

**CASE STUDIES TO IMPROVE ASIAN AMERICAN,
NATIVE HAWAIIAN, AND PACIFIC ISLANDER
HIV/AIDS DATA COLLECTION, REPORTING,
AND DISSEMINATION**

MAY 2013

APIAHF

ASIAN & PACIFIC ISLANDER AMERICAN HEALTH FORUM

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 26 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 of its continued partnership with the Centers for Disease Control and Prevention to provide HIV-prevention related capacity building assistance.

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.

TABLE OF CONTENTS

EXECUTIVE SUMMARY	5
INTRODUCTION	7
METHODOLOGY	10
HIV/AIDS AMONG AAS AND NHPIS IN THE U.S.	12
CASE STUDIES	
Hawaii	14
New York State	20
San Francisco	24
BRIGHT IDEAS	
Alaska	31
California	33
Florida	36
Los Angeles	39
Michigan	41
Minnesota	43
Nevada	45
RECOMMENDATIONS	47
APPENDIX: AA AND NHPI DEMOGRAPHIC AND SOCIOECONOMIC INDICATORS	49
ACKNOWLEDGEMENTS	58

EXECUTIVE SUMMARY

Despite numerous national, state, and local efforts to improve HIV/AIDS surveillance and epidemiology, there continues to be significant gaps in the collection, reporting, and dissemination of HIV/AIDS data related to Asian American, Native Hawaiian, and Pacific Islander (AA and NHPI) populations. Several states continue to aggregate or “lump” AA and NHPI data into an “other” category. Few states provide disaggregated AA and NHPI data in their surveillance reports and epidemiologic profiles. Despite these gaps, there have been some health departments who have sought to address their own internal as well as their constituents’ data needs related to AA and NHPI populations.

In 2011, the Asian & Pacific Islander American Health Forum (APIAHF) began a qualitative review of HIV/AIDS surveillance reports, epidemiologic profiles (epi-profiles), and other surveillance-related documents across 50 state health departments and several cities funded directly by the U.S. Centers for Disease Control and Prevention (CDC). Through this review, several jurisdictions were identified for further review to detail and document “promising” practices related to HIV/AIDS data collection, reporting, and dissemination for AA and NHPI populations.

This report includes in-depth case studies of three jurisdictions: New York, Hawaii, and San Francisco. All three represent jurisdictions with significant AA and NHPI populations and significant rates of HIV/AIDS in AA and NHPI populations. Each jurisdiction historically and/or currently demonstrates a level of responsiveness to increased needs for AA and NHPI HIV/AIDS data to inform planning and prevention service efforts. In developing these case studies, APIAHF also conducted multiple interviews with health department surveillance staff (current and former), health department leadership (e.g. Prevention Managers), community-based organization (CBO) representatives, and other stakeholders.

This report also includes “bright ideas” or mini-case studies of practices implemented by jurisdictions across the U.S. These mini-case studies include states where there are emerging AA and NHPI communities and/or trends of increasing impact of HIV/AIDS on AA and NHPI communities. Similar to the in-depth case studies, these “bright ideas” were developed based on review of available documents as well as key informant interviews with health department staff.

Across both the case studies and the “bright ideas,” several practices are highlighted, including:

- Conducting chart abstractions
- Reporting disaggregated AA and NHPI ethnic subgroup data
- Conducting routine monitoring of prevention indicators
- Expanding data collection forms
- Engaging in collaborations with AA and NHPI – serving CBOs
- Fostering AA and NHPI involvement in Community Planning Groups (CPGs)
- Including detailed AA and NHPI Census population and population growth data in the epi-profile
- Including detailed AA and NHPI Census socioeconomic data in the epi-profile
- Including special AA and NHPI sections in the epi-profile
- Posting disaggregated HIV/AIDS data online
- Developing AA and NHPI HIV/AIDS fact sheets and/or slide sets

Twelve recommendations are provided to support improved HIV/AIDS surveillance efforts for AA and NHPI populations.

For HHS and CDC:

1. Follow Department of Health and Human Services Implementation Guidance on Data Collection Standards on Race, Ethnicity, Sex, Primary Language, and Disability Status. Note that while this purpose of the Guidance is focused on surveys, the standards could be adapted for surveillance efforts.
2. Provide guidance and support to state and local health departments to increase their capacity to follow Department of Health and Human Services Implementation Guidance on Data Collection Standards on Race, Ethnicity, Sex, Primary Language, and Disability Status.
3. Convene state and local health department surveillance staff to support implementation of promising practices featured in this report.
4. Include goals and strategies related to improving HIV/AIDS data collection and reporting for AA and NHPI populations in department strategic plans.
5. Set new goals and strategies related to improving HIV/AIDS data collection and reporting for AA and NHPI populations in future updates to National HIV/AIDS Strategy.

For State and Local Health Departments:

6. Follow Department of Health and Human Services Implementation Guidance on Data Collection Standards on Race, Ethnicity, Sex, Primary Language, and Disability Status.
7. Discontinue the practice of lumping data for “Asian” and “Native Hawaiian/Pacific Islander” with other racial/ethnic categories (e.g. Native Americans) when presenting racial/ethnic data in HIV/AIDS surveillance reports and epidemiologic profiles. Instead, utilize separate “Asian” and “Native Hawaiian/Pacific Islander” categories when presenting racial/ethnic data in HIV/AIDS surveillance reports and epidemiologic profiles as well as related documents, presentations, and reports.
8. Jurisdictions with significant AA and NHPI populations are encouraged to collect and present disaggregated data by AA and NHPI ethnic subgroups in HIV/AIDS surveillance reports and epidemiologic profiles.
9. Collaborate with prevention planning groups, Ryan White planning councils, and other decision-making bodies as well as AA and NHPI serving CBOs to identify HIV/AIDS surveillance data needs.
10. In addition to implementing recommendations and promising practices featured in this report, consider amending health department surveillance policies and procedures accordingly.

For AA and NHPI Serving CBOs and Related Stake Holders:

11. Communicate AA and NHPI HIV/AIDS data related needs to local/state health departments. If applicable, utilize health department process for special data requests.
12. Communicate with health department surveillance staff, prevention planning groups, Ryan White planning councils, and other decision-making bodies to identify opportunities for improving HIV/AIDS data collection and reporting for AA and NHPI populations, particularly in surveillance reports and epidemiologic profiles.

The Department of Health and Human Services’ Office of HIV/AIDS and Infectious Disease Policy funded the development and production of this document. Technical assistance for the project and review of the report provided by CDC staff was informal. Neither HHS nor CDC has formally reviewed this document or checked the data for accuracy. The contents of this document represent the work and the views of the authors only.

INTRODUCTION

A HISTORY OF OMISSION

Data collection, reporting, and dissemination for AA and NHPI communities has historically lagged behind other advances in HIV prevention, treatment, and policy. Advocates and service providers working in AA and NHPI communities have consistently voiced frustration over the lack of access to accurate AA and NHPI HIV/AIDS data most often, due to the practice of using an “Other” category that combines AA and NHPI data from multiple racial/ethnic groups (most often with American Indian and Alaskan Natives) or the complete omission of AA and NHPI HIV/AIDS data altogether (e.g. only including Black, White, and Hispanic in tables, charts, and graphs that are labeled as providing data by race/ethnicity).

Several studies have reported on this:

- In a study of HIV prevention community planning conducted in the late 1990s, almost one out of four jurisdictions provided no HIV/AIDS data on AAs and NHPIs in their epidemiologic profile, a planning document used by HIV planning bodies to determine HIV prevention priorities.¹
- In a 2007 online health department survey, 50 percent of respondents indicated that HIV/AIDS data for AA and NHPI populations is grouped into an “Other” category in their HIV/AIDS surveillance reports.²
- A 2009 review of epidemiologic profiles and surveillance reports from a sample of states with the largest AA and NHPI populations revealed that several jurisdictions presented HIV/AIDS data for only three racial/ethnic groups (typically “White, Black, and Hispanic”). Moreover, when AA and NHPI data was included, often there was no reporting consistency. For example, one jurisdiction presented AA and NHPI HIV/AIDS data in the same report in at least five different ways: Other, Asian, Asian (non-Hispanic) and Hawaiian/Pacific Islander (non-Hispanic), Asian/Pacific Islander, and Asian and Hawaiian/Pacific Islander.³
- APIAHF conducted a 2011 review of epidemiologic profiles and surveillance reports of the 50 states as well as cities directly funded by CDC that revealed that at least 14 jurisdictions still continue to group AA and NHPI data in an “Other” category. Note that of these 14 jurisdictions, three are states that are ranked by the U.S. Census as being in the top 10 states with the largest AA or NHPI populations.

These data limitations for AA and NHPI populations exist not only in regards to HIV/AIDS data but also for other disease and health issues. Published data on health and health barriers for specific AA and NHPI subgroups remains sparse. Moreover, while Native Hawaiian and Pacific Islander populations are often grouped with Asians in statistical analyses, they represent a very different set of population groups with diverse history, cultures, and languages (Eliminating Health Disparities).⁴

¹ Bau I. *Asians and Pacific Islanders and HIV prevention community planning*. AIDS Education and Prevention.

² APIAHF. *Breaking Through The Silence: Key Issues and Recommendations to Address HIV/AIDS in the Asian American, Native Hawaiian, and Pacific Islander Communities*. San Francisco, CA: Asian & Pacific Islander American Health Forum, 2007.

³ APIAHF. *Myopic Exclusion: The Lack of Attention by Most Community Planning Groups to the HIV/AIDS Epidemic in Asian American, Native Hawaiian, and Pacific Islander Communities*. San Francisco, CA: Asian & Pacific Islander American Health Forum, 2007.

⁴ ETR Associates. *Eliminating Health Disparities; Conversations with Asian Americans*. Scotts Valley, California. ETR Associates (2004).

NATIONAL EFFORTS TO IMPROVE DATA COLLECTION, REPORTING, AND DISSEMINATION

Over the past 30 years, there have been significant attempts to improve racial and ethnic data collection reporting, including:

- 1977 – The White House’s Office of Management and Budget (OMB) issued the original *Race and Ethnic Standards for Federal Statistics and Administrative Reporting*.⁵
- 1997 – The White House’s Office of Management and Budget issued the *Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity*. The revised standards included the separation of the “Asian or Pacific Islander” category into two distinct categories – “Asian” and “Native Hawaiian or Other Pacific Islander.”⁶
- 2004 – CDC released the *Integrated Guidelines for Developing Epidemiologic Profiles: HIV Prevention and Ryan White CARE Act Community Planning*.⁷
- 2005 – The National Committee on Vital and Health Statistics released its *Eliminating Health Disparities: Strengthening Data on Race, Ethnicity, and Primary Language in the United States* including the recommendation for HHS to “increase and strengthen the capacity of its health statistics infrastructure to analyze, report, and disseminate data on the various ethnic, racial, and linguistic subpopulations in the United States and territories”⁸
- 2009 – Section 4302 of the Affordable Care Act required that any data standards published by the Department of Health and Human Services comply with standards created by the Office of Management and Budget (OMB).
- 2009 – The Institute of Medicine released *Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement* including the recommendation that “any entity collecting data from individuals for purposes related to health and health care should collect granular ethnicity data in addition to data in the OMB race and Hispanic ethnicity categories and should select the granular ethnicity categories to be used from a national standard set”⁹ 2010 – The White House released the National HIV/AIDS Strategy, subsequently followed by the release of the Department of Health and Human Services’ Implementation Plan and Operational Plan. Responding to comments from the community, all three documents cited a need for strengthened HIV/AIDS data collection and reporting for AA and NHPI communities. In particular, CDC prioritized that by end of 2011, it would:
 - Provide state health departments with greater concentrations of AAPI or American Indian/Alaskan Native populations with recommendations on effective HIV surveillance activities for these small populations.
 - Work with states with the largest AAPI communities to implement the best combination of approaches to prevent HIV that reach AAPIs at greatest risk for infection.

5 White House Office of Management and Budget. *Standards for the Classification of Federal Data on Race and Ethnicity*. http://www.whitehouse.gov/omb/fedreg_race-ethnicity. Published August 1995. Accessed August 24, 2011.

6 White House Office of Management and Budget. *Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity*. http://www.whitehouse.gov/omb/fedreg_1997standards. Published October 1997. Accessed August 24, 2011.

7 Centers for Disease Control and Prevention. *Integrated Guidelines for Developing Epidemiologic Profiles: HIV Prevention and Ryan White CARE Act Community Planning*. (2004).

8 National Committee on Vital and Health Statistics. *Eliminating Health Disparities: Strengthening Data on Race, Ethnicity, and Primary Language in the United States*. Washington, DC. U.S. Department of Health and Human Services. (2005).

9 Subcommittee on Standardized Collection of Race/Ethnicity Data for Healthcare Quality Improvement. *Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement*. Washington, DC. Institute of Medicine. (2009).

- 2010 – As part of the White House Initiative on Asian Americans and Pacific Islanders, the Department of Health and Human Services released its *Plan for Asian American, Native Hawaiian, and Pacific Islander Health* which included the goal to “improve the collection, reporting and disaggregation of race, ethnicity and primary language data on AA, NH and PIs within HHS Departments to reflect the revised OMB requirements for data collection, analysis, and reporting of racial and ethnic data in the Continental US, Hawaii and 6-Pacific Islands.”
- 2011 – The Department of Health and Human Services released the *Implementation Guidance on Data Collection Standards for Race, Ethnicity, Sex, Primary Language, and Disability Status*. The standards in the Guidance built upon previous OMB standards and added seven subgroups (Chinese, Filipino, Asian Indian, Vietnamese, Japanese, Korean and other Asian) that rolled up to the Asian OMB category and four Native Hawaiian and Pacific Islander subgroups (Native Hawaiian, Guamanian or Chamorro, Samoan and other Pacific Islander) that rolled-up to the Native Hawaiian or Other Pacific Islander OMB category. While the Guidance covered national population health surveys, the standards related to race and ethnicity data could potentially be applied to surveillance efforts.
- 2012 – CDC released a national *Epidemiologic Profile 2010: Asians and Native Hawaiians and Other Pacific Islanders*. This report represented a historic effort focusing on data related to HIV/AIDS, viral hepatitis, sexually transmitted diseases, and tuberculosis.¹⁰

HEALTH DEPARTMENTS CHALLENGES

In recent years, health department surveillance and epidemiology programs have had to adjust to significant cuts in funding. For example, between Fiscal Year 2004 and Fiscal Year 2007, there was a \$3 million dollar reduction in one of the main CDC funding opportunity announcements that supported health department HIV/AIDS surveillance efforts. In this same cooperative agreement, there was a reduction in the number of jurisdictions funded to conduct incidence surveillance, from 35 to 25.

In 2009, the Council of State and Territorial Epidemiologists (CSTE) released a National Assessment of HIV/AIDS Surveillance Capacity and noted that “despite increases each year in the number of individuals in the surveillance system, funding for HIV case reporting activities (e.g., identifying new cases, tracking disease status and indicators, de-duplicating cases, ascertaining death status) has not.” On average, health departments reported that an additional 5.3 full time equivalents (FTEs) were needed to fully carry out HIV/AIDS surveillance activities in their respective jurisdictions (CSTE National Assessment of HIV/AIDS Surveillance Capacity). Health departments also reported significant challenges to developing surveillance dissemination products, including time (65%), staff (63%), and funding (44%).

