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APIAHF
ASIAN & PACIFIC ISLANDER AMERICAN HEALTH FORUM

THE INTERSECTION BETWEEN HIV/AIDS AND DOMESTIC VIOLENCE IN ASIAN AMERICAN, NATIVE HAWAIIAN, AND PACIFIC ISLANDER WOMEN

WHITE PAPER: INTRODUCTION TO THE ISSUE

MAY 2011

The Asian & Pacific Islander American Health Forum (APIAHF) is a health justice non-profit organization dedicated to improving the health and well-being of more than 17 million Asian Americans, Native Hawaiians, and Pacific Islanders living in the United States and its jurisdictions. We believe that all persons have the right to be healthy, the right to live in a thriving community, and the right to quality, affordable, and accessible health care.

For the past 25 years, APIAHF has worked with community advocates, public health leaders, and policymakers to generate policies, programs, and systems changes to improve the health of Asian American, Native Hawaiian, and Pacific Islander communities.

Through our policy and advocacy efforts, APIAHF was instrumental in the creation of the White House Initiative on Asian Americans and Pacific Islanders, fought for the passage of the Patient Protection and Affordable Care Act, and continues to demand the inclusion of Asian Americans, Native Hawaiians, and Pacific Islanders in the collection and reporting of local, state, and national health data.

Among our many successful partnerships, APIAHF is proud to direct the largest ever investment in Asian American, Native Hawaiian, and Pacific Islander communities through a $16.5 million grant by the W.K. Kellogg Foundation.

Our work derives from three core values:

- Respect because we affirm the identity, rights, and dignity of all people.
- Fairness in how people are treated by others and by institutions, including who participates in decision making processes.
- Equity in power, opportunities, and resources to address obstacles hindering vulnerable communities and groups from living the healthiest lives.

MISSION

The Asian & Pacific Islander American Health Forum (APIAHF) influences policy, mobilizes communities, and strengthens programs and organizations to improve the health of Asian Americans, Native Hawaiians, and Pacific Islanders.

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INTRODUCTION

Why Discuss the Intersection between HIV/AIDS and Domestic Violence in Asian American, Native Hawaiian and Pacific Islander Women?

HIV/AIDS and domestic violence are significant concerns for the Asian American, Native Hawaiian and Pacific Islander (AA and NHPI) community. AAs and NHPIs face a number of societal, structural and cultural barriers affecting their risk of HIV infection, ability to get tested and be linked to care.

The purpose of this White Paper is to provide a brief introduction to the intersection of HIV/AIDS and domestic violence in the AA and NHPI community through a reproductive justice framework. A reproductive justice analysis of this intersection reveals that traditional HIV interventions fail to account for the societal and structural barriers women face, the effect that social constructs such as gender, patriarchy and culture have on women's health, and the effect of violence on women's reproductive health. In addition, this analysis is used to identify specific challenges AA and NHPI women face.

Traditional HIV/AIDS Interventions Fail to Consider Women's Realities

The HIV/AIDS epidemic has traditionally been viewed as a disease among men who have sex with men (MSM), with most research and prevention efforts being male focused and controlled.[1] For example, interventions such as the Abstinence, Be Faithful and Condom use (ABC) approach focus largely on male-controlled interventions such as condom use, and assume all people have the capacity and freedom to make individual decisions about contraceptive use.[2]

Women have distinct biological, social, and economic pressures that influence their risk for HIV infection and ability to access care. Interventions such as the ABC approach fail to account for these challenges by conflating marital sex with safe sex, neglecting the degree to which violence affects women's physical and mental health and failing to take into account how men's risk behaviors affect women's health. Specific populations of women, such as AA and NHPIs, face particular challenges not captured by traditional interventions. For example, AA and NHPI women's risk for HIV can be influenced by a number of factors, including their immigration experience, economic status, past or current exposure to violence or trauma, and relationship status.

