A Brown Paper:
The Health of South Asians in the United States

The *Brown Paper* is a groundbreaking compendium and review of health research and literature on South Asians in the United States. Published in 2002, the *Brown Paper* evaluates and summarizes existing knowledge about key health indicators for South Asian Americans.
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HIV/AIDS

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Objectives: The author reviewed available research on HIV/AIDS among South Asian Americans, including cultural issues related to sexuality and family formation, to describe limitations of current data and themes enabling and impeding future work.

Key Findings: Epidemiological data on HIV/AIDS among South Asian Americans is almost non-existent because this populations is usually included in the category of Asian American or Asian American and Pacific Islander. With nearly four million cases of HIV in India, traditional and cultural assumptions about sexuality must be challenged, including among South Asians in America. A few localized surveys of HIV/AIDS knowledge, beliefs, and behaviors, conducted among South Asians in Canada and the US, indicate inadequate knowledge, denial, risky behavior, and a powerful role of community and stigma as potential and actual impediments to HIV prevention.

Recommendations: For all levels of HIV/AIDS data collection and reporting, South Asians need to be identified specifically and accurately. Health promotion and social service agencies must address the knowledge and attitudinal needs of this community in a culturally appropriate manner, if South Asian Americans are to be protected from the HIV/AIDS epidemic.

Introduction: Epidemiology of HIV/AIDS among South Asian Americans

The limited data available on HIV/AIDS epidemiology specific to the South Asian American population are variable, inconsistent, and slow to emerge. Therefore, this paper relies heavily on data for Asian American and Pacific Islanders (AAPIs). Discussion of cultural issues in the US is supplemented with literature on Canada, India, and Pakistan.

The AAPI population accounts for slightly less than 1% of the number of cumulative cases of AIDS in the US, as reported to the Centers for Disease Control and Prevention (CDC) through 2000,[1] although this group represents approximately 4.2% of the US population.[1,2] In 2000, 380 new AIDS cases were reported for the AAPI community, making the rate of new infections 3.4 per 100,000 in 2000.[1] The cumulative known death total from AIDS among AAPIs is 3,055, of whom 2,724 were male and 331 were female.[1]

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[1] US Centers for Disease Control and Prevention. HIVA/AIDS Surveillance Report, 2000; US HIV and AIDS cases reported through December 2000. Atlanta, GA: Centers for Disease Control and Prevention; 2001.
[2] US Department of Commerce. 1990 Census of Population, General Population Characteristics. Washington, DC; US Department of Commerce; 1992.

The disproportionately low reported incidence (new cases reported per year) and prevalence (percentage of cases in the population) may suggest that this population has been relatively spared, and that a study of risk prevention within this population could offer insight into protective factors. Although this possibility must be considered, expansion of the epidemic in South Asia should raise concerns regarding this mobile population. Furthermore, it is critical to evaluate the accuracy of the available data.

It is usually agreed that AAPIs are often under-accounted in health surveys, which raises questions of accuracy in data.[3,4,5] AIDS cases-reporting forms may misidentify people's race and ethnicity, either by relying on misleading information on place of birth or through reliance's on inaccurate sources, such as medical record data or the subjective impression of a reported. Undocumented immigrants are particularly likely to be undercounted. Many barriers to seeking health care in general exist for immigrant communities, including lack of linguistic or cultural accessibility, lack of insurance, lack of awareness of resources, stigma of health issues, and distrust of social services.[3,6] Barriers to seeking HIV testing include stigma, fear of breaches in confidentiality, and US immigration policy.