10 Council of State and Territorial Epidemiologists. *National Assessment of HIV/AIDS Surveillance Capacity*. (2009)

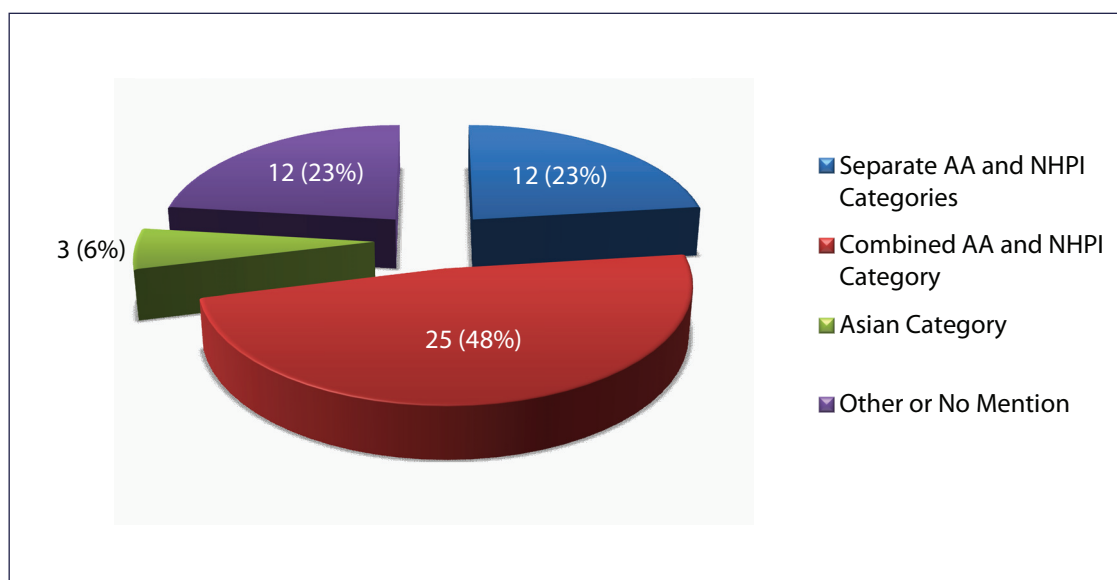
METHODOLOGY

Despite the previously mentioned challenges, several health departments have made significant strides in efforts to identify and describe the ongoing impact of HIV/AIDS in AA and NHPI communities. Historically, jurisdictions with significant AA and NHPI populations (e.g. California, New York, Hawaii, Los Angeles, and San Francisco) have been on the forefront of surveillance practices related to these populations. Some of these practices are profiled in the included case studies and bright ideas.

In recent years, a growing number of health departments have recognized the increasing diversity within their respective jurisdictions and have made efforts to improve their data collection, data reporting, and data dissemination for AA and NHPI communities. In a 2009 review of jurisdictional HIV/AIDS surveillance reports, at least 15 states lumped AA and NHPI HIV/AIDS data into an “other” category or made no mention of AAs and NHPIs. Since then, at least three of those states (Maryland, South Carolina, and West Virginia) have begun to include AA and NHPI data when presenting racial/ethnic level HIV/AIDS data.

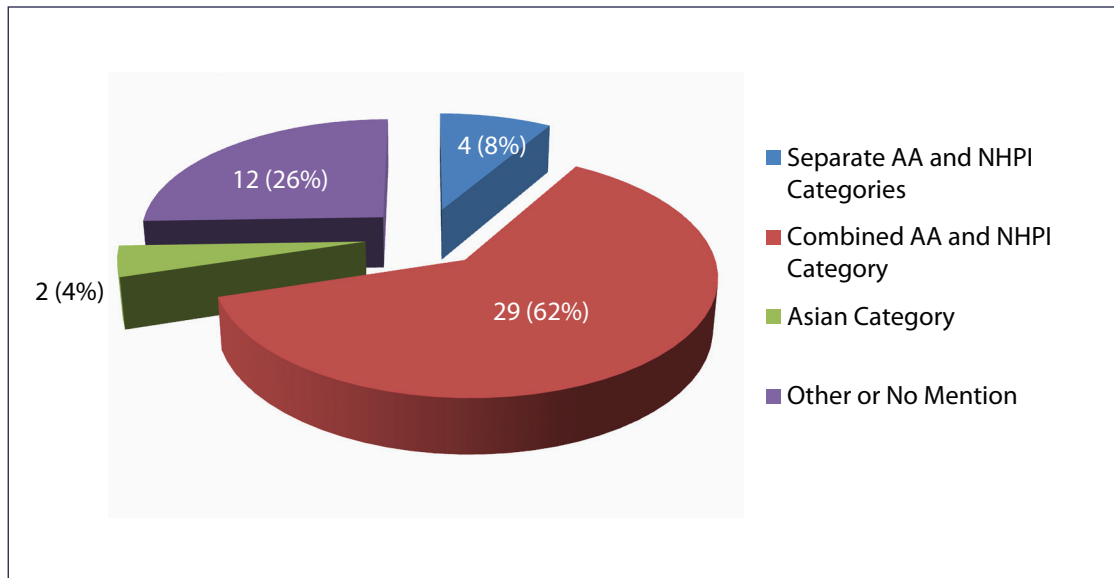
For this document, APIAHF conducted a review of HIV/AIDS surveillance reports from 52 jurisdictions and HIV/AIDS epidemiologic profiles from 47 jurisdictions available online. Of the surveillance reports reviewed, about one-fourth of the jurisdictions followed the Office of Management and Budget’s 1997 *Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity* that suggests classifying data into two separate categories for AAs and NHPIs. Nearly one-fourth combined AA and NHPI data into an “Other” category or did not mention AAs and NHPIs at all when presenting racial/ethnic data (see Chart 1).

Chart 1: AA and NHPI HIV/AIDS Data Classification in HIV/AIDS Surveillance Reports



Similarly, fewer than ten percent of epidemiologic profiles classified HIV/AIDS data into two separate categories for AAs and NHPs. Over one-fourth of the jurisdictions grouped AA and NHP data into an “Other” category or did not mention AAs and NHPs at all when presenting racial/ethnic data (see Chart 2).

Chart 2: AA and NHP HIV/AIDS Data Classification in HIV/AIDS Epidemiologic Profiles



This review served as the starting point for the selection of potential case study sites. Other key activities included the following:

- APIAHF formed an advisory group consisting of CDC and health department surveillance and epidemiology staff. This advisory group provided additional input to inform selection of case study sites, reviewed key informant interview tools, and reviewed initial drafts.
- APIAHF selected three consultants to conduct key informant interviews and draft the case studies.
- Consultants and APIAHF staff conducted 10 key informant interviews across three jurisdictions to inform development of the case studies.
- APIAHF staff conducted seven brief interviews to inform the “bright ideas.”

HIV/AIDS AMONG AAs AND NHPIs IN THE U.S.

Although HIV/AIDS incidence and prevalence are lower for AAs and NHPIs compared to other racial/ethnic populations, recent studies have indicated that the combined annual HIV diagnosis rates for AAs and NHPIs have been increasing.

- A CDC Morbidity and Mortality Weekly Report (MMWR) released on February 10, 2005 indicated that between 2001 and 2004, the estimated annual percentage change in HIV diagnosis rates was 8.1 for AANHPI males and 14.3 for AANHPI females. These were the only statistically significant increases among any racial/ethnic group.¹¹
- Another CDC MMWR released on June 27, 2008 revealed that among men who have sex with men (MSM), from 2001 to 2006, the largest proportionate increase in HIV/AIDS diagnosis rates was among Asian/Pacific Islander MSM aged 13-24 years (255.6%, Estimated Annual Percent Change = 30.8).

CUMULATIVE DATA

Men account for a large majority of the cumulative HIV/AIDS cases among AAs and NHPIs, however, the epidemic has had a growing impact on women:

- 9,317 AAs and NHPIs were estimated to have been diagnosed with AIDS in the U.S. since the beginning of the epidemic.¹²
- 3,542 AAs and NHPIs were estimated to have died from AIDS in the U.S. since the beginning of the epidemic.¹³
- At the end of 2009, there were estimated to be 5,564 AAs and NHPIs living with AIDS in the U.S.¹⁴

2010 DATA

In 2010, there were an estimated 885 HIV diagnoses among AAs and NHPIs in the 46 states and 5 dependent areas that currently have mature HIV reporting systems.¹⁵ Of the AA and NHPI HIV cases, males account for 83 percent of reported cases and females account for 17 percent of reported cases.

For AA and NHPI male adults and adolescents, the primary transmission mode is male-to-male sexual contact (86 percent of reported cases) (see Chart 3). For AA and NHPI female adults and adolescents, the primary transmission category is heterosexual contact (see Chart 4). For both men and women, the second largest reported mode of transmission is injection drug use (IDU).

11 Centers for Disease Control and Prevention (2006). *Racial/Ethnic Disparities in Diagnoses of HIV/AIDS --- 33 States, 2001—2004*. *Morbidity and Mortality Weekly Report*, 55(05);121-125.

12 http://www.cdc.gov/hiv/surveillance/resources/reports/2010report/pdf/2010_HIV_Surveillance_Report_vol_22.pdf#Page=23. Published February 28, 2012

13 http://www.cdc.gov/hiv/surveillance/resources/reports/2010report/pdf/2010_HIV_Surveillance_Report_vol_22.pdf#Page=42. Published February 28, 2012

14 http://www.cdc.gov/hiv/surveillance/resources/reports/2010report/pdf/2010_HIV_Surveillance_Report_vol_22.pdf#Page=54. Published February 28, 2012

15 http://www.cdc.gov/hiv/surveillance/resources/reports/2010report/pdf/2010_HIV_Surveillance_Report_vol_22.pdf#Page=19. Published February 28, 2012

Chart 3: Estimated Diagnoses of HIV infection among AA and NHPI Male Adults and Adolescents by Transmission Category, 2010 (n=738)

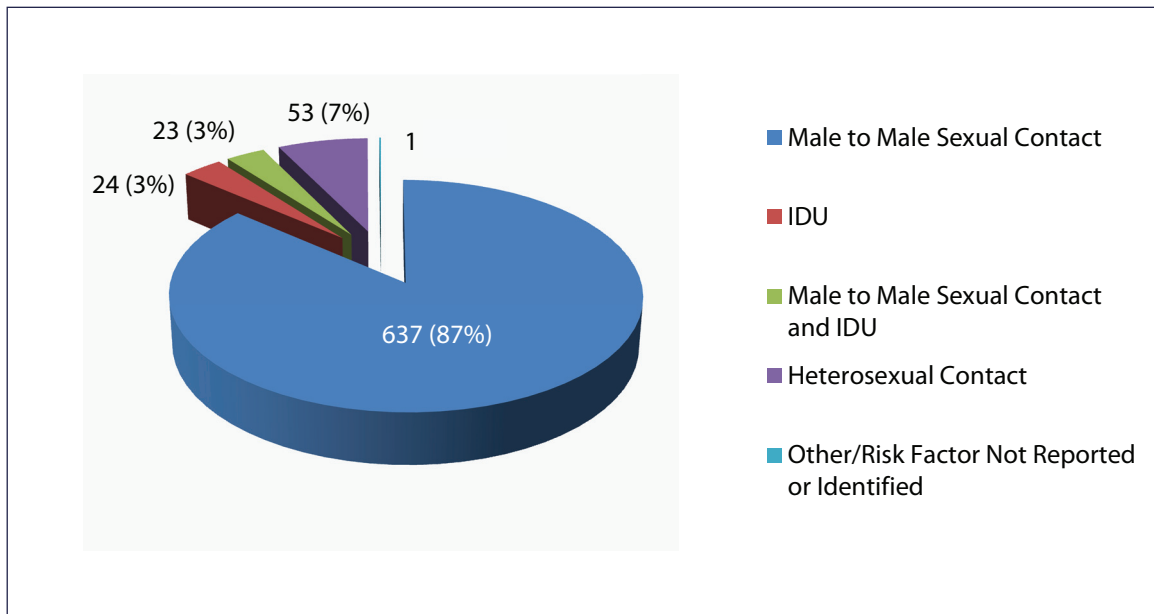
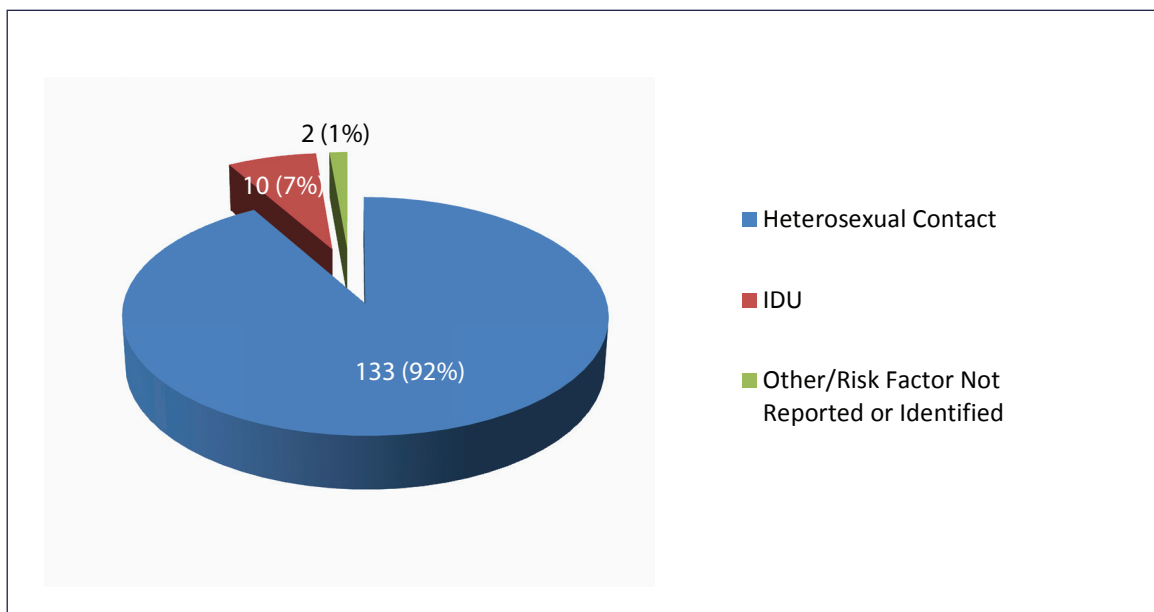


Chart 4: Estimated diagnoses of HIV infection among AA and NHPI Female Adults and Adolescents by Transmission Category, 2010 (n= 145)



CASE STUDY #1: HAWAII

INTRODUCTION

Located in the Pacific Ocean approximately 2,400 miles west of California, the state of Hawaii is comprised of eight main islands: the Big Island of Hawaii, Kahoolawe, Kauai, Lanai, Maui, Molokai, Niihau, and Oahu. According to the 2010 U.S. Census, Hawaii is home to 1,306,301 persons residing on seven islands.¹ Hawaii's population is concentrated on a single island, with 70% of the population residing on the island of Oahu.

Hawaii's population has grown by 12% between 2000 and 2010, while the population overall in the United States increased by 10% during the same time period. In 2010, 39% of the Hawaii's population self-identified as being AA alone. Filipino Americans represented the largest ethnic subgroup (38%) within the AA population in Hawaii, and represented 15% of Hawaii's overall population. Japanese Americans represented the second largest ethnic subgroup, comprising 14% of Hawaii's population. Persons self-reporting NHPI race alone comprised 10% of Hawaii's population, with NH representing 6% of the total population.

From 2000 to 2010, the AA population increased by 4%, while the NHPI population increased by 19%. Beginning with the census in 2000, individuals were allowed to self-report multiple race categories. In 2010, 57% of Hawaiians identified as AA alone or in combination with another race, and 26% reported being NHPI alone or in combination with another race.

Cumulatively since the beginning of the epidemic through 2010, there have been 3,282 AIDS cases reported in Hawaii². Hawaii represented less than 1% of cumulative AIDS cases reported through 2009 in the United States³. AAs and NHPIs represented 27% of cumulative AIDS cases reported in Hawaii. Since Hawaii did not begin code-based HIV reporting until 2001, and name-based HIV reporting was not initiated until 2008, data regarding the prevalence of HIV disease in Hawaii should be interpreted with caution as the true prevalence is likely underreported.

At the end of 2010, there were 2,318 persons reported to be living with HIV disease in Hawaii. AAs comprised 15% of persons living with HIV disease, while NHPIs comprised 9% of living cases. Because of the recent change to name-based HIV reporting, trends in HIV disease diagnoses over time are not available. In 2010, there were 176 persons newly reported with HIV (not AIDS) and 127 persons newly reported with AIDS. Among AIDS cases newly reported in 2010, 13% were among AAs and 11% were among NHPIs.