Gender-Based Interventions are Necessary and Demand a Reproductive Justice Framework

Reproductive justice provides a framework for understanding the epidemics of HIV and domestic violence through examining the intersections of gender, race, poverty, economics, politics and other oppressions.[3] Reproductive justice helps to explain why groups of women traditionally thought of as being at low-risk for HIV infection, such as married AA and NHPI women or those in relationships, are actually at risk for HIV. A reproductive justice framework also helps to explain how reproductive coercion affects reproductive health and how populations such as young women, immigrant women, trafficked women and sex workers face specific vulnerabilities affecting their health and risk for HIV infection.

[1] Women and HIV/AIDS Fact Sheet, amfAR AIDS Research, March 2008. Available at http://www.amfar.org/uploadedFiles/In_the_Community/Publications/Fact%20Sheet%20Women%20and%20HIV%20AIDS.pdf.

[2] S. Dworkin and A. Ehrhardt, Going Beyond "ABC" to Include "GEM (Gender Relations, Economics and Migration)": Critical Reflections on Progress in the HIV/AIDS Epidemic. American Journal of Public Health, 2007; 97(1): 13-18.

[3] A New Vision for Advancing Our Movement for Reproductive Health, Reproductive Rights and Reproductive Justice. Asian Communities for Reproductive Justice, 2005.

HIV/AIDS AND DOMESTIC VIOLENCE IN ASIAN AMERICAN, NATIVE HAWAIIAN, AND PACIFIC ISLANDER COMMUNITIES

Asian American, Native Hawaiian and Pacific Islander Men and Women are at Risk for HIV/AIDS

Asian Americans and Pacific Islanders represent one of the fastest growing ethnic groups in the United States, with the Asian American population alone in the U.S. growing 43% between 2000 and 2010 and the NHPI alone population growing 35% in the same time frame.[4] The Census Bureau projects that by the year 2050, the number of Asian Americans will be over 16 million or more than 9% of the population, and the number of Native Hawaiians and Pacific Islanders will be 2.6 million or .06% of the population.[5]

While AA and NHPI HIV/AIDS cases account for approximately 1% of cases nationally, the rate of new AIDS cases increased by fifteen percent from 2002 to 2005 in Asian Americans and Pacific Islanders.[7] In addition, recent analysis of CDC data shows that Asian Americans and Pacific Islanders were the only racial/ethnic group with a statistically significant increase in new HIV diagnoses (4.4%) between 2001 and 2008.[8] Moreover, preliminary analysis of CDC data shows that AA and NHPI HIV rates will exceed those of Latinos in five years and African Americans in ten years, if left unchecked.

A women's risk for HIV infection depends on a number of factors. For example, the mode of transmission influences HIV risk, and is generally lowest for oral sex and highest for anal sex.[9] Women's risk for HIV also depends on the presence of abrasions or genital trauma, viral load of the man, and the woman's health.[10]

Most new infections in AA and NHPI women are the result of high-risk heterosexual contact.[11] Thus, for many AA and NHPI women, their risk for HIV infection depends on their male partner's risk behaviors and their knowledge of those behaviors. Married AA and NHPI women, and those in relationships, are particularly vulnerable to HIV infection due to perceptions of low risk, the presumption that marital sex equals safe sex, and difficulties negotiating condom use in relationships. The vulnerability of AA and NHPI women to HIV will be explored further in the following sections by examining the interplay of gender, culture and patriarchy on women's health.

[4] Overview of Race and Hispanic Origin: 2010, The US Census Bureau (March 2011) available at http://www.census.gov/prod/cen2010/briefs/c2010br-02.pdf.
[5] American Community Survey 2007-2009, U.S. Census Bureau.
[6] HIV/AIDS Surveillance Report: Cases of HIV Infection and AIDS in the United States and Dependent Areas in 2007 vol. 19, The Centers for Disease Control and Prevention (2009) available at http://www.cdc.gov/hiv/topics/surveillance/resources/reports/2007report/pdf/2007SurveillanceReport.pdf.
[7] Asian/Pacific Islanders and HIV/AIDS, The RYA HIV/AIDS Program (August 2008) available at ftp://ftp.hrsa.gov/hab/Asian.Pacific.pdf.
[8] W. Adih, M. Campsmith, C. Williams, F. Hardnett, D. Hughes, Epidemiology of HIV among Asians and Pacific Islanders in the United States, 2001-2008. Journal of the International Association of Physicians in AIDS Care, April 20, 2011. Available at http://jia.sagepub.com/content/early/2011/04/19/1545109711399805.
[9] Women, Sexual Violence and HIV. amfAR AIDS Research, July, 2005. Available at http://www.amfar.org/uploadedFiles/In_the_Community/Publications/Women%20Sexual%20Violence%20and%20HIV.pdf.
[10] Id.
[11] HIV/AIDS among Women, CDC HIV/AIDS Fact Sheet (Revised August 2008). Available at http://www.cdc.gov/hiv/topics/women/resources/factsheets/pdf/women.pdf.

