ASIAN AND PACIFIC ISLANDER (API) AND HIV/AIDS RISK-RELATED BEHAVIORS

by

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Rodger L. Beatty, PHD, LSW

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Abstract

Description of problem: APIs in the US have experienced an increase of AIDS cases at a rate greater than other ethnic communities due to relatively low levels of knowledge regarding HIV and mechanisms of transmission, the high prevalence of risky sexual practices, and the absence or lack of educational interventions designed to reach API communities. Findings from this study further public health in terms of HIV prevention by providing information about the ideas APIs have about HIV/AIDS. **Objectives:** 1) To describe API knowledge level with regards to HIV/AIDS. 2) To identify HIV risk-related behavioral characteristics of APIs. 3) To identify types of prevention/intervention activities accessible to the API community. **Methods:** This study utilized a descriptive research design. Key informant participants recruited from the University of Pittsburgh Community were interviewed with questions about HIV/AIDS using a "snowball" sampling method, that is, request people's reference to other key informant participants. Subjects were paid $20 for their participation. The data was collected through a single 60-minute tape-recorded interview session in a common setting where the participant would not feel "labeled" in any manner and could openly participate. Confidentiality was guaranteed to encourage honest responses because the participants had to reveal personal information such as HIV status and HIV risk-related behaviors. **Results:** The participants demonstrated good levels of knowledge with regards to HIV/AIDS; the relationship between

HIV and AIDS, and also about ways their community can be at risk. Participants mentioned using condoms as a safe activity that places people less at risk for HIV/AIDS and not using condoms as an unsafe activity that puts their ethnic community more at risk of HIV/AIDS. **Discussion:** The myth that American APIs are the model minority is contradicted as APIs are often underserved in healthcare due to cultural, linguistic and lack of peer and community support for sexual and racial diversity hindering self-esteem and positive self-identity. Therefore, such issues are identified within the API community that are important to consider when developing HIV prevention and education programs, benefiting the target community, health professionals and researchers reaching a diverse population for future studies and interventions being promoted.

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1. INTRODUCTION

Asians in America. The diversity of the Asian American population accounts for more than thirty-two different Asian ethnic groups including Japanese, Chinese, Korean, Filipino, Thai, Vietnamese, Cambodian, Hmong, Laotian, Indonesian, Polynesian, Samoan, Tongan, Hawaiian, Asian Indian, and Guamanian. Within each ethnic subgroup, further differences exist based upon number of years in the United States, place of birth, language, history, immigrant/refugee status, and generation level (Sy et al. 1998). Also, the degree of acculturation for each family member depends upon years in the United States, age at time of immigration, exposure to the Western culture in the country of origin and in the United States, and overall adjustment to their new adopted environment. These factors have created a great deal of heterogeneity in terms of languages, cultural beliefs and practices on many different levels (Lee 2000).

Asian Cultural Values and Beliefs. Cultural themes of filial piety and harmony as well as the experience of oppression and discrimination have, over the years, shaped the disclosure patterns of both men and women of different ages in the API community (Yoshioka et al. 2001). Filial piety refers to the obligation of family members to care for each other, with obligations placed greater on the younger generation to unconditionally respect and care for the older generation and family ancestors and when such a task is not fulfilled, the family feels great shame (McLaughlin et al. 1998). Disclosure of HIV status has become a cultural issue in the API community, especially if they are clients in the health care system. Although there appear to be some differences among each of the sub population in the API culture, they also share a great

deal of common cultural values and beliefs. The similarities in some Asian countries, such as Japan, China and Korea in regards to their histories and origins may have contributed to the commonalities in their cultural values.

Asian cultural values of harmony and avoidance of conflict can affect the disclosure experiences of HIV-positive APIs (Yoshioka et al. 2001, McLaughlin et al. 1998, Lee, 2000). Disclosing HIV status is an emotionally difficult task for any individual. Issues of privacy, vulnerability, identification with a stigmatized role, and feelings of imposition on others arise (Yoshioka et al. 2001). Within the Asian culture the family is the basic unit that keeps the culture together, this means that the individual cannot act and make decisions independently of others in his/her family to fulfill his/her own needs, but must make decisions based on the needs of the entire family (Lee 2000). Filial obligation in the API culture can amplify the shame an individual living with HIV may feel, which may cause them to hide or ignore their diagnosis and isolate themselves from their family (McLaughlin et al. 1998).

The fear of becoming a burden on one's family expressed by the Asian culture is congruent with findings from past research on disclosure. Individuals did not wish to be an emotional burden by causing emotional distress and worry for family members. Their fear is manifested by placing their family members in a position to provide instrumental support which may be difficult, especially among immigrants whose families live overseas and/or are elderly (Yoshioka et al. 2001).

Japanese Cultural/Ethnic Profile. "In Japan, the concept "amae" refers to four principles that guide decision making in traditional Japanese families: One, collective family interests take priority over the interests of the individual; two, harmony must be preserved; three, the family is responsible for caring for its elders; and four, family members are interdependent" (McLaughlin

et al. 1998). Traditionally, the Japanese people attach stigma to emotional and mental problems or what one would call "Karma", which are attributed to genetics, punishment for past behavior or guidance from the family unit. The importance of caring for the parents in the Japanese culture must be looked at by the children with feelings of deep gratitude and happiness that they are able to return the caring that their parents have provided for them in the past. (McLaughlin et al. 1998, Lee 2000).

When it comes to non-verbal communication the Japanese community are typically quiet, polite and would not disagree or ask questions especially when it comes to people of authority. Facial expression and emotional outbursts are discouraged and controlled. They are sensitive to concepts of shame and saving face so explain procedures clearly, making sure to emphasize important details and to elicit feedback from the lcient to make sure that they understand what is being communicated (Lipson et al. 1996). In terms of health practices, donation of organs is not favored since balance and harmony between oneself, society and the universe is highly regarded that dying intact, without any surgeries, is of the utmost importance (Lipson et al. 1996).

Chinese Cultural/Ethnic Profile. Traditional Chinese beliefs center around the harmony, unity, and survival of the family. Hierarchical family relationships take priority over spousal relationships and friendships. The men, especially the first-born son has the greatest authority and responsibility. Women are subordinate to the men, and the children are taught to obey and care for their parents without question or resentment (McLaughlin et al. 1998). The concept of karma is also important in the Chinese culture and affects views of death, dying, and decision making. For example, many traditional Chinese people feel that it is bad luck to discuss illness or death because they believe talking about it can cause it to happen. An early death is often

interpreted as punishment for bad deeds performed in this lifetime or in a past life (McLaughlin et al. 1998).

Non-verbal communication within the Chinese community is based on avoidance of eye contact especially with authority figures which signifies a sign of respect. Asking questions is seen as disrespectful whereas, silence is seen as a sign of respect. Also for the Chinese community to "save face" they may not want to disclose personal information to health providers. When such a situation arise it is best to involve the family especially when addressing information concerning serious or terminal illness (Lipson et al. 1996).

The Chinese community's "concept of health is maintaining balance between Yin and Yang influences, not only in the body but in the environment" (Lipson et al. 1996). When screening or treating Chinese patients be aware of their beliefs and health practices, one such practice is allowing family involvement and participation when diagnosing. Also for communication barriers allow for interpreters to be present (Lipson et al. 1996).

Filipino Cultural/Ethnic Profile. Filipino culture believe that illness is caused by an imbalance in spirit or morals. Many Filipinos believe that most people get what they deserve and that if people behave badly, bad things will happen to them. They may also delay seeking treatment and attempt to care for themselves until there are signs of bleeding or extreme weight loss and then go to a hospital emergency room as a last resort. This culture is also hesitant to express signs of suffering in front of strangers or to discuss emotions with health care workers and may also avoid seeking help because they do not want to be a burden (McLaughlin et al. 1998).

When speaking English most Filipinos have a distinctive accent, and as a health care professional relaying a diagnosis remember to speak slowly and use simple medical

terminologies. They are typically shy and affectionate and have a high regard for authority figures such as nurses and doctors. Explain procedures or surgical intervention clearly, stopping frequently to allow for questions and feedback from the client as far as their level of comprehension of the prognosis. Also most importantly try to involve the clients' family when disclosing treatments (Lipson et al. 1996).

In terms of health practices, eating well is thought and seen as a good way to promote health but this does not necessarily mean that they are eating right. "Screening, if properly asked with due respect to modesty issues, will pose no problem, except in the area of sex and in the case of diagnosis with a poor prognosis. The family is a very strong support to any Filipino, sick or not" (Lipson et al. 1996).

Behavioral Manifestations of Asian Cultural Beliefs. To describe cultural differences in individuals from different racial and ethnic backgrounds, we need to understand and respect the patient's cultural values, beliefs, and practices. By being open minded and respectful toward their beliefs, values, and practices, you can help patients feel more comfortable. One factor that may differ from patient to patient is language. In some instances, those whose English is limited will often speak their native language whenever possible because their explanations and their understandings can be more accurate, and because it is more comfortable. So to overcome this barrier, one must pay attention to the sound of the accents that a provider might deal with most frequently, and by learning the most common substitutions people make. An example would be the usage and pronunciation of the syllables "P" and "F" and "S" for the "sh" sounds by Filipinos. Cultural influences are another factor that differentiates some patients from one another and when treating a patient who is from a different background, it is more effective to look into and check out any assumptions than to go ahead and end up making the wrong

treatment analysis. Some tips that can be followed by caregivers in treating patients from other cultures are: avoid making judgments about the patient's beliefs and practices, ask questions that would help you, as the provider, learn about the patient's view of his/her condition, and find out what other treatments the patient is using. By obtaining the confidence of the patient to communicate, the more they will become comfortable and adhere to treatment more readily. This leads us to the aspects of communication, which is not just limited to language. Communication is also expressed through facial expressions, body language, and tone of voice. Each of these plays a much greater role in cultures where people prefer indirect communication and talking around issues. This type of communication is relevant among the Asian culture in which directness in expressing negative feelings or information is discouraged. Also, in much of Asia, it is nearly impossible to say "no" directly because it not only signals disrespect, but also may cause the individual to feel inadequate. This type of taboo may pose a significant barrier between patient/provider relationship, especially when it comes to treatment procedures and in obtaining critical information from the patient. Gestures and facial expressions, which demonstrate emotions such as joy, affection, anger or being upset, are also other essential forms of communication that differ from culture to culture. For example, most Koreans are taught that laughter and frequent smiling make a person appear unintelligent, so they prefer to wear a serious expression. While Americans widen their eyes to show anger, Chinese people narrow theirs, while other cultures such as the Vietnamese culture consider anger a personal feeling and not something that must be displayed in public. Smiling and laughter may be signs of embarrassment and confusion on the part of some Asians. Distance and touch between cultures can be interpreted in different ways. For example, in the American culture, people are expected to stand about an arm's length apart when talking in a business situation, as being any closer is

reserved for more intimate contact or seen as aggression. In much of Asia, where cities are crowded and space is at a premium, jostling and bumping in public places are not seen as intrusive or inconsiderate and do not require apologies. Touching, such as a handshake, is generally accepted as a standard greeting in business, yet the kind of handshake differs. For example, in Asia a soft handshake with a second hand brought up under the first is a sign of friendship and warmth. Touching the head, even tousling a child's hair as an affectionate gesture, would be considered offensive by many Asians. Finally, cultures have different views on which topics are suitable for conversation while other topics are better left unsaid. For example, many Asian groups regard feelings as too private to be shared. In the Latin culture, it is generally appreciated when inquiries are asked about family members, while most Arabs and Asians regard feelings as too personal to discuss in business situations. So for the healthcare professional who needs personal information, particularly in sensitive areas involving intimate behavior and bodily functions in conducting assessments, it is less intrusive to spend time building trust and getting to know the individual and if necessary conduct such discussions in a soft unobtrusive tone.

Sexual Behaviors of Asian Americans. Asians living in the United States indicate differences in sexual conservatism from their counterparts living in Asian countries. Asian Americans were less likely than blacks and whites to have ever engaged in vaginal or oral sexual behavior. Asians were more likely to wait a slightly longer time before engaging in sexual activity with a new partner. In addition, they began vaginal sexual activitiy approximately half a year later than white participants. Although Asians tend to be more sexually conservative in initially engaging in vaginal sexual behavior, they do not differ from blacks, latinos, or whites in the average number of anal sexual partners per year (Lee 2000). Despite current low incidence

of HIV/AIDS for Asian Americans, research suggests that Asian Americans practice sexual behaviors that may place them at risk of HIV infection.

