

Dr. Howard K. Koh
Assistant Secretary for Health
Department of Health and Human Services
200 Independence Ave. SW
Washington, D.C. 20201

Dr. Ron Valdiserri
Deputy Assistant Secretary for Health, Infectious Diseases
Department of Health and Human Services
200 Independence Ave. SW
Washington, D.C. 20201

Re: Comments on the *National HIV/AIDS Strategy for the United States and Federal Implementation Plan*

October 15, 2010

Dear Doctors Koh and Valdiserri:

On behalf of the coalition of undersigned organizations invested in HIV/AIDS related efforts focused in Asian American, Native Hawaiian, and Pacific Islander (AA and NHPI) communities, the Asian & Pacific Islander American Health Forum (APIAHF) and the Asian & Pacific Islander Wellness Center (A&PI Wellness Center) are submitting the following comments to you in your respective roles in the coordination of the Department of Health and Human Service's development of implementation plans for the National HIV/AIDS Strateg (NHAS). We thank the Department of Health and Human Services for the opportunity to comment on the National Strategy and Federal Implementation Plan.

We strongly support the White House Office of National AIDS Policy's efforts in developing this historic strategy. Specifically, we commend the White House for their inclusion of AAs and PIs in surveillance efforts at the federal and state levels. While targeted and disaggregated surveillance of AA and NHPI populations is necessary toward addressing infection rates and health disparities in these populations, however, we believe that the primary focus on surveillance for AA and NHPI populations is insufficient.

As HHS moves forward with NHAS implementation planning at the department and agency levels, we ask that you consider the following:

- **Ambition:** Where the plan suggests a 25% reduction in new infections, we urge HHS to take this window of opportunity to stem an emerging epidemic in AA and NHPI communities, and prevent infection rates from reaching the alarming numbers seen in the African American and Latino communities.
- **Inclusion:** We urge HHS to consider AA and NHPI populations as significant sectors of the U.S. population facing HIV/AIDS, to consider the unique social determinants facing AA and NHPI men who have sex with men (MSM),

transgendered persons and women, and implement the strategies outlined in the following pages.

- **Funding:** Implementation of NHAS requires an overall increase in funding, not a shift in existing funding. We have witnessed that HIV prevention and care resources are often the first to get cut at the national, state, and local level, and this has left the AA and NHPI focused programs with a weakened infrastructure to respond to the increasing HIV prevention and care needs in their respective communities.
- **Transparency:** Implementation must include the opportunity for public comment periods and continued involvement of community stakeholders.

These four themes are echoed throughout this document. Our remaining feedback and recommendations are clustered into three primary sections: Section 1 provides feedback on the previously released *National HIV/AIDS Strategy*, Section 2 provides feedback on the previously released *NHAS Federal Implementation Plan*, and Section 3 provides recommendations for agency-level implementation plans.

SECTION 1: FEEDBACK ON THE NATIONAL HIV/AIDS STRATEGY

We urge HHS to focus not only on raw numbers of HIV/AIDS cases, but on infection rates and estimated annual percentage changes

AAs and PIs represent one of the fastest growing ethnic groups in the United States with the AA population alone in the U.S. growing 72% between 1990 and 2000.ⁱ The Census Bureau projects that by the year 2050, the number of AAs and PIs will be nearly 40 million or 9% of the population.ⁱⁱ While AA and NHPI HIV/AIDS cases account for approximately 1% of cases nationallyⁱⁱⁱ, the rate of new AIDS cases increased by 15% from 2002 to 2005.^{iv} A recent CDC Morbidity and Mortality Weekly Report noted that AA and NHPI populations were the only groups that showed statistically significant increases in estimated annual percentage changes (EAPC). Preliminary analysis of this 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. The window of opportunity for HIV prevention is clearly now. AAs and NHPIs have some of the lowest rates of testing for HIV, compared to other ethnic groups, in which over two-thirds of AAs and over one half of PIs have never been tested.^v We believe the most accurate measure of HIV/AIDS in AAs and NHPIs is through infection rates and changes in EAPC, and not raw numbers. We remind HHS that AAs and NHPIs continue to be at high-risk for HIV/AIDS and should be a focus of the National Strategy and implementation.

