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HIV/AIDS, Tuberculosis, and Hepatitis B Coinfection and the AAPI Population

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Are AAPIs at Risk?

Asian Americans and Pacific Islanders (AAPIs) had the highest estimated annual percentage increase of HIV/AIDS infection of all race/ethnicities between 2001 and 2004 (2.4% for males and 14.3% for females).ⁱ Rates of HIV/AIDS infection in the AAPI population have been subtly but steadily rising over the past decade and health providers in this community have grown increasingly concerned with the potential consequences of HIV/AIDS coinfection with tuberculosis (TB) and/or hepatitis B (hep B).

Experts in the HIV/AIDS field recognize that in order to preserve the health and well-being of people living with HIV/AIDS, we must develop a clearer understanding about coinfections. In the AAPI community, endemically high rates of TB and hep B as well as increases in AAPI HIV/AIDS have raised a red-flag for health and community leaders.

The reasons for concern are clear. Hep B and TB are preventable but life-threatening infections that disproportionately impact the AAPI community. However, data on HIV/AIDS coinfection with TB and/or hep B remains limited.

TUBERCULOSIS (TB)

Tuberculosis, which most commonly attacks the lungs, has declined in the United States, with the number of cases in 2005 totaling 14,093. The AAPI population has the highest TB case rate of any ethnic group; 19.6 times greater than non-Hispanic whites.ⁱ

The HIV/AIDS epidemic is considered to be a chief contributor to the recent increase in TB cases.ⁱⁱ At the end of 2001, one-third of all people living with HIV/AIDS worldwide were coinfecting with TB.ⁱⁱⁱ When an individual's immune system is weakened from HIV/AIDS, the door to both new active infection and reactivation of latent disease is opened.^{iv} HIV is the most powerful known risk factor for the reactivation of latent TB.ⁱⁱⁱ

Treating TB is both long and arduous, typically requiring anywhere from 6-12 months of treatment and multiple drugs.^{iv} HIV/AIDS coinfection with TB can compromise drug interaction and treatment adherence levels.^{iv}

Despite the known complications of TB and HIV/AIDS coinfection and the apparent risks to the AAPI community, little is known about coinfection risk for AAPIs.

HEPATITIS B (hepB)

Hepatitis B can lead to cirrhosis of the liver, liver failure, and liver cancer.^v In the United States, there are 1.25 million persons living with chronic hep B. AAPIs have a rate of chronic hep B infection that is 70 times greater than that of the non-Hispanic white and the Hispanic population, and is 14 times the rate of blacks.^{vi}

While 10% of the HIV-infected population, worldwide, is believed to be coinfecting with hep B, coinfection rates may be as high as 20% in Southeast Asia.^{vi} Vaccines are available to prevent hep B although there is no cure.^{vii}

The limited research available on hep B and HIV/AIDS shows that this coinfection, may alter the national progression of the hep B disease, resulting in rapid progression of liver disease and cancer. Similar effects have been documented in hep C/HIV/AIDS coinfection.^{viii}

Traditionally, in the United States and Western Europe, a stronger emphasis has been put on hep C and HIV/AIDS coinfection.^{ix} However, hepatitis experts agree that a concerted effort to understand the impact of all forms of viral hepatitis coinfection with HIV/AIDS is critical for the AAPI community.

What to consider

Internationally, countries in Asia and the Pacific Islands are home to some of the world's fastest growing rates of HIV/AIDS.^x Up to 70% of AAPIs in the United States are either first generation immigrants or refugees to the United States^{xi} and their TB and hep B rates more closely reflect epidemiological trends seen in Asia and the Pacific Islands. Reaching this population is critical as increased travel and mobility among these individuals may subsequently increase their risk of exposure to any number of diseases.

Domestically, the AAPI population has been difficult to reach as it does not share a common language or culture. A comprehensive AAPI campaign that targets the population's mix of more than 150 languages and dialects and 49 ethnicities^{xii} can be both difficult to plan and execute. Traditionally, HIV/AIDS, TB, and hep B AAPI outreach efforts have been based on language and ethnicity. AAPI HIV/AIDS screening and prevention efforts show that issues of stigma, lack of awareness and education around HIV/AIDS, and late-stage diagnosis have been formidable barriers to effective prevention and timely treatment.^{xii,xiii} In addition, there is a lack of disaggregated research on HIV/AIDS, TB, hep B and coinfections. Unless this research is conducted, targeted and effective interventions for this diverse population will remain nonexistent.

What can be done?

This opportunity to prevent a potentially devastating problem in the AAPI community is not only unique, it is time-sensitive. Increased research on HIV/AIDS coinfection with TB and/or hep B will help us acquire much needed information on an issue that is poorly understood. However, a greater comprehension of coinfections will lead to little unless HIV/AIDS, TB and hep B experts utilize their knowledge to form collaborative efforts that not only address each disease area but the larger coinfection issue overall.

ⁱTrends in Tuberculosis- United States, 2005. Morbidity and Mortality Weekly Report. 2006; 55 (11): 305-308.

ⁱⁱTuberculosis Fact Sheet. American Lung Association. 2006.

ⁱⁱⁱChan A, Perez H, Ben C, Ochoa C. Tuberculosis and HIV: A Partnership against the most Vulnerable. JIAPAC. 2003;2(3).

^{iv}World Health Organization. Tuberculosis. 2006.

^vHepatitis B Fact Sheet. The Asian Liver Center: Stanford University. 200x.

^{vi}HIV and Hepatitis. Recommendations for Management of Chronic Hepatitis B and C in HIV Coinfected Patients. Available at: http://www.hivandhepatitis.com/hiv_hcv_co_inf/2006/041806_a.html

^{vii}World Health Organization. Hepatitis B. 2000.

^{viii}Drak A, Mijch A, Sasadeusz J. Immune Reconstitution Hepatitis in HIV and Hepatitis B Coinfection, Despite Lamivudine Therapy as Part of HAART. Clinical Infectious Diseases. 2004; 39: 129-32.

^{ix}Pillero P, Faragon J. Hepatitis B Virus and HIV Coinfection. The AIDS Reader. 2002.

^xUNAIDS. Asia: Fact Sheet. 2006.

^{xi}Environmental Protection Agency: AAPI Initiative. Asian American and Pacific Islander-Primer. 2006.

^{xii}Zaidi IF, Crepaz N, Song R, et al. Epidemiology of HIV/AIDS Among Asians and Pacific Islanders in the United States. AIDS Education and Prevention. 2005; 17: 405-417.

^{xiii}Chin JJ, Kang E, Kim HJ, et al. Serving Asians and Pacific Islanders with HIV/AIDS: Challenges and Lessons Learned. Journal of Health Care for the Poor and Underserved. 2006; 17: 910-927.

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