Observations or prior scientific findings that serve as the basis for this study report that there has been an increasing risk of HIV infection among APIs. These findings have concluded that there are several factors associated with such an increase: API cultures are generally reluctant to talk about sexuality with others of Asian descent (Jemmott et al. 1999, Matteson et al. 1997, Hoang et al. 1985), APIs are generally less knowledgeable about HIV transmission and prevention than other racial/ethnic groups (Yoshioka et al. 2001, Matteson et al. 1997, Hoang et al. 1985), APIs engage in behaviors that may place them at risk for HIV infection (Grunbaum et al. 2000, Harachi et al. 2001, Choi et al. 1996, Hoang et al. 1985), sexual conservatism, family values, accentuation on social order, control of emotions and feelings, and parental expectations could affect API's HIV risk-related behavior and getting tested (Yoshioka et al. 2001, McLaughlin et al. 1998, Hoang et al. 1985), topics such as illness, death, sexuality, and homosexuality are considered taboo (Ramirez-Valles 2002, Yoshioka et al. 2001, Jemmott et al. 1999, Matteson et al. 1997, Hoang et al. 1985).

According to Wilson et al. (2004) the rates at which API gay men engage in HIV risk behaviors, particularly unprotected anal intercourse, has been reported to appear higher than other ethnic groups which places this group at high risk for HIV infection. Understanding the social contexts in which API gay men negotiate their sexuality and sexual behaviors may be highly relevant to our understanding and awareness of what places these men at risk (Wilson et al. 2004, Yoshikawa et al. 2004). Studies have shown that experiences of racism, homophobia, and anti-immigrant discrimination are just some of the predictors that places API gay men at risk (Wilson et al. 2004, Yoshikawa et al. 2004). Vietnamese homosexual men may be at highest risk

for HIV infection in the Vietnamese American population because of their preference for Anglo men who likely have a much higher incidence of HIV infection (Carrier et al. 1992). This preference for Anglo men was best described by Matteson (1997) and it states that seventy-one percent of those who gave reasons for prefering white partners stated that men of their own racial group do not fit their ideal of masculine attractiveness; they usually elaborated that they preferred men who were big, were thick muscled, or possessed other physical traits less common in Asian men. Furthermore, Carrier et al. (1992) asserted that the sexual activity of Vietnamese men with non-Vietnamese prostitutes and Thai and Vietnamese prostitutes may spread HIV infection into the heterosexual population.

2. LITERATURE REVIEW

HIV and AIDS: Human Immunodeficiency Virus (HIV) infection has been known to elicit a wide spectrum of disease states. It ranges from no symptoms to death from an opportunistic infection or malignancy. With no current cure or immunization against HIV, prevention of transmission is probably the only means of controlling this devastating epidemic (Faryna 1997).

What happens? HIV is the accepted term, worldwide, for Human Immunodeficiency Virus, the virus that causes Acquired Immunodeficiency Disease Syndrome (AIDS), which was named in 1983 (Grantham 1998). HIV is a retrovirus that infects and attacks T-4 lymphocytes, which are white blood cells also called CD4. T4 helper-cells are the main disease fighters of the body so damaging these cells can affect a person's disease-fighting capability and general health (UNAIDS 2004). Once the virus injects its ribonucleic acid (RNA) into the cell and attaches to the deoxyribonucleic acid (DNA) of the host cell and becomes part of the cell's genetic material, the virus replicates and produces hundreds of thousands of its own copies as it enters the blood stream. As a result, the number of the virus in the blood rises and the number of CD4 cells in the body declines (UNAIDS 2004). As the battle between the virus and the CD4 cells continues, the balance shifts in favor of the virus and the person becomes more susceptible to various infections. These infections are called "opportunistic infections" because they swarm the body using the opportunity of its low immunity. Opportunistic infections are caused by bacteria, virus, fungus and parasites that are present in the environment. Some of the common opportunistic infections that affect HIV-positive persons are Tuberculosis (TB),

Cytomegalovirus (CMV), Viral hepatitis, Herpes, Human papillomavirus (HPV), and Pneumocystis carinii pneumonia (PCP). HIV-positive persons are also prone to cancers like Kaposi's sarcoma and lymphoma (UNAIDS 2004).

HIV stands for Human Immunodeficiency Virus, which is the virus that weakens the immune system and causes AIDS. HIV is transmitted from one person to another by: contaminated blood products, semen and vaginal fluids by having unprotected anal, vaginal or oral sex without a condom; sharing unclean needles and syringes to inject drugs, steroids or vitamins, sharing needles for body piercing or tattoos; becoming "blood brothers"; and through pregnancy, birth or breastfeeding (AIDS Project Los Angeles 2003).

The Center for Disease Control and Prevention (CDC), Atlanta lists a series of AIDS-defining diseases. These AIDS-defining diseases have established that the infected individual has entered the later stage of HIV infection and has developed AIDS (UNAIDS 2004).

Table 1. Late Stage Symptoms of HIV/AIDS

- Lack of energy
- Weight loss
- Frequent fevers and sweats
- A thick, whitish coating of the tongue or mouth (thrush) that is caused by a yeast infection and sometimes accompanied by a sore throat
- Severe or recurring vaginal yeast infections
- Chronic pelvic inflammatory disease or severe and frequent infections like herpers zoster
- Periods of extreme and unexplained fatigue in combination with headaches, lightheadedness, and/or dizziness
- Rapid weight loss of more than 10 pounds not due to increased physical exercise or dieting
- Bruising more easily than normal
- Diarrhea
- Swelling or hardening of throat, armpit or groin glands
- Periods of continued, deep, dry coughing
- Shortness of breath that increases overtime
- Discoloured or purplish growths on the skin, from mucous membranes, or from any opening in the body
- Recurring or unusual skin rashes
- Severe numbness or pain in the hands or feet, the loss of muscle control and reflex, paralysis or loss of muscular strength
- An altered state of consciousness, personality change, or mental deterioration
- Children may grow slowly or fall sick frequently. HIV positive persons are also found to be more vulnerable to some cancers

HIV in the API Community: Federal health statistics, including AIDS data have presented five standard racial or ethnic categories (white, black, Hispanic, American Indian/Alaska Native, and Asian/Pacific Islander). Under this standard, an Asian or a Pacific Islander is defined as a "person having origins in any of the original peoples of the Far East, Southeast Asia, the Indian subcontinent, or the Pacific Islands" (Wortley et al. 2000). The majority of documented research studies reveal a lack of understanding about HIV, as well as engaging in unsafe behavior. Despite the efforts of many HIV education programs women within the Southeast Asian communities, in view of the strong expectation of modesty in both speech and conduct are able to identify certain behaviors such as prostitution and drug usage as risk factors for transmitting HIV, but have failed to perceive that they are at risk for HIV transmission (Loue et al. 1999). Margolis (1999) has indicated that the lack of knowledge of sexual relations is normally carried over when API individuals arrive in the United States and, are less knowledgeable about HIV than Caucasians, Hispanics, and African Americans. HIV/AIDS is one phenomenon that remains hidden in the Asian Community. One reason to explain this is that cultural restraints inhibit direct discussion of sexual activities and that APIs are generally reluctant to talk about their sexual activities, whether it be homosexual or heterosexual in nature, with others of Asian descent (Matteson 1997). Other issues contributing to the high proportion of cases without risk information among certain API subgroups may reflect language and cultural barriers that impeded risk ascertainment, as well as the number of APIs being undercounted because of race or ethnicity misclassification in the medical records, which is the source of information for case reports (Wortley et al. 2000). According to one study finding by Wortley et al. (2000) and Carrier et al. (1992) there were discrepancies between the 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-report was 4 of 12 (33%) among the API community. While Asian-American college students report lower rates of sexual activity relative to other racial/ethnic groups, once they become sexually active, their risk-taking behavior patterns are similar to those of sexually active young adults in other ethnic groups (Horan et al. 1993).

Human Immunodeficiency Virus poses a very serious health and developmental problem in the Asia Pacific region. Given the size of the population in the region the potential for epidemic growth is very real. Since the 1980s, more than six million people in the region have become infected. It is estimated that more than 500,000 people died of AIDS in Asia in 2000, which is about 1500 a day (WHO 2001). Although HIV was introduced later in Asia than in the rest of the world, and while the annual number of HIV infections in Africa peaked by 1997; it is predicted that infections in Asia will continue to increase well into the next century (Sy et al. 1998). What contributed to this increase were international travel, by sailors, traders, and fishermen who must travel for their livelihood. Their continued overseas contact and reentry from all sides of the globe as well as the steady flow of immigrants from all over the world will significantly impact the widespread diffusion of HIV in the United States and other countries (Sy et al. 1998). In the case of migrant workers and refugees there are major barriers to medical care; not only because of language, religious and cultural beliefs but also the lack of understanding of Western medicine and the inability to use the US health care system effectively (Hoang et al. 1985). For many of these people the US health care system can be confusing and appear culturally inappropriate in a way that it is a foreign concept to them, the health care facilities in the US all appear confusing by nature to the migrant workers and refugees resettling to their new environment (Hoang et al. 1985).

In June 2001, HIV/AIDS statistics and trends in the United States, as reported by the Centers for Disease Control and Prevention, states that there were 793,026 men, women and children diagnosed with AIDS. Of these individuals, 457,667 (58%) have died, between 850,000 and 950,000 people were living with HIV or AIDS, and approximately 40,000 new infections were occurring annually. The cumulative number of people with AIDS, as reported by the Centers for Disease Control and Prevention, 5,922 (1%) were of Asian and Pacific Islander descent. In 2000, it was estimated that 2,840 (1%) of the Asian and Pacific Islander were living with AIDS, while 597 (<1%) were HIV-positive (AIDS Project Los Angeles 2002, CDC 2001).

Despite reported low numbers of cases among API, underreporting and a lack of detailed HIV surveillance about APIs may mask the true nature of the epidemic among this culture (UCSF 2003). According to Chen (1995), there are three reasons APIs are underserved: First, it has been shown that for the past three decades the percentage growth of the API population has far exceeded that of any other in the United States racial or ethnic group. From 1980 to 1994, in comparison to the total US population, the API population doubled from 1.6 percent to 3.0 percent. It is also estimated that by the year 2020 the API population will increase to 4.4 percent of the United States population (Sy et al. 1998). Due to this growing epidemic of HIV/AIDS and the incredible population growth within the API community, many of the public health resources were unable to meet and place the needs of the API population. This lack of resources accounts for the low HIV surveillance of this population, which lacks all the detail, necessary for prevention to be effective. This is because few states collect or report HIV/AIDS surveillance data by Asian and Pacific Islander national origin/ethnicity and several do not report any data on APIs separately. What happens is that these states report data on APIs in an "Other" category.

Second, data regarding the health status of APIs are inadequate. These inadequacies include; significant gaps in the statistics collection by the federal health, misclassification and lack of sufficient ethnically specific data within the API health data (Chen et al. 1995). Since the baseline data for APIs lack this may be a principal reason they were not reported. Also neglecting or aggregating the API group into one homogenous category can mask enormous heterogeneity of health status changes within this population (Chen et al. 1995). Also many epidemiological profiles and needs assessments fail to include data about Asians and Pacific Islanders.

The third reason, according to Chen (1995), is the myth that Asian and Pacific Islanders are the model minority population. This erroneous myth that they can take care of things on their own was disproved when findings showed that the health status of APIs was really poorer than was initially believed. The "model minority" label has implications for the health and economic status of Asian Americans and by recent refugees and immigrants that their health problems are often ignored or trivialized in the Western society.

Furthermore, by describing Asian Americans as socio-economically and educationally successful, the "model minority" myth masks the needs of API communities. When good health is assumed based on this myth of success, specific health problems may be overlooked.