We urge HHS to focus on the unique barriers to prevention and care that AAs and NHPIs face

AAs and NHPIs experience a variety of barriers preventing these populations from testing for HIV, attaining quality care, achieving positive health outcomes and maintaining continuous care. The diversity of languages spoken by AAs create significant barriers in the healthcare setting, in which 73% of AAs speak a language other than English in their homes.^{vi} Additional barriers include large populations with limited

English proficiency (LEP), high immigrant populations with varying degrees of health literacy amongst AAs, economic factors and lack of culturally appropriate care and services.

One unique barrier facing AAs and NHPIs and other communities of color is HIV-related stigma. Nearly 70% of AAs and PIs infected with HIV are men who have sex with men (MSM).^{vii} AA and NHPI MSM populations face strong cultural barriers, including homophobia and presumed heterosexuality. Taboos over questions of sexual orientation and gender identity place unique burdens on transgendered AAs and NHPIs. HIV-related stigma and cultural taboos directly affect the health of AA and NHPI MSM and transgendered persons by preventing them from seeking HIV testing, accessing care and developing family support systems. We urge HHS to continue to develop and focus on strategies affecting MSM and transgendered populations of all races and ethnicities, and include approaches directly targeted to AA and NHPI MSM and transgendered populations.

We urge HHS to focus on the social determinants of HIV infection in women, including AA and NHPI women

Women make up more than one quarter of all new HIV/AIDS diagnoses and HIV was the 5th leading cause of death among women aged 35-44 in 2004.^{viii} Unlike Black, White or Hispanic women, AA and NHPI female infection rates rose from 2001 thorough 2004.^{ix} In 2005, 80% of AA and PI female infections were the result of high-risk heterosexual contact^x, caused by the inability to negotiate male condom use, physical abuse or sexual inequality. The unique social determinants facing women must be more thoroughly examined and should guide further implementation of NHAS. AA and PI women experience high rates of intimate partner violence, in which over 15% of 8,000 women surveyed experienced intimate partner violence, including rape.^{xi} We urge HHS to consider all forms of violence against women as social determinants, including economic coercion, restrictions on the ability to obtain healthcare, violence as the result of seropositive status, control over immigration information/documentation, abandonment, and physical and sexual violence.

AA and NHPI women face additional social determinants hindering their ability to test for HIV, obtain positive health outcomes and maintain continuous care. AA and NHPI women face unique relationship dynamics and are subject to cultural taboos regarding sexuality and promiscuity.^{xii} AA and PI women are less likely to access gynecological services, more likely to be diagnosed with HIV at later stages^{xiii} and face numerous language barriers. We remind HHS that women, including AA and NHPI women, must be considered in combating HIV/AIDS in the United States and implementation strategies must take into account the social determinants facing these populations. AA and NHPI female HIV infection rates are rising and strategies must be implemented to view these women as a significant part of our effort to combat HIV/AIDS.

We urge HHS to ensure that Native Hawaiians and the six-U.S. affiliated Pacific Island jurisdictions are included in the implementation of the National Strategy

While we recognize NHPs may not be as heavily impacted by HIV/AIDS as other groups, these historically disenfranchised populations face significant challenges to accessing culturally competent HIV prevention and care. And in particular for the six-U.S. affiliated Pacific Island jurisdictions, via their varying levels of affiliation with the U.S., HHS bears a responsibility of ensuring their inclusion in national level strategies and access to resources.

SECTION 2: FEEDBACK ON THE NHAS FEDERAL IMPLEMENTATION PLAN

We applaud the recommended implementation area related to surveillance in AA and NHPI communities included in the Federal Implementation Plan released on July 13, 2010 as a companion document to the National HIV/AIDS Strategy.

Specifically, we support the recommendation that federal and state agencies, particularly CDC, support surveillance activities in areas with great concentrations of AAs and NHPs, to better characterize HIV in smaller populations. Additionally, we appreciate the acknowledgement that policy makers need to appropriately respond to HIV in communities that represent a small share of the U.S. population.

We strongly urge HHS, specifically CDC, HRSA, SAMHSA, and NIH, however, to build upon these surveillance efforts for AA and NHPI communities.

While increased surveillance between federal and state partners is an important initial step, there now exists a critical window of opportunity to direct targeted efforts and resources to AA and NHPI communities through culturally competent HIV prevention and access to care. Simultaneously, an important component of reducing HIV-related health disparities in AA and NHPI communities is addressing the continued HIV-related stigma that exists in AA and NHPI communities.