Furthermore, AAPIs are found to have a higher rate of tuberculosis and hepatitis B, both considered co-morbidity factors for HIV/AIDS, as well as higher rates of pneumocystis carinii pneumonia (PCP), an opportunistic infection associated with AIDS. How these interactions function statistically and in terms of susceptibility to infection is not fully established, but the rates raise concern that AAPIs may be seeking HIV testing late. Thus, it is more difficult to monitor progress of the epidemic in this population and more difficult for AAPIs to benefit from needed interventions.[7,8]

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[3] Eckholdt HM, Chin JJ, Manzon-Santos JA, Kim DD. The needs of Asians and Pacific Islanders living with HIV in New York City. AIDS Education and Prevention. 1997; 9:493-504.
[4] Kelly J, Chu S, Diaz T, Leary L, Buehler JW. Race/ethnicity and misclassification of persons reported with AIDS. Ethnicity and Disease. 1996;1:87-94.
[5] Ghosh, Chandak. Healthy People 2010 and Asian Americans and Pacific Islanders.: Defining a baseline of information. Unpublished.
[6] Synder RE, Cunningham W, Nakazono TT, Hays RD. Access to medical care reported y Asians and Apcific Islanders in a west coast physicians group association. Medical Care Research Review. 2000;57:196-215.
[7] Asian and Pacific Islander Coalition on HIV and AIDS (APICHA). Overview of the impact of HIV/AIDS in Asian and Pacific Islander Communities. New York, NY: Asian and Pacific Islander Coalition on HIV and AIDS (APICHA); 1998.
[8] Eckholdt H, Chin J. Pneumocystis carinii pneumonia in Asians and Pacific Islanders. Clinical infectious Diseases. 1997;24:1265-67.

Table 1: Percentages of Asian American and Pacific Islanders (AAPI) among People Living with AIDS, (PLWA) Compared with Percentages of AAPI in the General Population, for Selected States, 1999.

State	AAPI % of Population	Total Number PLWA	AAPI as % of Total PLWA	Total Number AAPI PLWA
Hawaii	50.9	948	23.1	219
California	10.9	45,220	2.4	1,100
New Jersey	5.7	14,978	.5	68
New York	5.5	54,971	.7	387
Maryland	4.0	9,821	.1	13
Massachusetts	3.4	6,975	08	56
Virginia	3.6	5,725	.6	36
Illinois	3.4	9,889	.7	71
Texas	2.6	23,624	.4	99
Pennsylvania	1.8	3,717	1.2	45
Florida	1.7	34,074	2.0	70
Source: Centers for Disease Control and Prevention, 2001[9]				

Distribution by Racial Categories and Geography

Through December 2000, 5,728 cumulative cases of AIDS have been reported among AAPIs.[1] In 1999, the CDC reported that 2,579 AAPIs were living with AIDS, almost 1% of the 317,368 persons living with AIDS in the US at that time.[10] Because HIV is inconsistently reported by states, it is not possible to know the HIV rate in the national population, but it is important to note that the AIDS data are suggestive of HIV infections beginning up to 10 or more years previous.

Through December 1998, "five states, which account for 63% of the AAPI population in the US, reported 78% of the [AAPI AIDS] cases: California (45%), Hawaii (12%), New York (15%), Texas (3%), and Washington (3%)."[11] Table 1 elucidates this data. In 1997, almost 60% of AAPI AIDS patients were foreign born, but Chin observed in 1998 that this percentage of foreign born was declining in New York City.[12] It is also not known whether exposure occurred in the US or elsewhere. Most of reported AAPI AIDS cases that year were in New York City, San Francisco, and Los Angeles,[9] where large numbers and proportions of Asian American live.

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[9] Sy FS, Chng CL, CHoi ST, Wong FY. Epidemiology of HIV and AIDS among Asian and Pacific Islander Americans. AIDS Education and Prevention. 1998; 10: 4-18.
[10] US Centers for Disease Control and Prevention (CDC). HIV/AIDS Surveillance Report: US HIV and AIDS cases reported through June 1999. Atlanta, GA: (CDC); 2001.
[11] Wortley PM, Metler RP, Hu DJ, Fleming PL. AIDS among Asians and Pacific Islanders in the United States. American Journal of Preventive Medicine. 2000; 18:208-14.
[12] Chin J, Chou M, Patil S. Overview of the impact of HIV/AIDS in Asian and Pacific Islander communities. New York, NY: Asian and Pacific Islander Coalition on HIV/AIDS; 1998.