Hawaii's HIV/AIDS Surveillance Program is located within the integrated STD/HIV Prevention Branch of the Hawaii State Department of Health. The HIV/AIDS Surveillance Program receives only federal funding to conduct core HIV surveillance activities to monitor the trends in HIV morbidity and mortality. There are 2.5 full time equivalents (FTEs) who conduct core HIV surveillance activities in Hawaii.

Interviews were conducted with current and former STD/HIV Prevention Branch staff, a community based organization, and a former Centers for Disease Control and Prevention (CDC) HIV Prevention project officer to gain a better understanding of the data collection and data dissemination practices related to AAs and NHPIs in Hawaii. Three practices were identified from the key informant interviews as promising activities which could help improve data collection and data dissemination regarding HIV among AAs and NHPIs, and meet one of the recommended actions within the National HIV Strategy to "better characterize HIV among smaller populations" such as AAs and NHPIs. The promising practices include:

1. The reporting of AA and NHPI ethnic subgroup information in routine surveillance publications,
2. The collection of AA and NHPI ethnic subgroups within the HIV testing data system, and
3. The involvement of AAs and NHPIs in the community planning group (CPG).

PROMISING PRACTICE #1: REPORTING AA AND NHPI ETHNIC SUBGROUP INFORMATION

History

Hawaii has a dual reporting system for HIV disease, which means that laboratories are required to report test results related to HIV and medical providers are required to report cases of HIV disease to the Department of Health. The HIV/AIDS Surveillance Program generally relies on the receipt of laboratory information to initiate the investigation of a potential new case. Some providers may send in case reports, but often the Surveillance Program staff will either follow-up via phone or with an in-person visit to the provider to gather the necessary information. The small number of physicians who see patients with HIV makes it easier for Surveillance Program staff to develop strong relationships with the providers in order to request additional information as needed.

Hawaii has developed an addendum to the CDC HIV/AIDS case report form, which includes an area to report information on 26 ethnic subgroups among AAs and NHPIs. Although available on the case report form, surveillance staff are unclear of the level of discussion providers have with individuals to ascertain race information. There may also be underreporting by persons of certain race and ethnicity groups to the providers. The limited number of Surveillance Program staff, along with the increasing demands being placed on the staff, makes it difficult to pursue surveillance activities beyond the basic requirements and to probe for detailed race and ethnicity information.

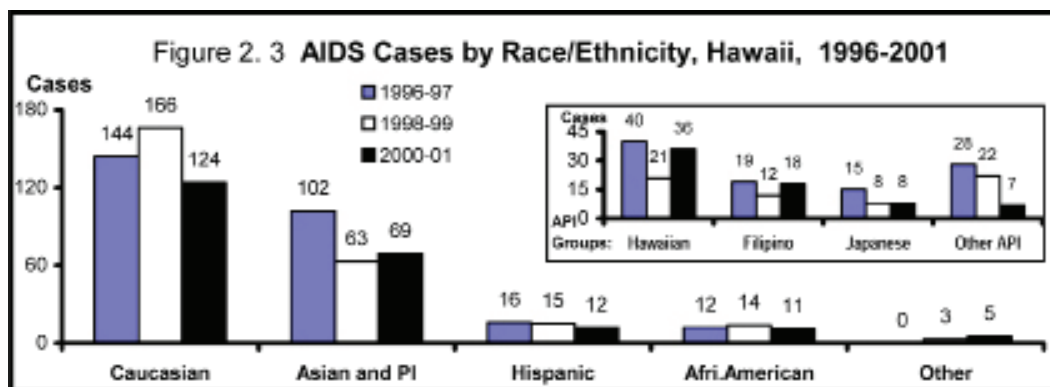
The significant size of the AA and NHPI community in Hawaii has helped encourage the collection and dissemination of data regarding the ethnic subgroups. It was important to the community and prevention planning efforts to be able to look at the rates of cases within the ethnic subgroups. Although collectively the AA and NHPI populations are not overrepresented in HIV or AIDS diagnoses, there are some subgroups that are overrepresented. For example, Hawaiians/Part Hawaiians represent a slightly greater proportion of AIDS cases than their proportion in the general state population.

Implementation

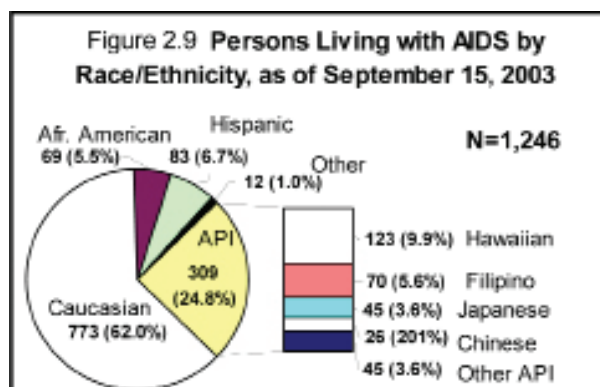
Routine surveillance reports include data related to ethnic subgroups. In the annual report released by the Surveillance Program, there is a table of cumulative AIDS cases and cases reported in the past five years by sex, transmission category and race, including the ethnic subgroups of Hawaiian/Part Hawaiian, Other PI, Japanese, Filipino, and Other Asians. This report was previously produced semi-annually, but beginning in 2009 the report was only produced annually due to limited resources. The increased demand for surveillance data to be used for activities historically outside the scope of many surveillance programs, such as initiating partner services and measuring linkage to care (with no increases in available resources), has made it challenging to regularly release data products.

The Integrated Epidemiologic Profile of HIV/AIDS in Hawaii, last published in 2005, provides additional examples of ways in which the Surveillance Program is able to present ethnic subgroup information among the AA and NHPI populations. The Surveillance Program includes inserts within several figures to display reported cases within the AA and NHPI populations (Example 1 and 2). The inserts allow the ethnic subgroup data to be displayed on a scale more appropriate for the size of the data. The epidemiologic profile contains sections to highlight key trends among populations at risk, and include sections specific to some of the larger AA and NHPI ethnic subgroups in Hawaii such as Filipinos and Hawaiians. These sections include more specific information about trends observed among these ethnic subgroups over time, and provide a summary of the geographic distribution specific to each ethnic subgroup.

Example 1. Figure from Integrated Epidemiologic Profile of HIV/AIDS in Hawaii, 2005¹⁶



Example 2. Figure from Integrated Epidemiologic Profile of HIV/AIDS in Hawaii, 2005¹⁷



The Surveillance Program maintains a delicate balancing act when presenting data. The large AA and NHPI populations in Hawaii necessitate the display of ethnic subgroup data. Although the AA and NHPI populations are relatively large in Hawaii compared to other jurisdictions, the low morbidity level often makes it difficult to present detailed AA and NHPI data while protecting the confidentiality of individuals. The HIV/AIDS Surveillance Program utilizes a numerator suppression rule to protect the confidentiality of individuals when the size of a cell being presented is less than four. To minimize cell suppression while still preserving the ethnic subgroup data, Surveillance Program staff may combine multiple years of data together when presenting trends or providing data on cumulative or living cases.

One of the difficulties of disseminating data on race and ethnicity in Hawaii is that until 2003 the HIV reporting system captured AAs and NHPIs as a single category. In addition, only one race category could be selected in the reporting system. After the change to allow the collection of AA and NHPI categories separately, the Surveillance Program did try to reclassify cases into the appropriate category. However, not all cases could be reclassified. The Surveillance Program also began to collect multiple races for individuals who classified themselves as more than one race in 2003. This is important since 24% of Hawaii's general population self-reported being of two or more races in the 2010 U.S. Census.

¹⁶ Hawaii State Department of Health. HIV/AIDS Surveillance Annual Report Cases to December 31, 2010. <http://hawaii.gov/health/healthy-lifestyles/std-aids/data-statistics/2010.pdf>. Published April 2011. Accessed July 10, 2011.

¹⁷ Hawaii State Department of Health. HIV/AIDS Surveillance Annual Report Cases to December 31, 2010. http://hawaii.gov/health/healthy-lifestyles/std-aids/aboutus/prg-aids/aids_rep/1h2005-1.pdf. Published April 2011. Accessed July 10, 2011.

Lessons Learned

By routinely presenting trends among the AA and NHPI ethnic subgroups, HIV prevention efforts can be targeted more specifically to groups at greater risk. Anecdotal evidence has suggested that there may now be a need to examine differences in characteristics between AA and NHPI populations which have lived in the area for several generations compared to the AA and NHPI populations that arrived more recently.

Sites wishing to disaggregate their ethnic subgroup data must first be able to collect the additional information. It may be helpful for surveillance programs to identify the ethnic subgroups that are most prevalent in their jurisdiction to determine which categories should be collected and presented. Sites should work with community based organizations serving these populations to determine the most culturally appropriate ways to define and group the AA and NHPI ethnic subgroups.

PROMISING PRACTICE #2: COLLECTING AA AND NHPI ETHNIC SUBGROUP INFORMATION WITHIN THE HIV TESTING DATA SYSTEM

History

The Hawaii Department of Health receives funding from the CDC to conduct HIV testing and other HIV prevention interventions. The Department of Health funds five AIDS service organizations to conduct HIV prevention and testing activities. The Department of Health also provides HIV test kits and resources to other community partners, including community health centers. HIV testing data can provide valuable information related to the frequency of testing, the level of positivity, and linkage to care and prevention services among various populations. These data have supplemented HIV surveillance data and have helped improve the targeting of HIV prevention activities.

In Hawaii, only the six standard race and ethnicity categories defined by the Office of Budget Management (OMB) in 1997 were collected with the HIV testing data (American Indian or Alaskan Native, Asian, Black or African American, Hispanic or Latino, Native Hawaiian or Other Pacific Islander, and White). This method of data collection did not allow for more detailed analyses of testing trends among the ethnic subgroup populations. One community based organization saw the limitation of this practice and began collecting the additional ethnic subgroup information in a separate database. Although this practice required increased staff time to record the additional information, the organization was able to analyze testing trends among the ethnic subgroups and was better able to target testing resources to specific populations. Since the organization served the AA and NHPI communities, it believed the additional resources expended to collect this information were necessary for program planning.

Implementation

In 2011, the Department of Health changed the data systems used to capture HIV testing information. The primary motivation for changing data systems was to improve the ability to extract and analyze the data. As part of the switch to the new HIV testing data system, it was determined that additional AA and NHPI ethnic subgroups should be captured. The community based organization which had previously collected additional ethnic subgroup information on its own was a strong influence on changing the statewide data collection practices. Also, the relatively large, and diverse, AA and NHPI community necessitated the ability to examine testing trends separately among the ethnic subgroups.

To determine the ethnic subgroups to be included in the HIV testing data collection system the Department of Health organized a series of meetings. The meetings included representatives from several areas within the health department including epidemiologists, HIV prevention staff, HIV surveillance staff, STD prevention workers, HIV testing program staff, program evaluators, and the branch chief. Representatives from community based organizations were also included in the meetings. The meeting resulted in a proposed list of AA and NHPI ethnic subgroups to be collected. The list was distributed to all directly funded agencies for review. The final list of AA and NHPI ethnic subgroups was based on a collaborative process involving a large number of representatives. This information will be available in future HIV testing reports and will be used for program planning purposes.

Lessons Learned

In the process of determining which AA and NHPI ethnic subgroups to collect, it was important to have individuals around the table with a strong understanding of the subgroups. When defining the ethnic subgroup categories, it was important to know how each group self-identified. The Department of Health plans to have regular meetings with its contractors to review the ethnic subgroup categories collected and determine if new categories are needed. Other sites wishing to implement this practice should seek out experts from the community to assist with developing a culturally appropriate list.

The change in data collection practices highlights the important role of community based organizations. The smaller size of community based organizations, in comparison to health departments, often means they can adapt more easily to changing demands or data requirements. Since the organizations work directly with the community they often have a better understanding of the characteristics of the population and their needs. Health departments may wish to partner with community based organizations to conduct pilot projects to assess the feasibility of collecting additional ethnic subgroup information before expanding the practice to the entire jurisdiction.

PROMISING PRACTICE #3: INVOLVEMENT OF AAs AND PI_s REPRESENTATIVES IN THE COMMUNITY PLANNING GROUP

History

Hawaii's community planning group (CPG) was formed in 1994, following a CDC requirement that all federally funded HIV prevention programs must establish a group of individuals reflective of the HIV epidemic in their jurisdiction responsible for developing a comprehensive HIV prevention plan. In 2005, the HIV care planning group was integrated into the CPG. At full capacity, the CPG included 28 seats for voting members. Other community members were also invited to participate in CPG meetings.

Implementation

During the initial formation of the CPG, Department of Health staff worked diligently to ensure the group represented the affected population. The large AA and NHPI communities within Hawaii necessitated their representation on the CPG. Department of Health staff worked with community based organizations to spread the message about the CPG. A HIV prevention listserv was also carefully utilized to provide information about the CPG. The thorough recruitment process resulted in a group that represented the communities affected by the HIV epidemic in Hawaii.

Although AA and NHPI populations represent a significant proportion of Hawaii's general population, these populations tend to be underrepresented in leadership roles. The Department of Health worked to develop leadership capacity among the AA and NHPI populations on the CPG. Members interested in leadership roles were invited to attend leadership training and conferences.

Representation of AA and NHPI populations on the CPG helped to encourage activities and discussions with the Department of Health to improve data collection and dissemination practices. One impact of the AA and NHPI communities' involvement in the CPG planning process was the development of a needs assessment of the Native Hawaiian community over ten years ago. The CPG hired a consultant to develop and conduct the needs assessment. The CPG provided input to ensure the questions developed were culturally appropriate. The assessment revealed the need for culturally appropriate prevention services among NH populations. The findings suggested that many of the CDC supported behavioral interventions were not appropriate for the NH population. Based on evidence reported from community members, it has been suggested that a more current needs assessment be completed among NH populations.

Lessons Learned

To recruit AAs and NHPs to the community planning process, it is important to utilize community based organizations serving these populations. By virtue of being based in the community, these organizations are comprised of, familiar with, and have strong rapport with community members. It may be beneficial for community based organizations to provide brief presentations on key data trends among the AA and NHP populations when encouraging participation in the CPG. In jurisdictions with smaller AA and NHP communities, it may be beneficial to conduct a presentation on the wide variety of cultures and traditions among the AA and NHP ethnic subgroups.

CONCLUSION

The large and diverse AA and NHP populations in Hawaii necessitate the need to collect and present data on ethnic subgroups. Although populations of AAs and NHPs may be smaller in other jurisdictions, many of the practices implemented in Hawaii can still be applied. Organizations can implement the following beneficial practices:

- By grouping multiple years of data together, or by examining trends in living cases, surveillance programs may be able to report data for the larger ethnic subgroups in their jurisdiction. Including inserts in figures to present data on a different scale can provide more clarity in trends not observable when included in a single figure.
- By collecting AA and NHP ethnic subgroup data within the HIV testing system, jurisdictions will have additional sources beyond traditional HIV surveillance data for examining risk behavior and testing trends.
- Including AA and NHP representation on the CPG or similar bodies can encourage the development of relevant data products for these communities.

These efforts will improve the ability to disseminate HIV data regarding the AA and NHP populations, and they will improve HIV prevention and care planning efforts.

CASE STUDY #2: NEW YORK

INTRODUCTION

According to the 2010 U.S. Census estimates, New York City's population of about 8.2 million people (up about 2% from 2000), has roughly 36% foreign-born residents.¹⁸ New York State's population is about 19.4 million people (also up about 2% from 2000). In 2010, AAs and NHPs comprised 11.8% of City residents (about 977,000). Chinese Americans are the largest ethnic subgroup (46%) within the AA population representing 5.4% of New York's overall population. NHPs represented 0.1% of New York City's population. From 2000 to 2010, the AA and NHP population increased by 32%. Native Hawaiians represented the largest Pacific Islander subgroup in New York, with a population of 1,992 persons in 2010.

