CHAMPs

Capacity-Building in HIV/AIDS for Medical Providers

Creating Successful HIV/AIDS Programs for Asian Americans, Native Hawaiian and Pacific Islanders in Community Health Centers:

A RESOURCE GUIDE

(AAPCHO) Association of Asian Pacific Community Health Organizations

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Capacity-Building in HIV/AIDS for Medical Providers

AAPCHO Association of Asian Pacific Community Health Organizations
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Dear Reader:

In 1998, the Capacity Building in HIV/AIDS for Medical Providers (CHAMPs) program began its work at the Association of Asian Pacific Community Health Organizations (AAPCHO). AAPCHO is a not-for-profit national health association dedicated to promoting advocacy, collaboration and leadership that improves the health status and access of Asian Americans, Native Hawaiians and Pacific Islanders within the U.S., its territories and freely associated states.

For over six years, the CHAMPs program has helped Community Health Centers (CHCs) address the growing rates of HIV/AIDS and Sexually Transmitted Infections (STIs) in their communities, and helped them transition from providing basic HIV prevention education to integrated testing and care services.

The CHAMPs program staff and advisory committee developed this resource for providers and program managers at CHCs or other health agencies developing comprehensive HIV/AIDS prevention and/or care programs for AAPIs. This document was meant to offer some guidance to providers in areas ranging from community needs assessments to monitoring/evaluation activities. It also lists program highlights from various CHAMPs project sites.

As HIV/AIDS continues to impact individuals of all ethnic and cultural backgrounds, the CHAMPs program encourages providers and communities to take action by providing culturally competent, linguistically appropriate HIV screening, prevention education and early intervention services.

We hope this guide will be helpful in your efforts to address HIV/AIDS in AAPI communities.

Sincerely,
Jeffrey B. Caballero, MPH
Executive Director
Association of Asian Pacific Community Health Organizations

INTRODUCTION

The CHAMPS Resource Guide may be useful to any organization that offers HIV/AIDS services, and is exploring the need for a similar program for Asian American and Pacific Islanders (AAPIs). It may also be useful to those organizations that currently offer health and social services for AAPIs, and would like to supplement these services with an HIV/AIDS support or education program. The resource guide was designed to provide: 1) tools and information to help your organization assess and articulate your reasons for creating an AAPI HIV/AIDS program, 2) an outline of the essential elements or "building blocks" of an HIV/AIDS program.

All successful community health programs are comprised of 5 main elements:

Element 1: Community Needs Assessment
Element 2: Organizational Needs Assessment
Element 3: Program Planning and Development
Element 4: Monitoring and Evaluation
Element 5: Implementation

This resource guide is divided into sections that describe each program element. Please note that this guide was created to give a brief overview of these components, as well as some issues for community health centers to consider when creating HIV/AIDS programs for AAPIs. For more detailed program planning information, we suggest you refer to the recommended reading list and resources that are included throughout this document.

◎ WHY FOCUS ON THE AAPI POPULATION?

Asian Americans and Pacific Islanders (AAPIs) are the fastest growing racial/ethnic population in the United States, increasing 95% from 1980-1990 and another 43% from 1990 to 1999. The AAPI population is expected to reach 37.6 million or 9% of the US population by the year 2050.

While often considered a single racial group this diverse group consists of 49 different ethnicities speaking over 100 different languages and dialects. Aggregating such a large and diverse group makes it difficult to understand the unique problems faced by each individual ethnic group. For instance, even limited information on this population highlights dramatic differences in its rates of insurance coverage and levels of access to health care. AAPI uninsured rates range from a high of 34% for Korean Americans to a low of 13% percent for Japanese Americans.

Current federal, state, and local government survey methods do not adequately address the various linguistic and cultural characteristics of this diverse population, particularly in areas with newly emerging immigrant populations. Without specific and accurate data about AAPI communities, federal and state programs and services are not adequately inclusive of or responsive to this population's needs.