According to data by the USDA Rural Conditions and Trends, while the average API family enjoys the highest median family income among all racial/ethnic groups, APIs also have one of the highest rates of poverty in urban and rural areas. Also the US Department of Agriculture states that, "The disparity between a high median family income and a poverty rate of fifteen percent suggests a high level of income inequality among rural Asian families." And

lastly an estimated twenty-seven percent of API families earn approximately one-quarter of the poverty level for a family of four.

Other issues surround this myth of the Asian and Pacific Islanders being a "model minority community" is the lack of knowledge of cancer risk factors and lack of age or gender relevant cancer screening practice such as performing breast self-examinations, mammograms, or Pap smears as well as liver cancer. In terms of Hepatitis B transmission and prevalence rates this must also be regarded of high priority since the rates among APIs are the highest of any racial or ethnic group. Hepatitis B is a major risk factor for liver cancer and accounts for up to eighty percent of liver cancers. There are also approximately eight percent to fifteen percent of Asian, African, and Pacific Islander populations that are chronically infected with Hepatitis B compared with less than two percent of North Americans; and approximately fifty percent of women who gave birth to Hepatitis B carrier infants in the United States were Asian foreign-born women.

The API's AIDS cases exposure can be comparable to that of other racial/ethnic populations. The proportion of men who have sex with men (MSM) to intravenous drug users (IDU) with AIDS in API men (75%/5%) is very similar to white men (76%/9%), but different from black (38%/26%) and Hispanic men (44%/37%). In the case of API women, forty-six percent report sex with an HIV-positive or high-risk partner as a risk indicator, compared to thirty-nine percent for white, thirty-six percent for black, and forty-six percent for Hispanic women (Sy et al. 1998).

Prevention of HIV high risk behaviors: Currents trends in research in HIV/AIDS now focus on what attributes encourage people to take risks. API communities need more resources to develop, evaluate and replicate HIV-prevention that are linguistically-accessible and

culturally-appropriate interventions (UCSF 2003). With such preventive interventions, individual characteristics that account for high risk techniques can then be developed more efficiently and effectively to combat the spread of HIV/AIDS (Margolis 1999).

Recent statistics show the urgent necessity for HIV-prevention programs that should be both effective and acceptable to the API communities in the United States (Loue et al. 1999). APIs have experienced an increase of AIDS cases at a rate greater than other ethnic communities (Loue et al. 1999), but those infected individuals were indicated to have been born outside of the United States, though they may have acquired HIV infection within the United States (Loue et al. 1999). APIs may be at an increased risk of contracting HIV infection due to relatively low levels of knowledge regarding HIV and mechanisms of transmission, the high prevalence of risky sexual practices, and the absence or lack of educational interventions designed to reach API communities (Loue et al. 1999, Jemmott et al. 1999, Margolis 1999). Margolis (1999) stated that one of the defenses against HIV was implementing an educational campaign to inform people as to what behaviors constituted a high-risk behavior and how the virus spreads. Despite increasing knowledge about HIV/AIDS, signs of effect in terms of the amount of change in behavior, specifically the amount of unsafe sexual behavior, have yet to be seen. Jemmott (1999) summarized challenges to the implementation of HIV prevention in the API community and these are; understanding API culture, which means understanding that they differ in language and dialects, religion, culture, immigration, histories experienced while in the United States, and nationalities. Acculturation and issues of immigration, this is where traditional beliefs, values, thought processes, and behaviors have become modified to customize or adapt themselves into mainstream American culture also understanding the importance of family togetherness in the API community. This challenge focuses on the culture's sexual conservatism, that social order

and control of emotions and feelings are highly valued within the API culture. The last challenge according to Jemmott (1999) is APIs sexual behaviors that they engage in that places them at risk for HIV infection, are the topics such as illness, death, sexuality, and homosexuality which are considered taboo. It is also important for the helping professional to be sensitive to the potential isolation caused by language barriers and fears of family intolerance and rejection. Professionals working with HIV-positive Asian patients must be attuned to issues of family dishonor that their patients may express and the lack of access to support and feelings of isolation that may be associated with this (Yoshioka et al. 2001).

Summary of Literature Review: The American population is changing as a result of immigration patterns and significant increases among racially, ethnically, culturally, and linguistically diverse populations in the United States. Cultural values, beliefs and expectations, sexism and stereotypes, ethnicity or sexual partner, and ethnic identity are some of the pertinent issues which may influence the sexual behavior of the API culture. Their values tend to emphasize harmonious interpersonal relationships, interdependence, mutual obligation or loyalty, and family (Lee 2000). Healthcare organizations and programs, along with federal, state and local governments must implement systemic changes in order to meet the health needs of this diverse population. Focusing on diversity suggests that alleviating a particular problem may require multiple interventions targeted in ways that can be utilized by different groups. Identical packaging of an intervention may be inappropriate and ineffective for all groups. To improve the quality of services and health outcomes, there would need to be high-quality primary healthcare that is accessible, effective and cost efficient. In addition to quality healthcare, there would be a need for healthcare workers who understand the different beliefs, values, traditions and practices

of a culture. With access to quality healthcare, there just might be hope to shape a person's approach to health and illness, especially for people living with HIV/AIDS.

3. STATEMENT OF THE PROBLEM

Asian and Pacific Islanders in the US as research showed have experienced an increase of HIV/AIDS cases at a rate greater than other ethnic communities due to relatively low levels of knowledge regarding HIV and mechanisms of transmission, the high prevalence of risky sexual practices, and the absence or lack of educational interventions designed to reach API communities. The API community consists of a culture that is very conservative that disclosing such private information is tabooed. Thus, causing a great deal of problem when health professionals and clinicians are trying to help patients within this culture or when researchers are trying to propose an intervention to help the API community in understanding about HIV/AIDS as far as their risk and how important it is to protect themselves by seeking testing when necessary and available.

The information gathered will provide the basis for future data-gathering and will give HIV prevention programs information that detail why APIs in the Pittsburgh area do not seek HIV counseling and testing as well as what behaviors place them at risk for HIV infection or re-infection. Also findings from this interview will further the field of HIV prevention by providing information about the perceptions APIs have in regards to HIV risk-related behavior and HIV testing.

4. SPECIFIC AIMS

What this research will accomplish is to gather data to describe about the different barriers that affect APIs from getting or seeking HIV/AIDS testing. As well as explore HIV risk-related behavioral characteristics of APIs, and to describe the differences between actual risk behavior and perceived risk.

The aims of this project are: 1) To identify the knowledge level of the API community with regards to HIV/AIDS in terms of definition, perception and transmission; 2) To identify HIV risk-related behaviors with regards to ways the API community can be at risk and less at risk for HIV/AIDS; and 3) To identify the types of prevention or intervention activities accessible to the API community.

5. METHODOLOGY

Design: This study utilizes an exploratory research design. Key informant participants were interviewed and asked a series of questions about HIV/AIDS. The purpose of this study was to look at API knowledge, attitudes, beliefs, and self-efficacy regarding HIV/AIDS and to assess their views of risk behaviors regarding HIV/AIDS among their own community.

Recruitment of Participants: Participants were recruited on-site within the University of Pittsburgh Community. Participants were volunteer APIs who have a significant role in the community of Pittsburgh (i.e., student or professional). The Principal Investigator used a "snowball sampling" method to attain the study sample that is, request people's reference to other key informant participants and to other resources. The participants were required to meet the following criteria in order to participate in this study:

1. Participants were of Asian American and Pacific Islander ancestry.
   Specifically, both parents were of Asian American and Pacific Islander ancestry.
2. Participants were educated with at least a high school degree or higher.
3. Participants were proficient in English.
4. Participants were between 18-65 years of age.
5. Study sample were consisted of multiple types of sexual orientation.

Procedure: A majority of the data was collected through tape-recorded interview sessions with participants in a common room setting which will be scheduled exclusively for the interview and conducted in a safe, secure area to prevent any disturbance during the course of the interview session. Individuals who fit the criteria and agreed to participate in the study were asked to meet for a single 60-minute session with the Investigator of the research project.

Participants were asked to respond to questions about: one, participant demographic information (i.e., age, gender, race/ethnicity, country of origin, etc.); two, information about where they obtain HIV information; three, whether or not they have been tested for HIV and STD; four, reasons for not being tested; and five, risk behaviors associated with HIV infection including sexual behavior and drug and alcohol use. Other questions were aimed to determine which behaviors APIs consider to be unsafe/safe behavior or behaviors, and of these, what most likely to put them at risk for HIV; which kinds of HIV prevention or education have APIs came in contact with and whether they think that they are at risk for HIV.

Interview and location. Interaction between the participant and Investigator occurred only once. The interviews were conducted with only the interviewer and the participant present in either the interview room or an area where the participant would not feel labeled in any manner and could openly participate. The participants were also guaranteed confidentiality because of the sensitive nature of the study. This confidentiality was assured to encourage honest responses because the participants had to reveal personal information such as HIV status and HIV risk-related behaviors. Participants, having been assured during the initial contact of confidentiality regarding any information they would divulge, were again reminded of this at the outset of the interview. They were also informed that the study was being conducted by a master's student in fulfillment of her research requirement. Prior to starting the interview session, the participants were informed that the session would be tape recorded with a structured set of questions so that the Investigator could compare the results between participants. Upon completion of the interview session those participants who chose to volunteer in this research received twenty dollars for participating.

Confidentiality, risks, and benefits. Participants who agreed to be interviewed were not asked to identify themselves by name or in writing during the course of the interview session. Each potential participant was given a brief description for the purpose of the interview, which addressed the age of possible participant, as well as confidentiality protections, risks, and benefits for participation.

Before the interview was conducted, the Principle Investigator and participant reviewed an information sheet (in place of an assent or informed consent document). Election of whether to participate was determined after assuring confidentiality and participants were given an information sheet that described the research, costs and benefits. Participants were also informed that any questions or concerns they had regarding the interview would be answered by the Principal Investigator and Co-Investigator. Participants were provided with the respective contact information. Protecting confidentiality of participants is of the utmost importance thereby none of the participants were asked to identify themselves by name or in writing.

Strict measures were undertaken to ensure confidentiality of information by maintaining audio tapes in a locked and secure area at the University of Pittsburgh accessible only to the Investigator. Once the audio tapes were transcribed and analyzed, they were erased and destroyed. The benefit of this project is enhanced understanding about barriers for APIs not getting tested for HIV and about their perceptions of HIV risk-related behaviors. The risks of completing this interview are minimal and do not involve any connection between consent form and interview tool, so that the confidentiality of the participant is protected. Safeguards for confidentiality are such that the participants' rights and welfare will not be violated during any phase or in any aspect of the study. The progress of the study was monitored monthly and data collected for a period of two months, at which time the data collection and recruitment period

ended. Each month during data collection, investigators examined participant recruitment, study procedures, benefit-to-risk of study participation, and ensured subject privacy and research data confidentiality. At the end of the two month period, all the data was compiled and analyzed over a three month period. The analysis compared participant responses collated into tables based on gender responses versus ethnicity responses.

6. INTERVIEW SCHEDULE

These are the interview questions used in this research project and are also found in the appendix section **(Appendix B)**.

Demographic information. Participants were asked to report standard demographic characteristics, such as their age, gender, ethnic background, and place of birth, as well as language spoken among their peer group, and how they self-identify their sexual orientation. Other questions that will be asked pertain to what role the participant plays in the community (i.e., whether they are a student or professional).

Where HIV information is obtained. This question indicated where the participants mostly obtain their information about HIV/AIDS and how aware they are to any new and updated news about health issues pertaining to the HIV infection.

Whether or not HIV and STD testing has been sought and the reasons for not seeking testing. Participants were asked questions on the degree of their knowledge and perception about why they have been tested or not for HIV. Examples of questions asked in this section are;

1. How does your ethnic community view HIV/AIDS in general?
2. If someone you knew was interested in the information, how would you explain the relationship between HIV and AIDS?
3. Are you afraid of testing positive for HIV?
4. Do you think you are at risk of being infected with HIV?

Risk behaviors associated with HIV infection. This section of the interview provided the Investigator insight on some of the potential HIV risk-related behavior of APIs and to what degree do they practice such risky behaviors in association with alcohol and drug use and their HIV status.