New York has been disproportionately impacted by the HIV epidemic. Cumulatively from the beginning of the HIV epidemic through 2009 there have been 165,805 AIDS cases reported among New York City residents.¹⁹ New York City represented 80% of AIDS cases reported in New York State,²⁰ and almost 14% of the cases reported in the United States,²¹ even though New York City represented only 42% of the population of New York State, and less than 3% of the population of the United States. Asian Americans and Pacific Islanders (AAs and PIs) represented more than 2% of cumulative AIDS cases reported in New York City. There were 108,886 persons living with HIV disease in New York City at the end of 2009. The 1,695 AAs and PIs living with HIV disease comprised a greater proportion of persons living with HIV disease in New York (1.6%), compared to the United States overall (<1%). The number of new HIV disease diagnoses in New York has increased from 87 new diagnoses in 2006 to 107 new diagnoses in 2009, while decreasing among all races from 4,152 in 2006 to 3,669 in 2009. The proportion of new diagnoses among AAs and PIs has fluctuated slightly from 2006 to 2009, ranging from 2.1% in 2006 to 3.1% in 2007 and 2008. AAs and PIs represented about 2.9% of new diagnoses in 2009.

HIV/AIDS Surveillance and reporting in New York City falls under the New York City Department of Health and Mental Hygiene, described below:

"The HIV Epidemiology & Field Services Program of the NYC Department of Health and Mental Hygiene is authorized by the New York State Department of Health to conduct HIV/AIDS surveillance in New York City. Along with surveillance, the program also conducts research on HIV prevalence, incidence, and behavior in populations at risk for HIV. Additionally, the staff of over 150 includes public health advisors, epidemiologists, physicians, and administrative staff."²²

The New York State Department of Health also handles surveillance and reporting on HIV/AIDS for New York City, as well as the rest of New York State. Located in Albany, New York, it has an overall structure of resources similar to, but somewhat larger than New York City's. Additionally, the AIDS Institute takes on many responsibilities in education, prevention, services, and most recently surveillance and epidemiology.

18 U.S. Census. 2010 Interactive Population Mapping. <http://2010.census.gov/2010census/popmap/>

19 New York City HIV/AIDS Annual Surveillance Statistics. New York: New York City Department of Health and Mental Hygiene, 2009. Updated December 2009. Accessed August 2011 at New York City HIV/AIDS Annual Surveillance Statistics. <http://www.nyc.gov/html/doh/html/dires/hivepi.shtml>

20 New York State HIV/AIDS Annual Surveillance Report. Bureau of HIV/AIDS Epidemiology (BHAE), AIDS Institute, New York State Department of Health (NYSDOH). <http://www.health.state.ny.us/diseases/aids/statistics/>

21 CDC (2009). Diagnoses of HIV Infection and AIDS in the United States and Dependent Areas, 2009. HIV Surveillance Report, Volume 21. <http://www.cdc.gov/hiv/surveillance/resources/reports/2009report/>

22 Bureau descriptions taken from Department web site: [<http://www.nyc.gov/html/doh/html/dires/hivepi.shtml>]

Interviews were conducted with health department epidemiologists, a non-health department researcher, and a community activist in order to characterize the barriers to achieving and maintaining best practices for collecting and reporting HIV/AIDS data for Asian Americans (AAs), Native Hawaiians (NHs), and Pacific Islanders (PIs). The following practices were identified from the key informant interviews as illustrations of the content and process that can clarify the dynamics of HIV among AAs and PIs:

1. Engaging in dialogue between community representatives and health department staff.
2. The utilization of country of birth data as a proxy for disaggregated race/ethnicity data.
3. Addressing concerns related to small data cell size.

PROMISING PRACTICE #1: ONGOING COMMUNITY-LED DIALOGUE

History

Early in the HIV/AIDS epidemics, a group of CBOs approached the departments of health for both New York City and New York State. The departments of health (city and state) sent an education representative to the first local AA and NHPI community-organized HIV/AIDS conference to give a presentation. A slide from the CDC was presented that noted prevalence of AIDS among “Black,” “White,” “Hispanic,” and “Other” races. Responding to questions about how this data was presented, the representative explained that city, county, and state level information was from the CDC, as per their guidelines. Because these guidelines often overlooked AAs and NHPIs, the community based organizations recognized the need to encourage the health departments to provide improved data for AA and NHPI communities.

Implementation

In December of 1986, a small group of CBO representatives held a meeting with a CDC director and asked why AA and NHPIs were presented in the “Other” category. The immediate response was “... because no one had asked.” At a subsequent August 1989 conference in Washington, the CBO representatives joined representatives from Native American communities in asking the Assistant Secretary of Health, James Mason, and CDC Director, Gary Noble, to distinctly include AA and NHPI data. Dr. Mason’s and Dr. Noble’s response was “it is simple to do” and promised to divide the “Other” column for the next monthly report in September with Asian/Pacific Islander and a second column of Native American, and Alaskan Native. When CDC released its next monthly surveillance report, all of the promised race elaborations were included.

The changes at the CDC level were not accompanied by changes at the New York City and State levels. In November 1989, New York City and New York State were still publishing the older race data categories of White, Black, Hispanic, and Other. This prompted another communication with CDC leadership that led to referrals to leaders in both New York City and State for more direct follow-up. Ultimately, New York State began using the Asian/Pacific Islander category and American Indian/Alaskan Native category in December 1989 followed by New York City in January 1990.

Lessons Learned

Health departments receive funding to conduct core surveillance activities, including data collection, reporting, and dissemination. If AA and NHPI data is not presented in a manner that is useful for planning or program efforts, community based organizations can take the opportunity to engage in dialog with health department and surveillance staff. As demonstrated in this case study, several meetings and ongoing follow-up at multiple (potentially local, state, and federal) level may be necessary to impact changes in surveillance practices.

PROMISING PRACTICE #2: UTILIZING COUNTRY OF BIRTH DATA AS A PROXY FOR DISAGGREGATED RACE/ETHNICITY DATA

History

Although HIV/AIDS data collection did not historically include data on self-reported ethnicity other than Hispanic, CBO and department representatives recognized that information on country of birth was collected. They noted that country of birth data did not necessarily infer a person's ethnic subgroup identification (e.g. a person born in China does not necessarily identify as Chinese, and in fact could be from any ethnic background). Yet, they knew that country of birth data could still be useful because it loosely inferred English proficiency (e.g. if an individual is born in the US, then it might be assumed that they will have a base level of English proficiency). Country of birth data could also offer HIV prevention and care providers with some level of insight into a person's childhood exposure to non-U.S. languages, traditions, cultural and social context, and the generation of immigration. This insight could help CBO staff develop programs that were culturally sensitive and linguistically appropriate.

Implementation

Like most health departments, the New York State and New York City health departments have tried to respond to requests for special data analysis from the community. Depending on staff size and availability, the health departments assigned an analyst to respond to these requests in as timely a manner as possible. Requests often started by analysts asking for what "runs" were needed. AA and NHPI serving CBOs in New York have often asked for HIV/AIDS incidence and prevalence data disaggregated by AA and NHPI ethnic subgroup. Earlier in the HIV epidemic, however, this data was not being collected on HIV counseling and testing forms.

Recognizing the value of country of birth as proxy markers, CBO representatives began making special request for data analysis on country of birth. According to key informant interviewees, more than half of HIV/AIDS case reports are missing data on country of birth which impacted the health department's ability to respond to these special data requests. Even though forms have space to report country of birth, often this space was left blank by the staff person filling in the form. Key informant interviewees attributed this lack of reporting to staff feeling rushed and/or not considering this country of birth data important.

Lessons Learned

While ethnic subgroup data or primary language spoken is not universally collected at the state and local level, most jurisdictions do collect country of birth data on their HIV/AIDS client intake forms when persons living with HIV/AIDS enroll for Ryan White services. Key informants believe that service providers may not understand the importance of country of birth data. Thus, it may be important for CBOs to collaborate with their local/state health department to emphasize the need for accurate data collection of country of birth data. Given current national discourse related to immigration reform, however, both undocumented individuals and their service providers may be reluctant to disclose country of birth data due to fears related to potential deportation.

Key informants acknowledged that getting health departments to collect additional data (e.g. country of birth, ethnic subgroup, primary language spoken, etc.) has broader systemic and resource implications. Thus, any request that requires additional data fields, changes in forms, and/or changes in data collection procedures are often met with initial resistance. It is therefore important for community based organizations to determine and prioritize specific pieces of data for which they will ask. It's also critical for community based organizations to recognize that efforts to encourage these systemic changes to data collection typically require a significant investment of time, energy, and resources.

PROMISING PRACTICE #3: ADDRESSING CONCERNS RELATED TO SMALL DATA CELL SIZE

History

All health departments have data release policies and standards that dictate how data should be presented, especially in instances when there are small data cell sizes. These policies help to reduce the likelihood that data

is published at a level that might inadvertently identify specific individuals (e.g. a table detailing HIV prevalence, gender, age, and zip code might “out” an AA female PLWHA, 60-70 years old, living in a specific zip code if there is only one AA female, 60-70 years old who lives in that specific zip code). Yet, for AA and NHPI populations, these policies have effectively led to either a complete omission of AA and NHPI data in published reports or the practice of grouping AA and NHPI data into an “Other” category.

Implementation

According to key informant interviewees, CBO representatives worked with health department staff to identify methods for displaying more detailed data in a manner that would still be informative for CBO programming usage yet still complied with data release policies.

An early project that was part of the CDC-led seroprevalence studies provided an opportunity to experiment with new ways to present data. This project involved the examination of how to depict the HIV/AIDS status of prisoners on entering prison. After various discussions and meetings, health department staff experimented with “color-coded data cells.” Staff developed tables that described groups by race, gender, and age in ten year segments. In lieu of raw numbers, cells were color coded based on data cell size (i.e. 0 to 5, 6 to 10, etc.). Presenting data in this manner allowed both health department staff and CBO representatives to have a better understanding of the very distinct patterns in the community. Similar methods were later used to analyze the drop in HIV seroprevalence among intravenous drug users in New York.

Lessons Learned

While these “color-coded data cells” may seem simplistic, they did represent early successes in helping program/prevention groups to see and understand the complexity of the HIV/AIDS epidemic. Key informant interviewees noted that they witnessed increased excitement among their colleagues as this data became more and more accessible.

Non-health department key informants noted that health department staff do not want to be held liable for inadvertently breaching confidentiality or anonymity, especially in regards to small sample cell sizes in published tables. Several key informants cited that in response to surveillance-related requests, health department staff have sometimes cited lack of funding or staffing as a barrier to accommodating requests.

Key informants also noted that changes in health department personnel sometimes also led to changes in surveillance policies and practices. As key surveillance and epidemiology staff transitioned out of their leadership roles, key informants at times found new support for their surveillance requests (e.g. data disaggregation, special data analyses, etc.). But if positive practices were not codified in official health department policies or procedures as “supportive” staff transitioned out, the inclusion of AA and NHPI surveillance sometimes regressed.

CONCLUSION

Community based organizations are an important consumer of the surveillance and epidemiology data collected, reported, and disseminated by health departments. Thus, health department surveillance and epidemiology efforts can benefit from actively seeking out the input of community based organizations and other stakeholders to inform HIV surveillance and epidemiology efforts. It is important that health departments codify positive surveillance practices for continuity.

Similarly, community based organizations can benefit from being proactive in communicating their data collection, reporting, and dissemination needs. The experiences of these key informant interviewees illustrate that changing processes, procedures, and systems can take a significant amount of time, energy, and resources. Their experiences also highlight the important and effectiveness of persistence and dialogue with a variety of key stakeholders.

CASE STUDY #3: SAN FRANCISCO

INTRODUCTION

San Francisco is a large, ethnically-diverse city located along the west coast of California. According to 2010 U.S. Census figures, San Francisco was the 13th most populous place in the United States and the 4th most populous place in California, with a population of 805,235²³. Between 2000 and 2010, the population of San Francisco increased just 4%, while a 10% increase was seen in the state of California and the United States overall. In 2010, Asian Americans (AAs) comprised 33% of the population in San Francisco; Chinese represented the largest ethnic subgroup (64%) within the AA population of San Francisco, and represented 21% of San Francisco's overall population. Native Hawaiians and Pacific Islanders (NHPIs) represented 0.4% of San Francisco's population. Samoans represented the largest NHPI subgroup in San Francisco, with a population of 1,988 persons in 2010. From 2000 to 2010, the AA population increased by 12%, while the NHPI population decreased by 13% in San Francisco.

San Francisco has been disproportionately impacted by the HIV epidemic. Cumulatively from the beginning of the HIV epidemic through 2009 there have been 28,409 AIDS cases reported among San Francisco residents¹⁸. San Francisco represented 18% of cumulative AIDS cases reported in California and 3% of cases reported in the United States, even though San Francisco represented only 2% of the population in California and less than 1% of the population in the United States^{24,25}.

San Francisco's Department of Public Health uses an "Asian/Pacific Islander" category in its HIV/AIDS related reports. AAs and Pacific Islanders (PIs) represented 3% of cumulative AIDS cases reported in San Francisco. There were 15,836 persons living with the HIV disease in San Francisco at the end of 2009. AAs and PIs comprised a greater proportion of persons living with the HIV disease in San Francisco (5%), compared to the United States overall (<1%). The number of new HIV disease diagnoses in San Francisco decreased from 520 new diagnoses in 2006 to 411 new diagnoses in 2009. The portion of new diagnoses among AAs and PIs has fluctuated slightly from 2006 to 2009, ranging from 6% in 2006 to 9% in 2007 and 2008. AAs and PIs represented 8% of new diagnoses in 2009.

The San Francisco Department of Public Health's HIV Epidemiology section is comprised of the HIV Surveillance Unit and the HIV Seroepidemiology Unit. The HIV Surveillance Unit receives both federal and state funding to conduct core HIV surveillance activities that provide an accurate picture of the trends in HIV morbidity and mortality in the city. In addition, the HIV Surveillance Unit receives federal funding to participate in the HIV incidence surveillance project and the HIV medical monitoring project. Ten full time equivalents (FTEs) are responsible for conducting core HIV surveillance activities in San Francisco. The HIV Seroepidemiology Unit consists of four FTEs and is primarily supported by the National HIV Behavioral Surveillance project, as well as other grant funded projects.

Interviews were conducted with HIV Surveillance Unit and HIV Seroepidemiology Unit staff to gain a better understanding of data collection and data dissemination practices related to AAs and NHPIs. Four practices were identified from the key informant interviews as promising activities which could help improve data collection and data dissemination regarding HIV among AAs and PIs:

1. The use of routine chart abstractions (i.e., review of medical records) to collect and validate race and ethnicity information,
2. The receipt of data from a community based health care organization serving AA and PI populations,
3. The inclusion of AA and PI ethnic subgroup information in routine surveillance publications, and

23 U.S. Census Bureau. 2010 Census Data. <http://factfinder2.census.gov/main.html>. Accessed July 10, 2011.

24 San Francisco Department of Health. HIV/AIDS Epidemiology Annual Report 2009. http://www.sfdph.org/dph/files/reports/Rpt-sHIVAIDS/AnnualReport2009Revision_03112011.pdf. Published July 2010. Accessed July 10, 2011.

25 Centers for Disease Control and Prevention. HIV Surveillance Report, 2009; vol. 21. <http://www.cdc.gov/hiv/topics/surveillance/resources/reports/>. Published February 2011. Accessed July 10, 2011.

4. The routine monitoring of HIV prevention indicators among the AA and PI populations.

PROMISING PRACTICE #1: CHART ABSTRACTIONS

History

The HIV Surveillance Unit has been conducting routine chart abstractions of both new and living HIV/AIDS cases for over 15 years. San Francisco has a dual reporting system, which means both laboratories and providers are required to provide reports to the Department of Public Health. Laboratories are required to report tests indicative of HIV infection to the Surveillance Unit and providers are required to report all HIV/AIDS cases. In order to ease the reporting burden on providers and to collect additional information, surveillance staff offer to visit medical facilities to complete new case reports and to assist providers as needed. This process fosters a relationship with the medical community and allows for an open dialogue to obtain missing or incomplete information, including data regarding race and ethnic subgroup.

