APIAHF

Health Brief

ASIAN AMERICANS AND PACIFIC ISLANDERS AND HIV/AIDS

HIV/AIDS

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HIV (Human Immunodeficiency Virus) is the virus that causes HIV disease and can lead to **AIDS** (Acquired Immune Deficiency Syndrome). HIV can severely weaken the immune system, making it difficult for an HIV infected person to fight disease and illness.For some individuals, symptoms may not appear for several years.

HIV is primarily spread through four body fluids in which the concentration of HIV is high: blood, semen/pre-ejaculation fluid, vaginal fluids, and breast milk. Although HIV has been detected in other fluids, its viral concentrations are not sufficient to transmit HIV. There are several modes for transmitting the virus:

- through unprotected intercourse (vaginal, anal, oral);
- through sharing injection drug equipment;
- from an HIV infected woman to her fetus (during pregnancy or birth) or by breast feeding;
- through other direct exposure to infected blood or needle sticks (occupational transmission), open cuts or sores, or other breaks in the skin that would facilitate direct blood-to- blood exposure.

HIV can be detected through an HIV antibody test. These antibodies are produced by the body's immune system when infected with HIV. A person may be diagnosed as HIV antibody positive or negative.

- *HIV positive* means the individual is infected with the virus and is capable of passing the virus.
- *HIV negative* means that the individual is not infected with HIV.

PREVALENCE

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Asian Americans and Pacific Islanders (AAPIs) are just as susceptible to HIV/AIDS as are other racial or ethnic groups. While the number of reported AIDS cases among Asian Americans and Pacific Islanders remains small, lack of detailed HIV surveillance, underreporting, and misclassification often mask the true impact of the HIV epidemic on AAPIs.[1]

- Nationally, as of December 2001, the cumulative number of AIDS cases reported among AAPIs in the United States is 6,157 (5,354 men and 802 women), less than 1% of total cases reported in the U.S.[2]
- Cases vary by region in the United States and territories, with most AAPI cases concentrated in the East and West Coasts, as well as Chicago, Hawai'i and Guam.
- Only the states of California, Hawai'i, and New Mexico, and the Pacific Island jurisdictions report AIDS cases among AAPIs by ethnicity/national origin. [3]

RISK FACTORS

Asian Americans and Pacific Islanders are often stereotyped as the "model minority" in health, education and economic status. However, AAPIs are often underserved in health care.[4] In fact, AAPIs have higher rates of many preventable diseases that are co-factors for HIV infection, such as tuberculosis and Hepatitis B.

MEN account for 87% of cumulative AIDS cases among AAPIs (up to December 2001).

- By exposure category, men who have sex with men (MSM) experience the severest impact of HIV/AIDS among adult/ adolescent AAPI males, accounting for 71% of cumulative AIDS cases, compared to 55% for Native American/Alaskan Native, 74% of White, 42% for Latino and 37% for Black MSM.[2]
- From January 2001 to December 2001, 53% of new AIDS cases reported among AAPI males were among MSM. [2]
- Studies have reported HIV prevalence rates as high as 27% for AAPI gay men in San Francisco and Orange County, CA.[5]

RISK NOT IDENTIFIED

Because many AAPIs face shame and stigma around issues of sex, sexuality, and drug use, many are not aware of HIV risk factors and feel uncomfortable discussing how to protect themselves. Issues of poverty, language and immigration status also cause barriers to accessing prevention and care services. Many health and human service providers do not perceive AAPIs, especially AAPI women, to be at risk for HIV. In most cases, AAPIs learn of their HIV status when they are already very sick, or through mandatory screening. This results in AAPIs failing to receive adequate diagnosis and early treatment.[6]

WOMEN account for 13% of cumulative AIDS cases among AAPIs. Forty-nine (49%) of adult/adolescent AAPI women reported heterosexual sex with an HIV positive or high-risk partner as a risk indicator, compared to 37% for Native American/Alaska Native, 40% for White, 47% for Latina, and 39% for Black women. [2]

An alarming number of AAPI women DID NOT identify what put them at risk for HIV/AIDS.

