Social Science & Medicine 162 (2016) 201–209

Contents lists available at ScienceDirect

Social Science & Medicine

journal homepage: www.elsevier.com/locate/socscimed

Involving immigrant religious organizations in HIV/AIDS prevention: The role of bonding and bridging social capital

ManChui R. Leung [a, *], John J. Chin [b], Miruna Petrescu-Prahova [c]

[a] Sociology, School of Public Health, University of Washington, 211 Savery Hall, Box 353340, Seattle, WA 98195, United States
[b] Urban Affairs and Planning, Hunter College, City University of New York, 695 Park Avenue, W1611, New York, NY 10065, United States
[c] School of Public Health, Health Promotion Research Center, University of Washington, 1107 NE 45th St., Suite 200, Seattle, WA 98105, United States

ARTICLE INFO

Article history:
Received 3 September 2015
Received in revised form
21 June 2016
Accepted 23 June 2016
Available online 24 June 2016

Keywords:
United States
HIV/AIDS
Social capital
Social network analysis
Religion
Immigrants organizations
Chinese
Asians

ABSTRACT

Immigrant religious organizations in the United States are uniquely positioned to address critical issues beyond religion because of their moral, social and cultural prominence in community life. Increasingly, religious organizations have taken on a leadership role around health issues such as decreasing HIV/AIDS stigma and misinformation. However, there are barriers for some religious leaders and organizations in adopting new health programs, especially if the issue is seen as controversial. Our study examines how social network structures among religious members influence organizational acceptance of new information or controversial ideas, like HIV/AIDS. Using social network analysis methods on data from 2841 contacts in 20 immigrant Chinese Buddhist temples and Christian churches in New York City, we tested whether an immigrant religious organization's likelihood of being involved in HIV/AIDS activities was associated with the presence of bonding or bridging social capital. These two forms of social capital have been found to mediate the levels of exposure and openness to new ideas. We found HIV/AIDS-involved religious organizations were more likely to have lower levels of bonding social capital as indicated by members having fewer ties and fewer demographic attributes in common. We also found HIV/AIDS-involved religious organizations were more likely to have higher levels of bridging social capital as indicated by members having significantly more ties to people outside of their organization. Our study highlights the importance of looking beyond religion type and leadership attributes to social network structures among members in order to better explain organization-level receptiveness to HIV/AIDS involvement.

Religious organizations are increasingly being recognized as important places to discuss HIV/AIDS prevention and decrease HIV/AIDS stigma (The White House, 2016; US Department of Health and Human Services, 2016). Despite this increased attention, little is known about why some religious organizations show willingness to get involved in HIV/AIDS issues, while others continue to be reluctant. To address this problem, previous studies have focused on examining the effects of religious doctrine (Lujan and Campbell, 2006; Sutton and Parks, 2013), individual leadership attitudes (Tesoriero et al., 2000), organizational mission (Chin et al., 2011; Derose et al., 2011) and member attitudes and beliefs (Bluthenthal et al., 2012; Chin et al., 2008) on religious organizational decisions regarding HIV/AIDS. To date, few studies have focused on immigrant communities and none have examined how the social network ties among religious members are associated with whether a religious organization decides to get involved in HIV/AIDS activities.

The social ties that form among members of religious organizations and non-members in the community or neighborhood contribute to the development of social capital. Social capital informs a religious organization's approach to secular and civic activities, including involvement in HIV/AIDS activities (Chin et al., 2011; Mock, 1992; Roozen et al., 1984; Smidt, 2003). We focus on two types of social capital, bonding and bridging, that have been found to mediate the levels of exposure and openness to new ideas (Putnam, 2000; Rogers, 2003). Bonding social capital tends to develop among people who have a lot in common, while bridging social capital tends to develop among people who are more dissimilar.

* Corresponding author.
E-mail addresses: mleung8@uw.edu (M.R. Leung), john.chin@hunter.cuny.edu (J.J. Chin), mirunapp@uw.edu (M. Petrescu-Prahova).

http://dx.doi.org/10.1016/j.socscimed.2016.06.042
0277-9536/

While some features of religious organizations may be very similar across religions, such as emphasizing norms of compassion, other features may differ greatly within and across religions, such as membership demographics, structures of authority and neighborhood contexts. Thus, religious organizations, even within the same religion or denomination, may foster very different types of social capital, resulting in variation in organizational missions and how they engage with secular issues such as health and HIV/AIDS issues (Chin et al., 2011, 2007b; Roozen et al., 1984; Smidt, 2003).

For immigrants adjusting to a new society, it may be difficult to be receptive to new health information and to differentiate between what is beneficial or detrimental to their health. Receptiveness to accurate health information is not always straightforward. Some health topics may be more consistently aligned with cultural and religious beliefs such as those encouraging the consumption of healthier foods. Other topics may conflict with existing beliefs and be less readily accepted, such as contraception, immunizations, treatments for mental health issues and HIV/AIDS prevention (Chaze et al., 2015; Gerend et al., 2013; Lowe and Moore, 2014; Villatoro et al., 2014). When these conflicts occur, many immigrants turn to trusted community members and organizations for guidance. This places immigrant religious organizations in a key position to either facilitate or impede the acceptance of important new information needed to decrease HIV/AIDS risk and stigma (Abraham, 2000; Kang et al., 2013). Among Asian immigrant religious organizations, health promotion activities such as health fairs and inclusion of health messages in religious sermons have increased (Cadge and Ecklund, 2007; Chin et al., 2008). Yet, few have actively addressed issues of HIV/AIDS risk and stigma despite increases in annual HIV/AIDS diagnosis rates among Asians and Pacific Islanders in the United States (Adih et al., 2011).