Here is what we do know about the barriers preventing AAPIs from accessing health care services:

Limited English Proficiency

Among AAPIs 76% of Hmong, 70% of Cambodians, 68% of Laotians, 61% of Vietnamese, 52% of Koreans, 51% of Chinese, 39% of Tongans, and 22% of Samoans are Limited English Proficient (LEP) and are unable to effectively interact with health care providers and social service agencies. Thus, even though LEP AAPIs may be eligible for state and federal benefits the absence of properly translated materials outlining these benefits and their eligibility requirements prohibits them from accessing these services. The end result is decreased access to health insurance and poorer health outcomes.

The Impact of Welfare Reform

Recent AAPI immigrants are another subgroup that faces barriers when accessing health care services. The Welfare Reform Act of 1996 continues to negatively impact access to health care for AAPI immigrant populations. For instance between 1994 and 1997, the unemployment rates of Southeast Asians increased though the groups' uninsured rates climbed steeply and Medicaid coverage plummeted (41% to 18%). This was due, in part, to Welfare Reform Act restrictions that denied public health benefits to newly-arrived legal immigrants. This act in turn contributes to the increasing number of uninsured AAPIs.

Recent immigrants are also reluctant to access services out of fear of being labeled a "public charge" by the Immigration and Naturalization Service and jeopardizing their future chances at citizenship. While these fears are often unwarranted due to new restrictions and clarifications, the lack of linguistically and culturally appropriate education on this topic makes it a persistent problem.

Lack of Affordable Health Care

According to the U.S. Bureau of the Census, since 1990 America's uninsured population has grown by nearly 10 million. In 1998 it reached 44.3 million, or one sixth of the total U.S. population. AAPIs, particularly those with lower levels of education and higher rates of poverty and those ineligible under current Medicaid criteria, find it especially hard to obtain insurance.

One reason for the lower rates of insurance among AAPIs is their employment patterns. For instance, Korean Americans, because of their high rates of self-employment or employment in small firms, are less likely to have access to employer-based health insurance. The result is that many Korean Americans have to choose between remaining uninsured or purchasing expensive private insurance.

	Chinese	Filipino	Korean	South East Asian	Japanese	South Asian
Uninsured	20%	20%	34%	27%	13%	22%
Medicaid/Other	3%	4%	4%	20%	3%	4%
Job-Based	67%	73%	48%	49%	77%	69%
Other Public	10%	3%	14%	4%	7%	5%

* Drawn from: Brown ER Ojeda, VE Wyn, R, and R Levan. Racial and Ethnic Disparities in Access to Heath Insurance and Health Care. UCLA Center for Health Policy and Research and Kaiser Family Foundation, April 2000

◎ WHY PROVIDE HIV/AIDS PROGRAMS TARGETING AAPIS?

The changing face of the HIV/AIDS epidemic has led to more women, youth, and people of color being impacted by the disease. How is the epidemic affecting the AAPI population?

> As of December 2001, the cumulative number of AIDS cases reported among AAPIs in the United Sates was 6,157.
>
> * Source: Centers for Disease Control and Prevention. Cases of HIV infection and AIDS in the United States, by race/ethnicity, 1998–2002. HIV/AIDS Surveillance Supplemental Report;14 (No.2): [inclusive page numbers]. Also available at: http://www.cdc.gov/hiv/

Undercounting and Unmet Needs

Though the AAPI population has great and unique needs, those needs often are not "on the radar screen". Underreporting of HIV/AIDS cases, lack of detailed HIV surveillance and misclassification often mask the true impact of the epidemic on AAPIs. As of December 2001, the cumulative number of AIDS cases reported among AAPIs in the U.S. was 6,157 (5,354 men and 803 women) or less than 1% of all reported cases. Underreporting and lack of surveillance data on AAPI sub-populations has made it difficult to obtain important information about risk factors, routes of transmission and health behaviors. Despite CDC's decision to stop using the "Other" category to report cases for AAPIs, most state and local health departments still report AAPI HIV/AIDS data as an "Other" category. The number of AAPIs with AIDS may be undercounted because of race or ethnicity misclassification in medical records, the main source of information for case reports. Medical record information does not necessarily reflect patient self-reports or self-identification and is limited by the accuracy of the information obtained by a provider.