Violence Against Women is Pervasive

Violence against women is pervasive across the globe, with one in three women experiencing gender-based violence in their lifetime. The United Nations defines gender-based violence as "any act of gender-based violence that results in, or is likely to result in, physical, sexual or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life." [13] Gender-based violence occurs across the lifecycle, from child abuse to intimate homicide in adulthood and is often "legitimized, obscured or denied by family, community and society, and perpetuated by the culturally-sanctioned devaluation of women."[14]

There are different forms of gender-based violence. This paper focuses on domestic violence and sexual violence because of their impact on women's physical and reproductive health, and in turn, risk for HIV infection. Domestic violence is a pattern of physical, sexual, emotional and economic abuses in romantic or intimate relationships. 41-61% of Asian Americans report experiencing domestic violence during their lifetime.[15] Domestic violence can occur in many forms, from coercive behavior to physical violence, and has a significant effect on women's sexual and reproductive health.

Sexual violence is defined by the World Health Organization as "any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work." [16] Most sexual violence is committed by persons known by the victim, such as family members, friends or community members.[17] For example, in a study interviewing 143 women, 56% of Filipinas and 64% of Indian and Pakistani women experienced sexual violence by an intimate.[18]

[12] Not a Minute More: Ending Violence Against Women, UNIFEM, 2003.
[13] Violence Against Women, World Health Organization, United Nations, 2009. Available at http://www.who.int/mediacentre/factsheets/fs239/en/index.html.
[14] Gender-Based Violence, Asian & Pacific Islander Institute on Domestic Violence. Available at http://www.apiidv.org/violence/analysis.php.
[15] This range is based on studies of women's experiences of domestic violence conducted among different Asian ethnic groups in the U.S. The low end of the range is from a study by A. Raj and J. Silverman, Domestic violence against South-Asian women in Greater Boston Journal of the American Medical Women's Association. 2002; 57(2): 111-114. The high end of the range is from a study by M. Yoshihama, Domestic violence against women of Japanese descent in Los Angeles: Two methods of estimating prevalence. Violence Against Women. 1999; 5(8):869-897.
[16] Violence Against Women, World Health Organization, United Nations, 2009. Available at http://www.who.int/mediacentre/factsheets/fs239/en/index.html.
[17] "[M]ost forced sex is committed by individuals known to the victim, such as the intimate partner, male family members, acquaintances, and individuals in position of authority." Violence Against Women and HIV/AIDS: Critical Intersections, World Health Organization (WHO) Information Bulletin Series, 1, 2002.
[18] M. Yoshihama , D. Bybee , C. Dabby, J. Blazevski, Lifecourse Experiences of Intimate Partner Violence and Help-Seeking among Filipino, Indian and Pakistani Women: Implications for Justice System Responses. Washington, DC: National Institute of Justice; 2011.

ATTITUDES AFFECT HEALTH: WHAT DO GENDER, CULTURE AND PATRIARCHY HAVE TO DO WITH HEALTH?

Gender, patriarchy and culture interact in complex ways that can influence a woman's physical health, relationship dynamics and the degree of control within her relationships. As such, domestic violence and HIV/AIDS also become issues of concern when gender discrimination, violence and other inequalities create social and health disparities.[19]

The Effect of Gender, Patriarchy, and Culture on Women's Health

The male/female binary of "gender" is a social construct defining how men and women should behave.[20] This gender binary perpetuates "patriarchy," a system for maintaining class, gender, racial and heterosexual privilege and the status quo of power.[21] "Culture" interacts with gender and patriarchy to form the boundaries of acceptable behavior and is used to justify gender inequality.[22] Culture is used to justify how women should be treated, and is used to defend or excuse actions such as violence against women.[23] In addition, culture can be responsible for how violence is viewed within a community, such as victim shaming, where a victim of violence is shunned by her family and community.[24]