What APIs consider being unsafe/safe behavior or behaviors most likely to put them at risk or less at risk for HIV. This will show the participants knowledge and experience on what they perceive as risky behavior in terms of their own practices and their community as a whole and whether they feel that they are at risk for HIV based on what they know about themselves.

What HIV prevention or education has APIs came in contact with. The following questions are about HIV prevention services. Prevention entails providing information about HIV/AIDS and risk behaviors related to HIV. This means helping individuals assess their personal risk behaviors, assisting individuals to acquire understanding, adopt attitudes and skills that would reduce risk of HIV transmission, and assisting individuals in developing a risk reduction plan for themselves.

Do they think that they are at risk for HIV? This question assessed personal experiences and how they perceive their own community's behavior with regards to the acquisition of HIV/AIDS.

7. DATA ANALYSIS

7.1. DATA TRANSCRIPTION

1. The demographic questionnaires **(SEE APPENDIX C)** was first organized and grouped in the following order:

    a. Gender
    b. Sexual Orientation
    c. Age
    d. Ethnicity
    e. Country of Origin
    f. Highest level of education
    g. Citizenship
    h. Profession
    i. HIV testing

2. Instead of using atlas (*Atlas.ti*) software to analyze and transcribe the tape-recorded interviews, it was instead decided upon to transcribe the interview tapes manually by the Principal Investigator.
3. The number of participants was small enough that the Principal Investigator transcribed the data by listening to the interviews using a portable head set and listened to the participant responses writing down their answers below the designated question on a blank participant questionnaire template.
4. All participant tape recorded interviews were transcribed within a three week period prior to being grouped and further analyzed by placing in tables for result comparison based on the demographics of the participants and the questions asked during the course of the interview.

5. The tables were grouped and categorized in two ways:

    a. Responses based on gender

        i. Male
        ii. Female

    b. Responses based on ethnicity

        i. Chinese
        ii. Korean
        iii. Japanese
        iv. South Asian
        v. Filipino

7.2. CHALLENGES

1. The biggest challenge encountered was the language barrier, because the majority of the participants were of different ethnic background as the Principal Investigator and since English was not the participants' first language it was difficult understanding some of the responses given by the participants to the questions presented during the course of the interview session.
2. There were portions of the tape recorded interviews that were very hard to understand because some of the participants' thoughts and ideas seemed to on tangent, this means that the participants' answers seemed to skip from one idea to another that the Principal Investigator had to interpret slightly what the participants were trying to convey with their responses.
3. Besides the participants' responses going on tangents there were portions of the tape recorded session that the participants' speech was too low to comprehend because of

certain signs of shyness and embarrassment (i.e., low voice and laughing) detected because of the responses that the participants had to disclose to the Principal Investigator.

8. RESULTS

8.1. PARTICIPANTS' CHARACTERISTICS

The demographic characteristics of the participants are presented in **Table 2**. A demographic profile of the sample reveals that 53.3 percent (n = 8) were female and 46.7 percent (n = 7) were male. The mean age for all participants was 27.2 (SD 3.88). The majority of participants self-identified as heterosexuals (93.3 %), while 6.7 percent identified as a gay male. The age ranges were between 20 to 40 years old; 33.3 percent were between 20 to 25 years old, 53.3 percent between 26 to 30 years old, and the remainder age distribution 31 to 35 years old (6.7 %) and 36 to 40 years old (6.7 %). The ethnic composition of over half of the participants was Chinese (60.0 %), while 20.0 percent were Korean, 6.7 percent were Japanese, 6.7 percent were South Asian individuals, and 6.7 percent were Filipino. None of the participants (100.0 %) were born in the United States, and 14 (93.3 %) admitted to being a non US Citizen while only one (6.7 %) is a US Citizen. The highest levels of education completed by the participants were: 80.0 percent with graduate or professional education beyond college (Master's Degree, Ph.D., MD) and 20.0 percent with a bachelor's degree. In terms of profession 80.0 percent were students and 20.0 percent were both student and working. Participants who did not get tested for HIV accounted for 53.3 percent while 46.7 percent did get tested for HIV within the past five years.

Table 2. Characteristics of Participants (N = 15)

Characteristic	Number	Percent
Gender		
Female	8	53.3
Male	7	46.7
Sexual Orientation		
Heterosexual	14	93.3
Gay	1	6.7
Bisexual	0	0
Lesbian	0	0
Other	0	0
Age		
20-25	5	33.3
26-30	8	53.3
31-35	1	6.7
36-40	1	6.7
Ethnicity		
Chinese	9	60.0
Korean	3	20.0
Japanese	1	6.7
South Asian	1	6.7
Filipino	1	6.7
Country of Origin (Were you born in the US?)		
No	15	100
Yes	0	0
Highest level of education		
Graduate or professional education beyond college (Master's Degree, Ph.D., MD)	12	80.0
Graduate from college	3	20.0
United States Citizen		
No	14	93.3
Yes	1	6.7
Profession		
Student	12	80.0
Student and working	3	20.0
*Tested for HIV		
No (n=4 male), (n=4 female)	8	53.3
Yes (n=3 male), (n=4 female)	7	46.7

* Considering HIV testing, four of the male API participants and four of the female API participants did not get tested for HIV. While three male API participants and four female API participants responded that they had been tested for HIV within the past five years.

9. FINDINGS

9.1. FINDINGS FOR QUESTION #1 (See Table 3)

General view of HIV/AIDS within the API community

Overall, the results of this study suggest several things. The participants had good levels of knowledge with regards to HIV/AIDS. Participants were observed to be low in terms of HIV related risk-taking. This observation was concluded based upon their responses given throughout the interview process which were collated and placed into tables.

The general view of HIV/AIDS within the API community varied in comparing responses based on gender and ethnicity. Examining the common responses it would seem that in general the API community view HIV/AIDS as a scary, incurable and dangerous illness that has not gotten enough attention. This may be due to cultural conservatism within the API community; HIV/AIDS is a topic that is not discussed at all due to feelings of guilt and embarrassment **(See Table 3 question #1)**.

A 26-year-old Chinese male stated:

> I would say most of the Chinese people are very afraid of HIV or they have a very strong fear of HIV or AIDS. When you talk about HIV or AIDS their reactions are something very poisonous and you don't even want to get in touch of it. And to some extent people try to avoid talking about it and don't want put this on the table and seldom discuss with each other.

A 25-year-old South Asian female stated:

> I think it's still not a topic which is discussed generally, they think it's embarrassing to have some questions for the parents or their teachers and even if they want to ask the doctor they don't want to do that, they want to talk on the phone.

Table 3. Asian and Pacific Islander (API) Interview Question Results, Gender versus Ethnicity Responses (Question 1) continued

1. How does your ethnic community view HIV/AIDS in general?

Male	N=7	Percent	Female	N=8	Percent
Scary, incurable, many relate it to some shameful act	2	28.6	They avoid to touch the issue and I think that people are not so aware of HIV	2	25.0
Related to some blood transfusion	2	28.6	Dangerous and harmful for family and for treating	1	12.5
They think it's the same thing	2	28.6	We know what the disease is and how to prevent and treat it	1	12.5
In my community I don't see many people that know the difference between them	1	14.3	You get it from sex and donating blood and IDU's	1	12.5
Not something discussed within the family	1	14.3	Associated with having bad sexual behaviors	1	12.5
It wasn't really a big issue in China	1	14.3	Terrible disease and that they can accept it if people around them have AIDS, they know that it can be spread by blood through an infected needle	1	12.5
They are very afraid and have a strong fear of HIV/AIDS, people try to avoid discussions of any kind related to HIV/AIDS	1	14.3	Problem has not gotten enough attention, they get HIV/AIDS from blood transfusion and illegal blood selling and they don't know how to protect themselves	1	12.5
			It's still not a topic which is discussed generally, they think it is embarrassing to have some questions for the parents or teachers, for the doctors most patients prefer to discuss HIV/AIDS issues over the phone	1	12.5
			My friends are all from different ethnical background but my understanding is that here in the United States they might be less tested and less aware of HIV so they get less likely tested	1	12.5

The above table compares gender ideas on how their ethnic community views HIV/AIDS in general and in the group consisting of male API participants they have indicated that their community view HIV/AIDS as scary, incurable, and related to some shameful act (28.6%) and related to blood transfusion (28.6%) and that HIV and AIDS are the same thing. While female API participants stated that HIV/AIDS was viewed by their ethnic community as an issue that is avoided and that people are not so aware of HIV (25.0%).

Table 3. continued

1. How does your ethnic community view HIV/AIDS in general?

Chinese • They have a very strong fear of HIV or AIDS • People try to avoid talking about it and seldom discuss it with each other • It wasn't really a big issue or probably the issue didn't get surfaced • Scary, incurable disease, related to a shameful act • I don't see many people that know the difference • I don't think they know too much about it • Has not gotten enough attention • It is dangerous and harmful for family and difficult for treating
Korean • They think that it is directly the same thing • Dangerous illness • AIDS is a disease • HIV, they are not sure • Associated with someone having a bad character
Japanese • My friends are all from different ethnical background but my understanding is that here in the United States they might be less tested and aware of HIV
South Asian • I think it's still not a topic which is discussed generally, they think it is embarrassing to have some questions for the parents or their teachers and even if they want to ask the doctor they don't want to do that, they want to talk on the phone
Filipino • I don't think I've met even one Filipino who discussed such matter. I'm assuming that if they don't talk about it they're probably not even concern with it. This is not something I even discuss with my family, but I know that they are aware of it. I'm not comfortable talking to my parents about it but I am with my brothers and sisters

Result summary for Table 3 question #1: In summarizing major common responses between the participants when the interview questions were categorized by ethnicity it was observed that in general HIV/AIDS was viewed as a topic which is generally not discussed which results in them being less aware of the epidemic and not being tested. But what they do know is that it is a scary, incurable and dangerous illness. Also that it is associated with a shameful act.

9.2. FINDINGS FOR QUESTIONS #2, #3, #4 (See Tables 4, 5, 6)

Knowledge about HIV/AIDS

When asked about how the participants would explain the relationship between HIV and AIDS, and also about ways their community can be at risk for HIV/AIDS; most of the participants knew the general definition of HIV and AIDS **(See Table 5 question #3)**. For example, 62.5 percent of the female participants stated, "HIV is a virus," and 37.5 percent stated, "AIDS is the disease".

In terms of ways people in the API community can be at risk for HIV/AIDS both male (28.6%) and female (37.5%) API participants seem to agree that having unprotected sex as one of the most important ways that their community can be at risk for HIV/AIDS **(See Table 4 question #2)**. But in looking at the data categorized by the participants' answers based on ethnicity **(See Table 4 question #2 summary result)**, the three most common responses about ways their community can be at risk for HIV/AIDS were; 1) IDU's, alcohol, and other substance abuse, 2) Blood transfusion, 3) Prostitution and survival sex.

Participants were asked about specific kinds of behavior they consider to be safe and unsafe activities that put people in their community either more at risk or less at risk for HIV/AIDS **(See Table 6 question #4)**. Participants mentioned protected sex by using condoms as a safe activity that places people less at risk for HIV/AIDS and unprotected sex by not using condoms as an unsafe activity that puts people in their own ethnic community more at risk of HIV/AIDS.

Table 4. Asian and Pacific Islander (API) Interview Question Results, Gender versus Ethnicity Responses (Question 2) continued

2. What are some ways people in your community can be at risk for HIV/AIDS?

Male	N=7	Percent	Female	N=8	Percent
Unprotected sex	2	28.6	Unprotected sex	3	37.5
Blood transfusion done in the hospital	2	28.6	IDU's, needle sharing	3	37.5
Homosexual relations	2	28.6	Prostitution	3	37.5
Not enough education	2	28.6	Illegal blood selling	2	25.0
Illegal blood buying and transfusion with some agencies that go to villages, these agencies are using contaminated needles with the virus	1	14.3	Infected blood and body fluid	1	12.5
			Lesions in mouth	1	12.5
			Difficult condom use negotiation	1	12.5
			Avoidance of topic	1	12.5
One night stand	1	14.3	Blood transfusion	1	12.5
Alcohol and other substance abuse	1	14.3	Alcohol and other substance abuse	1	12.5
Discrimination and poverty	1	14.3	Poverty and discrimination	1	12.5
Self-esteem, self-perceptions	1	14.3	Access to health care	1	12.5
Mother-to-child	1	14.3	I only know students and we are not at risk	1	12.5
Misunderstanding about how HIV and AIDS is transmitted and who has it and how doesn't have it	1	14.3	Survival sex	1	12.5

Based on the answers provided by both the male (28.6%) and female (37.5%) API participants they seem to agree that having unprotected sex as one of the most important ways that their community can be at risk for HIV/AIDS. The male API participants also indicated blood transfusion done in the hospital (28.6%) as another important way the API community can be at risk for HIV/AIDS. While the female API participants indicated IDU's and needle sharing (37.5%) and prostitution (37.5%) as most important when it comes to API risk for HIV/AIDS.

