., Nyamathi, A., Ullman, J. B., & Bentler, P. M. (2007). Impact of marriage on HIV/AIDS risk behaviors among impoverished, at-risk couples: A multilevel latent variable approach. *AIDS and Behavior, 11*(1), 87–97.
Wu, E., El- Bassel, N., Gilbert, L., & Chang, M. (2003). Intimate partner violence and HIV among urban minority women in primary health care settings. *AIDS and Behavior, 7*, 291–301.

Suggested Resources

Fox, A. Monogamy. *The Body. The complete HIV/AIDS resource*. Retrieved February 1, 2012 from http://www.thebody.com/content/art14030.html?ts=pf
http://www.newworldencyclopedia.org/entry/Monogamy. Retrieved February 1, 2012

Orphans

Ezer Kang and Cabrina Kang

In regions disproportionately affected by HIV in Africa, Asia, and South America the Joint United Nations Programme on HIV/AIDS (UNAIDS) defined "orphans as children who have lost one or both parents to HIV. Given the discrediting natur of the term "AIDS orphan," and the inaccurate labeling of orphans as necessaril HIV-positive, the description is referenced less in scholarship. In the context of th epidemic, orphans are also referred to as children made vulnerable by AIDS Although the definition of orphan carries significant programmatic and polic implications, few studies clearly define the term in the context of their work Moreover, medical and social science research have not reached a consensus o the sociodemographic characteristics that define children orphaned by AIDS. Lac of clarity and consensus on the definition have rendered accurate and detaile epidemiological surveillance and the development of evidenced-based psychosocial interventions challenging at best. Specifically, there is considerable variabilit in published studies on the age (under 19 or 15 years) and serostatus of a chil orphaned by AIDS, definition of caregiver who died (e.g., single or both parents maternal or paternal), and the child's relationship to the caregiver who died (e.g. biological parents or kinship guardians).

Although reports have provided estimates of paternal, maternal, and doubl (death of mother and father) orphans in regions of sub-Saharan Africa, it remain unclear how many have been orphaned due to AIDS in each parental deat category. Of note, the challenge of identifying children orphaned by AIDS is furthe complicated by the secrecy and stigma carried by families affected by HIV. Th United Nations Children's Fund (UNICEF) for example, provided specifi estimates of maternal (28,500,000), paternal (34,800,00), and double (10,300,000

E. Kang (✉)
Department of Psychology, Wheaton College, Wheaton, IL, USA
e-mail: ezer.kang@wheaton.edu

C. Kang
Wellesley College, Wellesley, MA, USA

orphans in Sub-Saharan Africa in 2010, and estimated that 15,700,000 children would be orphaned by AIDS without further defining nature parental death.

Some researchers have argued the merits of understanding orphans in African countries as a socially constructed category based on loss and need. This raised nuanced considerations as to whether children were to be considered orphans if they were well cared for by kin and had adjusted in culturally normative ways to parental deaths. Furthermore, would this broaden the definition of orphans to include young adults with fewer social and economic resources who face adjustment challenges? In Malawi, for example, researchers challenged the conventional premise that family and social infrastructure were in complete disarray as a result of parental death. They argued that children orphaned by AIDS underwent a process of social reconfiguration that could be normative when faced with familial disruption. As such, categorizing them as orphans carried unnecessary stigma that further perpetuated perceptions of them as passive victims.

In the USA, children orphaned by AIDS gained national attention with the emerging "boarder babies" crisis in New York City, particularly in Harlem where HIV-exposed and infected infants and children were left to board at hospitals because of parental abandonment, postpartum complications, and an inadequate foster care referral system. Between 1983 and 1989, 3–5% of pregnant women at Harlem Hospital were infected with HIV. Many of the newborns of these women were abandoned by their mothers and were referred to as boarder babies because they were cared for in hospitals until they were eventually placed with foster families. During this period of the crack cocaine epidemic, nearly 10% of babies born in Harlem went directly to foster care, primarily due to maternal drug-related problems, and these babies were eight times more likely to be HIV exposed than those babies discharged to their mothers.

The challenge of consistently defining children orphaned by AIDS across disciplines has resulted in equivocal findings on the extent of their vulnerabilities. Studies that examined the physical and emotional-behavioral effects of orphanhood have been hampered by sampling, methodological, and construct operationalization inconsistencies, rendering comparison of findings across studies unfeasible. Moreover, systematic reviews of studies that generally showed adverse developmental outcomes among variously defined orphans did not adequately consider potential confounding affects of baseline family functioning, support networks, or poverty. As such, the implications drawn from studies indicating the detrimental effects of orphan-hood (e.g., poor emotional and behavior functioning, academic achievement decline, poor reproductive health, high-risk sexual behavior) should be interpreted with caution, as the causal relationship between paternal/ maternal or parental death due to AIDS per se and reported adverse outcomes remains unclear. Other factors that predate a child's orphan-hood such as the developmental stage of the child, guardian-child relationships, child HIV serostatus, family wealth, extended family network, communal HIV stigma, and gender inequalities are important to consider when explicating the degree of vulnerability of orphans. It is noteworthy that several studies did not report negative outcomes, highlighting the importance of identifying individual and familial/ communal strengths and resources that contribute to a child's resiliency.