Gender, patriarchy and culture interact with economics and other societal factors to influence behavior, and in turn, women's health, sexuality and risk for HIV infection. These societal constructs generate negative perceptions about women's sexuality. For example, chaste women are exemplified for their sexual purity, while women who deviate from this norm are characterized as promiscuous. This clear distinction between socially acceptable and social deviant sexual behavior can influence the age at which a young woman experiences her first sexual encounter.[25]

Societal perceptions defining appropriate female sexuality also extend to how women operate within relationships. For example, some Asian American and Pacific Islander women feel there is a "romantic ideal" within relationships such that condoms are not necessary or associated with infidelity.[26] Thus, gender, patriarchy and culture affect how people think about and view female sexuality and influence the degree to which women are able to use protection during sexual activity and prevent HIV infection.

The Effect of Gender, Patriarchy, and Culture on Relationship Dynamics and Control

Gender inequities are encompassed within societal structures at all levels, including personal relationships. By defining the type of behavior that is socially acceptable, gender interacts with patriarchy and culture to influence relationship dynamics and the degree of power women have within relationships.[27]

For example, sexual jealousy can have an effect on relationship dynamics simply by introducing accusations of female promiscuity.[28] In addition, men may exert control in relationships and deny female agency by pressuring women to have sex or engage in unwanted sexual activity.

Moreover, relationship dynamics and control are also influenced by women's overall lower economic status. For example, some women may be unable to negotiate condom use if they are economically dependent on their male partner. In addition, women's lower economic status can be exploited through the creation of a market for the exchange of sex for necessities or money.

[19] F. Dinys, A Manual for Integrating the Programmes for Services of HIV and VAW. United Nations Entity for Gender Equality and Empowerment, 2009. Available at http://www.preventgbvafrica.org/content/development-connections-manual-integrating-programmes-and-services-hiv-and-violence-against-.
[20] G.Gupta, Plenary Address XIIIth International AIDS Conference: Gender, Sexuality, and HIV/AIDS: The What, the Why, and the How. International Center for Research on Women (ICRW), July, 2000. Available at http://siteresources.worldbank.org/EXTAFRREGTOPGENDER/Resources/durban_speech.pdf.
[21] Gender-Based Violence, Asian & Pacific Islander Institute on Domestic Violence. Available at http://www.apiidv.org/violence/analysis.php.
[22] Id.
[23] Id.
[24] Id.
[25] See generally G. Wingood and R. DiClemente, Application of the Theory of Gender and Power to Examine HIV-Related Exposures, Risk Factors, and Effective Interventions for Women. Health Education and Behavior, 2000; 27(5), 539-565.
[26] Dorothy Chin, HIV-Related Sexual Risk Assessment Among Asian/Pacific Islander American Women: An Inductive Model. Social Science & Medicine, 1999; 49: 241-251.
[27] HIV-Related Sexual Risk Assessment Among Asian/Pacific Islander American Women: An Inductive Model
[28] B. Lichtenstein, Domestic Violence, Sexual Ownership, and HIV Risk in Women in the American Deep South. Social Science and Medicine, 2004; 60(4), 701-714.

THE EFFECT OF VIOLENCE ON HEALTH AND HIV RISK

Gender-based violence and oppression are used as tools to insulate gender norms and expectations from change. They serve to control, punish and silence alternatives to the status-quo. As the United Nations Entity for Gender Equality and Empowerment (UNIFEM) manual noted, gender-based violence, including domestic violence, intersects with HIV and shares a "common basis in gender inequalities, intersected with other sources of discrimination such as ethnicity, age, level of education, socioeconomic status, area of residence, sexual orientation, among others." Violence has a direct effect on health and health outcomes.