Table 4. continued

2. What are some ways people in your community can be at risk for HIV/AIDS?

Chinese • At least for me there is no inappropriate sex behavior, and I have very limited knowledge about how HIV is spread in the population • Lack of education • Casual sex and unprotected sex • Illegal blood buying and selling • Homosexual relations • Blood transfusion • I only know Chinese students and I think we don't get much risk • Unprotected sex • IDU's • Infected blood • Body fluid • Lesions in the mouth
Korean • Unprotected sex • Blood transfusion/donation • Mother-to-child transmission • Homosexual relations • Prostitution • Condom use negotiation more difficult for women than for men
Japanese • Alcohol and other substance abuse • Discrimination • Poverty • Access to health care • Survival sex
South Asian • Blood transfusion • Sharing needles by IDU's • Sex workers
Filipino • Alcohol and other substance abuse • Poverty • Discrimination • Self-esteem, self-perceptions

Result summary for Table 4 question #2: The three most common responses the participants indicated when asked about ways their community can be at risk for HIV/AIDS they mentioned: 1) IDU's, alcohol, and other substance abuse; 2) Blood transfusion and 3) Prostitution and survival sex.

Table 5. Asian and Pacific Islander (API) Interview Question Results, Gender versus Ethnicity Responses (Question 3) continued

3. If someone you knew was interested in the information, how would you explain the relationship between HIV and AIDS?

Male	N=7	Percent	Female	N=8	Percent
HIV might be a virus	4	57.1	HIV is a virus	5	62.5
AIDS is when you start exhibiting symptoms and become susceptible to other diseases	2	28.6	AIDS is the disease	3	37.5
			AIDS is the natural evolution of HIV infection	1	12.5
AIDS is a disease	1	14.3	AIDS is if someone had HIV they will have symptoms because they had HIV first	1	12.5
AIDS might be a kind of symptom when the virus breaks out	1	14.3			
Same thing, just different names	1	14.3	AIDS is if you have that phenotype and it destroys your immune system then you get the disease	1	12.5
I don't know, I'm not sure	1	14.3			
I don't know the difference between HIV and AIDS	1	14.3	People who get HIV can't recover	1	12.5
			AIDS I think is the same as HIV	1	12.5
			HIV is a medical test to show that you have AIDS	1	12.5
			I think there is some subtle difference but I don't know	1	12.5

Both male and female API participants are in agreement that in explaining the relationship between HIV and AIDS both sexes indicated HIV as a virus (57.1% for males versus 62.5% for the females). The female API participants however, stated that AIDS is the disease (37.5%). While 28.6 percent of the male API participants stated that AIDS is when you start exhibiting symptoms and become susceptible to other diseases

Table 5. continued

3. If someone you knew was interested in the information, how would you explain the relationship between HIV and AIDS?

Chinese • I don't know the difference between AIDS and HIV • HIV is a virus • AIDS is the disease • It is the same thing and just different names • AIDS is when you start exhibiting symptoms • I think there is some subtle difference but I don't know • HIV is a positive test to show that you have AIDS • People who get HIV cannot recover • AIDS is if you have that phenotype that will destroy your immune system and then you get the disease
Korean • HIV is something not as dangerous compared to AIDS • HIV is a virus • AIDS is when we start exhibiting symptoms
Japanese • HIV is the virus that causes the disease, you can get infected by the virus but not acquire AIDS. • AIDS is the natural evolution of HIV infection
South Asian • HIV is a virus • AIDS is that infection that's caused by that virus, the disease
Filipino • HIV is the virus that causes full blown AIDS. It is when you sero-convert and you have the virus • AIDS is when your T-cell count if low it's when you may or may not start exhibiting symptoms but that's the level that you start being susceptible to other diseases

Result summary for Table 5 question #3: When the participants were asked how they would explain the relationship between HIV and AIDS within their own ethnic community most of the participants knew the general definition of HIV and AIDS.

Table 6. Asian and Pacific Islander (API) Interview Question Results, Gender versus Ethnicity Responses (Question 4) continued

4. In your own words what kind of behaviors do you consider to be safe and unsafe activities that put people in your community at risk?

Male	N=7	Percent	Female	N=8	Percent
Safe			**Safe**		
protected sex	6	85.7	Protected sex	6	75.0
Avoid blood contamination	2	28.6	Don't use dirty and bloody needles	3	37.5
Free needle exchange	1	14.3	Avoid getting blood and injections in the hospital	3	37.5
Something low risk is unprotected oral sex	1	14.3	Mother-to-child by taking medicines	2	25.0
Monogamy	1	14.3	No multiple sex partners	2	25.0
Go to clean hotels and hygiene issues	1	14.3	Monogamy	1	12.5
			Don't go to dirty clinics to clean your teeth	1	12.5
Unsafe					
Unprotected sex, blood transfusion	5	71.4	Don't swallow ejaculation during oral sex	1	12.5
Sex industry	2	28.6			
Avoid agencies that sell contaminated blood	1	14.3	Healthy sex activities	1	12.5
			Go to big and clean hospitals	1	12.5
IDU's	1	14.3	Prohibit prostitution	1	12.5
Multiple sex partners	1	14.3	Testing the blood for HIV	1	12.5
			Don't go to public places	1	12.5
			Unsafe		
			Unprotected sex	6	75.0
			Bloody needle infection	3	37.5
			Prostitution	2	25.0
			Illegal clinics	1	12.5
			Casual sex	1	12.5
			Blood transfusion	1	12.5
			Accidental needle prick	1	12.5
			Mother-to-child	1	12.5
			Dirty hotels, public places	1	12.5

The table shows 85.7 percent of the male API participants are in agreement with 75.0 percent of the female API participants about protected sex being a safe kind of behavior that puts the API community less at risk for HIV/AIDS. Both male API participants (71.4%) and female API participants (75.0%) indicated that unprotected sex was an unsafe activity that puts their ethnic community more at risk for contracting HIV/AIDS.

Table 6. continued

4. **In your own words what kind of behaviors do you consider to be safe and unsafe activities that put people in your community at risk?**

Ethnicity	Safe	Unsafe
Chinese	-go to clean hotels, clean hygiene -protected sex (using condoms) -avoid casual sex -avoid blood contamination -free needle exchange -HIV testing -prohibit prostitution -monogamy (sex with only one person) -go to clean hospitals -avoid dirty and bloody needles -avoid dirty clinics	-sex other than the vagina -unprotected sex -prostitution -blood transfusion -IDU's -blood contamination -unclean bathrooms -casual sex -one night stand -don't go to illegal clinic
Korean	-protected sex (using condoms) -monogamy (sex with only one person) -don't swallow the sperm during oral sex	-blood transfusion -multiple sex partners -prostitution -one night stand
Japanese	-protected sex by using condoms -not sharing needles -testing the blood for HIV -from mother-to-child by taking medicine	-unprotected sex -sharing needles with someone who's infected -blood transfusion, but it's very rare now -accidental needle prick -mother-to-child
South Asian	-avoid needle sharing -protected sex by using condoms -from mother-to-child by taking medicines	-unprotected sex -sex workers -using unclean infected needles
Filipino	-something low risk would be unprotected oral sex	-unprotected sex

Result summary for Table 6 question #4: In responding to what kind of behaviors the participants consider to be safe and unsafe activities the participants mentioned protected sex by using condoms as a safe activity that places people less at risk for HIV/AIDS and unprotected sex by not using condoms as an unsafe activity that puts people in their own ethnic community more at risk of HIV/AIDS.

9.3. FINDINGS FOR QUESTIONS #5, #6 (See Tables 7 and 8)

Risk Perception

When comparing gender versus ethnicity responses of the participants **(See Table 7 question #5)** about how each of them would feel if they tested positive for HIV a majority of the responses were in agreement that they would feel afraid, scared and frustrated among others. They also viewed it as a life ending situation, not only from the living but from society.

For example a 23-year-old Chinese female stated:

> Yes, I think actually when I hear this news I will be very scared. So the next I would think is why I would get this and probably go several months and years to get peace and then I would go to doctor for help and then tell my family and my friends, I think that they have the right to know that and I would do what I can to protect the other people. I will see the doctor to ask advice and ask if he can cure my disease.

Forty-two percent of the men API participants responded to feelings of frustration and fright while 87.5 percent of the female API participants stated that they would be afraid and scared if they tested positive for HIV.

When asked if they thought that they could be at risk of being HIV infected, 57.1 percent of the male API participants said "yes" and 42.9 percent indicated that they are not at risk of being infected with HIV. However, none of the female API participants responded "yes" to having any possibility of being infected with HIV but 100 percent of them did respond "no" to being possibly at risk of being infected with the infection **(See Table 8 question #6)**.

Table 7. Asian and Pacific Islander (API) Interview Question Results, Gender versus Ethnicity Responses (Question 5) continued

5. Are you afraid of testing positive for HIV?

Male	N=7	Percent	Female	N=8	Percent
Yes			**Yes**		
I would be a little afraid	1	14.3	Yes, I would be very scared and wonder why I got it	2	25.0
Frustrated, scared, depressed, terrible	1	14.3			
Sure although I don't know what positive test mean	1	14.3	I am afraid to test positive and most AIDS patients know that	1	12.5
			Off course I would be afraid, in my country it means execution from social life. Expelled from society	1	12.5
			I would feel terrible, like the world is ending	1	12.5
			Off course, to my knowledge it is a death sentence to get HIV/AIDS	1	12.5
			Yeah kind of, but I think I will spend my time with my family	1	12.5
Total yes answers with reasons	**3**	**42.9**	**Total yes answers with reasons**	**7**	**87.5**
No			**No**		
No, I get tested regularly	1	14.3	I took the test and since I got married we use condoms for protection	1	12.5
I don't think that I would be afraid because I've received higher education and the treatments have become much more advanced	1	14.3			
If I didn't know what it was I would be afraid	1	14.3			
Not knowing about AIDS but now I know more about it and I'm not so Afraid	1	14.3			
Total no answers with reasons	**4**	**57.1**	**Total no answers with reasons**	**1**	**12.5**

In comparing gender responses to feelings of having tested positive for HIV 42.9 percent of the men API participants responded to feelings of frustration and fright while 57.1 percent more responded to having no feelings of fright about testing positive for HIV.

Female API participants (87.5%) stated that they would be afraid and scared among other reasons they have for testing positive for HIV and only 12.5 percent have stated that they would not be afraid of testing positive because of being in a monogamous marriage and that they use condoms.

Table 7. continued

5. Are you afraid of testing positive for HIV?

	Chinese • Yes • I don't think so because I've received higher education and I think now the treatments have become much more advanced • Frustrating, scary, depressed, terrible • Off course, to my knowledge it is a form of death sentence • I would feel terrible, like the world is ending and it would be a big disaster for my life and family • Yes, I would wonder why I got this and then I would go to the doctor for help and then tell my family and friends
	Korean • When I first knew about HIV/AIDS I was afraid • Not knowing about AIDS but now I know more about it and I'm not so afraid • Off course I would be afraid. Because in my country if I had a positive test that means it's execution from social life. Expelled from society
	Japanese • I took the test, now I'm not taking it because I got married and now we have a deal and we use protection. But I'm from the health field so I used to be tested every year
	South Asian • I would feel bad, very bad and I don't believe that it is me that's infected with HIV
	Filipino • No, I have a pretty good attitude about it, I get tested regularly. I've even slipped up and done unprotected sex. I'm aware of my risk level but I do protect myself

Result summary for Table 7 question #5: When asked about how each of the participants would feel if they tested positive for HIV a majority of the responses were in agreement that they would feel afraid, scared and frustrated among others. They also viewed it as a life ending situation, not only from the living but from society.