Most studies fail to provide data on HIV/AIDS for subgroups of AAPIs. Only California, Hawaii, New Mexico, and Pacific Island jurisdictions report ethnic subgroups.[13] A few innovative studies and reports, focusing on selected populations and issues, highlight the need for more population-specific data.[5,14,15,16,17,18,19,20,21,22,,23,24,25]

Table 2. Male Adult/Adolescent AIDS Cases by Exposure Category, Comparing AAPI Population with US Totals, Cumulative Through December 2000

Exposure Category	US Total		AAPI Total	
	Number	%	Number	%
Men who have sex with Men (MSM)	355,409	56%	3,562	72%
Injecting Drug Use (IDU)	140,536	22%	258	5%
MSM and IDU	48,989	8%	184	4%
Hemophilia/coagulation disorder	4,907	1%	70	1%
Heterosexual Contact	29,460	5%	198	4%
Blood transfusion, components, or tissue	4,971	1%	112	2%
Unknown	51,179	8%	586	12%

Source: Centers for Disease Control and Prevention, 2001.[1]

[13] Asian and Pacific Islander American Health Forum. Need for improved data for Asian Americans and Pacific Islanders. Comments on Draft Health People 2010 Objectives. San Francisco, CA: Asian and Pacific Islander American Health Forum; 1998.
[14] Raj A, Bodas A. HIV-related knowledge, risk perceptions and behavior of South Asian women in Greater Boston. Proceeding from Annual Conference of the American Public Health Association. Boston, MA; 2000,
[15] Wong FY, Chng CL, Choi KH. HIV Prevention Among Asian and Pacific Islander American men who have sex with men: theories, research, applications, and policies: Special Supplement to AIDS Education and Prevention 10 (Supplement A). New York, NY: Guildford Publications, Inc; 1998.
[16] Chin D. HIV-related sexual risk assessment among Asian/Pacific Islander American women: an inductive model. Social Science and Medicine. 1999; 49: 241-51.
[17] Sullivan PS. AIDS in men who have sex with men: trends in racial/ethnic groups. Paper presented at the Gay Men of Color HIV Prevention and Research Summit; 1995.
[18] Bannerji K, Gill G. South Asian cultural diversity: issues and areas of discussion related to HIV/AIDS. Toronto, Canada: Alliance for South Asian AIDS Prevention; 1996.
[19] Bhatteracharya G, Cleland C, Holland S. Knowledge about HIV/AIDS: the perceived risks of infection and sources of information of Asian-Indian adolescents born in the USA> AIDS Care. 2000; 12:203.
[20] Bhattacharya G. Drug Use among Asian-Indian adolescents: identifying protective and risk factors. Adolescence. Spring 1998; 33(129): 169-184.
[21] California Department of Health Services. AIDS Registry: Cases reported as December 31, 1996. Sacramento, CA: California Department of Health Services; 1996.
[22] Banerjee K. Deadly silence: Indian-American women and the threat of HIV. Unpublished.
[23] Gunter K, Maticka-Tyndale E, Godin G, Singer SM, Bradet R. Ethnocultural communities facing AIDS: a national study. Beliefs and behaviors related to HIV/AIDS: Report for the South Asian communities. Toronto, Canada: National Health Research and Development Program; 1994.
[24] Gupta N. First national conference on HIV/AIDS and South Asians in the US. Los Angeles, California: August 2001. Unpublished.
[25] Srinavasan S, Guillermo T. Toward improved health: disaggregating Asian American and Native Hawaiian/Pacific Islander data. American Journal of Public Health. 2000; 90:1731-1734.

The available data relate to diverse measures, making generalizations and comparisons impossible. For example AAPIs, who account for 11.1% of California's population in 1998, accounted for 2.5% of the reported AIDS cases.[26] In 1998, new York City, the 79 reported AAPI AIDS cases accounted for 11% of new all new AIDS cases that year; in Los Angeles, 6 cases accounted for 1%, and in San Francisco, 11 cases accounted for 2% of the total new reports. Such divergent figures cannot be generalized to national trends, but demonstrate why national data are inadequate for understanding the impact of the epidemic in diverse localities.