Approximately 15 years ago, the Surveillance Unit began collecting data on AAs and PIs as two separate categories instead of as a single category. At the same time, the Surveillance Unit also began collecting ethnic subgroup information for these populations. This change was driven largely by requests from the community. The relatively large AA population within San Francisco necessitated collecting this more detailed information for program planning purposes. The implementation of the practice to collect ethnic subgroup information seemed to be initiated by collaborations between the HIV Surveillance Unit and the community.

The Surveillance Unit began collecting information regarding ethnic subgroups and collecting data for AAs and PIs separately before the CDC HIV surveillance forms had been modified to reflect the 1997 Office of Management and Budget (OMB) standards requiring this. These variables were initially added as local fields in the HIV/AIDS Reporting System (HARS) and were collected by surveillance staff on the standard CDC HIV / AIDS case report forms when completing medical chart abstractions. When changes were made in HARS to collect data on AAs and PIs separately to follow the 1997 OMB standards, the Surveillance Unit transitioned seamlessly. With the CDC release of electronic HIV/AIDS Reporting System (eHARS) and revised case report forms, San Francisco continued to incorporate the collection of more detailed AA and PI data. By conducting chart abstractions itself, instead of relying on passive provider reporting, the Surveillance Unit was able to collect more complete information to describe HIV among AAs and PIs, even when these fields were not available on the case report form.

Implementation

New HIV cases are generally identified by the Surveillance Unit through the receipt of test results from laboratories. Surveillance Unit staff then contact the medical provider to arrange a time to complete a chart abstraction. If there is evidence of medical care at other facilities listed in the medical record, Surveillance Unit staff will follow up with the additional facilities to gather additional information. Surveillance staff routinely conduct prospective chart reviews on all living cases, with each case reviewed approximately every 18 to 24 months. The length of time between chart reviews is recorded in the surveillance system. This practice was originally initiated based on the need to identify opportunistic infections, collect treatment information, and identify co-infections. The prospective chart review process also allows for Surveillance Unit staff to validate race and ethnicity information previously collected. Regular contact with providers through the chart abstraction process can help facilitate communication to obtain additional information on race and ethnicity data as needed.

The routine record abstractions performed by Surveillance Unit personnel are a resource intensive activity. However, chart abstractions allow for the collection of a wealth of surveillance information well beyond more complete race and ethnicity information. The San Francisco Surveillance Unit has four and a half FTEs dedicated to conducting chart abstractions; these staff members are responsible for reviewing records for approximately 16,000 living cases every 18 to 24 months, as well as reviewing medical records for approximately 400-500 new HIV diagnoses annually. With changes in laboratory technology for diagnosing HIV coming in the near future, active surveillance activities (including routine visits to medical providers to conduct chart abstractions) will be necessary to initiate case reporting. The additional burden of collecting ethnic subgroup information for AA and PI populations would be minimal.

Lessons Learned

With the conversion of many medical practices to electronic health records (EHR), surveillance staff noted that access to medical records has become more restrictive in San Francisco. The requirements to gain access to EHRs varied by site and necessitated persistence on the part of the Surveillance Unit staff to learn the appropriate procedures for requesting access. EHRs are not standardized, and ethnic subgroup information is often not routinely recorded or available in many of EHRs. Since an EHR can often be reviewed directly in the Surveillance Unit, contact with the medical facility can be minimal. This can make it more difficult to initiate contact to collect this additional information. The Surveillance Unit staff have worked to maintain relationships with the medical facilities, but this does require additional time and effort.

Other sites wishing to replicate the chart abstraction practice must develop strong relationships with staff at the medical facilities. This process requires patience, persistence, and educational efforts. Developing a strong active surveillance system will improve not only the completeness of race and ethnicity data, but also other key surveillance variables. San Francisco's small geographic area makes it easier to conduct in-person record reviews. Surveillance sites with larger geographic areas may want to target high volume reporting sites for conducting active surveillance or develop strong relationships over the telephone.

Surveillance staff may want to develop educational tools for providers regarding the importance of collecting self-reported race and ethnic subgroup information. Use of educational tools could improve the providers' ability to obtain self-reported race information that is detailed and accurate. For sites with limited staff available to conduct active surveillance activities, it might be beneficial to develop a procedure to flag all cases initially reported as AA, PI, or with an unknown race. These records would likely represent a small proportion of all identified cases and could easily be targeted for additional surveillance follow up to obtain more granular ethnicity data with the provider.

PROMISING PRACTICE #2: COLLABORATION WITH A COMMUNITY BASED HEALTH ORGANIZATION SERVING THE AA AND PI COMMUNITIES

History

Over ten years ago, the HIV Surveillance Unit developed a collaborative relationship with a community based health organization (CBO) serving AA and PI communities in San Francisco. This CBO received funding from the San Francisco Department of Public Health to provide HIV Counseling and Testing services. The CBO was required to report all positive test results to the Surveillance Unit. The relationship was strengthened by the CBO's desire to ensure that AAs and PIs were accurately represented when disseminating HIV surveillance data in reports. The CBO has been providing information to the Surveillance Unit for over 10 years.

Implementation

The CBO completes case reports for all persons newly diagnosed at the facility and also provides information regarding persons seeking care at the CBO to the Surveillance Unit. Surveillance Unit staff also complete chart abstractions with the CBO on a regular basis. The data from this CBO has helped improve the completeness of race and ethnic subgroup reporting among AAs and PIs in San Francisco.

Lessons Learned

Other sites wishing to implement this practice should identify and establish relationships with CBOs serving AA and PI communities. The Asian & Pacific Islander American Health Forum (<http://www.apiahf.org/hiv>) may provide a starting point for identifying potential collaborators. Surveillance staff may also want to collaborate with their HIV Prevention program to offer HIV testing resources at CBOs targeting AA and PI communities. In addition to the routine reporting of new HIV diagnoses at AA and PI CBOs, sites could consider conducting a validation study of the clients served by the CBO. The validation study could primarily focus on comparing race and ethnic subgroup information to improve the completeness of race and ethnicity reporting.

PROMISING PRACTICE #3: REPORTING AA AND PI ETHNIC SUBGROUP INFORMATION

History

By collecting ethnic subgroup data among AAs and PIs, the Surveillance Unit has been able to produce data reports and respond to data requests regarding AA and PI populations. Reports released on the San Francisco Department of Public Health's website for sexually transmitted diseases and communicable diseases include AAs and PIs as a single category. In order to improve reporting of ethnic subgroup data the HIV Surveillance Unit has taken steps to disseminate AA and PI data at a more granular level, primarily due to requests from the community.

Implementation

The Surveillance Unit previously included a table in their quarterly surveillance report regarding cumulative AIDS cases reported among Asian and Pacific Islander ethnic subgroups through June 2010 (Example 1). The table included cumulative AIDS cases by transmission category among Chinese, Japanese, Filipino, Southeast Asian, Korean, and Pacific Islander populations. Beginning with the quarterly report in September 2010, data regarding the Asian and Pacific Islander ethnic subgroups was no longer included. The inclusion of HIV (not AIDS) cases in the quarterly surveillance report beginning in September 2010 resulted in some minor restructuring of the surveillance report. Among cumulative HIV (not AIDS) cases, the number of AAs and PIs was small and, as a result, the Surveillance Unit decided to no longer include the table by AA and PI subgroup in the report.

Example 1. San Francisco Quarterly AIDS Surveillance Report, June 2010²⁶

Table 4. AIDS Cases by Transmission Category and Asian/Pacific Islander Ethnicity, San Francisco, 1980-2010

Transmission Category (1)	Chinese No. (%)	Japanese No. (%)	Filipino No. (%)	Southeast Asian No. (%)	Korean No. (%)	Pacific Islander No. (%)
Adult/Adolescent						
Gay or bisexual male	154 (80.6)	80 (82.5)	224 (80.9)	65 (73.0)	9 (81.8)	46 (65.7)
Injection drug user (IDU)	6 (3.1)	0 (0.0)	8 (2.9)	4 (4.5)	1 (9.1)	9 (12.9)
Gay or bisexual male IDU	9 (4.7)	12 (12.4)	23 (8.3)	7 (7.9)	1 (9.1)	8 (11.4)
Lesbian or bisexual IDU	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	2 (2.9)
Hemophiliac	0 (0.0)	1 (1.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)
Heterosexual (2)	4 (2.1)	2 (2.1)	11 (4.0)	5 (5.6)	0 (0.0)	4 (5.7)
Transfusion recipient	9 (4.7)	1 (1.0)	6 (2.2)	3 (3.4)	0 (0.0)	0 (0.0)
Risk not reported/Other (3)	7 (3.7)	1 (1.0)	4 (1.4)	5 (5.6)	0 (0.0)	1 (1.4)
Pediatric (0-12 years) (4)	2 (1.0)	0 (0.0)	1 (0.4)	0 (0.0)	0 (0.0)	0 (0.0)
Total	191 (100)	97 (100)	277 (100)	89 (100)	11 (100)	70 (100)

The Surveillance Unit responds to all data requests, including those for information among AA and PI at the ethnic subgroup level. A data release policy is in place, which limits the release of data based on a combination of the numerator and denominator rule, and consideration of the time period over which the data are displayed. If a cell within the data being released has a small value and the population size is also small, the specific value will be suppressed. Secondary suppression of values may result if the user might be able to back calculate the value originally suppressed.

The AA and PI data collected by the Surveillance Unit are used for prevention planning activities. In the 2010 HIV Prevention Plan, AAs and PIs were included as sub-prioritized populations within the men who have sex with men (MSM) and transgender populations based on incidence, prevalence, and behavioral data. Population

²⁶ San Francisco Department of Health. San Francisco Quarterly AIDS Surveillance Report, June 2010. <http://www.sfdph.org/dph/files/reports/RptsHIVAIDS/qtrtrtp062010.pdf>. Published August 2010. Accessed July 10, 2011.

estimates of AA and PI ethnic subgroups were included in the Epidemiologic Profile section of the Prevention Plan to provide an understanding of the general AA and PI population in San Francisco (Example 2).

Example 2. San Francisco 2010 HIV Prevention Plan²⁷

Lessons Learned

Currently the Surveillance Unit receives a limited number of requests for data by race and ethnicity, including

EXHIBIT 4 Ethnic Identification Among San Francisco's Asian and Pacific Islander Population

ETHNICITY	NUMBER	PERCENT*
Chinese (except Taiwanese)	161,912	64%
Filipino	35,543	14%
Vietnamese	16,825	7%
Japanese	9,386	4%
Other Asian	8,046	3%
Korean	7,597	3%
Asian Indian	6,655	3%
Other Asian, not specified	2,023	1%
Cambodian	961	0.4%
Thai	890	0.4%
Taiwanese	833	0.3%
Pakistani	778	0.3%
Laotian	342	0.1%
Hmong	173	0.1%
Indonesian	132	0.1%
Sri Lankan	81	0%
Malaysian	41	0%
Bangladeshi	0	0%
TOTAL	252,218	100%

Source: U.S. Census Bureau, 2008 American Community Survey
 *Percent does not total to 100 due to rounding.

requests for detailed AA and PI data. Regular requests from the community for additional AA and PI data could encourage the Surveillance Unit to include such data in routine surveillance reports. A major barrier for releasing data regarding AA and PI on the ethnic subgroup level is the concern of patient confidentiality. With small numbers of reported cases among AA and PI, data release policies often limit the amount of information that can be released.

Other sites wishing to disseminate data regarding AA and PI ethnic subgroups must first be able to collect more detailed information during routine surveillance activities. Sites should also examine their data release policies to ensure the policy protects the confidentiality of individuals, while still releasing as much information as possible to assist in planning and prevention efforts. For example, instead of grouping categories with small numbers, sites could include the disaggregated categories with text noting that the number of cases is less than a particular value (i.e., "less than 5").

²⁷ San Francisco Department of Public Health, HIV Prevention Section. San Francisco 2010 HIV Prevention Plan. <http://www.sfhiv.org/documents/CompletePlan.pdf>. Published January 2010. Accessed July 10, 2011.

PROMISING PRACTICE #4: ROUTINE MONITORING OF HIV PREVENTION INDICATORS

History

The HIV Seroepidemiology Unit routinely monitors behavioral indicators such as unprotected sexual intercourse, unprotected intercourse with persons of unknown HIV status, HIV testing patterns, and STD morbidity data to assess changes in risk behaviors. Regular monitoring provides an early warning signal for populations where HIV transmission could be increasing, and can be used to determine populations to target for HIV and STD prevention efforts. Routine monitoring examines data indicators by race and ethnicity, age, sex, and behavioral risk.

Implementation

Routine monitoring indicated increased risk behaviors among AA and PI men who have sex with men (MSM) from 1999 to 2002. The findings of the routine monitoring were published in the *Journal of AIDS Education and Prevention* in 2004²⁸. The monitoring compared trends in the AA and PI MSM community to trends in the white MSM community. Indicators examined included percent of MSM reporting unprotected anal intercourse with two or more partners in the last six months, percent of MSM reporting unprotected anal intercourse with two or more partners of unknown HIV status in the last six months, reported cases of male rectal gonorrhea, and the rate of reported cases of early syphilis among MSM. There were data sources such as percent positivity among MSM at HIV testing sites and reported STD cases among MSM living with AIDS which could not be used due to the small sample size among AAs and PIs.

The release of this information resulted in increased targeting of HIV prevention efforts to the AA and PI MSM community. Routine monitoring was continued to examine changes in the behavioral indicators after a period of increased prevention efforts. The results of the routine monitoring from 1999 to 2005 were published in the *Journal of Sexually Transmitted Diseases* in 2006²⁹. Indicators examined among AAs and PIs included the rate of reported male rectal gonorrhea cases, the rate of reported early syphilis among MSM, the percent reporting two or more sex partners in the last six month, and the percent ever testing for HIV. The indicators were compared against trends in HIV prevalence and incidence among AA and PI MSM. The evaluation noted an overall decrease in HIV risk among AA and PI MSM. This strategy highlights the benefit of continued monitoring for early detection of changes in behavioral risks to influence changes in prevention strategies.

Lessons Learned

Effective monitoring makes use of a wide variety of data sources, which are maintained by different organizational units or programs. Collaboration is imperative to effectively leverage all available resources. San Francisco's HIV Seroepidemiology Unit frequently collaborates with the HIV Prevention Section to increase the number of available resources. For example, HIV Prevention staff may conduct interviews for a special project. Using a wide variety of data sources can be beneficial, especially when exploring smaller populations such as AAs and PIs, as the combined sources may provide a more comprehensive picture not available from a single data source.

Sites wishing to implement routine monitoring must determine which data sources are available, and what new data may need to be collected. When assessing the available data source, sites should encourage participation for multiple programs within the health department and seek participation from CBOs. CBOs may have valuable resources often overlooked by the health department. Design of a written protocol to describe the frequency and general methods for conducting analysis would be beneficial for ensuring the practice is sustained over time.

28 McFarland W, Chen S, et al. Gay Asian men in San Francisco follow the international trend: increases in rates of unprotected anal intercourse and sexually transmitted diseases, 1999-2002. *AIDS Education and Prevention*. 2004;16:13-18.

29 Raymond HF, Chen S, et al. Trends in sexually transmitted diseases, sexual risk behavior, and HIV infection among Asian/Pacific Islander men who have sex with men, San Francisco, 1999-2005. *Sexually Transmitted Diseases*. 2006; 33(10).

CONCLUSIONS

Collection of detailed ethnic subgroup data assures that HIV prevention and care planning efforts can accurately assess the needs of AA and PI populations. Strong relationships with providers, especially those that serve the AA and PI communities, are needed in order to facilitate accurate reporting of race and ethnicity information. Active surveillance methods to encourage the reporting of detailed race and ethnicity information can improve available data. Partnering with organizations that serve AAs and PIs communities can facilitate the collection of accurate race and ethnicity data.

With more detailed ethnic subgroup data available, sites are able to present more detailed AA and PI population information as the need arises. Sites must balance patient confidentiality with meeting public health program planning needs when preparing data for release. Examining trends in behavioral risk from multiple data sources can provide an early warning for possible changes in HIV transmission patterns among AAs and PIs. These efforts will strengthen HIV surveillance activities among AAs and PIs and provide valuable resources during HIV prevention and care planning efforts.