The opportunity of an expanded targeted approach will achieve better health indicators in AA and NHPI communities and may also establish a demonstrated model of targeting HIV prevention resources for emerging communities that can be documented and proven effective.

SECTION 3: RECOMMENDATIONS FOR AGENCY-LEVEL IMPLEMENTATION PLANS

Building upon the previously released federal implementation plan, we have outlined additional actions that we encourage HHS to incorporate into the various federal-level implementation plans.

Goal 1: Reducing New HIV Infections

1.1 Allocate public funding to geographic areas consistent with the epidemic:

Lead Agency/ Other Agencies	Suggested Actions To Be Performed
HHS OS, CDC, HRSA	By mid-2011, HHS OS and relevant agencies will host consultation with the six U.S.-affiliated Pacific Island jurisdictions to ensure that the unique needs and challenges of this region are considered when allocating prevention funding to targeted populations and communities.

1.2 Target high risk populations:

Lead Agency/ Other Agencies	Suggested Actions To Be Performed
CDC/HRSA, SAMHSA, HHS OS	By end of 2011, CDC in consultation with HRSA, SAMHSA, and HHS OS will develop and implement a plan of recommended action steps for reducing the proportion of HIV-positive AA and NHPI individuals with undiagnosed HIV infection. Currently, CDC estimates that nearly 30% of AA and NHPIs living with HIV/AIDS are unaware of their status. This is the highest proportion across all racial/ethnic groups.

1.2.1 Prevent HIV among gay and bisexual men and transgender individuals:

Lead Agency/ Other Agencies	Suggested Actions To Be Performed
HHS OS	By the end of 2010, HHS OS will convene consultations to address HIV prevention among gay and bisexual men and transgenders. HHS OS and related agencies will ensure organizational representation from AA and NHPI communities across the U.S. and the six U.S.-affiliated Pacific Island jurisdictions.
CDC	By mid 2012, CDC will expand its work evaluating adaptations of specific interventions for gay and bisexual men and transgender populations, including AAs and NHPIs. Specifically, CDC will issue a report that documents previous and current adaptation and evaluation efforts of interventions targeted to AA and NHPI populations.
CDC/NIH	By end of 2012, CDC and NIH will conduct research on socio-contextual factors that drive HIV risk among AA and NHPI women. Based on this research, CDC will develop recommendations for essential prevention activities and services for AA and NHPI women.

1.3 Address HIV prevention in Asian American and Pacific Islander (AAPI) and American Indian and Alaska Native (AI/AN) populations:

Lead Agency/ Other Agencies	Suggested Actions To Be Performed
CDC	By mid-2011, CDC will convene an external working group consisting of health department and CBO representatives, familiar with AA, NHPI, and AI/AN issues to identify recommendations on effective HIV surveillance activities. In particular, this working group will identify strategies to 1) ensure that Asian American, Native Hawaiian, and Pacific Islander (AA and NHPI) and AI/AN data is reported in tables, charts, and graphs related to racial/ethnic level HIV/AIDS data; 2) discourage the practice of lumping AA and NHPI and AI/AN data into an “Other” category when racial/ethnic level HIV/AIDS data is reported; and 3) disaggregate AA and NHPI data by ethnic subgroup.
CDC	By end of 2012, CDC will incorporate these recommendations into future HIV surveillance cooperative agreements and technical guidances for health departments. CDC should monitor and provide capacity building assistance related to these recommendations.
CDC, HRSA	By end of 2010, CDC and HRSA will ensure that there are multiple AA and NHPI representatives on the CDC/HRSA Advisory Committee on HIV and STD. These representatives will have personal or professional experience with domestic HIV prevention and/or care efforts with AA and NHPI communities.
CDC, SAMHSA, NIH	By mid-2011, CDC, SAMHSA, and NIH will convene a joint consultation and/or external working group with state health department and CBO representatives from the states with the largest AA and NHPI communities with the purpose of identifying the best combination of approaches to prevent HIV that reach AAs and NHPIs at greatest risk for infection. Additionally, the agencies will prioritize research gaps for AA and NHPI communities (including the dearth of evidence based interventions) and identify strategies/funding opportunities to fill these gaps.
CDC	By end of 2010, CDC will support state health departments in increasing AA and NHPI representation on state community planning groups and increasing the awareness and attention of CPGs to the growing HIV epidemic among AA and NHPI communities.
CDC, SAMHSA, HRSA	By end of 2011, CDC, SAMHSA and HRSA will increase HIV prevention, care and treatment resources to CBOs and health departments to address the epidemic among AA and NHPI communities in order to strengthen the linkages between testing and care. This is inclusive of efforts to address HIV in the six U.S.-affiliated Pacific Island jurisdictions.