Table 3. Female Adult/ Adolescent AIDS Cases by Exposure Category, Comparing the AAPI Population with US Totals, Through December 2000

Exposure Category	US Total		AAPI Total	
	Number	%	Number	%
Injecting drug Use (IDU)	52,991	41%	110	16%
Hemophilia/ Coagulation disorder	283	0%	6	1%
Heterosexual contact	52,520	50%	346	49%
Blood transfusion, components, or tissue	3,806	3%	100	14%
Unknown	20,504	16%	145	21%
Source: Centers for Disease Control and Prevention, 2001[1]				

Distribution by Exposure Category

Tables 2 and 3 compare the data on HIV/AIDS exposure categories for the AAPI population, **demonstrating** patters for the nation as a whole at the end of 2000. The differences suggest a pattern of HIV/AIDS infection in the AAPI community, which mimics the early stages of the epidemic in the US, suggesting that the epidemic may have reached this population later than others, but it is expanding within this population.[**Error! Bookmark not defined.**,15]

Two important features emerge from this data. First, among AAPI women, the rate of unknown or unspecified exposure category is higher than for Americans overall, 21% as compared with 16%. In addition, the rate attributed to blood transfusions for AAPI women is 14%, as compared with 3% among the general US population, and 2% among AAPI men. (It should be noted that with the small numbers, the significance of these comparisons is uncertain). These features suggest the need to gather more information on how the epidemic is affecting AAPI women in different communities. Several possible explanations may be contemplated: AAPI women may know less about how HIV is transmitted, they may be less inclined to believe that their sexual partner/husband could have infected them, they may feel less reluctant to cite blood transfusion as the source than other possible exposure categories, and/or AAPI women may be less effectively interviewed for information.[16]

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[26] Facer M, Jungkeit M, Chen M. HIV/AIDS among racial/ethnic groups in California. California; California Department of Health Services, Office of AIDS; 2000.

Second, a substantial majority of reported AIDS cases among AAPIs were attributed to sexual contact between men (MSM), 72% among AAPIs, as compared with 56% among all US populations. On reviewing studies of AAPI MSM, Sy et al, found prevalence rates from 1.4% to 27.8%, "…depending on study design, means of recruitment, locations used for data collection, and whether participants self-identify as gay, bisexual, or heterosexual."**Error! Bookmark not defined.**

In 1999 the California Department of Health Services reported 2,284 cumulative cases of AIDS among AAPIs. For 73.2% of these overall and for 80% of males, gay/bisexual contact (G/B) was the reported source of infection, as compared with 70.8% for California overall. California is one of the few states that reports AIDS data by ethnic subgroup: Among the 26 Indian AIDS cases, 16 reported G/B as the source, and among the 10 Pakistani AIDS cases, 7 reported G/B as the source.

Distribution by Age and Sex

Table 4 presents data on the distribution of AIDS cases reported through December 2000, by sex and age at diagnosis, comparing AAPI cases to US totals. In these characteristics, the patterns are similar for AAPIs and for the US population at large.

Table 4. AIDS Cases by Sex, Age at Diagnosis, and Race/Ethnicity, US

Sex and Age at Diagnosis	US Total		AAPIs	
	Number	%	Number	%
Male				
0-12	4,571	1&	27	0%
13-24	21,865	1%	199	4%
25-34	224,113	35%	1,711	35%
35-44	253,633	40%	1,949	39%
45-54	98,669	15%	810	17%
55+	37,170	6%	301	5%
Male Subtotal	640,022	100%	4,997	100%
Female				
0-12	4,337	4%	24	3%
13-24	9,428	7%	49	7%
25-34	49,691	37%	238	33%
35-44	48,056	36%	242	33%
45-54	15,680	12%	101	14%
55+	7,249	5%	77	11%
Female Subtotal	134,441	100%	731	100%

Source: Adapted from Centers for Disease Control and Prevention[1]

HIV/AIDS: Global and South Asian Context

Awareness of HIV/AIDS among South Asian Americans can be stimulated not only educational efforts in the US, but also by concern about how HIV/AIDS affects their countries of origin. One international public health question is whether and to what extent international mobility, such as travel, immigration, study, and business, can lead to cross-national exposure risk. Additionally, South Asians in the US may play significant roles in financial, charitable, and scientific services to their home countries, and may have political impact in stimulating the international and US response to the AIDS crisis around the world.