Exposure to Violence and Health Outcomes

The experience of childhood, domestic or sexual violence can increase the chances for poorer health and behavioral outcomes. Exposure to childhood violence or adverse events is correlated with a number of negative health outcomes later in life, including high stress levels, depression and the development of chronic diseases. Exposure to domestic or sexual violence has also been linked to negative health outcomes and behaviors later in life such as chronic diseases, sexually transmitted diseases (STDs), unwanted pregnancies and repeated abortions. Negative health behaviors include increased numbers of sexual partners, substance abuse, and ability/inability to use protection during sexual activity. Women who have experienced violence are more likely than women who have not, to have traded sex for necessities, used drugs or been forced to have sex with an HIV positive person.

Violence, Relationship Control and Reproductive Coercion

Women in violent relationships face a number of barriers affecting their health. According to an article published in the American Journal of Public Health, women who are at "highest risk for domestic violence are demographically similar to women at risk for HIV infection." This similarity is due in part to the fact that women in battering relationships have lower relationship power, which can affect their risk for HIV infection. Relationship power is a method of conceptualizing the degree of power people have within relationships, and is influenced by the societal constructs of gender, patriarchy and culture.

Reproductive coercion is a form of relationship power involving control or manipulation of a woman's reproductive health. Reproductive coercion is a significant problem in abusive relationships and can occur through a variety of forms. For example, batterers may verbally abuse partners prior to sexual activity, threatening to impregnate them. Batterers may also use economic coercion to prevent partners from purchasing contraceptives or condoms and/or hide or tamper with contraceptive pills. In addition, batterers may play "condom roulette" by picking holes in condoms or force their partner to carry a pregnancy to term. These coercive tactics place women's health at risk by resulting in unwanted pregnancies, exposing women to sexually transmitted diseases and resulting in other physical and emotional trauma.

[29] J. Campbell, Health Consequences of Intimate Partner Violence, The Lancet, Vol. 359, April 13, 2002.
[30] A Manual for Integrating the Programmes for Services of HIV and VAW
[31] Health Consequences of Intimate Partner Violence
[32] J. Clark and B. Nagy, Trainings to Integrate Sexual and Domestic Violence Screening into Family Planning Settings: Key Components for Success. Family Violence
[33] Prevention Fund, Family Violence Prevention & Health Practice; June 25 2010. Available at http://endabuse.org/health/ejournal/2010/06/trainings-to-integrate-sexual-and-domestic-violence-screening-into-family-planning-settings-key-components-for-success/.
[34] Id.
[35] C. Deamant, S. Barkan, J. Richardson, M. Young, S. Holman, K. Anastos, J. Cohen, and S. Melnick, Domestic Violence and Childhood Sexual Abuse in HIV-Infected 36 Women and Women at Risk for HIV. American Journal of Public Health, 2000; 90(4) 560-565.
[37] Id.
[38] Domestic Violence and Childhood Sexual Abuse in HIV-Infected Women and Women at Risk for HIV.
[39] A. Campbell, S. Tross , S. Dworkin, M. Hu, Manuel J, M. Pavlicova and E. Nunes, Relationship Power and Sexual Risk among Women in Community-Based
[40] Substance Abuse Treatment. Journal of Urban Heath: Bulletin of the New York Academy of Medicine, 2009; 86(6):951-964.
[41] Trainings to Integrate Sexual and Domestic Violence Screening into Family Planning Settings: Key Components for Success
[42] A. Moore, L. Frohwirth and E. Miller, Male Reproductive Control of Women Who Have Experienced Intimate Partner Violence in the United States, Guttmacher
[43] Institute. Available at http://www.guttmacher.org/pubs/journals/socscimed201002009.pdf.
[44] Id.
[45] Id.

STIGMA AND CULTURAL BARRIERS IN ASIAN AMERICAN, NATIVE HAWAIIAN AND PACIFIC ISLANDER WOMEN AND VULNERABLE POPULATIONS

Stigma plays a significant role in how HIV and STDs are understood, prevented and treated. AA and NHPIs, in particular, face strong cultural barriers including sensitivity to discussions of sexuality, presumed heterosexuality, homophobia and the general perception that AA and NHPIs are not at risk for HIV/AIDS. Asian Americans are comprised of many distinct cultures, some of which value familial or collective thought over that of the individual, creating greater family influence over sexual norms.[42] Moreover, many Asian cultures consider sexuality and illness/disease to be "taboo," rendering discussions of STD prevention difficult.[43] Specific populations of AA and NHPIs, including married women or those in relationships, youth, immigrants, trafficked women and those engaged in sex work, face a number of specific vulnerabilities affecting their risk for HIV.