Table 8. Asian and Pacific Islander (API) Interview Question Results, Gender versus Ethnicity Responses (Question 6) continued

6. Do you think you are at risk of being infected with HIV?

Male	N=7	Percent	Female	N=8	Percent
Yes			**Yes**		
Yes	2	28.6	None of the female API participants thought that they could be at risk for HIV	0	0.0
I think we can be infected when we don't even realize	1	14.3			
I think I have a possibility to be infected and be HIV positive	1	14.3			
Total yes answers with reasons	**4**	**57.1**	**Total yes answers with reasons**	**0**	**0.0**
No			**No**		
No, I'm married	1	14.3	I think I am not, I am careful	1	12.5
I don't think so at all, I'm completely safe	1	14.3	No definitely not, because before I came to the United States I got tested	1	12.5
No, I believe that if you pay attention to hygiene issues and practice safe sex behaviors and know who you Have sex with there should be no Problem	1	14.3	No, but it's not zero, but I will try my best to reduce percentage of that risk	1	12.5
			Don't think so, if I get married and my husband is unfaithful then I might be at risk	1	12.5
			I don't know, but knowing about the risks I can protect myself and avoid risky behaviors	1	12.5
			No, because I have not done such kind of risky behavior	1	12.5
			I don't think so	1	12.5
			No, because most of the time I stay in my room, my office and at home, so I don't think I'm at risk	1	12.5
Total no answers with reasons	**3**	**42.9**	**Total no answers with reasons**	**8**	**100**

When the API participants were asked if they thought that they could be at risk of being infected with HIV, 57.1 percent of the male API participants said "yes" and 42.9 percent indicated that they are not at risk of being infected with HIV.

None of the female API participants responded to a "yes" answer indicating that they could be at risk of being infected with HIV but 100 percent of the female API participants did respond "no" to being possibly at risk of being infected with HIV.

Table 8. continued

6. Do you think you are at risk of being infected with HIV?

Chinese • No, I believe that if you pay attention to hygiene issues and practice safe sex behaviors there should be not problem • No, I don't think so since I don't have sexual relations with anyone • No, I think I'm quite safe because I'm married • Yes • No, because most of the time I stay in my room, office and at home • I don't know, but knowing what HIV is I know how to protect myself • Don't think so, I'm not married then I am not at risk • No, but it's not zero, I will try my best to reduce my percentage of risk • I think I am not, I am careful
Korean • I think we can be infected when we don't even realize • I think I have a possibility to be infected and be HIV positive • No definitely not, because before I came to the United States I got tested and I don't have any sexual relations
Japanese • I don't think so
South Asian • No, because I have not done such kind of behavior at least in my knowledge
Filipino • Yeah, actually to tell you the truth I've done many things and I know that sounds awful but I'm okay

Result summary for Table 8 question #6: In summarizing the responses given by the participants in terms of their thoughts of being at risk of infection, the majority of them indicated they are not at risk. Reasons given by each participant varied; some indicated that they got tested recently, that they are married or are careful and aware of their behaviors, and some have indicated that they do not have any sexual relations with anyone or are not doing any type of risky behaviors therefore they feel that they are not at risk of being infected with HIV.

9.4. FINDINGS FOR QUESTION #7 (See Table 9)

HIV/AIDS prevention or education activities encountered

When asked about obtaining information about HIV prevention or education one Korean female participant stated: "I think my case is a little unusual compared to other Asians because my major is a social work and I work in health education and I had an experience to talking with people. Some people see things in the brochure or the internet, but now I think that the government they advertise to the people using the television commercials. I think also the high schools they speak to the students".

Most of the participant responses varied but what they agreed on was that television (50.0% female, 42.9% male) and the internet (37.5% female, 28.6% male) were the most important place where any HIV prevention or education was acquired; while the responses based on ethnicity most of the participants indicated posters, internet websites and the television. Others have mentioned some type of course taken in high school, books, magazines, and newspapers **(See Table 9 question #7)**.

Table 9. Asian and Pacific Islander (API) Interview Question Results, Gender versus Ethnicity Responses (Question 7) continued

7. What HIV prevention or education have you come in contact with in the past?

Male	N=7	Percent	Female	N=8	Percent
From television or exhibition about HIV and AIDS	3	42.9	Television	4	50.0
			Internet websites	3	37.5
Internet websites	2	28.6	News, media	2	25.0
Some health course when I was in college	1	14.3	My own study	1	12.5
			Some magazines	1	12.5
Posters	1	14.3	Discuss with friends	1	12.5
Classes in high school where they taught us about condoms	1	14.3	I work in health education and I have experience talking with people	1	12.5
Very little, the education has not been there, and this topic have been tabooed and people don't want to talk about this kind of issues	1	14.3	Brochures	1	12.5
			Class discussion	1	12.5
			Newspapers	1	12.5
			Some type of lecture in high school, but it's limited	1	12.5
School orientation where the international cultural office distributed condoms and other materials pertaining to HIV/AIDS (pamphlets), there was also a discussion portion	1	14.3	Books	1	12.5
			School work	1	12.5
			Posters on the streets	1	12.5
			Medical school	1	12.5
			Nothing at all	1	12.5

42.9 percent of male API participants and 50.0 percent of API women participants stated that the television was where they had encountered HIV prevention or education in the past. Also both male (28.6%) and female (37.5%) API participants agreed that the second most important place, the Internet, is where any HIV prevention or education is acquired.

Table 9. continued

7. What HIV prevention or education have you come in contact with in the past?

Chinese • During orientation the international cultural office distributed condoms and pamphlets and held discussion sessions about HIV/AIDS • Through my studies but before that the education has not been there, the topic has been tabooed • Posters, internet websites • Health courses in college and high school • Television • Nothing at all • News • Books • Newspapers • Own study • Magazines • Peers
Korean • Internet • Television • My major is social work and I work in health education and I had an experience of talking with people • Brochures • High school lectures
Japanese • In the beginning stage prevention was only for the MSM population and nothing was done for the heterosexual population. I have never been approached to get tested, and my knowledge is a little biased because I was in medical school, but from what I recall the main target was the MSM
South Asian • In course work • School work • Media, television • Posters on the streets
Filipino • Classes in high school where they teach us about condoms, it wasn't very extensive and there were a lot of things that they didn't say. I think it was minimal and inadequate education

Result summary for Table 9 question #7: The major responses given by the participants in terms of what HIV prevention or education they have come in contact with in the past; most of them indicated posters, internet websites and the television. Others have mentioned some type of course taken in high school, books, magazines, and newspapers.

9.5. FINDINGS FOR QUESTION #8 (See Table 10)

When the participants were asked on what they thought about the prevention or education activities that they have obtained in the past fifty percent of the women participants indicated that it had an effect in their attitudes and behaviors about HIV while the other fifty percent indicated that it did not have any effect in their attitudes and behaviors about HIV. For the male API participants 85.7 percent responded "yes" and 14.3 percent replied "no" to having any of their attitudes and behaviors affected by any of the HIV/AIDS prevention activities they have come in contact with in the past. In terms of the responses based on ethnicity the majority of the participants indicated that the activities encountered did have an effect in their attitudes and behaviors. Several reasons mentioned were that they learned that HIV/AIDS is preventable, knowing about the issues it has corrected a lot of wrong concepts about the epidemic and that it kept people on the look out about the dangers of being infected **(See Table 10 question #8)**.

One 37-year-old Japanese female participant stated when asked about how the prevention or education activities encountered affected her life, "It affected me that I needed to take more care. I kept track of the whole epidemic since the beginning since I've been working with them in the health field".

Table 10. Asian and Pacific Islander (API) Interview Question Results, Gender versus Ethnicity Responses (Question 8) continued

8. Do you think that these activities had any effect in your attitudes and behaviors about HIV?

Male	N=7	Percent	Female	N=8	Percent
Yes			**Yes**		
Yeah I think so, before I would be afraid of any contact with someone who has HIV/AIDS, but now I have better knowledge of how it is transmitted	1	14.3	I think that it's useful, most of us have some common sense about this issue	1	12.5
			I think so, I believe that they tell me the truth	1	12.5
			Yeah I think so, I'm more confident	1	12.5
Yes, I learned more, and my attitude changed towards those that are infected	1	14.3	in my attitude toward sex and I know of efficient ways to protect myself		
			It affected me that I needed to take	1	12.5
I would certainly think so, knowing a little about yourself, has corrected a lot of wrong concepts I had before	1	14.3	more care. I kept track of the whole epidemic since the beginning since I've been working with them in the health field		
I understand more about HIV/AIDS through the internet and television	1	14.3			
I realized that one of the pathway of the disease is by blood transfer	1	14.3			
Yes, somehow it has changed my perception and behavior about every American being at risk of HIV/AIDS, that HIV or AIDS is preventable and I know a lot more about how it is spread	1	14.3			
Total yes answers with reasons	**6**	**85.7**	**Total yes answers with reasons**	**4**	**50.0**
No			**No**		
It was limited educational material, but in college I've been active in HIV outreach groups and I've done training on it	1	14.3	I'm not sure, it depends on the information presented, there are a lot of misleading information out there and that could cause problems	1	12.5
			I don't think so, my knowledge of HIV is from the media, from what people tell me, friends and family, and not from education	1	12.5
			I don't think so	1	12.5
			No	1	12.5
Total no answers with reasons	**1**	**14.3**	**Total no answers with reasons**	**4**	**50.0**

When asked if prevention/education activities that API participants came in contact with in the past had any effect in their attitudes and behaviors about HIV 85.7 percent of the male API participants replied "yes" and only 14.3 percent responded "no".

For the female API participants 50.0 percent responded "yes" and another 50.0 percent replied "no" to having any of their attitudes and behaviors affected by any of the HIV/AIDS prevention activities they have come in contact with in the past.

Table 10. continued

8. Do you think that these activities had any effect in your attitudes and behaviors about HIV?

	Chinese • Yes, I learned that HIV/AIDS is preventable • I would certainly think so, knowing about the issues it has corrected a lot of wrong concepts I had before • Yes, I learned more, and my attitude changed towards those that are infected • Yeah, know that casual contact is okay but blood contact is bad • No • Yeah I think so, I'm more confident in my attitude toward sex and I know how to efficiently protect myself • I don't think so • I think so • I think that it's useful and most of us has some common sense about this issue
	Korean • I am able to understand the information about HIV/AIDS in the internet and television • I think it is all about acquiring the right information about HIV/AIDS, some information is misleading about certain issues concerning HIV/AIDS and such misleading information causes problems
	Japanese • It affected me that I needed to take more care. I kept track of the whole epidemic since the beginning since I've been working with them in the health field
	South Asian • I don't think so
	Filipino • It was limited educational material, since we don't talk about it if we specifically target the API group and try to get the word out. I think they need to start talking about sex before we can even make them acknowledge that there is all these other issues surrounding HIV and AIDS

Result summary for Table 10 question #8: When the participants were asked if the HIV prevention or education they have come in contact with in the past had any effect in their attitudes and behaviors about HIV the majority of the responses indicated that the activities encountered did have an effect in their attitudes and behaviors. Several reasons mentioned were that they learned that HIV/AIDS is preventable, knowing about the issues it has corrected a lot of wrong concepts about the epidemic and that it kept people on the look out about the dangers of being infected.

9.6. FINDINGS FOR QUESTION #9 (See Table 11)

In terms of other services or interventions or activities regarding HIV/AIDS 71.4 percent of the male API participants responded that they had no other contact with any services or interventions regarding HIV/AIDS outside of the education/prevention materials previously mentioned on **Table 9 question #7** and 28.6 percent mentioned that they have received other services or interventions. The female API participants on the other hand stated that 62.5 percent of them had not received outside HIV services or interventions other than the education/prevention materials mentioned on **Table 9 question #7** and an equal percentage of 62.5 percent mentioned that they did receive other services or interventions or activities in their community that have reduced their risk for HIV. With the ethnically categorized data most of the participants indicated that they have not encountered any other services. However, some participants did mention having encountered some interventions in the internet, television and by talking to friends and family members about HIV/AIDS issues.