Studies in sub-Saharan Africa have consistently noted the general benefits of preserving family caretaking roles and challenging the long-term merits of institutional care. Concerns have included sustainability of institutional care, adaptive reintegration into society where HIV stigma persists, inadequate monitoring and accountability, and cost effectiveness of supporting residential facilities compared to community- or family based care. Recent studies in economically disadvantaged rural regions of Asia and Africa have found that double orphans residing in government supported community-based small group homes, managed by house-parents for a small number of children orphaned by AIDS, generally reported higher levels of mental health, physical, and educational functioning compared to orphans under kinship or institutional care (e.g., orphanage). The advantages of community group homes lie in a child's proximity to family settings, and living in a family oriented household. Moreover, economic assistance mitigates the stressors of meeting basic daily needs. Pervasive poverty in these regions coupled with community members and families emerging to collectively care for children orphaned by HIV have led to external funding and capacity building efforts to help ensure community ownership and sustainability of responses.

Related Topics: Caregiving and caregivers, Children, Stigma and stigmatization, United Nations

Suggested Readings

Chirwa, W. C. (2002). Social exclusion and inclusion: Challenges to orphan care in Malawi. *Nordic Journal of African Studies, 11*(1), 93–113.

Chuong, C. & Operario, D. (2012). Challenging household dynamics: Impact of orphanhood, parental absence, and children's living arrangements on education in South Africa. *Global Public Health, 7*(1), 42–57.

Hong, Y., Li, X., Fanf, X., Zhao, G., Zhao, J., Zhao, Q., et al. (2010). Care arrangements of AIDS orphans and their relationship with children's psychosocial well-being in rural China. *Health Policy and Planning, 26*, 115–123.

Nicholas, S. W., & Abrams, E. J. (2002). Boarder babies with AIDS in Harlem: Lessons in applied public health. *American Journal of Public Health, 92*, 163–165.

Richter, L. M., Sherr, L., Adato, M., Chandan, U., Desmond, C., Drimeie, S., et al. (2009). Strengthening families to support children affected by HIV and AIDS. *AIDS Care, 21*(S1), 3–12.

Sherr, L., Mueller, J., & Varrall, R. (2009). Evidence-based gender findings for children affected by HIV and AIDS – a systematic overview. *AIDS Care, 21*(S1), 83–97.

Sherr, L., Varrall, R., Mueller, J., & Workgroup, J. L. I. C. A. (2008). A systematic review on the meaning of the concept 'AIDS Orphan': Confusion over definitions and implications for care. *AIDS Care, 20*(5), 527–539.

Stigma and Stigmatization

Ezer Kang

As Weiss and Ramakrishna noted in 2006, stigma is "a social process or personal experience characterized by exclusion, rejection, blame or devaluation that results from experience or reasonable anticipation of an adverse social judgment about a person or group." In HIV-related stigma, this judgment is conferred by one's HIV-seropositive status. Framed as an individually constructed trait, early research on HIV stigma has focused on stereotype formation and its behavioral and emotional consequences. Studies have identified two categories of stigmatization—enacted and felt stigma, distinguished by experiences of actual discrimination (enacted stigma) and one's perceived fear of encountering stigmatizing practices (felt stigma). Both forms of HIV-related stigma are intertwined with the illness course and uniquely sustained or mitigated by the responses of broader society, friends, and families. Moreover, there are multiple layers of stigma particularly among women and ethnic and sexual minorities living with HIV. Perceptions of marginalization and social rejection, for example, could be perpetuated by virtue of one's serostatus, risk behaviors associated with HIV transmission, undocumented immigration status, gender, or sexual orientation. The immediate consequence of enacted HIV-related stigma is a loss or diminution of individual status. People living with HIV (PLHIV) who experience status loss often report poor mental health outcomes (depression, negative self-worth, social isolation), delayed access to and inconsistent utilization of HIV care, poor medical treatment adherence, and avoidance of serostatus disclosure, particularly among racial and ethnic minorities in the USA and groups that contend with inequalities that predate learning about their HIV serostatus.

Following an experience of actual discrimination, many PLHIVs develop a heightened "stigma consciousness" which informs their world view and behavior. Specifically, they vigilantly avoid situations that would place them at risk for repeated discrimination on account of their HIV-serostatus. They maintain their

E. Kang (☒)
Department of Psychology, Wheaton College, Wheaton, IL, USA
e-mail: Ezer.Kang@wheaton.edu

illness a secret within public and personal social networks—a task that becomes a consuming priority. The emotional demand of sustaining this heightened sense of vigilance or awareness of social devaluation often has *more* deleterious effects than the immediate consequences of a discriminatory event.