BRIGHT IDEA: ALASKA'S ASIAN/HAWAIIAN/PACIFIC ISLANDER DATA IN THE EPIDEMIOLOGIC PROFILE

Asians and Pacific Islanders account for 5.5% of the general population in Alaska and 2% of cumulative HIV cases diagnosed. Throughout the epidemiologic profile (often referred to as the opi-profile), whenever racial/ethnic data is presented, Asian/Hawaiian/Pacific Islander data is detailed, except for in cases where data is suppressed per the state's data release policy.

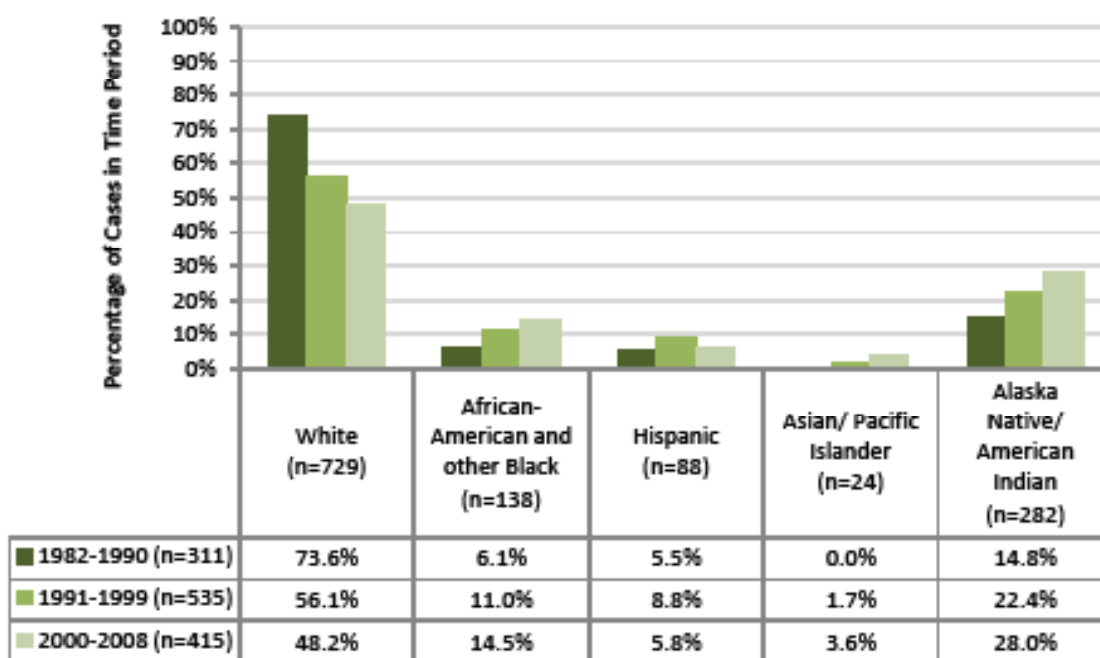
In describing the socio-demographic characteristics of the population, epidemiology staff utilize population estimates from Alaska's Department of Labor and Workforce Development. The epi-profile includes data such as:

- Estimated 2008 Asian/Pacific Islander male population (17, 588 individuals)
- Estimated 2008 Asian/Pacific Islander female population (20,284 individuals)
- Estimated 2008 Asian/Pacific Islander population (37,872 individuals)
- The median age for Asian and Pacific Islander persons (25.8 years)

Additionally, the epi-profile provides data related to geographic distribution noting that “of the 37,872 Asian and Pacific Islander persons living in Alaska, 56.7% reside in the Municipality of Anchorage, and a total of 21% live in the Fairbanks, North Star, Kodiak Island and Matanuska-Susitna Boroughs.”

The epi-profile includes trend data regarding the percentage of diagnoses during specific time periods (see below). Similar trends and data are given for HIV/AIDS diagnosis by race and ethnicity for males separately and for HIV/AIDS diagnosis by race and ethnicity for females separately.

Figure 16. HIV/AIDS Diagnoses by Race and Ethnicity, Both Sexes – Alaska, 1982-2008 (n=1,261)



Alaska's epidemiologic profile is included in the 2010-2012 Alaska HIV Prevention Plan which is available online at: <http://www.epi.hss.state.ak.us/hivstd/hppg/HIVPrevPlan10.pdf>

For more information, contact:

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Alaska Department of Health and Social Services
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melissa.boyette@alaska.gov

Alaska Census Quick Stats

- Alaska ranks 35th among states with the largest Asian Alone populations (44,541).³⁰
- Alaska ranks 14th among states with the largest Native Hawaiian and Pacific Islander Alone populations (4,499).³¹

Alaska HIV/AIDS Quick Stats

- Cumulatively between 1982 and 2011, there have been 34 reported cases of HIV/AIDS among Asians/ Pacific Islander in Alaska.³²

³⁰ U.S. Census Bureau. *The 2011 Statistical Abstract*.

³¹ U.S. Census Bureau. *The 2011 Statistical Abstract*. <http://www.census.gov/compendia/statab/2011/ranks/rank15.html>. Accessed August 24, 2011.

³² Alaska's Health & Social Services. *Epidemiology Bulletin*. http://www.epi.hss.state.ak.us/bulletins/docs/b2012_07.pdf. Published March 2012. Accessed February 23, 2013.

BRIGHT IDEA: CALIFORNIA'S HIV/AIDS DATA DISAGGREGATION BY ASIAN/PACIFIC ISLANDER SUBGROUPS

California Department of Public Health's Office of AIDS has a long history of responding to requests for HIV/AIDS data analysis. For example, the staff regularly meets with various stakeholder groups to make them aware of the opportunity to make data requests as well as to solicit input and feedback on the most useful data to include in the state's epidemiological profile.

One such request came from a local stakeholder group asking for further analysis of HIV/AIDS cumulative cases disaggregated by Asian/Pacific Islander subgroups and mode of exposure. Typically, at least one staff person is assigned to conduct the analysis per request. The Office of AIDS tries to respond as best they can in the context of current staffing, resources, and sensitivity to confidentiality issues.

The resulting analysis is reviewed by up to three different levels of leadership (i.e. Section Chief, Branch Chief, and Division Chief). In this instance, leadership noted the potential value of making disaggregated Asian/Pacific Islander data more broadly available and asked that it be published on the Office of AIDS website.

For this request, one staff person spent about eight hours to develop the programming code, analyze and verify data, and develop the summary table. Once an analysis is run, the programming code is archived so that minimal time is needed to re-run a query. Staff estimate that to conduct this particular analysis again with updated data, it might only take one staff person about two to four hours to complete.

This summary table (see next page) and other related resources are available online at the Office of AIDS' HIV and Asians and Pacific Islanders page: <http://www.cdph.ca.gov/programs/aids/Pages/OAAsian.aspx>

Additional data requests can be made by submitting a request form available online: <http://www.cdph.ca.gov/pubsforms/forms/CtrlForms/cdph8532.pdf>

For more information, contact:

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California Department of Public Health
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**HIV/AIDS ASIAN/PACIFIC ISLANDER SUBGROUPS
BY GENDER AND MODE OF EXPOSURE
CUMULATIVE CASES REPORTED AS OF NOVEMBER 30, 2008****

ASIAN/ PACIFIC ISLANDER SUBGROUPS	MALES			FEMALES - ALL MODES
	MSM	OTHER	TOTAL	
Asian	193	35	228	20
Chinese	338	52	390	33
Filipino	948	79	1,027	108
Japanese	270	32	311	29
Korean	58	17	75	12
Malayan	18	"	20	"
Taiwanese	48	7	58	"
Singaporean	8	0	8	"
Vietnamese	198	38	234	17
Laotian	23	5	28	"
Thai	103	41	144	35
Cambodian	48	22	70	25
Indonesian	40	9	48	"
Burmese	11	9	20	"
Asian Indian	31	24	55	9
Pakistani	"	"	13	0
Bangladeshi	"	"	"	0
Sri Lankan	"	"	7	"
East Indian	23	10	33	"
Pacific Islander	23	5	28	"
Hawaiian	88	10	98	"
Samoan	33	17	50	17
Tongan	"	"	10	0
Tahitian	"	"	"	0
Guamanian	45	9	54	"
North Mariana	"	0	"	0
Palauan	0	"	"	0
Fijian	"	"	"	"
Micronesian	"	0	"	0
Unknown	1,008	292	1,300	280
TOTAL	3,596	726	4,322	598

HIV reporting began in April 2005. AIDS reporting began in March 1993.

MSM/BI – Men who have sex with men / Bisexual men.

** Source: California Department of Public Health, Office of AIDS, HIV/AIDS Case Registry Section, data as of November 30, 2008.

" Data withheld to ensure case confidentiality.

For more information, call the HIV/AIDS Case Registry Section at (916) 449-5866.

Revised: 12/18/2008, BBL

California Census Quick Stats

- California ranks 1st among states with the largest Asian (alone or in any combination) populations (5,399,600).³³
- California ranks 2nd among states with the largest Native Hawaiian and Pacific Islander (alone or in any combination) populations (251,729).³⁴

California HIV/AIDS Quick Stats

- As of June 30, 2012 there 4,258 Asians/Pacific Islanders living with HIV/AIDS.³⁵

33 U.S. Census Bureau. *The 2011 Statistical Abstract*. <http://www.census.gov/compendia/statab/2011/ranks/rank14.html>. Accessed August 24, 2011.

34 U.S. Census Bureau. *The 2011 Statistical Abstract*. <http://www.census.gov/compendia/statab/2011/ranks/rank15.html>. Accessed August 24, 2011.

35 California Department of Public Health. *HIV/AIDS Surveillance in California*. <http://www.cdph.ca.gov/data/statistics/Documents/SSSemiAnnualRptJune2012.pdf>. Published June 2012. Accessed February 23, 2011.

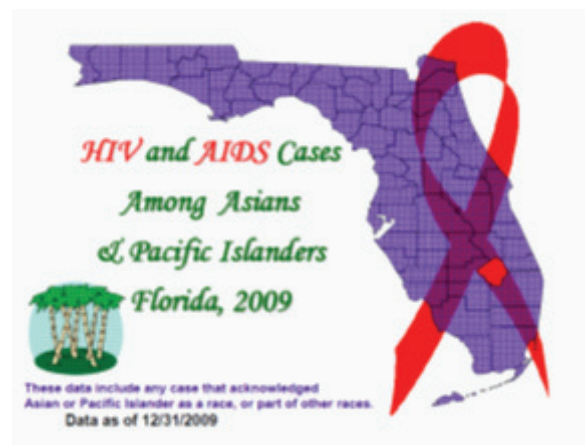
BRIGHT IDEA: FLORIDA'S ASIAN FACT SHEET AND ASIAN & PACIFIC ISLANDER SLIDE SETS

For over a decade, the Florida Department of Health's Bureau of HIV/AIDS has developed fact sheets with corresponding slide sets for a variety of demographic and at-risk groups. These are updated on an annual basis and include a one-page "HIV/AIDS among Asians" fact sheet and an 11-slide "HIV and AIDS Cases Among Asians & Pacific Islanders" slideshow.

The fact sheet (see next page), which includes data for Native Hawaiian and Pacific Islanders, provides highlighted HIV and AIDS incidence data at the national and Florida levels. It also compares risk behavior profiles and provides summarized analysis of risk behaviors and of survival rates. Finally, at the bottom of the fact sheet, suggested strategies related to Asian American, Native Hawaiian, and Pacific Islander populations are offered.

The slide sets includes the following slides and more:

- Adult AIDS Cases Among Asians and Pacific Islanders by Year of Report
- Adult HIV (regardless of AIDS) Cases Among Asians and Pacific Islanders by Year of Report
- Asian & Pacific Islander By Gender
- Asian & Pacific Islander By Age Group
- Annual Prevalence of Adult HIV/AIDS Cases Asian / Hawaiian / Pacific Islanders By Sex
- Living Adult HIV/AIDS Cases (PLWHAs) By Mode of Exposure and Sex
- Transmission Rates Among Asians Living with HIV In the US Compared to Florida
- Median Time (in months) from AIDS Diagnosis to Death By Race/Ethnicity in 4 Time Periods



Using a standardized template that pulls numbers from state HIV/AIDS Surveillance Report Data, a health department staff person spends about five hours to query the data, update the fact sheet and slideshow, and edit comments as needed. In 2007, data queries were modified to include not just individuals who identified as Asian-only or Native Hawaiian/Pacific Islander-only, but also those who identified as Asian or Native Hawaiian/Pacific Islander in combination with one or more other races.

Both the fact sheet and the slide sets are available online at http://www.doh.state.fl.us/disease_ctrl/aids/trends/trends.html

For more information, contact:

Lorene Maddox, MPH
(850) 245-4444 x2613
Lorene_Maddox@doh.state.fl.us

HIV among Asians

(data includes Native Hawaiians and Other Pacific Islanders)

United States 2009

- ✦ The estimated AIDS case rate among Asians in the U.S. in 2009 was 3.1 per 100,000 population which was lower than that for whites at 4.7 per 100,000 population.
- ✦ The prevalence of certain risk behaviors differs among Asians living with HIV disease in Florida compared to the U.S. (see table below).

Prevalence of Selected Risk Factors for HIV disease among Asian Populations in Florida and the U.S.

	Males		Females	
	US thru 2008	FL thru 2010	US thru 2008	FL thru 2010
MSM	77%	73%	—	—
IDU	6%	3%	9%	9%
MSM/IDU	3%	3%	—	—
Heterosexual	13%	20%	87%	91%
Other/NIR	1%	1%	5%	2%

Florida 2010

- ✦ Asians represent less than 1% of newly reported adult HIV cases in Florida each year. In 2010, 34 (0.7%) of the 5,187 HIV cases reported in Florida were Asians**.
- ✦ The majority (70%) of Asians were diagnosed with HIV infection between the ages of 20-39, where only 48% of all newly reported HIV cases reported in Florida were within this age range.
- ✦ Nearly one fourth (24%) of Asians living with HIV disease in Florida in 2010 were women.
- ✦ Of the 507 Asians living with a diagnosis of HIV through 2010, 68% were Asian alone, 10% were Hispanic, and 22% were multi-race.

Survival Rates for Asians

According to both national and Florida data, the survival time from AIDS diagnosis to death is significantly shorter for Asians than whites. Of the AIDS cases that died in Florida from 2001-2010, Asians had a median survival of only 32 months. This compares to 65 months for whites, 49 months for Hispanics, 46 months for blacks and 39 months for American Indians.

Key steps to reducing HIV disease in Asian populations:

- ✦ Raise awareness about HIV disease and related risks among Asians;
- ✦ Encourage individuals to be tested for HIV/AIDS;
- ✦ Increase youth involvement in HIV community planning, decision making and HIV prevention programming;
- ✦ Reduce barriers to HIV testing, prevention and care by reducing HIV/AIDS stigma; and
- ✦ Disseminate information on the health benefits of condoms and other risk reduction measures.

Data sources:

- ✦ Florida data: FL Department of Health, Bureau of HIV/AIDS
- ✦ For more Florida data, go to <http://floridaaids.org/>, then *Trends and Statistics*, then *Slide Shows* to find the slide set on Asians
- ✦ U.S. data: HIV Surveillance Report, 2009 (most recent available) Vol. 29
- ✦ For national facts, go to: <http://www.cdc.gov/hiv/resources/factsheets/index.htm> or <http://www.kff.org/hivaids/>



Florida Census Quick Stats

- Florida ranks 8th among states with the largest Asian (alone or in any combination) populations (552,482).³⁶
- Three percent of the total Asian Alone or in Combination population in the US reside in Florida.³⁷
- Florida ranks 7th among states with the largest Native Hawaiian and Pacific Islander Alone populations (24,720).³⁸
- Two percent of the total Native Hawaiian and Pacific Islander Alone or in Combination population in the US reside in Florida.³¹

Florida HIV/AIDS Quick Stats

- In 2009, 52 of the 5,539 HIV cases reported in Florida were among Asians.³⁹
- Of the 458 living Asians HIV/AIDS cases reported through 2009, 69% were Asian alone, 10% were Hispanic, and 21% were multi-race.³³

36 U.S. Census Bureau. *The 2011 Statistical Abstract*. <http://www.census.gov/compendia/statab/2011/ranks/rank14.html>. Accessed August 24, 2011.