Scientific research (Sy et al. 1998, Jemmott et al. 1999) indicates that implementing HIV prevention among APIs creates challenges because AIDS prevention efforts raise topics that are difficult for APIs to discuss publicly. Topics such as illness, death, sexuality, and homosexuality are considered taboo. Also illness and death are considered topics of bad luck and discussion is believed to precipitate some other kind of misfortune. It was however, observed by this study that although such barriers do exist within this community, the level of knowledge within the study sample was quite high.

Table 11. Asian and Pacific Islander (API) Interview Question Results, Gender versus Ethnicity Responses (Question 9) continued

9. Outside of HIV education/prevention materials that you have come in contact with, are there any other services or interventions or activities that you have come in contact with in your community that have reduced your risk for HIV?

Male	N=7	Percent	Female	N=8	Percent
None			**None**		
No	4	57.1	No	4	50.0
No, not at all but public conversations or talk shows try to improve and increase	1	14.3	No, but now I am doing my graduate degree in HIV and I get some knowledge from school and from talking to people and also my Parents	1	12.5
Total	**5**	**71.4**	**Total**	**5**	**62.5**
Other			**Other**		
My peer group and the people that I hang out with are very HIV/AIDS conscious	1	14.3	Internet	2	25.0
Internet surfing or in some chat rooms, where people can discuss freely the HIV/AIDS issue through the virtual world as suppose to face-to-face interaction	1	14.3	Agencies in Korea provide freely HIV testing and they also provide advertisements for people	1	12.5
			Friends	1	12.5
			Books	1	12.5
Total	**2**	**28.6**	**Total**	**5**	**62.5**

In terms of other services or interventions or activities regarding HIV/AIDS 71.4 percent of the male API participants responded that they had no other contact with any services or interventions regarding HIV/AIDS outside of the education/prevention materials previously mentioned on Table 7 question #7 and 28.6 percent mentioned that they have received other services or interventions.

The female API participants on the other hand stated that 62.5 percent of them had not received outside HIV services or interventions other than the education/prevention materials mentioned on Table 7 question #7 and an equal percentage of 62.5 percent mentioned that they did receive other services or interventions or activities in their community that have reduced their risk for HIV.

Table 11. continued

9. Outside of HIV education/prevention materials that you have come in contact with, are there any other services or interventions or activities that you have come in contact with in your community that have reduced your risk for HIV?

Chinese • Internet surfing • Chat rooms • Television talk shows, media • No, not much • None • Friends and family discussions • Books • No
Korean • No • Agencies in Korea provides free HIV testing • Television advertisements
Japanese • No, but again I don't belong to a specific community
South Asian • No, but now I am doing my degree in HIV and I get some knowledge from school and from talking to people and also my parents
Filipino • My peer group and the people I hang out with are very HIV/AIDS conscious

Result summary for Table 11 question #9: When the participants were asked about any other services or interventions or activities that they have come in contact with in their community that have reduced their risk for HIV most of the participants indicated that they have not encountered any services other than what they had indicated for their responses to Table 8 question #7. However, some participants did mention having encountered some interventions in the internet, television and by talking to friends and family members about HIV/AIDS issues.

10. DISCUSSION

10.1. PURPOSE

The purpose of this descriptive study was to illustrate the characteristics of the Asian and Pacific Islander (API) sample regarding HIV/AIDS. But also to assess the extent which the API participants are a risk group for HIV/AIDS acquisition. The characteristics described were the API's knowledge of HIV/AIDS, their attitudes towards HIV/AIDS, and any behaviors that may put them or their community at risk for the transmission of HIV/AIDS. This chapter presents a discussion of the misconceptions about HIV/AIDS, limitations of this study, and implications for the prevention of HIV infection and suggestions for future research.

10.1.1. Misconceptions about HIV/AIDS

The myths and misconceptions about HIV/AIDS within the API community varied according to prior observations and scientific findings from little to no knowledge about HIV transmission and prevention (Yoshioka et al. 2001, Matteson et al. 1999, Hoang et al. 1985) to sexual conservatism, family values, accentuation on social order and control of emotions and feelings, parental expectations could affect APIs from getting tested and participating in risky behaviors (McLaughlin et al. 1998).

The following statements are actual responses from participants in this study:

A 33-year-old Korean female stated:

> I think many of the Koreans, the Koreans society is a little bit safety from aids because many compared to other Asian countries our society is still less affected with HIV so they think that the Korean society is still safe. So even though they had casual sex they don't think that they need to protect themselves.

A 24-year-old Filipino male stated:

> I don't think they are I don't think I've met even one Filipino who've discussed such matter I don't even talk about it so I don't even know but I'm assuming that if they don't talk about it they're probably not even concern with it. This is not something I even discuss with my family not in my whole life but I know that they are aware of it I'm not comfortable talking to my parents about it but I am with my brothers and sisters.

A 26-year-old Chinese male stated:

> This is pretty much like a stereotype but the first time I came to the United States my parent you know because I call may parents occasionally in China and we talk on the phone and they tell me please don't have sex with Americans so yeah, this kind of misunderstanding not every American has AIDS or HIV, not every Asian doesn't have HIV or AIDS. But you know somehow this misunderstanding does exist. And I did kind of follow my parents suggestion and try not to have any intimate relationships with white or black or any other race.
> Very interesting I had a very close relations with an American girl and we almost reached that point but I eventually stopped it because of what my parents told me and so some other ways I don't know cause my Asian community or the Chinese community I assume that they practice sex pretty traditionally and it's not like a I don't know at least for me there is no inappropriate sex behavior I have very limited knowledge about how HIV is spread in the population.

The "model minority" label has implications for the health and economic status of Asian Americans because their health problems are often ignored or trivialized. This suggests that they can take care of things on their own. Such a classification further overlooks the diversity among Asian Americans and some of the unique problems faced by recent refugees and immigrants.

By describing Asian Americans as socio-economically and educationally successful, the "model minority" myth masks the needs of AAPI communities. When good health is assumed based on this myth of success, specific health problems may be overlooked.

10.1.2. Limitations of the Study

The use of a one time interaction descriptive interview designs has limitations. Delving deeply into the contextual lives of the sample as well as examining actual and perceived behaviors within the samples ethnic community in terms of HIV/AIDS issues is restraining. However, this design as well as its' findings should be considered despite several study limitations.

First, the results are not generalizable to the entire Asian and Pacific Islander (API) population, 100 percent of the sample participants were foreign-born, and 93.3 percent were not United States Citizens. The present study was unable to investigate differences within API sub groupings. Given the total number and demographics of the sample **(See Table 2)**, research is needed to compare HIV risk behavior in this subgroup and among American-born and foreign-born APIs, all of which are important for designing culturally sensitive HIV prevention programs.

Second, in contrast to many studies the recruitment of the sample was not obtained through any print ads in mainstream and ethnic papers. It also did not rely on paper-pencil responses therefore; the problems of generalizing from a small and geographically limited sample in an academic community are obvious. This study was not able to access API populations within a local community that might be less knowledgeable about HIV/AIDS and those who engage in risky behaviors, greatly limiting the sampling frame. In addition, limited resources and time did not permit a more in depth gathering of information from a broader network of American-API residents.

Monetary incentives were offered to recruit the participants during the course of the study. In the beginning the procedure for recruiting participants was voluntary since the project

was not a grant funded research. But unfortunately no potential participant wanted to volunteer for the study without being compensated and with the target population being the type of culture that did not disclose such personal information (i.e., sexual behaviors or any issues related to HIV/AIDS topic). The project had to change how the participants were recruited and found funding for the completion of the study. Attitudes and opinions regarding paying subjects for research caused some debates among researchers; even though it has become a common procedure to recruit subjects for a research study some people have seen it as problematic and possibly even offensive or unethical (Grady 2001). When potential participants inquired about this project they were advised of their right to refuse or withdraw from the study at any time without penalty, except for the fact that they would not obtain any payment, since payment is only given to them upon completion of the interview. Giving monetary incentives for research participation has its' drawbacks such as subjects' inability to be completely honest during the course of the project (i.e., survey method or interview method) and that type of limitation was certainly anticipated by the Principal Investigator of this research project (Grady 2001).

Social desirability bias is another limitation that could have been encountered during the course of this study. Social desirability risk is the tendency of respondents to say things that will make them look good in the interviewer's eyes. These respondents may have had a tendency to exaggerate their views in one direction (Albice 2000). They may not have responded honestly to questions asked and may not have given inaccurate information about their sexual history because they felt embarrassment or guilt. This was observed when comparing the responses gathered from the interview between the male and female participants. It was observed that having the Principal Investigator being of a different ethnicity as most of the participants indicated a language barrier and comprehension of the questions by the participants that some of

the participants' responses seemed to go on tangents and appeared strained due to the English language not being the participants' primary language spoken on a daily basis. Also being of a different gender as some of the participants limited the variation of the participants' responses to the questions during the interview session. It was observed that the male participants' responses were not as varied as the responses given by the female participants during the course of the interview session. Lastly, the sample may have responded as they thought the interviewer wants them to answer in a way that makes them appear more competent and more successful. As well as deliberately provide inaccurate data to hide risky health behavior or behaviors.

Cultural bias may also be a factor since this study involved participants of a different ethnicity and even gender than the researcher. Also because it is usually not culturally acceptable for APIs to discuss sex openly or admit to having sexual encounters or participating in risky behaviors, it is also possible that respondents were less likely to have reported their behavior accurately. They may not have responded honestly to questions since sex is a topic that is taboo within API culture.

10.1.3. Implications for Future Research and Prevention of HIV infection

This study has explored the possibility of assessing knowledge and attitudes about HIV/AIDS within the Asian and Pacific Islander (API) community. The study provided ample data from each participant in order to assess their level of knowledge, behaviors and attitudes, however, this researcher feels that it did not sufficiently challenge the participants with any questions which went beyond asking for very basic HIV/AIDS knowledge or scenarios which were, perhaps, not sufficiently personal so as to truly measure one's attitudes toward the disease. There are some implications here for future research and prevention of HIV infection.

Since the API communities do not discuss sexuality openly in public, it could be suggested that HIV/AIDS education needs to be promoted where the API communities will feel less threatened. HIV prevention programs cannot be effectively implemented if the target group is not receptive to obtaining sex-related information and is not willing to or comfortable openly discussing sexual topics (Lee 2000). Therefore, health educators, health professionals, clinicians and researchers need to initiate culturally and linguistically appropriate HIV/AIDS prevention programs and need to address barriers that exist before developing HIV prevention programs for the API community. The barriers are (a) cultural taboos and sanctions that discourage the open discussion of sexual topics and (b) the resulting discomfort or inhibition that the API population may experience when discussing sexual topics (Lee 2000). Programs that could be designed should systematically attempt to increase the API community's comfort with talking about sex and also training that will increase their skills and education level about safer sex techniques and addresses their sexuality without any discomfort or feelings of guilt.

Another suggestion for future research and prevention of HIV infection would be to have the presenters or health professionals of any proposed intervention programs be matched with the target group in order to increase the likelihood of participation in the programs. What this means is that the presenter should be similar in background (i.e., ethnicity) and gender. As the current study results provided it has been observed that having the presenter, not necessarily being of the same ethnic background, but of the same gender, the participants were more responsive and less uncomfortable which resulted in more varied responses.

Health care settings should provide education and training that promote understanding and appreciation of diverse cultures. Effective educational interventions should include an intimate knowledge of the target population and to remain nonjudgmental when the participants

provide information that reflects values that differ from their own. Other important issues that need to be considered for future research and when proposing any prevention of HIV infection targeted towards the API population is to learn about the cultural traditions of the groups you are working with and also pay close attention to body language, lack of response, or feelings of tension may signify that the participant is experiencing some conflict due to cultural issues therefore they are hesitant to respond. Being culturally competent and sensitive to their own values and beliefs will definitely benefit those health professionals and researchers from reaching such a diverse population for future studies and interventions being promoted.