2.1 Design and evaluate innovative prevention strategies and combination approaches for preventing HIV in high risk communities:

Lead Agency/ Other Agencies	Suggested Actions To Be Performed
NIH/CDC	By mid-2011, NIH will work with CDC to develop and implement a plan for evaluating promising community-generated ('homegrown') HIV prevention interventions, including interventions that are culturally appropriate and linguistically accessible for AA and NHPI populations.
NIH/CDC	By mid-2011, NIH will work with CDC to develop and implement a plan for evaluating the effectiveness of evidence based HIV prevention interventions that have been adapted and tailored for AA and NHPI populations.

2.2 Expand prevention with HIV-positive individuals:

Lead Agency/ Other Agencies	Suggested Actions To Be Performed
CDC	By end of 2010, CDC will work with States and localities to promote and implement scalable interventions with individuals living with HIV to lower their risk of transmitting HIV, including interventions for AAs and NHPIs living with HIV.

3.1 Utilize social marketing and education campaigns:

Lead Agency/ Other Agencies	Suggested Actions To Be Performed
CDC	By end of 2010, CDC will initiate a CDC-wide review of all social marketing and education campaigns related to HIV, STI, substance abuse and risk behaviors that increase risk of HIV transmission and will work to expand evidence based efforts to achieve maximum impact. In particular, CDC will assess the extent to which these campaigns are culturally appropriate and linguistically accessible to AA and NHPI populations,
CDC	By end of 2011, CDC will work with States and localities to expand public-private partnerships to focus on reaching high risk communities, including high risk AA and NHPI communities and the general AA and NHPI public, and/or the general public to prevent HIV/STI infection.

**Goal 2: Increasing Access to Care and Improving Health Outcomes
for People Living with HIV**

1.1 Facilitate Linkages to Care:

Lead Agency/ Other Agencies	Suggested Actions To Be Performed
HRSA	By end of 2010, HRSA will begin to develop information templates to enable health departments to provide customized, local information on where to access care and support services that are culturally competent and linguistically accessible for AA and NHPI populations. Such information could be disseminated online, at community health centers and other facilities.
HRSA/CDC, VA, HUD	By end of 2011, HRSA in collaboration with CDC, VA, HUD and other relevant agencies will develop plans that support health care providers and other staff who deliver HIV test results to conduct linkage facilitation to ensure AA and NHPI clients with limited English proficiency have access to culturally and linguistically appropriate care following a positive diagnosis.
CDC, HRSA, SAMHSA	By end of 2011, CDC, HRSA, SAMHSA and other relevant HHS agencies will work with States, the six U.S.-affiliated Pacific Island jurisdictions, tribal governments, localities, and CBOs to promote co-location of providers of HIV screening and care services as a means of facilitating linkages to care and treatment, and to enhance current referral systems within CBOs.
HRSA	By end of 2010, HRSA will encourage centers applying for New Access Point grants to include comprehensive and support services for people living with AIDS. To provide comprehensive HIV services in community health centers, exceptions must be made to reflect the high number of patient visits to treat HIV. In this context, CBOs who are in a position to become Federally Qualified Health Centers (FQHC) should receive specialized technical assistance to achieve this status. HRSA should expand its selection criteria for funding FQHCs to reflect lower provider ratios, e.g. from 1,000-1,500 per Full Time Employee to 250-300 for HIV patients and lowered numbers of total patients on an annual basis.

1.2 Promote collaboration among providers:

Lead Agency/ Other Agencies	Suggested Actions To Be Performed
HHS OS	By end of 2011, HHS agencies will develop plans and work with States to implement training opportunities for health care providers that will highlight the importance of program collaboration and service integration to reduce missed opportunities for identifying HIV infection. This should include specific plans to highlight opportunities in AA and NHPI communities to link HIV screening with STD, TB, and hepatitis B screening.
HHS OS	By end of 2011, HHS agencies should explore opportunities to streamline and coordinate grant application and reporting requirements across HIV prevention and care, especially for low-resource, low-staff jurisdictions such as the six U.S.-affiliated Pacific Island jurisdictions.
CDC	By end of 2011, CDC should continue to identify opportunities to streamline and coordinate grant applications and reporting requirements across HIV, STD, TB, and viral hepatitis, especially for low-resource, low-staff jurisdictions such as the six U.S.-affiliated Pacific Island jurisdictions.