Married Asian American, Native Hawaiian and Pacific Islander Women and Women in Relationships

HIV risk for married AA and NHPI women, and those in relationships, is influenced by a number of factors. Married women, and those in relationships, face a strong societal perception that marital sex equals safe sex. This presumption is dangerous, given that the majority of new HIV infections in AA and NHPI women are the result of high-risk heterosexual contact.[44] Thus, for many AA and NHPI women, marital sex or sex within relationships has the potential to be the most high-risk sex they will engage in.

A woman's risk for HIV infection frequently depends on the risk behaviors of her male partner, and her knowledge of those behaviors. Women in relationships and married women can be placed at risk for HIV through male infidelity, including men who have sex with men (known as men on the "down low"). In addition, AA and NHPI women in relationships may be unable to negotiate condom use because condom use is highly stigmatized and can imply infidelity in some cultures.[45] These societal barriers create challenges for interventions aimed at lessening HIV risk for women in relationships, as they must take into account these complex relationship dynamics.

In addition to cultural pressures and dynamics within relationships, AA and NHPI women face external societal pressures and stigma surrounding HIV and STDs. Asian American and Pacific Islander women may fear negative community reaction to an HIV diagnosis, due to the disease's association with sexuality.[46] For example, in a study conducted among Asian American and Pacific Islander women, persons who were infected with HIV as the result of blood transfusions were treated differently by community and family members than those infected through sexual activity, where the later were viewed as "sluts" having a "shame about them."[47]

[42] S. Cochran, V. Mays, and L. Leung, Sexual Practices of Heterosexual Asian-American Young Adults: Implications for Risk of HIV Infection. Archives of Sexual Behavior, 1991; 20(4) 381-391.
[43] D. Chin and K. Krosen, Disclosure of HIV Infection Among Asian/Pacific Islander American Women: Cultural Stigma and Support. Cultural Diversity and Ethnic Minority Psychology, 1999; 5(3): 222-235.
[44] HIV/AIDS among Women, CDC HIV/AIDS Fact Sheet, Aug. 2008. Available at http://www.cdc.gov/hiv/topics/women/resources/factsheets/pdf/women.pdf.
[45] HIV-Related Sexual Risk Assessment Among Asian/Pacific Islander American Women: An Inductive Model. Social Science & Medicine, 1999; 49: 241-251.
[46] Disclosure of HIV Infection Among Asian/Pacific Islander American Women: Cultural Stigma and Support
[47] Id.

Young Asian American, Native Hawaiian and Pacific Islander Women

Young women have the highest STD rates compared to other age groups and face a number of challenges, both biological and societal.[48] For instance, a young women's biology affects her risk for HIV infection as the immaturity of her genital tract makes coerced or forced sex especially harmful.

Young AA and NHPI women face specific societal challenges revolving around their lower economic status and the "double standard"[49] around female promiscuity and sexuality. Young AA and NHPI women may internalize the societal and cultural emphasis on virginity and chastity,[50] causing them to be uncomfortable discussing sex and sexuality. In addition, the cultural avoidance of sexuality and labeling of the subject as taboo[51] creates situations where many young women lack sufficient knowledge about their sexual and reproductive health. Young women's lack of knowledge and education is further compounded by external factors, such as lack of access to comprehensive sex education and dominance of abstinence-only-until-marriage education in many public school districts. Abstinence-only-until-marriage education fails to provide young women with sufficient knowledge of their sexual and reproductive health and erroneously assumes pregnancy prevention is inclusive of STD prevention. Moreover, in addition to these societal and cultural barriers, young women's lower economic status renders them vulnerable to violence and coercion and can affect the onset of sexual activity.