Data from the United Nations AIDS Program (UNAIDS) for South Asian countries are presented in Table 5. Of the 36.1 million people infected with HIV worldwide, the National AIDS Control Organization of India (NACO) estimates that almost four million are in India (including only those between ages 15 and 49).[27] The most common mode of transmission is thought to be heterosexual sex (83%), although the full variety of transmission modalities is found.[28] To understand this data, one must consider that sex work has legal restrictions, but is not completely illegal, and that sodomy is illegal and sometimes prosecuted.

In south Asian nations, complacency and assumptions about traditionally conservative behavior regarding sexuality and drug abuse are being challenged by the data and by more recent reports. The NAZ Foundation and the Humsafar Trust have conducted valuable studies on the behaviors of men who have sex with men in India, Bangladesh, and Pakistan.[29,30,31,32,33,34,35,36] Popular Indian news magazines available in the US have published stories about professionals and business class individuals in India whose lives have been devastated by the disease.[37] The same complacency and assumptions about

[27] National AIDS Control Organization (NACO). HIV/AIDS Indian scenario, HIV sentinel surveillance round, NACO; 2000
[28] National AIDS Control Organization (NACO). Indian Scene, Monthly Update, NACO; 2001.
[29] Khan S. Culture contexts of sexual behaviours and identities and their impact upon HIV prevention models; an overview of South Asian men who have sex with men. Indian Journal of Social Work. 1994; 55.
[30] Khan S. Culture, sexualities, and identities. Men who have sex with men in India. Journal of Homosexuality. 2001; 40:99-115.
[31] Asthana S, Oostvogels R. The social construction of male 'homosexuality' in India: implications for HIV transmission and prevention. Social Science and Medicine. 2001; 52:707-721.
[32] Mackay, Tim. Naz Foundation International. Sexual health of males in South Asian who have sex with males. London, UK: John Snow, International; 2001.
[33] The Humsafar Trust. A baseline study of knowledge, attitude, behavior and practices among the men having sex with men in selected sites of Mumbai. Mumbai, India: 2000.
[34] Baweja H, Katiyar A. The Indian face of AIDS. India Today. 1992;40-48.
[35] Bolinger RC, Tripathy SP, Quinn TC. The human immunodeficiency virus epidemic in India: current magnitude and future projections. Medicine. 1995; 74:97-106.
[36] Katiyar A. Brothers to bedrooms. India Today. 1995;114.
[37] Baria F. AIDS striking home. India Today. 1997;59-65.

"traditional behavior" are beginning to be challenged in the South Asian communities in North America.[18,38]

South Asian Cultural Values, Acculturation, and HIV

Highlighting similarities in traditional cultural forms among South Asian Americans may obscure significant differences, such as group differences based on religion, region of origin, length of time since immigration, as well as individual differences. Yet common features of South Asian culture have important bearing on HIV/AIDS issues for this population, especially when considering public health promotion and health care initiatives.[39]

Defined hierarchies have traditionally structured much of South Asian life. Roles and responsibilities are traditionally set forth for family members, as are responsibilities of families to the community. The individual's identity is, to a large extent, formed by and imbedded in his or her internalization of family and community expectations.[40,41,42]

Individuals and families hold well-understood expectations of caring for, and being care for by, each other and the community. Each individual's behavior, reputation, and action reflect upon the family and the community.[18,42,43] In this context, "who you are" is understood to define "what you do." And "what you do" is dictated by "who you are." This way of defining individual identity is quite different from the mainstream American values of individuals and self-actualization, implicit in much of public health promotion.[18,44,45,46]

The prescribed responsibilities of young people include studying preparing for adulthood, and responding to parents' expectations. Individuation is not seen as one of the goals of adolescence. Parents, when able, extend financial support to children well into adulthood, and adult children expect to provide for their parents. Discussion of sex is discouraged in