Unique Obstacles to Accessing HIV Services

Additional cultural, linguistic, economic and legal barriers to HIV/AIDS prevention and care significantly affect AAPIs. Many health and human service providers do not perceive AAPIs, especially AAPI women, to be at risk for HIV. In most cases, AAPIs learn of their HIV status when they are already very sick, or through mandatory screening. A hesitation on the individual's part to discuss issues such as drugs, sexual behavior, illness and death, can also prevent some AAPIs from obtaining necessary information and services. AAPI men who have sex with men (MSM) are at a significant risk for HIV and may encounter a lack of support from their families, peers, and community, which can impact their self-esteem and self-identity and in turn, affect prevention and care. The service needs of gay and bisexual AAPI men with AIDS are very important, as 81% have sex with men. By exposure category, MSM experience the severest impact of HIV/AIDS among AAPI males, accounting for 72% of cumulative AIDS cases. Immigrant AAPIs may also be limited English proficient, which creates a problem because few programs provide interventions, education or peer support in Asian and Pacific Islander languages. Culturally appropriate HIV prevention and education programs may be unavailable to geographically isolated and marginalized AAPI populations, such as recent immigrants, injection drug users (IDUs), lesbian/gay/bisexual/transgender (LGBT) populations or youth.

Highest Risk Groups within the AAPI Population

Newly emerging and existing trends within AAPI populations are becoming particularly alarming, as rates of infection and co-infection continue to rise. AAPIs are more likely to be diagnosed at an advanced stage of HIV and suffer from opportunistic infections at the time of diagnosis. AAPIs have higher rates of many preventable diseases that are strongly associated with HIV, such as tuberculosis and hepatitis B. A San Francisco, CA-based study of AAPI drug users not in treatment, revealed that drug users who are hidden from the street drug scene engage in HIV risk behaviors. Patterns of drug use, sexual behaviors and characteristics of social networks among AAPI drug users are unique to their ethnicity, gender and immigrant status. For example, Filipino drug users engaged in riskier behaviors, such as having sex with IDUs, having drug-using sex partners and/or having sex while using drugs, than other groups. Immigrant AAPI women who work in massage parlors often engage in high-risk activities that put them at risk for HIV infection, yet have immediate survival needs that may limit their access to HIV prevention or health care services.

Additionally, AAPI AIDS cases by exposure category can be drastically different when compared to other racial/ethnic populations. The proportion of MSM to injection drug users with AIDS in AAPI men (75% to 5%) is similar to White men (76% to 9%) yet very different from Hispanic (44% to 37%) and Black men (38% to 26%). Among women, 46% of AAPI women report sex with an HIV+ or high risk partner as a risk indicator, compared to 39% for White, 36% for Black, and 46% for Hispanic women. Among all women, AAPIs accounted for 19% of cumulative AIDS cases that indicated, "risk not reported or indicated," which is the highest percentage among all racial/ethnic groups.

What the AAPI Population Needs

The most effective efforts to address HIV/AIDS for AAPIs involve multi-directional

approaches. Rapidly growing and diverse AAPI populations need comprehensive HIV/AIDS-related surveillance data, including data disaggregated by AAPI national origin/ethnicity. More research on cultural protective factors and cultural barriers to effective HIV prevention among AAPIs is also needed, along with acknowledgement of stigma and discrimination that inhibits effective HIV/AIDS prevention and care. While programs for AAPI MSM must remain a high priority, attention must be focused on other populations at risk, including AAPI youth, transgenders and women. As with all well-developed HIV prevention interventions, it is critical to include members of the target community in the design and implementation of programs and recruit AAPI community members as paid staff and volunteers in HIV/AIDS programs.