- Among the cumulative AIDS cases reported in adult/adolescent AAPI women, "risk not reported or indicated" accounted for 22% of the cases. This is the highest percentage among all racial/ethnic groups compared to 20% for Black, 15% for Native American/Alaskan Native, 12% for Latina, and 12% for White women. [2]

- Among cumulative HIV cases reported in adult/adolescent AAPI women, "risk not reported or identified" accounted for 51% of the cases reported compared to 45% for Black, 28% for Native American/Alaskan Native, 49% for Latina, and 31% for White women. [2]

For AAPI men, the numbers without an identified risk are also high compared to other racial/ethnic groups. Among cumulative AIDS cases reported in adult/adolescent AAPI males, 13% of AAPI men reported "risk not reported or identified" compared to Blacks (14%), Native American/Alaskan Native (7%), Latino (10%), and White men (4%). [2]

UNDERREPORTING AND MISCLASSIFICATION

Underreporting and lack of surveillance data on AAPI sub-populations has created barriers to accessing information on risk factors, routes of transmission, and health behaviors.

Even though the CDC has stopped using the "Other" category to report cases for AAPIs and Native Americans/Alaskan Natives, most state and local health departments, still report AAPI HIV/AIDS data as an "Other" category.

Additionally, the number of AAPIs with AIDS may be undercounted because of race or ethnicity misclassification in medical records, the main source of information for case reports. Medical record information does not necessarily reflect patient self-reports or self-identification and is limited by the accuracy of the information obtained by a provider.[3] One analysis of AAPIs with AIDS found the discrepancy between race listed on the AIDS case report and that listed on the death certificate was 45 of 377 (12%), and the discrepancy between the race listed on the AIDS case report and that provided by self-reports was 4 of 12 (33%).[7]

PREVENTION

There are cultural, linguistic, economic and legal barriers to HIV prevention and care among Asian Americans and Pacific Islanders.

There are cultural, linguistic, economic and legal barriers to HIV prevention and care among Asian Americans and Pacific Islanders. Cultural avoidance of discussing issues of sexual behavior, illness and death can prevent AAPIs from obtaining necessary information and services. In addition, although AAPI MSM are at a significant risk for HIV, the lack of peer and community support for sexual and racial diversity also serve as barriers to self-esteem and healthy self-identity. Immigrant AAPIs may also have limited English proficiency, with few programs providing interventions in AAPI languages. [8]

Effective HIV prevention and education programs for AAPIs can use many culturally and linguistically appropriate strategies.

- 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 AAPIs populations such as AAPI gay men, peer-based programs are important.
- Interventions that include the development of non-verbal and other more indirect communication skills also are more culturally appropriate.

OPPORTUNITIES FOR DEVELOPMENT

More resources are needed to develop, evaluate and replicate linguistically accessible and culturally appropriate HIV prevention interventions for AAPI communities.

Rapidly growing and diverse AAPI communities need comprehensive HIV/AIDS-related surveillance data, including data disaggregated by AAPI national origin/ethnicity.[3] More research on cultural protective factors and cultural barriers to effective HIV prevention among AAPIs is also needed. While programs for AAPI MSM must remain a high priority,[9] attention must be focused on other AAPIs at risk, including AAPI youth, transgenders and women.[10] As with all well-developed HIV prevention interventions, it is critical to conduct a community needs assessment, engage members of the target community in design and implementation of programs, and recruit AAPI community members as paid staff and volunteers in HIV/AIDS programs.

RESOURCES

For more information on HIV/AIDS and AAPIs:

- University of California, San Francisco AIDS Research Institute Center for AIDS Prevention Studies, *What are Asian and Pacific Islander HIV Prevention Needs?,* 1998. (Fact Sheet #33E).
- Maldonado, M. *"HIV/AIDS and Asians and Pacific Islanders."* National Minority AIDS Council, 1999.
- Asian & Pacific Islander Wellness Center, San Francisco, CA 415-292-3400 TTY 415-292-3410 www.apiwellness.org
- Asian & Pacific Islander Coalition on HIV/AIDS, New York, NY 212-334-7940 www.apicha.org
- Asian Health Coalition of Illinois, Chicago, IL 773-878-3539 www.asianhealth.org
- Asian Pacific AIDS Intervention Team, Los Angeles, CA 213-553-1988 www.apaitonline.org
- Malama Pono: Kaua'i AIDS Project, Lihu'e, Hawai'i 808-246-9577www.malama-pono.org

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[10]Jemmont LS, Maula EC and Bush E. Hearing our voices: Assessing HIV prevention needs among Asian and Pacific Islander women, *J Transcultural Nursing*. 1999; 10 (2): 102-11.