The social setting in which stigma is perceived and experienced influences the degree of psychological damage exerted on PLHIVs. Stigmatizing encounters experienced within one's family and peer networks, as well as institutional settings including employment, healthcare, or recreation have varying affects on PLHIVs depending on the significance placed in these specific settings. Experiencing avoidance from family members or awkward social interactions in healthcare settings, for example, impacts adults with HIV more adversely than experiencing such avoidance or awkwardness in other social settings. Not all PLHIVs experience diminished well-being or negative emotional consequences from HIV-stigma. Responses to stigma-related events vary depending on the timing of the occurrence, one's repertoire of self-protective strategies, and the extent to which stigmatizing traits can be concealed.

Few studies have found that stigmatizing beliefs against PLHIVs are significantly correlated with lower HIV knowledge and beliefs, suggesting the importance of both correcting misinformation about HIV and mitigating the influences of stigma. Addressing HIV knowledge and stigma is particularly critical given the relationship between stigma and high risk sexual behavior. Studies, for example, have also found that stigmatizing perceptions of persons with HIV are associated with increased sexual risk behavior (multiple partners), less frequent use of condoms, and voluntary HIV testing in two major cities in China.

Although overt expressions of HIV-related stigmatization in the USA have declined since the 1990s, many people continue to have misinformed fears of HIV transmission by casual social contact, and punitive and negative attitudes towards persons living with HIV. Moreover, historic associations between HIV and marginalized groups such as gay men and injecting drug users continue to inform public attitudes towards PLHIVs.

Similarly in rural regions of East Asia, illness stigma is based largely on misconception of casual HIV transmission coupled with cultural proscriptions against high-risk groups. Recent scholarship, for example, has reconceptualized HIV stigma in China as a "moral process" that undermines one's social and familial obligation to preserve "face"—both moral (*lian*) and social (*mianzi*)—which governs inner social networks of family and kinship ties, and outer networks (e.g., friends, neighbors). Another dimension of HIV stigma to consider is pubic fear of HIV contagion—one that is shaped and reinforced by ingrained misconceptions of HIV transmission or unfamiliarity with the epidemic. Stigma in rural China is largely enacted by excluding and isolating PLHIVs out of fear of infection and not necessarily motivated by socio-moral condemnation of HIV risk behavior. In some regions, the inclination to avoid social contact with PLHIVs may reflect more instinctual self-preservation rather than a malicious intent to discredit another. In a study of HIV- and drug abuse-related stigma among the Dai community in the Dehong prefecture of Yunnan, HIV illness did not reinforce stigma against drug abusers per se; rather, the illness solicited a compassionate response, largely motivated by a desire to earn merits and ensure happiness and prosperity in the next life.

Recent scholarship has conceptually reframed HIV-related stigma as a social rather than individual process that perpetuates and sustains relations of power that exclude and devalue people and groups. This approach shifts the focus from how individuals act towards one another to consider how culture and history construct social hierarchies and breed intergroup difference and domination that underlie HIV and AIDS-related stigma. As such, researchers have challenged conventional individual-level interventions (e.g., cognitive-behavioral approaches) and argued for structural interventions aimed at shifting community paradigms about HIV and its intersection with other causes of inequity. This approach, for example, has recently informed studies that examine the unique roles of African American and Chinese ethnic churches in reshaping cultural scripts on HIV prevention in their respective communities.

Related Topics: Discrimination, faith community, gender identity, hate crimes, risk behaviors, risk groups.

Suggested Reading

Alonzo, A. A., & Reynolds, N. R. (1995). Stigma, HIV and AIDS: An explorations and elaboration of a stigma trajectory. *Social Science and Medicine, 14*(3), 303–315.

Link, B. G., & Phelan, J. (2001). Conceptualizing stigma. *Annual Review of Sociology, 27*, 363.

Major, B., & O'Brien, L. T. (2005). The social psychology of stigma. *Annual Review of Psychology, 56*, 393–421.

Parker, R., & Aggleton, P. (2003). HIV and AIDS-related stigma and discrimination: A conceptual framework and implications for action. *Social Science and Medicine, 57*(2003), 13.

Stutterheim, S. E., Pryor, J. B., Bor, A. E. R., Hogendijk, R., Muris, P., & Schaalma, H. P. (2009). HIV-related stigma and psychological distress: The harmful effects of specific stigma manifestations in various social settings. *AIDS, 23*, 2353–2357.

Weiss, M. G., & Ramak, J. (2006). Stigma interventions and research for international health. *Lancet, 367*, 536.

Yang, L. S., Kleinman, A., Link, B. G., Phelan, J. C., Lee, S., & Good, B. (2007). Culture and stigma: Adding moral experiences to stigma theory. *Social Science and Medicine, 64*, 1524–1535.