◎ ADDITIONAL FACTS & FIGURES

APIAHF fact sheets - http://www.apiahf.org/search/search.pl?Terms=fact+sheet+and+HIV&Match=1&Realm=All

CDC HIV/AIDS Surveillance Reports and Supplemental Reports -

- Estimated numbers of diagnoses and rates (per 100,000 population) of AIDS, by persons' race/ethnicity, age category, and sex, 2002—United States http://www.cdc.gov/hiv/stats/hasr1402/table5.htm
- Estimated numbers of persons living with HIV/AIDS at the end of 2002, by race/ethnicity, sex, and exposure category—30 areas with confidential name-based HIV infection reporting http://www.cdc.gov/hiv/stats/hasr1402/table9.htm
- Estimated numbers of persons living with AIDS at the end of 2002, by race/ethnicity, sex, and exposure category—United States http://www.cdc.gov/hiv/stats/hasr1402/table11.htm
- Estimated proportion of persons surviving, by months after AIDS diagnosis during 1994–2001 and by race/ethnicity—United States http://www.cdc.gov/hiv/stats/hasr1402/figure4.htm
- Cases of HIV infection (not AIDS) for male adults and adolescents, by exposure category and race/ethnicity, reported through December 2002— 39 areas with confidential name-based HIV infection reporting http://www.cdc.gov/hiv/stats/addendum/tableA2.htm
- Cases of HIV infection (not AIDS) for female adults and adolescents, by exposure category and race/ethnicity, reported through December 2002— 39 areas with confidential name-based HIV infection reporting http://www.cdc.gov/hiv/stats/addendum/tableA4.htm
- AIDS cases and annual rates (per 100,000 population), by metropolitan area and age category, reported through December 2002—United States http://www.cdc.gov/hiv/stats/AIDS_CasesAnnual%20_Rates2002.pdf

CDC Morbidity and Mortality Weekly Report - http://www.cdc.gov/mmwr/

The Kaiser Family Foundation – State Health Facts On-line

- Cumulative AIDS Cases - All Ages by Race/Ethnicity http://www.statehealthfacts.kff.

org/cgi-bin/healthfacts.cgi?action=compare&category=HIV%2fAIDS&subcategory=Cumulative+AIDS+Cases&topic=All+Ages+by+Race%2fEthnicity

- New AIDS Cases - All Ages by Race/Ethnicity http://www.statehealthfacts.kff.org/cgi-bin/healthfacts.cgi?action=compare&category=HIV%2fAIDS&subcategory=New+AIDS+Cases&topic=All+Ages+by+Race%2fEthnicity
- Annual AIDS Case Rate - Adult/Adolescent by Race/Ethnicity http://www.statehealthfacts.kff.org/cgi-bin/healthfacts.cgi?action=compare&category=HIV%2fAIDS&subcategory=Annual+AIDS+Case+Rate&topic=Adult%2fAdolescent+by+Race%2fEthnicity
- Persons Living with AIDS - All Ages by Race/Ethnicity http://www.statehealthfacts.kff.org/cgi-bin/healthfacts.cgi?action=compare&category=HIV%2fAIDS&subcategory=Persons+Living+with+AIDS&topic=All+Ages+by+Race%2fEthnicity

CDC Office of Minority Health

- Racial & Ethnic Populations Data http://www.cdc.gov/omh/Populations/populations.htm
- Minority HIV/AIDS Initiative – Publications on Organizational Infrastructure http://www.omhrc.gov/omh/aids/ta/4C5_organizational_toc.htm

◎ HIV/AIDS PROGRAMS IN THE COMMUNITY HEALTH CENTER SETTING

Community Health Centers (CHCs) nationwide serve over 600,000 Asian American and Pacific Islander (AAPI) patients. The Association of Asian Pacific Community Health Organization's (AAPCHO) membership of 19 community-based health centers alone serve over 200,000 patients annually, of which over 75% are AAPI. Approximately 72% of AAPCHO patients are under the federal poverty level, 60% are LEP, and 37% are uninsured (BPHC Uniform Data System, 2003).

CHCs not only serve our most vulnerable populations, but they effectively provide quality and affordable primary health care to these individuals. Through CHCs, community specific health issues are addressed. Because CHCs are located within the community and provide culturally and linguistically competent services, CHC patients trust their providers and tend to participate heavily in screening, prevention, education and treatment efforts. Given the community-based nature of CHCs' governance structures and service provision, CHC board members, clinicians and staff are often best able to gauge the opinions and needs of the community they serve.

