Center for AIDS Prevention Studies
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what are Asian and Pacific Islander HIV prevention needs?

are A&PIs at risk for HIV?

Asians and Pacific Islanders (A&PIs) are as susceptible to HIV infection as are other racial or ethnic groups. A&PIs are the fastest growing population in the US. From 1980 to 1994, the A&PI population doubled from 1.6% to 3.0% of the total US population. It is estimated that the A&PI population will increase to 4.4% of the US total, over 12 million persons, by the year 2020.[1]

While the number of reported AIDS cases among A&PIs remains small—about 1% of total cases reported in the US[2]—underreporting and a lack of detailed HIV surveillance about A&PIs may mask the true nature of the epidemic among A&PIs. Only the states of California, Hawai'i and New Mexico, local health departments in Los Angeles, San Francisco, Oakland and New York City and the territory of Guam report AIDS cases among A&PIs by ethnicity/national origin.[3]

who are A&PIs at risk?

A&PIs are extremely diverse, comprising over 40 different nationalities that speak over 100 languages and dialects. A&PIs include Chinese, Filipinos, Koreans, Hawaiians, Indians, Japanese, Samoan, Vietnamese, among others.[4] The 2000 Census will count Asian Americans separately from Native Hawaiians and other Pacific Islanders.

AIDS cases by exposure category among A&PIs can be compared to other racial/ethnic populations. The proportion of men who have sex with men (MSM) to injection drug users (IDUs) with AIDS in A&PI men (75% / 5%) is very similar to White men (76% / 9%) and different from Black (38% / 26%) and Hispanic men (44% / 37%). Among women, 46% of A&PI women report sex with an HIV+ or high risk partner as a risk indicator, compared to 39% for White, 36% for Black, and 46% for Hispanic women.[5]

AIDS cases among A&PIs vary by region in the US, with most cases concentrated in the East and West Coasts and in Chicago, Hawai'i and Guam. New York City and San Francisco account for about 38% of total AIDS cases among A&PIs in the US.[5]

what puts A&PIs at risk?

A&PIs are often stereotyped as the "model minority" in terms of health, education and economics. However, A&PIs are often underserved in health care. Because of the rapidly increasing size of and the differences within the A&PI communities, there is still little data on health status and behavioral risks. A&PIs have higher rates of many preventable diseases that are strongly associated with HIV, such as tuberculosis and hepatitis-B.[6] In fact, A&PIs have the highest rate of PCP as their AIDS-defining illness, which might indicate barriers to accessing PCP prophylaxis medications.[7]

Many gay A&PI men do not perceive themselves to be at risk for HIV. For example, a study of gay A&PI men in San Francisco, CA, found that most (57%) of the men practicing anal intercourse used alcohol before intercourse. One fourth (24%) of the men reported unprotected anal intercourse. However, 85% believed they were unlikely to contract HIV and 95% believed they were unlikely to transmit HIV.[8]

A study of Asian drug users not in treatment in San Francisco, CA, revealed that drug users who are hidden from the street drug scene engage in HIV risk behaviors. Patterns of drug use, sexual behaviors and characteristics of social networks among Asian drug users are unique to their ethnicity, gender and immigrant status. For example, Filipino drug users had engaged in riskier behaviors than the other groups, such as having sex with IDUs, having drug using sex partners, and having sex while using drugs.[9]

Immigrant A&PI women who work in massage parlors often engage in activities that put them at risk for HIV infection. However, for many of the women, immediate survival needs take priority over HIV prevention, or even health care. Problems with the police, sex work, immigration, family planning and language barriers all need to be addressed as risk factors for this population.[10]

Says who?

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what are barriers to prevention?

There are cultural, linguistic, economic and legal barriers to HIV prevention among A&PIs. For example, cultural avoidance of discussing issues of sexual behavior, illness and death can be barriers to HIV prevention. In addition, although A&PI MSM are at significant risk for HIV, the lack of peer and community support for sexual and racial diversity often are barriers to self-esteem and positive self-identity.[11] Foreign-born A&PIs may have low or no English skills, and very few programs provide interventions in A&PI languages.[5]

The exclusion of most HIV+ individuals under US immigration law prevents many A&PIs from obtaining permanent immigration status and scares immigrants away from government services such as HIV testing. The disqualification of many immigrants from Medicaid, SSI and other public benefits under the welfare and immigration laws also deters A&PIs from preventive health care, including HIV prevention.[12]

what's being done?

The HIV community planning process requires that states and cities prioritize their HIV prevention based on epidemiology. A&PIs should be prioritized in areas where there is higher incidence of HIV/AIDS cases among A&PIs such as Los Angeles, CA, San Francisco, CA, New York City, NY and Hawai'i. However, in areas where there may be lower numbers of A&PI HIV/AIDS cases reported, it is still important for the community planning group and the health department to collect data about the unmet needs of A&PI communities for HIV prevention.[11]

Effective HIV prevention and education programs for A&PIs can use many culturally appropriate strategies. For example, given strong group and collective norms, it is important to implement interventions that incorporate the entire family and community rather than focus solely on individual behavior change. For more marginalized A&PI populations such as A&PI gay men, peer-based programs are important. Interventions that include the development of nonverbal and other more indirect communication skills also are more culturally appropriate. Outreach activities can be conducted at cultural events, bars, churches and temples, beauty parlors and massage parlors.[13]

One prevention program in San Francisco, CA, used culturally tailored brief group counseling to reduce HIV risk among A&PI MSM. The project fostered positive ethnic and sexual identities by addressing topics such as having dual identities, community, racism and homophobia, and practiced eroticizing and negotiating safer sex. Men who participated became more knowledgeable and more concerned about HIV infection, and reported fewer sexual partners. Chinese and Filipino men reported reductions in unprotected anal intercourse.[14]

what still needs to be done?

Rapidly growing and diverse A&PI communities need comprehensive HIV/AIDS-related surveillance data, including data disaggregated by A&PI national origin/ethnicity.[5] More research on the cultural protective factors and cultural barriers to effective HIV prevention among A&PIs is also needed.[15]

Given that by year 2000 Asia will report the highest number of new HIV infections globally, and given projected immigration and migration patterns of A&PIs, a greater focus on HIV prevention targeting A&PIs living in the US is critical.[5,16]

More resources are needed to develop, evaluate and replicate linguistically accessible and culturally appropriate HIV prevention interventions for A&PI communities. While programs for A&PI MSM must remain a high priority, attention must be focused on other A&PIs at risk, including A&PI youth, transgenders and women. As with all well-developed HIV prevention interventions, it is critical to conduct a community needs assessment, engage members of the target community in the design and implementation of programs, and recruit A&PI community members as paid staff and volunteers.[11,15]

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