37 Asian & Pacific Islander Institute on Domestic Violence. *2010 Census Data Results for the Asian Population and the Native Hawaiian and Other Pacific Islander Population*. <http://www.apiidv.org/files/2010Census-WHIAPI-2011.pdf>. Published May 2011. Accessed August 24, 2011.

38 U.S. Census Bureau. *The 2011 Statistical Abstract*. <http://www.census.gov/compendia/statab/2011/ranks/rank15.html>. Accessed August 24, 2011.

39 Florida Department of Health. *HIV/AIDS among Asians (data includes Native Hawaiian / Other Pacific Islander)*. http://www.doh.state.fl.us/disease_ctrl/aids/updates/facts/09Facts/2009_Asian_Fact_Sheet.pdf. Accessed August 24, 2011.

BRIGHT IDEA: LOS ANGELES'S SOCIAL DETERMINANT DATA AND SCALED GRAPHS

With over 1.4 million individuals who identified as Asian alone or in combination with one or more other races in 2009, Los Angeles County has the most Asians compared to any other county in the U.S.⁴⁰

Similar to other health departments, the Los Angeles County Department of Public Health staff include in the epidemiologic profile a detailed description of the County's residents in regards to population, population growth, and various socioeconomic determinants. Where other health departments provide socioeconomic data aggregated for the general population, Los Angeles County's epidemiologic profile provides data on these socioeconomic determinants by racial/ethnic group, including Asian/Pacific Islanders. Racial/ethnic data is provided, for example:

- In 2007, Asian/Pacific Islander mothers delivered 17% of all births.
- Over two-thirds of Asian/Pacific Islanders are foreign born.
- Asian/Pacific Islander residents originate from China/Taiwan (29.4%), the Philippines (23.6%), Korea (15.6%), Japan (8.9%), Vietnam (7.2%), India (5.9%), and many other and unspecified countries account for another 9.1%.
- The median household income for Asian/Pacific Islander residents was \$61,518
- 17% of Asian/Pacific Islanders are uninsured
- Asians have a 7% high school dropout rate. Pacific Islanders have a 23% dropout rate.
- Only 4.2% of Asian/Pacific Islanders saw a mental health professional in the past year.

In the HIV/AIDS section of the epidemiologic profile, staff provide various tables, charts, and graphs to describe the impact of the HIV/AIDS epidemic. In all instances where racial/ethnic level data is provided, staff include data for Asian/Pacific Islanders. Moreover, for a few of the line graphs, staff inserted a separately scaled graph for Asian/Pacific Islander data so that trends were more observable.

Two people are assigned to develop the county's epidemiologic profile. It took about ten hours to analyze HIV/AIDS data as well as to develop the separately scaled graphs on Asian/Pacific Islanders in the epidemiologic profile.

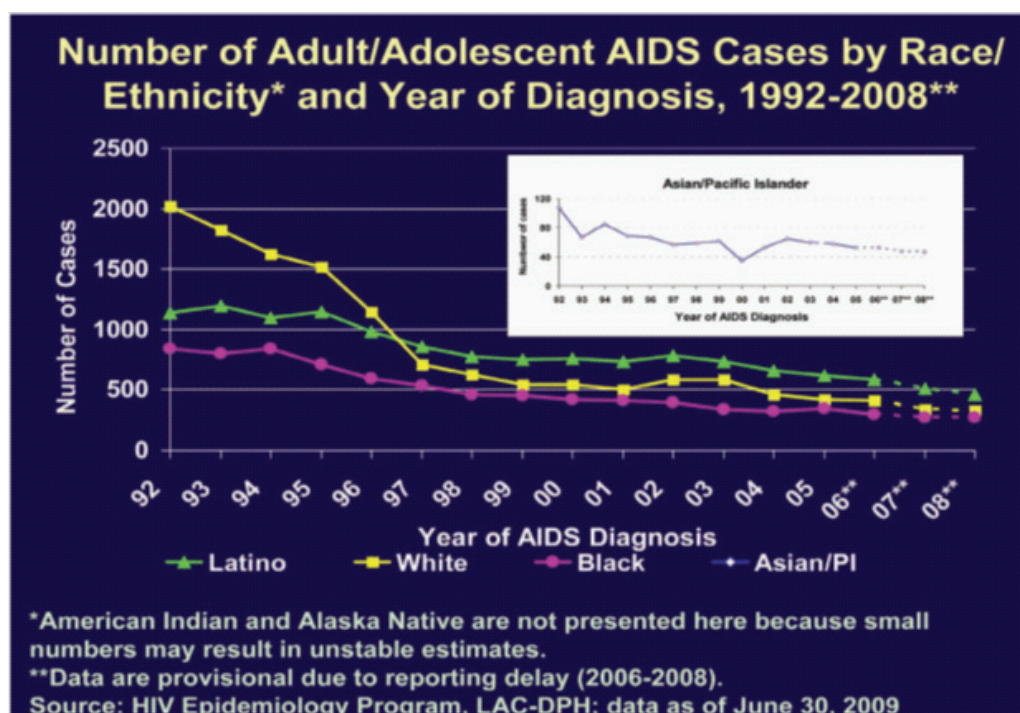
Los Angeles' most recent epidemiologic profile is available online at:
<http://publichealth.lacounty.gov/wwwfiles/ph/hae/hiv/2009-epi.pdf>

For more information, contact:

HIV Epidemiology Program
Los Angeles County Department of Public Health
(213) 351-8196
hivepiemail@ph.lacounty.gov

40 U.S. Census Bureau. *Facts for Features: Asian/Pacific American Heritage Month: May 2011*. http://www.census.gov/newsroom/releases/archives/facts_for_features_special_editions/cb11-ff06.html. Published April 29, 2011. Accessed August 24, 2011.

Example: Graph from Los Angeles' 2009 Epidemiologic Profile:



Los Angeles Census Quick Stats

- 15% of the total population in Los Angeles are Asian (alone or in any combination) (1,467,785).⁴¹
- 0.5% of the total population in Los Angeles are Native Hawaiian and Pacific Islander (alone or in any combination) (45,600).⁴²

Los Angeles HIV/AIDS Quick Stats

- As of December 31, 2011 3% of person living with HIV/AIDS in Los Angeles County were Asian/Pacific Islander (1,427).⁴³

⁴¹ U.S. Census Bureau. 2011 American Community Survey 5-year Estimates.

⁴² U.S. Census Bureau. 2011 American Community Survey 5-year Estimates.

⁴³ Los Angeles County Department of Public Health. 2011 Annual HIV Surveillance Report. http://publichealth.lacounty.gov/wwwfiles/ph/hae/hiv/2011_Annual%20HIV%20Surveillance%20Report.pdf.

BRIGHT IDEA: MICHIGAN'S ASIAN, NATIVE HAWAIIAN, AND PACIFIC ISLANDER SECTION IN THE EPIDEMIOLOGIC PROFILE

In early 2001, a local community based organization (CBO) that served Arab-American communities asked the Michigan Department of Community Health to add a question about Arabic ethnicity on the HIV/AIDS Case Report Form that read "Does this patient consider him or herself Arabic?" With this additional data, the health department was able to analyze and disseminate HIV/AIDS on Arab-Americans in order to help inform the CBO's HIV prevention efforts. This data was added into subsequent epidemiologic profiles as a one-page summary in the "Special populations" section.

About four years ago, the health department was asked why similar summaries were not available for other racial/ethnic minority communities. This request prompted the health department to re-tool the "special population" section of the epidemiologic profile. The most recent epidemiologic profile contains a "special population" summary for Asian, Native Hawaiian, and Pacific Islander communities.

The "Special Populations: Arab-Americans" and the "Special Populations: Asians, Native Hawaiians, and Pacific Islanders" sections of the epidemiologic profile include data such as:

- Cumulative HIV diagnosis
- HIV prevalence
- Percentage distribution of counties of initial HIV diagnosis
- Distribution by age at the time of initial HIV/AIDS diagnosis

Both sections also include pie graphs depicting:

- Males living with HIV/AIDS by mode of transmission
- Females living with HIV/AIDS by mode of transmission

2010 Profile of HIV/AIDS in Michigan

Special Populations: Asians, Native Hawaiians & Pacific Islanders

Data from HIV/AIDS Reporting System (eHARS)

In this report Asians, Native Hawaiians and Pacific Islanders (A/NH/PI) have been combined into one race/ethnicity category. This group makes up one percent of those living with HIV in Michigan and one percent of the general population of Michigan. (Table 5, page 3-85)

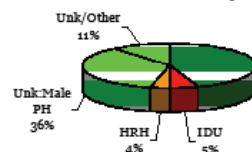
MDCH estimates that there are approximately 90 A/NH/PI persons living with HIV disease in Michigan. Sixty-one percent of this population live in the Detroit Metro Area, where most of these cases were diagnosed. Of the 77 reported cases, 49 percent are HIV, not AIDS and 51 percent are AIDS. Of those who have progressed to AIDS, 59 percent were concurrently diagnosed with AIDS at the same time as their initial HIV diagnosis. This is higher than the proportion of all concurrent AIDS diagnosis (43 percent), indicating that A/NH/PI persons test later than the persons living with HIV statewide.

The counties where A/NH/PI were initially diagnosed with HIV include Wayne (27 percent), Oakland (25 percent), Ingham (6 percent), Kent (6 percent), Kalamazoo (4 percent), Jackson (3 percent), Macomb (3 percent), and unknown and out of state (14 percent). The remaining 10 percent are among Barry, Bay, Calhoun, Eaton, Genesee, Ottawa, Saginaw, Shiawassee and Washtenaw counties.

The age at HIV diagnosis (including those with AIDS) is similar to the age distribution for all cases in Michigan, with four percent ages 0-19, 10 percent 20-24, 32 percent 25-29, 34 percent 30-39, 17 percent 40-49, three percent 50-59, and none age 60 and older. The main difference is that more HIV-infected A/NH/PI persons were 25-29 at HIV diagnosis (32 percent A/NH/PI v 17 percent all cases).

For more data on A/NH/PI persons living with HIV in Michigan, please see Tables 22 & 23, pages 3-103-104.

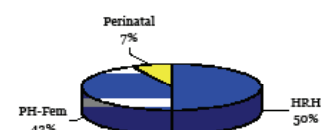
Figure 59: Asian/Pacific Islander/Native Hawaiian Males, Living with HIV/AIDS in Michigan, by Mode of Transmission (N = 56)



Among the 21 females, almost all were infected heterosexually (overall, 50 percent HRH and 43 percent PH-Fem). None were attributed to injection drug use and seven percent were infected through perinatal transmission. See Figure 60.

Seventy-three percent of the cases are among males and 27 percent are among females. Among the 56 male cases, less than half (44 percent) were attributed to MSM and five percent attributed to injection drug use. Forty-seven percent have an unknown mode of transmission. See Figure 59.

Figure 60: Asian/Pacific Islander/Native Hawaiian Females, Living with HIV/AIDS in Michigan, by Mode of Transmission (N = 21)



Michigan, Page 3-77

Additional tables later in the epidemiologic profile include:

- Table 20: Demographic Information on Arab-American HIV/AIDS Cases Currently Living in Michigan, 2010
- Table 21: Sex, Risk and Age at HIV Diagnosis Among Arab-American HIV/AIDS Cases Currently Living in Michigan, 2010
- Table 22: Demographic Information on Asian, Native Hawaiian and Pacific Islander HIV/AIDS Cases Currently Living in Michigan, 2010
- Table 21: Sex, Risk and Age at HIV Diagnosis Among Asian, Native Hawaiian and Pacific Islander HIV/AIDS Cases Currently Living in Michigan, 2010

Table 20: Demographic Information on Arab-American HIV/AIDS Cases Currently Living in Michigan, 2010

	REPORTED PREVALENCE				CONCURRENT AIDS	
	HIV, not AIDS		AIDS		TOTAL	
SEX	Number	Percent of Total	Number	Percent of Total	Number	Percent of Total
Males	20	78%	42	91%	71	86%
Females	8	22%	4	9%	12	14%
RISK*						
Male-Male Sex	17	46%	21	48%	38	48%
Injection Drug Use	3	8%	2	4%	5	6%
MSM/IDU	1	3%	3	7%	4	5%
Blood Products	1	3%	1	2%	2	2%
Heterosexual	6	16%	7	15%	13	16%
HRH	4	11%	6	13%	10	12%
PH-Female	2	5%	1	2%	3	4%
Perinatal	1	3%	0	0%	1	1%
Undetermined	8	22%	12	26%	20	24%
PH-Male	4	11%	8	17%	12	14%
Unknown	4	11%	4	9%	8	10%
AGE AT HIV DIAGNOSIS						
0 - 12 years	1	3%	0	0%	1	1%
13 - 19 years	3	8%	1	2%	4	5%
20 - 24 years	3	8%	5	11%	8	10%
25 - 29 years	11	30%	6	13%	17	20%
30 - 39 years	11	30%	17	37%	28	34%
40 years and older	7	19%	17	37%	24	29%
Unspecified	1	3%	0	0%	1	1%
AREA OF RESIDENCE AT DIAGNOSIS						
Detroit Metro Area	35	95%	43	93%	78	94%
Out-State	2	5%	3	7%	5	6%
TOTAL	37	100%	46	100%	83	100%

*See page 1-3 for descriptions of prevalence estimate calculations and pages 6-7,8 for risk category groupings. Risk categories used in Michigan are newly defined as of July 2007.

One health department staff person is assigned to develop the epidemiologic profile. Staff estimates that the four tables take up to three days to analyze and develop, and that each "Special Population" section takes up to four days to draft and edit.

The 2010 Epidemiologic Profile of HIV/AIDS in Michigan is available online at:

http://www.michigan.gov/documents/mdch/2010_EPI_PROFILE_ENTIRE_335483_7.pdf

For more information, contact:

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Michigan Census Quick Stats

- Michigan ranks 14th among states with the largest Asian Alone populations (236,669).⁴⁴
- Michigan ranks 22nd among states with the largest Native Hawaiian and Pacific Islander Alone populations (4,134).⁴⁵

Michigan HIV/AIDS Quick Stats

- As of April 2011, it is estimated that 100 out of 19,500 persons living with HIV in Michigan were Asian/Pacific Islander.⁴⁶

44 U.S. Census Bureau. The 2011 Statistical Abstract. <http://www.census.gov/compendia/statab/2011/ranks/rank14.html>. Accessed August 24, 2011.

45 U.S. Census Bureau. The 2011 Statistical Abstract. <http://www.census.gov/compendia/statab/2011/ranks/rank15.html>. Accessed August 24, 2011.

46 Michigan Department of Community Health. Quarterly HIV/AIDS Report, Michigan. http://www.michigan.gov/documents/mdch/April_2011_Statewide_Quarterly_Stats_351248_7.pdf. Published April 2011. Accessed August 24, 2011.

BRIGHT IDEA: MINNESOTA'S SOCIAL DETERMINANTS OF HEALTH IN THE EPIDEMIOLOGIC PROFILE

While CDC's Integrated Guidelines for Developing Epidemiologic Profiles states that an epidemiologic profile should describe the "characteristics of the general population in the geographic area covered by the profile," the Minnesota Department of Health (MDH) has taken the opportunity to provide U.S. Census and socio-economic data disaggregated for racial/ethnic populations. This level of detail potentially provides health department staff, planning bodies, and community-based organization staff with a more detailed understanding of local social determinants of health in order to better inform their decisions and efforts.

The "General Population Demographics" section of the Epidemiologic Profile of HIV/AIDS in Minnesota (2010) includes data for Asian/Pacific Islander (and other racial and ethnic groups) such as:

- 2.9% of Minnesota's male population identify as Asian/Pacific Islander
- 2.9% of Minnesota's female population identify as Asian/Pacific Islander
- 19% of Minnesota's Asian/Pacific Islander population lives at or below the poverty level
- 6% of Minnesota's Asian/Pacific Islander population are uninsured

The state's planning bodies help to identify the most important social determinants of health that they would like to see included.