Transgender Asian Americans, Native Hawaiians and Pacific Islanders

Transgender AA and NHPIs face significant cultural and economic barriers that impact their ability to access testing, treatment and support services for HIV and domestic violence. Transgender persons face discrimination across many aspects of their life, including employment, and report high numbers of forced sexual activity and rape.[52] With limited economic opportunities, some transgender persons engage in sex work as a means of survival, with one study conducted in San Francisco finding that one third of female-to-male persons had engaged in sex work.[53] Discrimination in health care is also common, causing many transgender persons to avoid contact with physicians and medical personnel due to provider discomfort and stigma.

Immigrant Asian American and Pacific Islander Women

Immigrant Asian American and Pacific Islander women are at high risk for violence and HIV/AIDS due to complex immigration restrictions and language barriers. Immigration restrictions, such as the five-year waiting period for federal means tested public benefits, restrict immigrant women's ability to access safety-net programs such as Medicaid, and negatively affects their ability to access reproductive health care. In addition, women entering the United States on a derivative visa are dependent on their husbands for their legal immigration status and can experience adverse impacts if they leave their spouses before a specified time period. Language barriers compound these obstacles, making it difficult for battered immigrant women to leave their batterers, become economically self-sufficient, and communicate with health care workers.

In addition to immigration restrictions and language barriers, some Asian American and Pacific Islander women arrive from conflict zones, where sexual violence is used as a systematic method of targeted gender-based violence.[54] Immigrant women arriving from conflict zones frequently experience physical and mental trauma as a result of sexual assault, and may be further stigmatized by their families and communities and blamed for subsequent HIV infections. In addition, immigrant women may experience sexual assault during relocation from their home countries, such as in detention centers or by immigration custodians.

[48] Application of the Theory of Gender and Power to Examine HIV-Related Exposures, Risk Factors, and Effective Interventions for Women
[49] S. Cochran, V. Mays, and L. Leung, Sexual Practices of Heterosexual Asian-American Young Adults: Implications for Risk of HIV Infection. Archives of Sexual Behavior, 1991; 20(4): 381-391.
[50] Domestic Violence, Sexual Ownership, and HIV Risk in Women in the American Deep South
[51] HIV-Related Sexual Risk Assessment Among Asian/Pacific Islander American Women: An Inductive Model
[52] K. Clements-Nolle, R. Marx, R. Guzman and M. Katz, HIV Prevalence, Risk Behaviors, Health Care Use, and Mental Health Status of Transgender Persons. American Journal of Public Health, 2001; 91(6): 915-921.
[53] Id.
[54] The War Within: Sexual Violence Against Women and Girls in Eastern Congo, Human Rights Watch, June 2002. Available at http://www.hrw.org/node/78573 (noting that sexual violence in armed conflict is accepted). See also S. Kohsin Wang, Violence & HIV/AIDS: Violence Against Women and Girls as a Cause and Consequence of HIV/AIDS. Duke Journal of Gender Law and Policy, May 2010; 17 Duke J. Gender L. & Policy 313.

Trafficked Women and Sex Workers

Sex work is a direct result of economic inequities [55] and is perpetuated through predatory sexual behavior. For many women, sex work is their only viable means of survival. [56] AA and NHPI women engaged in sex work may be forced into the industry through trafficking and enslavement. Women engaged in sex work frequently report high rates of rape and physical and mental trauma, as well as restrictions on freedom. [57] Women engaged in sex work are at high risk for STD infections, with 94% of participants in one study reporting at least one STD. [58] Moreover, men sometimes exploit women's economic inequities by offering to pay more for unprotected sex. [59]

[54] The War Within: Sexual Violence Against Women and Girls in Eastern Congo, Human Rights Watch, June 2002. Available at http://www.hrw.org/node/78573 (noting that sexual violence in armed conflict is accepted). See also S. Kohsin Wang, Violence & HIV/AIDS: Violence Against Women and Girls as a Cause and Consequence of HIV/AIDS. Duke Journal of Gender Law and Policy, May 2010; 17 Duke J. Gender L. & Policy 313.
[55] K. Shannon, T. Kerr, S. Allinott, J. Chettiar, J. Shoveller, and M. Tyndall, Social and Structural Violence and Power Relations in Mitigating HIV Risk of Drug-Using Women in Survival Sex Work. Social Science & Medicine, 2007; 66: 911-921.
[56] Id.
[57] Rothschild C, Reilly M, and Nordstrom S, Strengthening Resistance: Confronting Violence Against Women and HIV/AIDS, Center for Women's Global Leadership, 2006.
[58] T Nemoto, D Operario, M Takenaka, M Iwamoto, and M Nhung Le, HIV Risk Among Asian Women Working at Massage Parlors in San Francisco. AIDS Education and Prevention. 2003; 15(3), 245-256.
[59] Social and Structural Violence and Power Relations in Mitigating HIV Risk of Drug-Using Women in Survival Sex Work

