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## **Let's Not Ignore a Growing HIV Problem for Asians and Pacific Islanders in the US**

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### **Abstract**

Recent analyses reported in the Morbidity and Mortality Weekly Report (MMWR) show that, among all racial groups in the US, Asians and Pacific Islanders (APIs) had the only statistically significant increases in HIV/AIDS diagnosis rates in the most recent four-year period. Yet this fact is not noted in the discussion or editorial notes in the MMWR issue where this information is reported. Because HIV rates in API communities are still relatively low, we have a critical opportunity to develop effective prevention programs for API American communities before these alarming indicators translate into markedly higher HIV prevalence in API communities in the US, as has occurred in other US communities and in the Asia/Pacific region.

### **MMWR's Startling Statistics: A Wake-Up Call**

In 1989, founding members of the Asian and Pacific Islander Coalition on HIV/AIDS (APICHA) in New York City had the foresight to advocate for better reporting of AIDS statistics so that Asians and Pacific Islanders (APIs) and Native Americans would no longer be lumped into the "Other" category. They reasoned that it would be impossible to know what was happening in their communities without adequately disaggregated information. They appealed to James O. Mason, M.D., Assistant Secretary for Health at the US Department of Health and Human Services and head of the US Public Health Service at the time, who agreed with this logic. He enacted changes that for the first time would show AIDS data for Asians and Pacific Islanders and Native Americans in their own categories in public reports.

This important change has allowed us to track HIV/AIDS in API communities over the years, and this information is now readily available to the general public. However, we may not be registering what it is telling us. Although total HIV/AIDS cases and estimated HIV prevalence for APIs in the US are relatively low, there are alarming indicators of rapid increase. Recently, the Centers for Disease Control and Prevention (CDC) published some startling statistics in the *Morbidity and Mortality Weekly Report* (MMWR – the same publication that unknowingly documented the first cases of AIDS in the US when it reported on five cases of *Pneumocystis carinii* pneumonia among gay men in Los Angeles)<sup>1</sup> showing that annual HIV/AIDS diagnosis rates are increasing among APIs in the US faster than in any other racial group.<sup>2</sup> The CDC's analyses, based on a review of HIV/AIDS data covering 2001 through 2004, showed that, of all racial groups, APIs had the highest estimated annual percentage change (EAPC) in annual HIV/AIDS diagnosis rates. The EAPC for API males was 8.1 and 14.3 for API females. In contrast, while African Americans/Blacks continued to have distressingly high annual HIV/AIDS diagnosis rates, rightly called a "state of emergency," they had a statistically significant annual percentage decrease in rates during the same period (-4.4 for males and -6.8 for females).<sup>2</sup>

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In fact, APIs were the only racial group with statistically significant percentage increases in annual HIV/AIDS diagnosis rates, with API women having the largest increase of all. While it is notable that there were also increases for white men and for Native American men and women, these increases were not statistically significant.<sup>2</sup>

According to the MMWR article, “average annual rates of HIV diagnoses . . . were calculated using race/ethnicity- and age-specific census data as the denominators,” indicating that changes in underlying population size were taken into account, especially important given the rapid growth of the API population.<sup>2</sup> There are, however, some limitations to the MMWR information. For example, it is based on the 33 states that have name-based HIV/AIDS surveillance. But this is true for the data for all the racial groups. The MMWR authors note that despite this limitation, the patterns they observed using the combined HIV/AIDS data from the 33 states were similar to those observed using AIDS-only data from all 50 states. One might also argue that we are seeing increases in API diagnoses because of increasing access to HIV testing in the four-year period (2001-2004), rather than because of increases in prevalence. This is a difficult argument to make, since HIV testing availability has likely improved for all groups in that period.

### **Silence in the Community, Lack of Awareness in Government and Research**

From an epidemiological perspective, the fact that APIs are the only group to have a statistically significant increase in HIV/AIDS diagnosis rates is striking, yet this fact is not noted, even in passing, in the discussion or editorial notes in the MMWR issue where this information is reported.<sup>2</sup> A fact sheet on APIs and HIV produced by the CDC two months later also failed to note this important information.<sup>3</sup> Moreover, a very recent MMWR report updating some of the previous report’s data did not include an update of the EAPC data specifically and made no mention at all of APIs in the discussion or editorial notes.<sup>4</sup> Historically low HIV rates among

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APIs in the US may have conditioned us to dismiss what the data are telling us. But we have made this mistake before with devastating results.

To their credit, the CDC and the Health Resources and Services Administration (HRSA), as well as state and local governments and forward-looking private foundations, have proactively funded prevention and care services targeting APIs, and urban areas with major API populations – such as New York City, San Francisco, Los Angeles and Honolulu – have successful community-based AIDS service organizations that specifically target API communities. It is not clear, however, if the resources are adequate to meet the current need or responsive to growing evidence of the rapid increase of HIV in API communities. The MMWR data suggest that something is not working, at least on the prevention side, in API communities.

Regarding the adequacy of health research on APIs, a previous study has shown that for the six areas of disparity in minority health services listed in *Healthy People 2010: Understanding and Improving Health*,<sup>5</sup> including HIV/AIDS, API-focused studies were substantially under-represented in federally funded research, proportional to the API share of the US population (approximately 4% currently and projected to grow to 11% by the year 2050).<sup>6</sup> Similarly, a review of state and local HIV prevention plans mandated by the CDC found that APIs are often not represented in state and local planning bodies, that there are significant gaps in many state and local HIV surveillance systems that still make it difficult to track the epidemic among APIs and the many sub-ethnic groups that make up this category, and that API populations are rarely mentioned in HIV prevention priorities.<sup>7</sup>

A failure to acknowledge the problem can also be found on the community side. HIV/AIDS and associated behaviors, including extramarital sex, homosexuality, and drug use, are highly stigmatized in API communities.<sup>8-16</sup> Silence about HIV/AIDS among API community members may perpetuate the notion that it is not a problem.