CHCs, as providers that serve virtually all patients regardless of their ability to pay, often face numerous challenges. In many instances HIV/AIDS services are merely one subset of a health center's much larger service offering. There are competing priorities for limited staff, resources and time. Providers who do not specialize in HIV/ AIDS or work in HIV service agencies have higher learning and acceptance curves to overcome. For patients or clients, there is the fear that a visit to the family's doctor for HIV services may result in a breach of confidentiality or observation by other community members.

Despite these challenges, numerous CHCs provide HIV/AIDS service programs that effectively meet the needs of their communities. AAPCHO's member centers for instance, provide excellent models of HIV/AIDS programs targeted to meet the unique needs of AAPIs. These centers have a broad and varied experience in implementing successful HIV services and interventions, and currently offer a solid foundation for HIV/AIDS outreach education, screening and HIV/AIDS services.

AAPCHO COMMUNITY HEALTH CENTER HIGHLIGHTS

- **Asian Health Services, Oakland, CA**

  Asian Health Services (AHS), is a community health center that collaborates with other providers and organizations. The STD/AIDS Prevention and Care Training (SAPCT) program at AHS is designed to provide clinical and health education staff with the skills to effectively address sexually transmitted disease and HIV/AIDS related issues with People Living With AIDS and patients who are at risk for STDs.

  Asian Health Services
  818 Webster Street, Oakland, CA 94607
  PH 510.986.6830 F 510.986.6890
  www.ahschc.org

- **Asian Pacific Health Care Venture, Los Angeles, CA**

  Asian Pacific Health Care Venture (APHCV), which provides primary health care and community health education and promotion programs to low-income and medically underserved AAPI communities in Los Angeles, California, has successfully implemented over 100 outreach and health education programs individually, and in collaboration with other community-based organizations. These programs reach over 10,000 youth, women, business communities, and schools annually. APHCV's HIV/AIDS programs started in 1991 and are funded by the Los Angeles Department of Health Services. APHCV provides bilingual and bicultural health care support in five AAPI languages (Thai, Vietnamese, Cambodian, Japanese, and Tagalog). APHCV offers a full spectrum of primary care, family planning, HIV counseling and testing, and HIV/AIDS education and prevention services.

  Asian Pacific Health Care Venture
  1530 Hillhurst Avenue, Suite 200, Los Angeles, CA 90027
  PH 323.644.3880 F 323.644.3892
  www.aphcv.org

- **Charles B. Wang Community Health Center, New York, NY**

  The Charles B. Wang Community Health Center (CBWCHC) is a community-based health care facility that primarily serves low income, uninsured or underinsured, and medically underserved Asian Americans in the NYC metropolitan area. In 2003, the health center began providing HIV testing to uninsured women who utilized the clinic's family planning services. The center also plans to increase its HIV testing

among Fujianese women, and is developing a media outreach campaign that incorporates culturally competent HIV prevention messages for Fujianese men.

Charles B. Wang Community Health Center
268 Canal St., New York, NY 10013
PH 212.379.6988 F 212.379.6936

- **Family Health Center, Worcester, MA**

Family Health Center (FHCW) is located in a large urban community in Worcester, Massachusetts. In 2002, FHCW celebrated its 30th anniversary and provided 83,325 services to 16,915 patients. FHCW provides HIV counseling, testing, medical care, and case management services. Through its Southeast Asian Health Program, the center conducted focus groups to help identify the causes of HIV/AIDS in the Vietnamese community. FHCW is the Ryan White/Title III grantee in Worcester. A portion of these services are subcontracted to Great Brook Valley Health Center, their sister community health center in Worcester. FHCW is an active participant in the HIV Consortium of Central Massachusetts (HCCM) and the Ryan White Care Consortia for all of Worcester County. Family Health Center conducts outreach efforts to high risk individuals for counseling and testing.

Family Health Center
26 Queen Street, Worcester, MA 01610
PH 508.860.7700 F 508.860.7990
www.fhcw.org

- **Guam Department of Public Health and Social Services, Guam, U.S.**

The Guam Community Centers (Northern and Southern Regional Community Health) provide primary health care, acute outpatient care, urgent care, emergency services and preventative services to the uninsured, underserved and indigent populations of the territory. The STD/HIV and Title II Division of the Department of Public Health and Social Services is responsible for HIV CTR, PCRS, Prevention for Positives, Health Education Risk Reduction, STD and HIV Surveillance, Capacity Building, STD Clinical Services, and ADAP Services. In response to the growing number of HIV/AIDS and STD cases in Guam, these two parties developed a partnership to reduce the number of STD and HIV infections in the region. This collaboration resulted in CHCs providing STD and HIV counseling and screening, partner services, treatment and other referral services, increased technical assistance for CHCs on the integration of HIV prevention and care activities, and support for CHC clinical staff.