2.1 Increase the number of available providers of HIV care:

Lead Agency/ Other Agencies	Suggested Actions To Be Performed
HRSA	By end of 2010, HRSA will issue guidance encouraging medical, dental, pharmacy, physician assistant, nurse practitioner, social work, and nursing schools to implement curricula that include HIV-specific training, as well as offer suggestions for connecting LEP clients to culturally and linguistically competent HIV care services. The curricula should encompass issues of race/ethnicity, gender and gender identity, sex and sexual orientation and age to ensure providers are competent in quality HIV health diversity.
HRSA/NIH, OMH	By end of 2011, HRSA, NIH and OMH will develop a proposal to fund training programs to increase interest, representation and competence of health professionals, researchers, and racial and ethnic minority students in research, public health and HIV/AIDS care, including AA and NHPI students.

2.2 Strengthen the current provider workforce to improve quality of HIV care and health outcomes for people living with HIV:

Lead Agency/ Other Agencies	Suggested Actions To Be Performed
HRSA	By end of 2010, HRSA will work with its AETCs to expand training for HIV clinicians and provider organizations to address provider-associated factors (e.g., cultural competency, provider continuity) that affect treatment adherence, including working with AA and NHPI clients.
DOL, HRSA	By end of 2011, DOL and HRSA will work with health professions associations and collaborate on workforce training efforts to increase the number of health providers who are culturally competent and to ensure systems are in place to provide linguistically accessible services.

3.1 Enhance client assessment tools and measurement of health outcomes:

Lead Agency/ Other Agencies	Suggested Actions To Be Performed
HRSA	By end of 2011, HRSA will work to expand training for non-clinical health providers to build a national standard of HIV competence to affect treatment adherence.

Goal 3: Reducing HIV-Related Health Disparities

2.1 Establish pilot programs that utilize community models:

Lead Agency/ Other Agencies	Suggested Actions To Be Performed
HHS OS	By end of 2011, HHS OS will work with relevant HHS agencies to enhance the effectiveness of HIV prevention and care services provided for high-risk AA and NHPI communities. In particular, this is an opportunity to address the low rates of HIV testing in AA and NHPI communities and subsequent linkage to care for those who test positive. Another opportunity is to fund AA and NHPI serving CBOs who already have a history providing integrated HIV, STD, and viral hepatic prevention, screening and treatment efforts, as a way of identifying promising practices of implementing program collaboration and service integration at the CBO level.

2.3 Promote a more holistic approach to health:

Lead Agency/ Other Agencies	Suggested Actions To Be Performed
HHS OS/CDC, HRSA, NIH, AHRQ	By end of 2011, HHS OS will coordinate among HHS agencies to mine existing databases to explore associations between HIV infection and social determinants of health for AA and NHPI communities.

3.1 Engage communities to affirm support for people living with HIV:

Lead Agency/ Other Agencies	Suggested Actions To Be Performed
HHS OS/DOJ, DOL	By end of 2011, HHS OS, DOJ, and DOL Offices of Faith Based and Community Initiatives will develop a plan for engaging more AA and NHPI faith leaders to promote nonjudgmental support for people living with HIV.

3.2 Promote public leadership of people living with HIV:

Lead Agency/ Other Agencies	Suggested Actions To Be Performed
HRSA/CDC, HHS OS	By end of 2011, HRSA, CDC, and HHS OS will develop recommendations for strengthening the parity, inclusion, and meaningful representation of AA and NHPI (and other people of color) living with HIV on planning and priority-setting bodies.