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[38] Lee S, Ejanda A. Asian and Pacific Islander HIV Needs Assessment in Georgia, 1999-2000. Center for Pan Asian Community Service, Inc.; 2000.
[39] Chng CL. Providing culturally competent HIV prevention programs. American Journal of Health Studies; 2000.
[40] Desai PN, Coelho GV. Indian immigrants in America: some cultural aspects of psychological adaptation. In: Saran P, Eames E, eds. Praeger; 1980:363-87.
[41] Durvasula RS, Mylvaganam GA. Mental health of Asian Indians: Relevant issues and community implications. Journal of Community Psychology. 1994; 22:97-108.
[42] Hines PM, Garcia-Preto N, McGoldrick M, Almeida R, Weltman S. Intergenerational relationships across cultures. Families in society: The Journal of Contemporary Human Services. 1992; 323-38.
[43] Kakar S. Male and female in India: identity formation and its effects on cultural adaptation. In: Brown RH, Coelho GV, eds., Volume 38. Williamsburg, Virginia: Department of Anthropology, College of William and Mary; 1986:27-41.
[44] Roland A. In search of self in India and Japan. New Jersey: Princeton University Press; 1988.
[45] Bharat S. HIV/AIDS and the family: issues in care and support. The Indian Journal of Social Work. 1995:177-94.
[46] Alliance for South Asian AIDS Prevention (ASAP). Discrimination and HIV/AIDS in South Asian Communities. Toronto, Canada, Alliance for South Asian AIDS Prevention; 1999.

the home. Marriage is traditionally viewed as responsibility of all young people to the family and community. Sexual activity is considered acceptable only within marriage, or between same-sex partners, is discouraged and kept secret, although these activities have been known in South Asian society, art, and literature, throughout history.[29,32,47,48,49,50,51,52,53,54]

In this context, stigma becomes more than an individual concern. Loyalty, commitment, and fulfilling one's duty are expressed through protecting one's family and community from shame. An individual's fear of being ostracized because of negative, stigmatizing attitudes of one's family and community can be compounded by concern for the welfare of one's family in the community, even concern for the community as a whole.[46] In these ways, the power of external stigma can be further magnified by internalization.

In addition to the roles of stigma as a potential deterrent to seeking HIV information, testing, and treatment, thee impact of perceived community norms upon individual behavior, in the context of these traditions, is not well understood. A number of authors have investigated the mean, in the South Asian cultural context, of men having sex with men, suggesting that such activity may often not be seen as defining one's sexual identity.[29,30,31,48] Some US-based studies have considered how being gay-identified affects HIV risk behavior, including among AAPI populations, and have found that not having a defined gay identity increases risk behavior.[55]

Cultural values supporting strong family and community loyalty, duty, and support can, in these ways, deter individuals and communities form undertaking HIV/AIDS prevention education and from providing support to the affected individuals and families.[18] The same cultural values of loyalty, duty, support, and security for family and community can also be powerful in encouraging families and communities to provide preventive education and to reach out to those members who may be affected by illness, or those potentially at risk.

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[47] Nag M. Sexual behavior and AIDS in India. New Delhi, India: Vikas Publishing House Pvt. Ltd,;1995.
[48] Khan B. Sex, Longing and not belonging: A Gay Muslim's Quest for Love and Meaning. Oakland, CA: Floating Lotus Books; 1997.
[49] Khan S. Culture and sexuality: as assessment of our communities. London, UK: The Naz Project; Publication date not given.
[50] Ratti R. A lotus of another color: an unfolding of the South Asian gay and lesbian experience. Boston, MA: Alyson Publications, Inc.; 1993.
[51] Murray S, Roscoe W. Corporealizing medieval Persian and Turkish tropes. In: Murray S, Rocoe W, eds. New York: New York University Press; 1996:132-41.
[52] Mutjaba H. The Other Side of Midnight: Pakistani male prostitutes. In: Murray A, Roscoe W, eds. New York: New York University Press; 1996:267-74.
[53] Naqvi N, Mujtaba H. Two Baluchi buggas, a Sindhi zenana, and the status of hijras in contemporary Pakistan. In: Murray S, Roscoe W, eds. New York, NY: New York University Press; 1996: 262-66.
[54] Cohen L. The pleasures of castration: The postoperative status of hijras, jankhas and academics. In: Abramson PR, Pinkerton SD, eds. Chicago, IL: The University of Chicago Press; 1995:276-304.
[55] Chng CL, Geliga-Vargas J. Ethnic identity, gay identity, sexual sensation seeking and HIV risk taking among multi-ethnic men who have sex with men. AIDS Education and Prevention. 2000;12(4):326-39.

