What are Asian and Pacific Islanders' HIV prevention needs?

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Are APIs at risk?

Asians and Pacific Islanders (APIs) are one of the fastest growing ethnic populations in the United States.1 It is projected that by 2050, APIs together will comprise 8% of the total US population, or 34 million persons.[1,2]

Asians and Pacific Islanders are extremely diverse and represent 49 different ethnic groups and over 100 languages. APIs include Chinese, Filipinos, Koreans, Hawaiians, Indians, Japanese, Samoans and Vietnamese, among other groups. Most APIs live in concentrated metropolitan areas such as Honolulu, HI; San Francisco, CA; New York City, NY and Los Angeles, CA.[2]

Between 2001 and 2004, APIs represented less than 1% of all US HIV/AIDS cases, yet APIs had the highest estimated annual percentage increase in HIV/AIDS diagnosis rates of all race/ethnicities (8.1% for males and 14.3% for females).[3] When populations such as APIs show low prevalence (overall numbers) but high increases in incidence (new diagnoses), prevention efforts are crucial to keep future HIV/AIDS cases low.

Underreporting and a lack of detailed HIV surveillance mask the true nature of the epidemic among APIs. One study found that API AIDS diagnoses may be underreported by as much as 33%.[4] This may in part be due to the misclassification of race and ethnicity in medical records, the source of information for case reports.[2,5] For example, persons with Filipino surnames may be mistakenly recorded as Latino. In addition, the lack of detailed demographic information on specific ethnicity and place of birth makes it difficult to track differences in the AIDS epidemic for API subpopulations and develop ethnically-targeted public health measures.[2]

Who are APIs at risk?

HIV transmission in API men occurs mostly between men who have sex with men (MSM), followed by men who have high-risk heterosexual contact or are injection drug users (IDUs). In 2005, MSM transmission accounted for 71% of all API AIDS diagnoses to date.[6] Among API women, HIV transmission occurs mostly when a woman has sex with a man who is at increased risk, followed by women who are IDUs.[6]

While API MSM are most affected by HIV/AIDS, diagnosis rates among API women have increased (14.3%), as noted above.[3] The CDC does not categorize transgendered women (persons born as men but who identify and live as women), but one study showed a 13% HIV prevalence among API transgendered women in San Francisco, CA.[7]

What puts APIs at risk?

Among API MSM, social discrimination and the lack of family, peer and community support for sexual and racial diversity can negatively impact self-esteem and positive self-identity, thereby increasing their HIV risk.8 In one study, 57% of gay API men in San Francisco, CA, used alcohol prior to engaging in anal intercourse; approximately 24% reported unprotected anal intercourse. However, 85% believed they were unlikely to contract HIV.[9]

APIs have significantly lower rates of HIV testing than the rest of the US population, despite reporting similar rates of risk behavior,[2] and often delay seeking HIV services. In one study of young API MSM in San Francisco, CA, 24.4% of participants had never tested for HIV. Additionally, 2.6% tested HIV+, of whom 61.5% were unaware they were positive, and 38.5% reported recent unprotected sex.[10] Untested HIV+ APIs are more likely to engage in high-risk behaviors and unknowingly infect other persons.[11] Those that delay seeking services are at greater risk of presenting with advanced AIDS at diagnosis and acquiring co-infections like hepatitis B, tuberculosis and PCP.[5,12]

Immigrant API women employed in massage parlors often engage in activities that put them at risk for HIV infection. However, for many of these women, immediate survival needs take priority over HIV prevention. Problems with the police, sex work, immigration, family planning, language barriers, and a lack of condom use policies in parlors all constitute risk factors for this population.[13]

What are barriers to prevention?

Although APIs are often stereotyped as the "model minority,"17% of APIs lack health insurance and cannot receive adequate medical treatment and healthcare services.[14] Because of limited API health and behavioral risk data, resources are often channeled to other populations, without assessing or acknowledging API healthcare needs.[14]

Among APIs, the cultural avoidance of issues such as sexual behavior, illness and death creates barriers to HIV prevention, breeds stigmatization and negatively impacts the psychological and mental health of those living with the illness.[15]

Approximately 40% of APIs are limited English proficient (low or no English skills),[14] and few culturally competent intervention programs exist for ethnically, culturally and linguistically diverse API populations. One study found that language is the most common barrier to receiving healthcare services for APIs with HIV/AIDS.[12]

What's being done?

There are many national and local programs that provide HIV prevention and education services for APIs,16 as well as capacity building and technical assistance efforts for agencies serving APIs.[17] For example:

The Asian and Pacific Islander Coalition on HIV/AIDS (APICHA) developed the Bridges Project, a community-based intervention to reduce disparities in care for HIV+ APIs in New York. It created linkages with hospitals and medical providers, provided case management and advocacy services and offered cultural competency training for providers. It was effective in improving service use and reducing barriers for non-English speaking, Asian-primary-language and undocumented participants.[12]

Life Foundation, in Honolulu, HI, has been running community-level programs for Pacific Islander MSM and transgenders since 1999. "UTOPIA Hawai'i" is based on the Mpowerment model and has been very successful in reaching high risk Pacific Islanders that would have never accessed HIV services before.[18]

The Health Project for Asian Women (HPAW) addressed Asian female sex workers at massage parlors in San Francisco, CA, with two interventions: Massage Parlor Owner Education Program and Health Educator Masseuse Counseling Program. HPAW staff escorted masseuses to health clinics, handed out safer sex kits and provided translation, referrals and advocacy services. Masseuses participated in a 3-session counseling intervention and massage parlor owners received an education session.[13]

Asian & Pacific Islander Wellness Center conducted an anti-stigma HIV media campaign targeting Chinese communities of San Francisco, CA, using bus shelter posters, newspaper advertisements and a documentary featuring local community leaders, people living with HIV and their families. They also lead the annual National Asian & Pacific Islander HIV/AIDS Awareness Day with over fifteen events across the US to increase acceptance of HIV among families and A&PI communities.[19]

What needs to be done?

We have a golden opportunity to keep numbers low among APIs, but that opportunity may be disappearing quickly as APIs have the highest increases in HIV/AIDS diagnosis rates of any racial group in the US. HIV prevention programs for APIs should focus on those at greatest risk, including MSM, women, transgenders and substance users. Programs can help APIs develop and strengthen support systems, as well as focus on prevention and healthcare needs, such as early testing for HIV, hepatitis B and TB. More culturally and linguistically-appropriate prevention and healthcare services for APIs need to be developed and evaluated.

Stigma around HIV, homosexuality, sex work and drug use should be addressed with anti-stigma campaigns that increase discussions on HIV/AIDS prevention and lead to greater acceptance of APIs living with HIV. Collaborating with policymakers and new partners such as faith-based organizations can help to address stigma among APIs.

Given the enormous diversity among APIs in the US, it is important to improve surveillance systems and quality of data and consistently collect information on subpopulation ethnicity and birthplace.[3] Research is needed on HIV and co-infections (hepatitis B and tuberculosis) and on acculturation and its relationship to HIV.

Says who?

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