The combination of high rates of religious association (Chin et al., 2011, 2008, 2005), high rates of social and behavioral risk factors (Bhattacharya, 2004; Chin et al., 2007b; Zaidi et al., 2005) and low rates of HIV/AIDS awareness (Chin et al., 2007b, 2005; Kang et al., 2003, 2000), calls attention to the need to find new avenues and methods to increase HIV/AIDS prevention efforts in Asian immigrant communities. By using social network data from 20 Chinese immigrant religious organizations (10 Buddhist temples and 10 Christian churches) in New York City, we pose the following research question: What types of social capital, as indicated by social network measures, are associated with involvement in HIV/AIDS activities among immigrant religious organizations? This analysis aims to highlight the social network structures of members as an important factor in religious organizational involvement in HIV/AIDS programs, and to give insight into additional access points for collaboration between public health and religious organizations in immigrant communities.

1. Background

1.1. HIV/AIDS and Chinese immigrants in New York City

New York City continues to be one of the main epicenters of HIV/AIDS in the United States. Despite an extensive HIV/AIDS service infrastructure, many immigrants still face significant barriers to accessing HIV/AIDS information and services. These barriers are further exacerbated among the low-income, non-English speaking and undocumented immigrants (Wiewel et al., 2013). Although HIV prevalence among Asians and Pacific Islanders in the United States has been relatively low, addressing prevention and stigma remains important because of significant percentage increases in annual HIV/AIDS diagnosis since 2011 (Adih et al., 2011; Chin et al., 2007a). In New York City, foreign-born cases among Asians and Pacific Islanders comprise the majority (72%) of cumulative AIDS cases and they were the only racial and ethnic group to not have a statistically significant decrease in the number of new HIV diagnosis from 2011 to 2014. Additionally, along with Blacks, Asians and Pacific Islanders had the lowest short-term survival after diagnosis from 2009 to 2013, suggesting delays in diagnosis and barriers to care (HIV Epidemiology and Field Services Program, 2015).

The Chinese are the largest Asian ethnic group in New York City and the second largest immigrant group in New York City overall. Seventy-one percent are foreign-born, and over a third recently arrived in 2000 or later (New York City Department of City Planning, 2013). The socioeconomic background of Chinese immigrants widely varies with some immigrating with advanced educational degrees, and others with very low levels of education. Compared to the overall New York City population, the Chinese population has less education, lower English-language skills, lower incomes, and higher working-age and older-adult poverty rates (Asian American Federation, 2013).

There is a dual context of HIV/AIDS risk for Chinese immigrants, especially among the less educated, less skilled and undocumented. First, prior to reaching the United States, they are more likely to be exposed to HIV because many originate from or migrate through parts of mainland China and Southeast Asia with the highest HIV prevalence rates in the region (Wiewel et al., 2015). Among the undocumented, who are more likely to be men migrating without their families, their HIV risk increases en route to the United States via sexual contact with high risk partners or through drug use (Achkar et al., 2004; Chin et al., 2007a, 2007b; Joint United Nations Programme on HIV/AIDS (UNAIDS), 2013). Second, many face significant environmental and behavioral risk factors after arriving in the United States, such as high rates of poverty, low rates of education, low levels of HIV/AIDS knowledge and testing, limited access to medical care, and high levels of risky behaviors (Bhattacharya, 2004; Chen et al., 2015; Chin et al., 2007a; Kang et al., 2005, 2000; Zaidi et al., 2005). Beyond the individual level, HIV/AIDS stigma among Chinese immigrants remains persistent (Chen et al., 2015; Kang et al., 2005). This stigmatization has consequences that increase HIV/AIDS risk, including delays in HIV testing and care (Bhattacharya, 2004; Kang et al., 2011), marginalization and isolation of individuals living with HIV/AIDS (Chen et al., 2015; Chin et al., 2005), increased mental illness due to stress and a heightened sense of shame (Chin et al., 2007b; Kang et al., 2005), and lost opportunities for prevention education (Kang et al., 2000).

1.2. Religion, immigrants, and social capital

Historically, religious organizations have provided immigrants with much more than spiritual and moral guidance. For generations of immigrants, religious organizations have also provided cultural refuge, a wide range of social services, and a sense of community. Their prominence in the community as well as their unique cultural influence and trustworthiness gives religious organizations a distinct leadership role in non-religious issues such as health promotion. Religious organizations are also distinct from political and other forms of community association given their assumed legitimacy, moral imperative and infrastructure to meet a large range of community needs (Guest, 2003; Hirschman, 2004; Putnam, 1995; Putnam and Campbell, 2012; Smidt, 2003). Their multi-faceted role and widespread presence fosters substantial levels of social capital to help immigrants cope with the challenges of acculturation.

Social capital facilitates individual and collective actions that would not be possible in its absence. Some scholars have focused on social capital as an individual-level ability to “secure benefits by virtue of membership in social networks or other social structures”