Goal 4: Achieving a More Coordinated National Response to the HIV Epidemic in the United States

1.1 Ensure coordinated program administration:

Lead Agency/ Other Agencies	Suggested Actions To Be Performed
HHS OS/HUD, VA, DOL, SSA, and DOJ	By end of 2010, HHS OS will work with HUD, VA, DOL, SSA, DOJ, and other relevant Departments or agencies to establish an ongoing process to discuss coordination of planning and services delivery for domestic HIV programs. HHS OS will also work with state health departments and community planning groups to ensure local/state input and decision-making in the coordination of planning and services delivery.
HHS OS/HUD, VA, DOL, SSA, and DOJ	By end of 2010, HHS OS, HUD, VA, DOL, SSA, and DOJ will release draft implementation plans for at least a 30-day public comment period.
HHS OS/HUD, VA, DOL, SSA, and DOJ	At the end of each calendar year, HHS OS, HUD, VA, DOL, SSA, and DOJ will produce a joint progress report on HIV/AIDS program collaboration in AA and NHPI communities and convene a public meeting with AA and NHPI community stakeholders to discuss progress and next steps.

In addition, we ask that AA and NHPI communities be represented on federal advisory bodies, including: CDC/HRSA Advisory Committee (CHAC), Presidential Advisory Council on HIV/AIDS, NIH Office of AIDS Research Advisory Council (OARAC), inter-agency working groups created through the National HIV/AIDS Strategy, advisory groups resulting from healthcare reform initiatives, advisory groups associated with the

Office of Minority Health, Office of Women's Health, White House Counsel of Members and the State Medical Care Advisory Committees.

Next Steps

In closing, we ask that you help ensure that AAs and NHPs are specifically included in each of the implementation plans developed by the respective agencies within HHS. We look forward to working in partnership with HHS to continue the development of these agency-level implementation plans and the deployment of efforts and resources.

We ask that you consider convening an HHS-wide meeting on the implementation of the National Strategy with AA and NHP communities by mid-2011. We believe there is tremendous value and potential in bringing together governmental and community representatives to prioritize challenges and develop innovative solutions and can build on the lessons learned and action steps identified during the CDC's first AA and NHP consultation, earlier this year.

Should you have any further questions, please do not hesitate to contact:

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Lina Sheth, A&PI Wellness Center, lina@apiwellness.org, (415) 292-3420 x 320.

Sincerely,

Organizational Sign-Ons as of October 13, 2010 (in alphabetical order)

AIDS Services in Asian Communities – Philadelphia, PA
Asian & Pacific Islander American Health Forum – San Francisco, CA / Washington, DC
Asian & Pacific Islander Coalition on HIV/AIDS – New York, New York
Asian & Pacific Islander Wellness Center – San Francisco, CA
Asian Americans for Community Involvement – San Jose, California
Asian Health Services – Oakland, California
Asian Pacific AIDS Intervention Team – Los Angeles, California
Asian Pacific Healthcare Venture – Los Angeles, California
Asian Pacific Policy & Planning Council – Los Angeles, California
Asian Services in Action – Akron, Ohio
Center for Pan Asian Community Services – Atlanta, Georgia
Chinese Planning Council – New York, New York
Family Health Project – New York, New York
Guam HIV/AIDS Network (GUAHAN) Project – Barrigada, Guam
Hawaii Island HIV/AIDS Foundation – Kailua Kona, Hawaii
Life Foundation – Honolulu, HI
Malama Pono Health Services – Lihue, Hawaii
Massachusetts Asians & Pacific Islanders for Health – Boston, MA
Pacific Island Jurisdictions AIDS Action Group

Cc:

Jeffrey Crowley, White House Office of National AIDS Policy
Christopher Bates, HHS Office of HIV/AIDS Policy
Dr. Helene Gayle, Presidential Advisory Commission on HIV/AIDS
Kiran Ahuja, White House Initiative on Asian Americans and Pacific Islanders
Representative Michael Honda, Chair of Congressional Asian Pacific American Caucus
(CAPAC)
Representative Madeline Bordallo, Chair of CAPAC Health Taskforce
Mayra Alvarez, HHS Office of Health Reform
Frances Ashe-Goins, HHS Office on Women's Health
Dr. George Askew, Administration for Children and Families
Jenny Backus, HHS PDAS for Strategy and Planning
Mary Bowers, HHS Office on Women's Health
Greg Case, HHS Administration on Aging
Dr. Laura Cheever, HRSA HIV/AIDS Bureau
Dr. H. Westley Clark, SAMHSA Center for Substance Abuse Treatment
Janet Cleveland, CDC Division of HIV/AIDS Prevention
Sonsiere Cobb-Souza, OMH Division of Program Operations
Dr. Sylvie Cohen, HHS Office of the Assistant Secretary for Administration
Dr. Rosaly Correa-de-Aurajo, HHS Office on Disability
CDR Gregory Davis, HHS Office of the Surgeon General
Carl Dieffenbach, NIH National Institute of Allergy and Infectious Diseases
Daniel Dodgen, HHS Division for At Risk Individuals, Behavioral Health, and
Community Resilience
Agnes Donahue, HHS Office of Public Health Service
Greg Downing, HHS Office of the Assistant Secretary for Planning and Evaluation
Kevin Fenton, CDC National Center for HIV/AIDS, Viral Hepatitis, STD and TB
Prevention
RADM Scott Giberson, IHS
Dr. Garth Graham, OMH
Fred Hellinger, HHS Agency for Healthcare Research and Quality
Rosie Henson, HHS Office of Public Health and Service
Warren Hewitt, SAMHSA Center for Substance Abuse Treatment
Sally Howard, HHS Office of the General Counsel
Dr. David Hunt, HHS Office of Provider Adoption Support
Kenneth Johnson, HHS Office for Civil Rights
Evelyn Kappeler, HHS Office of Adolescent Health
Dr. Susan Karol, IHS
Kimberly Konkel, HHS Center for Faith-Based and Neighborhood Partnerships
Alexia Kelley, HHS Center for Faith-Based and Neighborhood Partnerships
Richard Klein, FDA
Elizabeth Lee, HHS Office of the Assistance Secretary for Legislation
Caya Lewis, HHS Centers for Medicare and Medicaid Services
Jim Mason, HHS Office of Intergovernmental Affairs
Dr. Jonathan Mermin, CDC Division of HIV/AIDS Prevention
Sue Moskosky, HHS Office of Population Affairs

Deborah Parham-Hopson, HRSA
Dalton Paxman, HHS Region 3
Angela Powell, HRSA Bureau of Primary Health Care
Karen Robinson, HHS Departmental Appeals Board
RADM Penelope Slade-Sawyer, HHS
David Rutstein, HHS Office of the Surgeon General
Wendy Wertheimer, NIH Office of AIDS Research
Jack Whitescarver, NIH Office of AIDS Research

ⁱ “The Asian Population: 2000 Census Brief,” The US Census Bureau (February 2002) available at <http://www.census.gov/prod/2002pubs/c2kbr01-16.pdf>.

ⁱⁱ “Population Projections of the United States, by Age, Sex, Race, and Hispanic Origin: 1993 to 2050,” The US Census Bureau (February 1996) available at <http://www.census.gov/prod/1/pop/p25-1130/>.

ⁱⁱⁱ “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>.

^{iv} “Asian/Pacific Islanders and HIV/AIDS,” The RYA HIV/AIDS Program (August 2008) available at <ftp://ftp.hrsa.gov/hab/Asian.Pacific.pdf>.

^v “Stigma, HIV/AIDS and Asians & Pacific Islanders,” Banyan Tree Project, available at http://www.banyantreeproject.org/extras/factsheets/btp_stigma_fs_FINAL.pdf.

^{vi} “We the People: Asians in the United States, Census 2000 Special Report,” The US Census Bureau (December 2004) available at <http://www.census.gov/prod/2004pubs/censr-17.pdf>.

^{vii} “HIV/AIDS among Asians and Pacific Islanders,” CDC HIV/AIDS Fact Sheet (Revised August 2008) available at <http://www.cdc.gov/hiv/resources/factsheets/API.htm>.

^{viii} “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>.

^{ix} Id.

^x Id.

^{xi} Patricia Tjaden and Nancy Thoennes, “Extent, Nature, and Consequences of Intimate Partner Violence,” U.S. Dep’t of Just., NCJ 181867 (2000) available at <http://www.ojp.usdoj.gov/nij/pubs-sum/181867.htm>.

^{xii} “In focus groups, Asian and Pacific Islander women noted cultural taboos against discussing sexual topics and power differentials between genders as reasons for difficulty in getting their partners to use condoms.” “HIV/AIDS among Asians and Pacific Islanders.”

^{xiii} In 2004, the percentage of Asians and Pacific Islanders receiving an AIDS diagnosis within one year of HIV diagnosis was 44%, compared to 37% for whites.” Id.