For South Asian Americans, some of the traditional values may have provided some protection from the HIV/AIDS epidemic in the US in terms of population-wide statistics. How this situation may be affected by acculturation for this population is unknown. Data are not yet available, for example, to indicate whether the possible tendency of initiating sexual behavior later is protective, or if a lack of knowledge or beliefs about sexual risk increases risk. In a national study of 5,385 White and 408 AAPI high school students (not identified by sub-group), Hou and Basen0Engquist found, "White students were 2.7 times more likely to be sexually experienced, and 2.5 times more likely to use alcohol or other drugs before sex than AAPIs." They also found however, "there were no significant differences between these two groups in the age of initiating sex, the number of lifetime partners, the proportion of being currently sexually active…and condom use behavior."[56]

A study conducted by the National Development and Research Institutes of New York found that while the majority of the 165 Asian Indian adolescents surveyed (born in the US) knew that unsafe sex with an HIV-infected individual created a risk of infection, many were not aware of other crucial facts about transmission.[19] In a 1992 survey of 2,026 California high school students, of whom 186 were AAPI, Schuster, et al found that 73% of AAPI adolescents had never had vaginal intercourse, compared with 50% of White, 43% of Latino, 38% of African American, and 48% of other. The AAPI students were also less likely than other groups to have participated in any sexual activity in the past year and were more likely than other groups to have used condoms specifically. They also were more likely to expect parental disapproval for sexual activity.[57]

To the extent that South Asian adolescents experience acculturation stress and family conflict they may be more vulnerable to engaging in risk-taking behavior, such as alcohol and drug abuse, which in turn can contribute to further risk-taking behavior such as unsafe sexual activity.[20] Thus, neither the stress of the acculturation process, nor the potential impact of becoming increasingly acculturated as a population, are understood well enough to gauge the impact upon HIV risk or protection for South Asian Americans.

Conclusions

Although the strength of cultural traditions may have served thus far to provide some protection from the HIV epidemic for the South Asian American community as a whole, there is no evidence to support complacency in this matter. There are also reasons to be concerned for the welfare of affected individuals and families within this population. Indeed, stigma and complacency can inhibit realistic surveillance, prevention education, community support, and use of available treatment. Individuals already impacted by the infection, and those who may be at risk, need culturally appropriate and accessible education and services from the South Asian community, from mainstream GLBTQ

[56] Hou SI, Basen-Engquist K. Human immunodeficiency virus risk behavior among White and Asian/Pacific Islander high school students in the United States: does culture make a difference? Journal of Adolescent Health. 1998; 23:221-31.
[57] Schuster MA, Bell RM, Nakajima GA, Kanouse DE. The sexual practices of Asian and Pacific Islander high school students. Journal of Adolescent Health. 1998; 23:221-31.

support systems, and from the general public health community. By building upon the strengths inherent in the South Asian community's particular heritage, it is reasonable to hope that such coordinated efforts may be able to hope that such coordinated efforts may succeed in minimizing the negative impact of the epidemic, both in terms of infected individuals and in terms of negative social experiences for those most directly affected.