CONCLUSION

HIV and domestic violence intersect at a number of points through a complex interplay of societal and structural barriers. Women's physical, sexual and reproductive health is directly impacted by these barriers, and the interaction of gender, patriarchy and culture affects women's relationship dynamics and control. Moreover, specific populations of women, such as Asian American, Native Hawaiian and Pacific Islanders face distinct challenges affecting their risk for infection, ability to remain uninfected and access care. Given the degree to which women's health is affected through this complex interaction of forces, it is vital that domestic violence advocates and HIV/AIDS service providers understand the unique challenges faced by women, as this understanding is necessary for formulating effective and culturally appropriate interventions.

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The Asian & Pacific Islander Institute on Domestic Violence (API Institute) works to eliminate domestic violence in Asian and Pacific Islander communities by:

- Increasing awareness about the extent and depth of the problem.
- Making culturally-and linguistically-specific issues visible.
- Strengthening community models of prevention and intervention.
- Identifying and expanding resources.
- Informing and promoting research and policy.
- Deepening understanding and analyses of the issues surrounding violence against women.

RESOURCES

HIV/AIDS

CDC factsheet on HIV in the United States: http://www.cdc.gov/hiv/resources/factsheets/us.htm.

CDC factsheet on HIV/AIDS among Asians and Pacific Islanders: http://www.cdc.gov/hiv/resources/factsheets/API.htm AIDS.GOV HIV 101 basics: http://www.aids.gov/hiv-aids-basics/.

Women and HIV

Family Violence Prevention Fund factsheet: The Facts on Reproductive Health and Partner Abuse: http://www.knowmoresaymore.org/wp-content/uploads/2008/07/factsheet-on-rh-and-dv-nov-2010.pdf.

Sandra L. Martin and Rebecca J. Macy, Sexual Violence Against Women: Impact on High-Risk Health Behaviors and Reproductive Health. VAW Net: Applied Research Forum, National Online Resource Center on Violence Against Women, June 2009. Available at http://new.vawnet.org/category/Main_Doc.php?docid=2034.

Marguerite L. Baty, The Intersection of HIV and Intimate Partner Violence: Considerations, Concerns, and Policy Implications. Family Violence Prevention Fund, Family Violence Prevention and Health Practice E-Journal, 2008. Available at http://endabuse.org/health/ejournal/archive/1-7/hiv_ipv.php.

Gender-Based Violence and HIV Among Women: Assessing the Evidence. amfAR AIDS Research, June 2005. Available at http://www.amfar.org/uploadedFiles/In_the_Community/Publications/Gender%20BAsed%20Violence%20and%20HIV%20Among%20Women.pdf.

Health Care and Domestic Violence

For more information about gender-based violence and domestic violence, please visit the Asian & Pacific Islander Institute on Domestic Violence at http://www.apiidv.org.

Asian & Pacific Islander American Health Forum factsheet on the impact of health care reform on the treatment of HIV/AIDS: http://www.apiahf.org/resources/resources-database/impact-health-care-reform-prevention-diagnosis-and-treatment-hivaids-as.

Asian & Pacific Islander American Health Forum factsheet on the impact of health care reform on survivors of violence: http://www.apiahf.org/resources/resources-database/impact-health-care-reform-asian-american-native-hawaiian-and-pacific-is.

Technical Assistance

For technical assistance on gender-based violence and domestic violence in the AA and NHPI community, please contact the Asian & Pacific Islander Institute on Domestic Violence at http://www.apiidv.org.

For more information on how to integrate reproductive coercion and domestic violence, please contact Futures without Violence at http://www.futureswithoutviolence.org/.

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