Guam Department of Public Health & Social Services
P.O. Box 2816, Hagatna, Guam 96932
PH 671.735.7311 F 671.734.2437

- **International Community Health Services, Seattle and King County, WA**

International Community Health Services (ICHS), which provides a comprehensive range of primary health care services for low-income, limited or non-English speak-

ing AAPIs, incorporated programs of the Asian Pacific AIDS Council (APAC) into its service offering. The program, established in 1989, provides HIV prevention and intervention services to AAPI residents, including high-risk youth, and men who have sex with men. The clinic's direct services include counseling for AAPIs living with HIV or AIDS, support for family members, linking clients to affordable housing, and other support services based on the client's needs.

International Community Health Services
720 8th Avenue, South Suite 100, Seattle, WA 98104
PH 206.461.3617 F 206.461.4857

- **Kalihi-Palama Health Center, Honolulu, HI**

  Kalihi-Palama Health Center (KPHC) is a full service outpatient health center. In 2003, this CHC served 17,154 patients through 79,668 visits. KPHC formed an advisory group to identify strengths and needs related to HIV/AIDS services at KPHC, conducted needs assessment surveys on HIV/AIDS prevention and care services at the health center; planned HIV/AIDS prevention and care activities in partnership with local ASOs and other community based organizations; and coordinated training for key health care providers to serve as on-site HIV/AIDS and STD trainers/consultants.

  Kalihi-Palama Health Center
  915 North King Street, Honolulu, HI 96817
  PH 808.848.1438 F 808.841.1265
  www.healthhawaii.org

- **Kwajalein Community Health Center, Republic of the Marshall Islands**

  The Kwajalein Community Health Center (KCHC) is the sole provider of prevention and primary health care services for the communities in the Kwajalein Atoll. The CHC serves an annual population of approximately 11,000 in which 51% are under the age of 25. KCHC began a prevention campaign, with an emphasis on youth outreach, and seeks to continue this work with added provider training. Current activities include preventive health education on STI/HIV through lectures and discussions in schools and in the community, and through the distribution of in-language brochures. Mandatory HIV testing was conducted by rapid test to all prenatal injection drug users, blood donors, STI patients, patients receiving physical examinations (to satisfy school and employment requirements), plus uncontrolled diabetes, AFB positive TB patients, and voluntary walk-in patients. Pre-test and post-test HIV counseling was provided to all tested patients. HIV/AIDS CME & CNE was made available to all providers of the KCHC.

  Kwajalein Community Health Center
  P.O. Box 5219, Ebeye, Marshall Islands, MH 96970
  PH 692.329.8030 F 692.329.3385

- **Waianae Coast Comprehensive Health Center, Waianae, HI**

  Waianae Coast Comprehensive Health Center (WCCHC) provides primary care services to approximately 24,000 patients each year. STD/HIV prevention, treatment

and outreach services are provided to homeless, transient, intravenous drug users, gay/lesbian/transgender populations. The center also focuses on prevention for HIV-positive clients. WCCHC provides HIV prevention talks and rap sessions at both the high school and community college level. WCCHC joined forces with the HIV/STD prevention branch and the Life Foundation to create ways of providing prevention for HIV positive individuals. WCCHC also increased its pre/post testing and counseling hours, added some time for outreach to beaches and parks, and worked with other gender-specific outreach workers to reach target populations such as TG/SIW clients. The center mixes both western and traditional healing practices for all clients. WCCHC has participated and coordinated several island-wide and state-wide consortiums and trainings.

Waianae Coast Comprehensive Health Center
86-260 Farrington Highway, Waianae, HI 96792-3188
PH 808.696.7081 F 808.696.7093
www.wcchc.com