For AAPI communities, there is a public health reality: "Once upon a time, some people believed that Asians were immune to AIDS…but that has been proven wrong. Its not who you are, its what you do." A culturally appropriate outreach brochure from one organization working with Asian groups emphasizes, "The Banyan tree is… a symbol of inner peace and harmony. Its large branches have provided shelter and its deep roots have provided support to travelers and immigrants for thousands of years. Through our Banyan Tree Project we hope to extend the same support and comfort to persons living with HIV/AIDS."[58],[59]

Recommendations

The recommendations emerging from this review and work of others fall into four interrelated areas: data collection and surveillance, design of educational, prevention and outreach services, community involves, and resource allocation.[60] The importance of culturally and ethnically appropriate public health studies, health promotion, and health care services must be recognized at all levels.[61,62] Several organizations and consultations have made valuable recommendations, which should be considered when working on issues of HIV/AIDS in the South Asian American communities.[13,24,25,63]

Data Collection and Surveillance

- The CDC, Health Resources and Services Administration, the US Census, and all state, territorial, and local health departments should collect and disaggregate data regarding Asian Americans by ethnicity, primary language, nation of birth, and nation of family origin.[13]

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[58] Asian Human Services of Chicago. Once upon a time…Chicago, IL: Asian Human Services of Chicago; 1997.
[59] Asian Human Services of Chicago. The Banyan Tree Project. Chicago, IL: Asian Human Services of Chicago; 1999.
[60] Yep GA. HIV/AIDS in Asian and Pacific Islander communities in the US: A review, analysis, and integration. In: Buchanan D, Cernada G, eds. Amityville, New York: Baywood Publishing Company, Inc.; 1998: 179-201.
[61] Improving Access to Services for Persons with Limited English Proficiency. Executive Order #13166;2000.
[62] National Asian and Pacific Islander HIV/AIDS Policy Recommendations. 1996.
[63] Nemoto R, Wong FY, Ching A, Chgn CL, Bouey P, Hanrickson M, et al. HIV seroprevalence, risk behaviors and cognitive factors among Asian and Pacific Islander American men who have sex with men: A summary and critique of empirical studies with methodological issues. AIDS Education and Prevention 1998; 10:31-47.

- Use standardized definitions and categories for face, ethnicity, and national origin in vital statistics and other health data collected at state, territorial, and local levels.[64]
- Collect data on South Asian American intensively in areas where the population is relatively concentrated; over-sampling should be conducted national and locally.[25] Although data from such studies may not be reliably generalized to other communities, without them, important data about substantial segments of the population become lost in national averages.
- Ensure culturally acceptable and valid data collection and understand how beliefs may bear on health behavior, risk taking, and risk prevention.[9,23,65,66]

Design of Educational, Prevention, and Outreach Services for South Asian Americans

- Test the usefulness of ecological models in which theories and strategies of prevention and go beyond the individual to involve families and community.[63,66,67]
- Promote the understanding, through communication strategies, that "AIDS" is an issue belonging to and including the South Asian community.[60]
- Promote the merits and acceptability of help seeking and of providing support, through both interpersonal and indirect, culturally specific communication and outreach.[60]
- Conduct focus groups to elicit culturally specific experiences of stigma, fears, and family and community support, as well as views of AIDS specific public health messages.[46,68] Yep recommends, for example, "Use social influence techniques to change and maintain perceptions of condoms as effective, enjoyable and easy to use."[60]

Community Involvement and Resources Allocation

- Organizations serving South Asian communities need to become highly informed and involved regarding HIV/AIDS risks and prevention. They need to foster the expansion of the South Asian tradition of providing support to community members and families coping with illness.

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- Involve at least a few HIV-affected individuals to help overcome denial and stigma, with regard to the illness itself and with regard to the behaviors associated with illness.[69],[70]
- Agencies and organizations serving the gay, lesbian, bisexual, transgendered, and questioning (GLBTQ) members of the general population, as well as agencies providing HIV/AIDS services to the general population, need to develop culturally appropriate and inclusive programming for the South Asian segment of their communities.[3,9,67]
- Boards, and decision-making bodies of agencies and organizations doing research and providing service, at local, state, and national levels, must represent the diversity of the communities they serve, including South Asian Americans.
- Allocate resources specifically to the tasks of disaggregated data collection; creating and disseminating linguistically and culturally appropriate educational resources; and providing services, support, and treatment that are both culturally and financially accessible.

About the Author

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