### **Contributors to the Growing HIV Problem in API communities**

In fact, the data presented in MMWR should not be surprising given what we have known about HIV risk in API communities. For example, there is accumulating evidence that certain API subgroups engage in relatively high rates of high-risk behaviors, including API heterosexual men having unprotected sex with sex workers,<sup>9, 17</sup> API female sex workers inconsistently using condoms with customers,<sup>18</sup> and API MSM having unprotected anal sex at increasingly higher rates,<sup>19</sup> often while using alcohol or other drugs.<sup>20</sup>

The fact that API women experienced a higher percentage change in HIV diagnosis rates than API men suggests that HIV infection is continuing to move beyond the API subgroups it was most concentrated in (e.g., API MSM) earlier in the epidemic. Although MSM transmission continues to account for the highest proportion of HIV/AIDS cases among APIs in the US, this proportion has been decreasing, while the proportion due to heterosexual transmission among females has been increasing. As noted above, API females nationally (for whom heterosexual sex accounts for 81% of HIV/AIDS cases)<sup>21</sup> had a higher estimated annual percentage change in HIV/AIDS diagnosis rates compared to API males (for whom MSM transmission accounts for 67% of cases nationally).<sup>21</sup>

High levels of HIV stigma in API communities have numerous consequences that affect HIV risk, including delays in HIV testing and care,<sup>17, 22</sup> particularly among undocumented<sup>16</sup> and other foreign-born<sup>23</sup> APIs. Behavioral Risk Factor Surveillance System data show that nationally, APIs have significantly lower rates of being tested for HIV than the rest of the US population, despite reporting similar rates of risk behavior.<sup>21</sup> Given the primacy of family, APIs may delay testing and care for fear of shaming or being abandoned by relatives due to implications of “inappropriate” behaviors (e.g., non-marital sex, homosexual sex, drug use).<sup>9, 17</sup>

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Stigmatization results in marginalization and isolation of individuals living with HIV, poor mental health,<sup>24</sup> and lost opportunities for education and discussion regarding prevention and care.<sup>16</sup>

Compared to other populations, APIs are uninformed regarding HIV, as there are limited linguistically and culturally appropriate sources for information regarding HIV.<sup>25</sup> Many APIs have strong expectations regarding sexual modesty, inhibiting participation in mainstream HIV/AIDS education and frank discussion of high-risk behaviors.<sup>25</sup> Foreign-born APIs may be particularly at risk because of low HIV knowledge. Among recent adult immigrants, inadequate information and low provider awareness in their home countries<sup>16</sup> suggest low levels of HIV knowledge at time of entry. Consequently, API populations may have misperceptions regarding HIV, ranging from denial<sup>9</sup> to fear of transmission through casual contact.<sup>8, 16</sup>

Finally, the fact that AIDS has reached epidemic proportions in parts of Asia, home to 60% of the world's population, may have implications for how HIV/AIDS develops in API American communities. Globally, approximately 8.5 million Asians are currently living with HIV, including 1.1 million infected in 2005 alone (nearly a quarter of the 4.9 million new infections world-wide that year).<sup>26</sup> The combination of the rapid spread of HIV in Asia, continued high levels of bi-directional migration between Asia and the US, and potential sexual network linkages between the infected and uninfected suggests that at least part of the increase in diagnosis rates among API Americans may be related to the HIV epidemic in Asia. In a recent needs assessment study involving in-depth qualitative interviews with 35 HIV-positive APIs, 17 participants discussed their beliefs about how they were infected. Two HIV positive Chinese heterosexual men reported being undocumented immigrants who believed they were infected prior to entering the US during long interim stays in Southeast Asia (up to three years), where they were waiting to be transported into the US.<sup>24</sup> The existence of this pattern of infection is supported by an HIV subtype analysis in a purposive sample of individuals living with HIV in NYC, which included six Chinese immigrant men who stopped in Burma or Thailand for 6 to 9

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months before arriving in the US, during which time they reported having engaged in high-risk activity with female sex workers. Their HIV subtype was found to be the most common heterosexually transmitted subtype in Thailand.<sup>27</sup>

### **Time to Take Stock and Take Action**

Although there are continuing deficits in our HIV surveillance system that create difficulties in tracking HIV/AIDS among APIs, the data we do have provide a warning that we should heed. It is imperative that government agencies highlight this sort of critical data that they have taken great pains to collect and report and also further improve surveillance systems to allow us to understand the way the epidemic is unfolding among the many API sub-groups. Instead of ignoring this disturbing increase in HIV/AIDS diagnosis rates in API communities or dismissing it as an anomaly, government and researchers should make efforts to further our understanding of its causes and implications through additional research. The fact that APIs are the only group showing statistically significant increases in HIV/AIDS rates suggests that API communities should be prioritized for HIV prevention and care programming. Government and private foundations should work with researchers, community leaders and providers toward supporting current HIV prevention and care programs and developing new sustainable, creative, culturally competent and linguistically appropriate programs to stem the increases we are seeing.

This fire may be relatively small right now, but the data reported in MMWR and other evidence indicate that it is growing rapidly and will continue to do so. Data showing relatively low rates of HIV prevalence among APIs for the moment, coupled with data showing that APIs have experienced the highest increase in HIV/AIDS diagnosis rates among all racial groups in the US, together indicate that we have a critical opportunity to develop effective prevention programs before these alarming indicators translate into markedly higher HIV prevalence in API



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American communities, as has occurred in other communities in the US and in the Asia/Pacific region. Let's not miss this opportunity again.

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