In conclusion, it is important to consider the many and diverse issues, cultural values and beliefs, and sexual behaviors of the API community when developing HIV prevention and education programs for them. While the impact of HIV/AIDS among this population appears to be relatively low compared to other ethnic/racial minority groups, the current system of health data collection and surveillance does not provide a true picture of the nature and trends in the HIV/AIDS epidemic among APIs. This leaves researchers and health professionals with a great challenge ahead of them to target APIs. What this study hopefully accomplished is a contribution to a better development of culturally appropriate and effective HIV prevention programs for the Asian and Pacific Islander population.

APPENDIX A

RESEARCH PARTICIPANT INFORMATION

TITLE: Asian and Pacific Islander (API) and HIV/AIDS risk related behaviors.

INVESTIGATOR: Margaret C. Salud, Bachelors Degree in Science, Microbiology, Minor in Chemistry
Graduate Student, MPH Candidate
Masters of Public Health, Behavioral Management of Communicable Diseases
Department of Infectious Diseases and Microbiology
Graduate School of Public Health
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(412) 683-2847

Co-INVESTIGATOR: Rodger L. Beatty, PhD, LSW
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(412) 383-1775

SOURCE OF SUPPORT: Pennsylvania Prevention Project

DESCRIPTION:

To formally introduce myself I am Margaret Salud, and I am currently a candidate for the Masters of Public Health, Behavioral Management of Communicable Diseases at the Graduate School of Public Health in the Department of Infectious Diseases and Microbiology. As part of my thesis project I have decided to conduct a study which involves Asian and Pacific Islanders and HIV/AIDS risk related behaviors, and being of Asian decent I thought it very appropriate for me to identify HIV risk related behavioral characteristics of APIs including drug and alcohol behavior as well as to describe the differences between actual risk behavior and perceived risk.

My goal for conducting this research is to gather data and to describe the different barriers that affect Asian and Pacific Islanders (API) from getting or seeking HIV/AIDS tested. For that reason, we will be interviewing participants around University of Pittsburgh. The participants will be interviewed and recorded (approximately 60 minutes).

The interview will gather information about: (1) participant demographics; (2) where HIV information is obtained; (3) whether or not HIV testing has been sought; and (4) the reasons for not seeking testing. The information gathered from the interview will provide the basis for future data-gathering and will give HIV prevention programs information about why APIs do not seek HIV counseling and testing and what behaviors place them at risk for HIV infection or re-infection. Other questions aimed to be answered by conducting this research is to determine: (1) What APIs consider to be unsafe/safe behavior or behaviors most likely to put them at risk for HIV? (2) What HIV prevention or education have APIs came in contact with? (3) Do they think that they are at risk for HIV?

As a participant who volunteers to be interviewed you will not be asked to identify yourself by name or in writing. The interview will be primarily conducted by the Principal Investigator at the University of Pittsburgh Keystone building (3520 Fifth Avenue 2nd floor conference room, Pittsburgh, PA 15213) which will be scheduled exclusively for the interview and conducted in a safe, secure area to prevent any disturbance during the course of the interview session. After the interview the audio tape will be placed in a locked cabinet by the Principal Investigator. No consent forms will be given as this would preclude your confidentiality which thereby concludes that the risks of participation in the study are minimal and that your rights and welfare will be in no way violated. The benefit of this interview is enhanced understanding about why at risk APIs are not getting tested for HIV and about their risk behaviors. The risks of completing this interview are minimal and do not involve any connection of consent form and survey tool, so that your confidentiality as a participant is protected. However, those who choose to volunteer for the interview may find some personal distress related to the sensitive nature of some of the questions. You as a participant may feel frustration, anxiety, and/or boredom during the interview, and if such feelings should arise, you may stop at anytime. Safeguards for confidentiality are such that participants, rights and welfare will not be violated in any phase or aspect of the study.

If you chose to volunteer to participate in this research you will receive twenty dollars for participating which will be given only after completion of the interview session. This interaction will be one time only and it is important to note that no time will your name be discussed during the interview session to the Principal Investigator. Your participation is voluntary, and you may withdraw from this project at any time. If you choose not to participate you will be thanked for your time. Once the interview is complete the audiotapes will be kept secure in a locked area at the University of Pittsburgh by the Principal Investigator at the end of each event, until the data are ready to be analyzed. Upon transcription of information, data will be aggregated and tapes will be destroyed. This study is being conducted by Margaret Salud, who can be reached at (412) 683-2847, if you have any questions.

Remember: This interview session is confidential and voluntary.

Thank you

APPENDIX B

PARTICIPANT INTERVIEW QUESTIONS AND SCRIPT

Tape Recorders:

Turn on the tape recorder.

A. Welcome, Introductions and Introductory Comments:

1. Welcome and thank you!

First of all I would like to say welcome and thank you for making it to today's interview session. Please come in and make yourself comfortable I hope that you found the place fairly easy to find.

2. Introduction

Before we get started I would like to introduce myself. My name is Margaret Salud. I am a graduate student at the School of Public Health here at the University of Pittsburgh where I am currently a candidate for the Masters of Public Health, Behavioral Management of Communicable Diseases Program. As part of my thesis project I have decided to conduct a study which involves the Asian and Pacific Islander communities, especially in terms of what you think and feel as far as your own ethnic community's perceptions, knowledge, attitudes and beliefs concerning issues with HIV/AIDS.

My stake in doing this project is simply because being of Asian decent it has come to my attention that HIV/AIDS is an increasing epidemic in the Asian and Pacific Islander community. And what I am trying to accomplish here is to learn by gathering information what your personal views are on how your ethnic community perceive HIV/AIDS as well as gain some insights on what your feel could make things better as far as what type of prevention and educational tools that should be out there to help our community.

3. What to expect

What I will do next is to explain to you just a little bit about what is to be expected during the course of the hour that you will be here. You have in front of you a "Research Participant Information Script" and it describes briefly what my research is about as far as what type of questions that I will be asking and basically what is to be expected during the course of the interview. Just to highlight the important aspects of the study for starters, the

whole interview session will be tape recorded and to safeguard your privacy no names will be used during the interview, that no identifying information is to be provided, and that the tapes once the interview is finished will be locked securely until the data are ready to be transcribed and analyzed. This interaction will be one time only and upon transcription of the information from the audiotape, data will be aggregated and tapes will be destroyed.

The series of questions that I will be asking you will gather information about: one, where HIV information is obtained; two, whether or not HIV testing has been sought; three, what your ethnic community considers to be unsafe/safe behavior or behaviors most likely to put them at risk for HIV; four, what HIV prevention or education you have come in contact with in the past; and five, certain demographic questions which will be in the form of a paper questionnaire, two pages in length which you will be doing at the end of the interview. Once we have gone through with all the interview process and all your questions and concerns have been answered you will then receive your twenty dollars payment for participating in the project which before you receive, I will have to ask you to initial a document stating receipt of the twenty dollars and also provides us with a record of your participation.

4. Confidentiality

As a participant keeping your confidentiality is of the utmost importance thereby you will not be asked to identify yourself by name or in writing. After completion of the interview and we have discussed any issues and answered any questions the audiotape will be securely locked in a file cabinet in a secure area at the University of Pittsburgh accessible only to myself and the Co-Investigator, until it is ready to be transcribed and analyzed. Once the audiotapes are transcribed and analyzed it will be destroyed. There will be no names or any other identifying information discussed with others on the research team.

The risk of completing this interview are minimal and do not involve any connection of consent form and survey tool, so that your confidentiality as a participant is protected and that your rights and welfare will not be violated in any phase or aspect of the study. Your confidentiality if my primary concern. It is important during and after the interview. The use of the tape recorder is merely to ensure accuracy of information that you will give me during the course of the interview session. Also I would like to emphasize that there are no right or wrong responses, and no good or bad responses. Lastly just so we are not interrupted I ask that you turn off all cell phones/beepers.

B. Interview Questions:

1. Could you tell me a little bit about what your ethnic background is, such as, where your family is from and which ethnic community you relate or more likely to assimilate with?

2. How does your ethnic community view HIV/AIDS in general?

3. What are some ways people in your community can be at risk for HIV/AIDS?

4. If someone you knew was interested in the information, how would you explain the relationship between HIV and AIDS?

5. In your own words what kind of behaviors do you consider to be safe and unsafe activities that put people in your community at risk or less at risk?

6. Are you afraid of testing positive for HIV?

7. Do you think you are at risk of being infected with HIV?

8. What HIV prevention or education have you come in contact with in the past?

9. Do you think that these activities had any effect in your attitudes and behaviors about HIV?

10. Outside of HIV education/prevention materials that you have come in contact with, are there any other services or interventions or activities that you have come in contact with your community that have reduced your risk for HIV?

Is there any additional information you would like to share?

C. Closing comments

I would like to thank you again for coming and helping me further complete my thesis project. You have been a great help and your contributions in today's interview session is very much appreciated. I have learned a lot from today's session as I hope you did as well. Everything that we have discussed in today's interview session has been for the benefit of the Asian and Pacific Islander community with the hopes that today's findings will further the field of HIV prevention by providing future health interventions and non-API health care provider regarding issues with HIV/AIDS and the perceptions of different API communities have in regards to HIV risk-related behavior and HIV testing. Is there anything else that I could do for you today as far as any other questions or comments and any other concerns that you may have regarding today's interview? If any other questions do arise in the near future please do not hesitate to contact me by telephone or by email. Again I would like to say thank you for participating in today's interview session and have a nice day.

APPENDIX C

PARTICIPANT DEMOGRAPHIC QUESTIONNAIRE

The following questions will help us better understand your opinions and, if necessary, make changes in future interviews. Feel free to express any ideas and reactions, either positive or negative. **Please do not put your name on this questionnaire.**
Thank you.

Please circle your response to each idea using the following scale:

1 = low, 2 = average, 3 = high 4 = very high

1. your comfort level while participating in this interview……...1 2 3 4

2. your comfort level with the person asking the questions……1 2 3 4

3. your comfort level with the questions……...1 2 3 4

4. your belief that ***important*** information was discussed in this interview……..1 2 3 4

5. the ability of the interviewer (the person asking the questions) to do the interview……..……..1 2 3 4

6. the interviewer's acceptance of your views…….1 2 3 4

7. personal satisfaction with your contributions to the interview……...…1 2 3 4

The following information allows us to know some general information about you.

1. What is your sex?
   _____ Male _____Female
   _____Other (Please describe:_____)

2. What is your sexual orientation?
   _____gay _____straight _____bisexual _____lesbian _____other

3. What is your age? _____

4. What is your race/ethnicity?

_____Filipino	_____Thai	_____Korean
_____Hawaiian	_____Samoan	_____Other
_____Asian Indian	_____Japanese	(Please describe)_____
_____Cambodian	_____Guamanian	
_____Laotian	_____Indonesia	
_____Chinese	_____Vietnamese	

5. Country of origin? (Were you born in the US?)
   _____ Yes _____ No (Specify which Asian country_____)

6. What is your father's highest level of education?
   _____ 1. Less than 9th grade
   _____ 2. Some high school
   _____ 3. High school graduate
   _____ 4. Some college or other education beyond high school
   _____ 5. Graduate from college
   _____ 6. Graduate or professional education beyond college (for example, Master's Degree, Ph.D., M.D.)
   _____ 7. Don't know or this does not apply to me

7. What is your mother's highest level of education?
   _____ 1. Less than 9th grade
   _____ 2. Some high school
   _____ 3. High school graduate
   _____ 4. Some college or other education beyond high school
   _____ 5. Graduate from college
   _____ 6. Graduate or professional education beyond college (for example, Master's Degree, Ph.D., M.D.)
   _____ 7. Don't know or this does not apply to me

8. What is your highest level of education?
   _____ 1. Less than 9th grade
   _____ 2. Some high school
   _____ 3. High school graduate
   _____ 4. Some college or other education beyond high school
   _____ 5. Graduate from college
   _____ 6. Graduate or professional education beyond college (for example, Master's Degree, Ph.D., M.D.)
   _____ 7. Don't know or this does not apply to me

9. Are you a United States citizen? _____Yes _____No

10. What is your primary language among your peer group? _____

11. What is your profession?

_____student
_____student and working
_____some other type of professional
(Specify please:_____)
_____other (Specify please:_____)

12. Have you been tested for HIV?

_____yes _____no

If yes, when were you last tested? _____
If no, why were you not tested? _____

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