MDH staff acknowledged that in the past, when presenting HIV/AIDS surveillance and other data, information for smaller populations did not always get included. In response to community feedback that this inclusion was important, MDH staff have been more cognizant of ensuring that data for various populations are consistently included. Note that this approach applies to not just racial/ethnic groups such as Asian/Pacific Islanders but also other populations such as the gay, lesbian, bisexual, transgender community and persons with sensory disability(ies).

One MDH staff person is assigned to develop the state's epidemiologic profile. Previous epidemiologic profiles incorporated data from the U.S. Census 2000. MDH staff are looking forward to including more recently released data (2009) from the U.S. Census' American Community Survey.

Minnesota's epidemiologic profile is available online at <http://www.health.state.mn.us/divs/idepc/diseases/hiv/epiprofile/index.html>

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Minnesota Census Quick Stats

- Minnesota ranks 16th among states with the largest Asian (alone or in any combination) populations (237,825).⁴⁷
- Minnesota ranks 26th among states with the largest Native Hawaiian and Pacific Islander (alone or in any combination) population (5,640).⁴⁸

Minnesota HIV/AIDS Quick Stats

- In 2010, 6 of the 331 HIV cases reported in Minnesota were among Asians.⁴⁹
- As of 2011 3% of person living with HIV/AIDS in Minnesota were Asian/Pacific Islander (8).⁵⁰

47 U.S. Census Bureau. The 2011 Statistical Abstract. <http://www.census.gov/compendia/statab/2011/ranks/rank14.html>. Accessed August 24, 2011.

48 U.S. Census Bureau. The 2011 Statistical Abstract. <http://www.census.gov/compendia/statab/2011/ranks/rank15.html>. Accessed August 24, 2011.

49 Minnesota Department of Health. 2010 New HIV Infections Summary Tables. <http://www.health.state.mn.us/divs/idepc/diseases/hiv/stats/inc2010.pdf>. Accessed August 24, 2011.

50 Minnesota Department of Health HIV/AIDS Surveillance System. HIV Surveillance Report, 2011. <http://www.health.state.mn.us/divs/idepc/diseases/hiv/stats/inc2011.pdf>. Published December 2011. Accessed February 23, 2013.

BRIGHT IDEA: NEVADA'S ASIAN/PACIFIC ISLANDER SECTION IN THE EPIDEMIOLOGIC PROFILE

Like other jurisdictions, Nevada's epidemiologic profile is driven by the needs of the state HIV prevention community planning group, which includes a membership slot for an Asian/Pacific Islander (API) representative.

In developing the most recent epidemiologic profile for the 2011-2016 Comprehensive State HIV Prevention Plan, Nevada State Health Division surveillance staff wanted to first ensure that sufficient data was available regarding the planning group's priority populations. Staff then took the opportunity to ensure that data was available for all race/ethnicity populations, including Asian/ Pacific Islanders, and developed population summaries for the epidemiologic profile.

Surveillance staff noted that while the number of cases among Asian/Pacific Islanders has historically been small, there has been an increasing trend. Further analysis is required to determine whether this trend can be attributed to increased risk-taking behavior and/or increased utilization of HIV testing services.

While Asian/Pacific Islanders are not currently a prioritized population, staff hope that this data may be of use to community based organizations and might support grant applications to focus on the Asian/Pacific Islander community.

The Asian/Pacific Islander section of the epidemiologic profile includes data such as:

- 2.9% of persons living with HIV/AIDS in Nevada in 2008 were Asian/Pacific Islander
- 3.0% of new infections in 2008 were among Asians/Pacific Islanders
- Geographic distribution of new infections among Asians/Pacific Islanders
- Trends of new infections among Asians/Pacific Islanders by sex, 2004-2008
- Percent of new HIV infections in Nevada among Asians/Pacific Islanders, by age at diagnosis
- Percent of new HIV infections in Nevada among Asians/Pacific Islanders, by risk of transmission

One Nevada State Division of Health staff person is assigned to develop the state's epidemiologic profile. It took about 10 hours to analyze HIV/AIDS data as well as to develop the charts, graphs, and text for the Asian/Pacific Islander section of the epidemiologic profile.

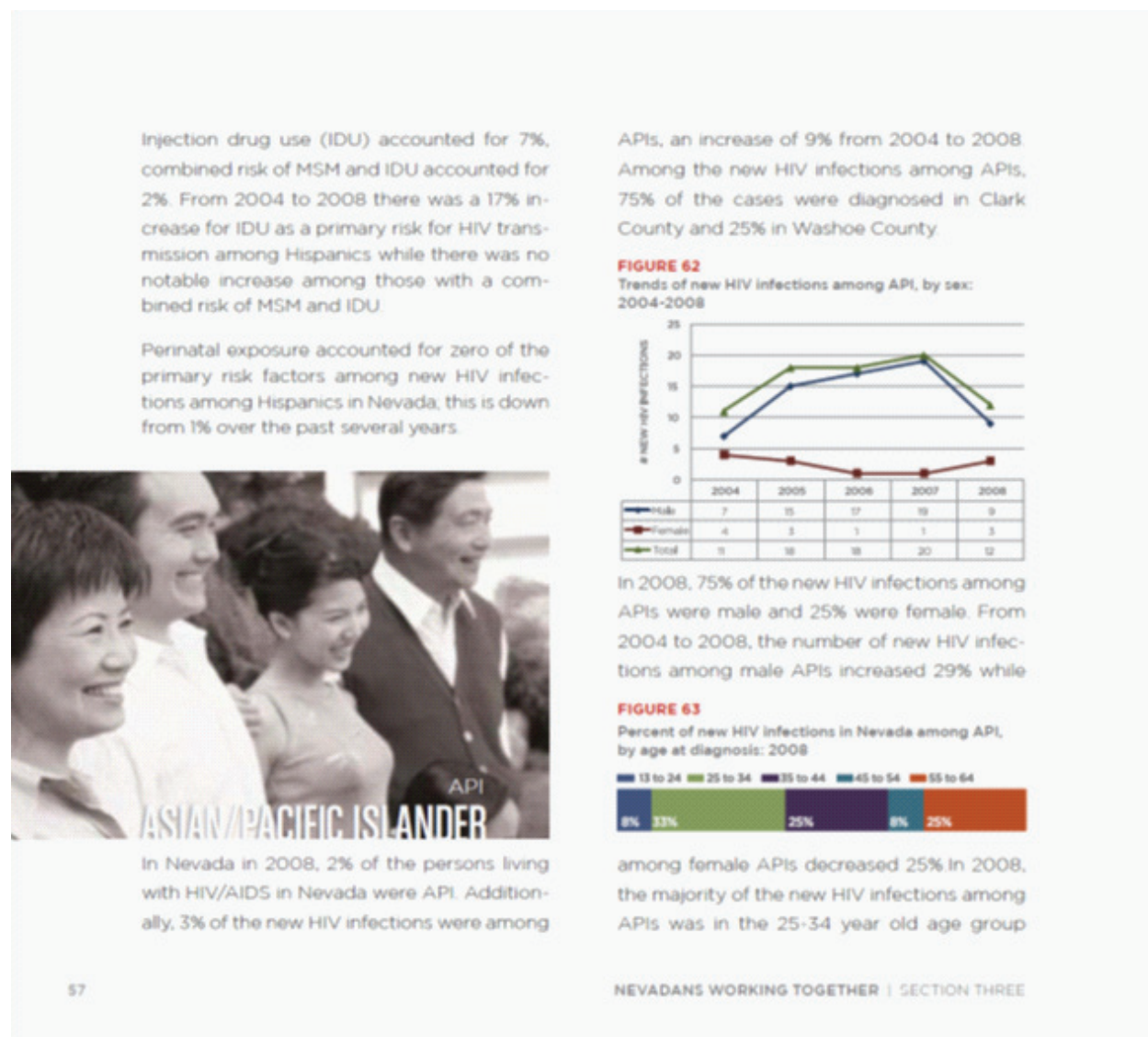
Nevada's 2011-2016 Comprehensive State HIV Prevention Plan, which includes the epidemiologic profile, is available online at:

http://health.nv.gov/PDFs/HIV_STD_TB/2011-2016_ComprehensiveStateHIVPreventionPlan.pdf

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Excerpt from Nevada's Epidemiologic Profile:



Nevada Census Quick Stats

- Nevada ranks 17th among states with the largest Asian (alone or in any combination) populations (230,336).⁵¹
- Nevada ranks 8th among states with the largest Native Hawaiian and Pacific Islander Alone populations (14,270).⁵²

Nevada HIV/AIDS Quick Stats

- In 2008, 12 of the 435 new HIV infections in Nevada were Asian/Pacific Islander.⁵³

51 U.S. Census Bureau. 2011 American Community Survey 5-year Estimates.

52 U.S. Census Bureau. The 2011 Statistical Abstract. <http://www.census.gov/compendia/statab/2011/ranks/rank15.html>. Accessed August 24, 2011.

53 Nevada Department of Health and Human Services, State Health Division. Comprehensive State HIV Prevention Plan 2011-2016. http://health.nv.gov/PDFs/HIV_STD_TB/2011-2016_ComprehensiveStateHIVPreventionPlan.pdf. Accessed August 24, 2011.

RECOMMENDATIONS

Based primarily on the promising practices identified in the three case studies and six “bright ideas” mini-case studies, APIAHF offers the following 12 recommendations to improve HIV/AIDS data collection, reporting, and dissemination.

Recommendations for HHS and CDC

1. **Follow Department of Health and Human Services implementation Guidance on Data Collection Standards on Race, Ethnicity, Sex, Primary Language, and Disability Status.** Note that while the purpose of the Guidance is focused on surveys, the standards could be adopted for surveillance efforts.

These standards add seven Asian subgroups (Chinese, Filipino, Asian Indian, Vietnamese, Japanese, Korean and other Asian) and four Native Hawaiian and Pacific Islander subgroups (Native Hawaiian, Guamanian or Chamorro, Samoan and other Pacific Islander).

2. **Provide guidance and support to state and local health departments to increase their capacity to follow Department of Health and Human Services Implementation Guidance on Data Collection Standards on Race, Ethnicity, Sex, Primary Language, and Disability Status.**
3. **Convene state and local health department surveillance staff to support implementation of promising practices featured in this report.**
4. **Include goals and strategies related to improving HIV/AIDS data collection and reporting for AA and NHPI populations in departmental strategic plans.**
5. **Set new goals and strategies related to improving HIV/AIDS data collection and reporting for AA and NHPI populations in future updates to National HIV/AIDS Strategy.**

Recommendations for state and local health departments

1. **Follow Department of Health and Human Services Implementation Guidance on Data Collection Standards on Race, Ethnicity, Sex, Primary Language, and Disability Status.**
2. **Discontinue the practice of lumping data for “Asian” and “Native Hawaiian/Pacific Islander” with other racial/ethnic categories (e.g. Native American) when presenting racial/ethnic data in HIV/AIDS surveillance reports and epidemiologic profiles. Instead, utilize separate “Asian” and “Native Hawaiian/Pacific Islander” categories when presenting racial/ethnic data in HIV/AIDS surveillance reports and epidemiologic profiles as well as related documents, presentations, and reports.**

When data does not meet jurisdictions’ data release policy for specific charts, graphs, and tables, jurisdictions can indicate that there are “less than 5 cases” as opposed to lumping or completely omitting AA and NHPI data.

3. **Jurisdictions with significant AA and NHPI populations are encouraged to collect and present disaggregated data by AA and NHPI ethnic subgroups in HIV/AIDS surveillance reports and epidemiologic profiles.**

While some health departments have proactively provided special data analysis and/or reports proactively or in response to special data requests, this information is often not included in HIV/AIDS surveillance reports and epidemiologic profiles, the two primary sources of HIV/AIDS data that HIV prevention and care planning groups utilize as a basis for their prioritization and resource allocation decisions.

4. Collaborate with prevention planning groups, Ryan White planning councils, and other decision-making bodies as well as AA and NHPI serving CBOs to identify HIV/AIDS surveillance data needs.
5. In addition to implementing recommendations and promising practices featured in this report, consider amending health department surveillance policies and procedures accordingly.

Recommendations for AA and NHPI serving CBOs and related stakeholders

1. Communicate AA and NHPI HIV/AIDS data related needs to local/state health departments. If applicable, utilize health department process for special data requests.
2. Communicate with health department surveillance staff, prevention planning groups, Ryan White planning councils, and other decision-making bodies to identify opportunities for improving HIV/AIDS data collection and reporting for AA and NHPI populations, particularly in surveillance reports and epidemiologic profiles.

The White House's National HIV/AIDS Strategy (NHAS) provides a moment of opportunity for federal, state, and local agencies to work in partnership with community based organizations and other stakeholders to target surveillance and HIV prevention efforts in jurisdictions with significant concentrations of AAs and NHPs. As per NHAS, "Federal and State agencies should consider efforts to support surveillance activities to better characterize HIV among smaller populations" such as AAs and NHPs.

The case studies and bright ideas profiled in this document indicate that there have been significant advances in data collection, data reporting, and data dissemination of HIV/AIDS data for AA and NHPI communities in multiple jurisdictions. Recognizing that several health departments (particularly those with lower HIV/AIDS incidence) are facing significant budget reductions, many of the practices profiled in this document require minimal staff time and budget. Moreover, they provide a solid baseline for operationalizing the surveillance related activities that are outlined in the NHAS as well as the corresponding federal agency implementation and operational plans.

Improved HIV/AIDS surveillance, however, should be viewed as just the starting point and not the end point for HIV prevention and care efforts targeted to AA and NHPI populations.

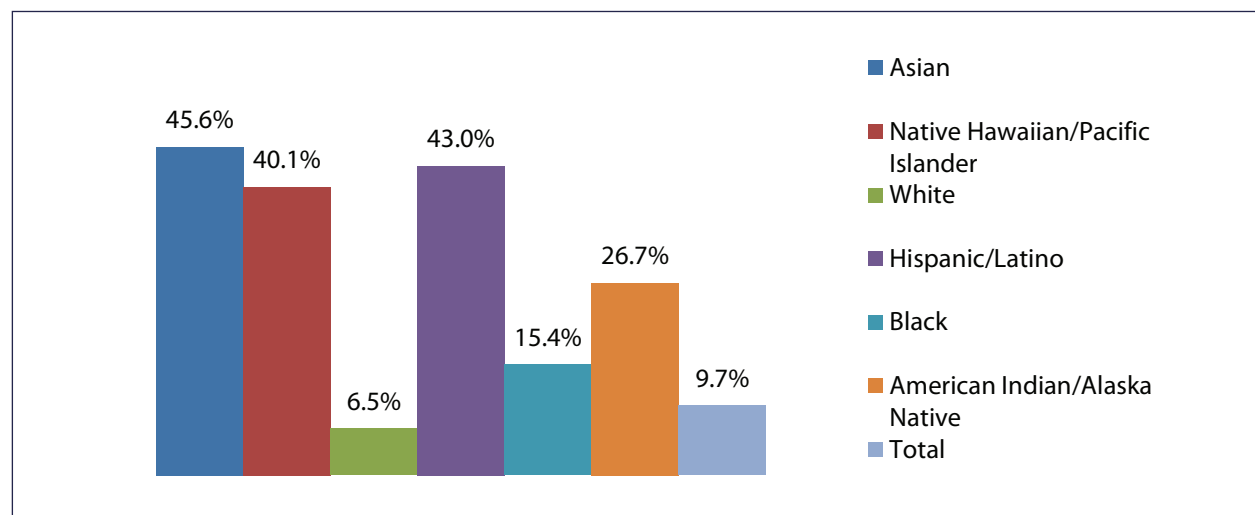
APPENDIX: AA AND NHPI DEMOGRAPHIC AND SOCIOECONOMIC INDICATORS

AAs and NHPIs represent over 50 diverse ethnic subgroups that speak over 100 different languages and dialects. According to the 2010 Census, the AA and NHPI population in the U.S. has grown to over 18.5 million individuals (Table 1). Over the past decade, AAs and NHPIs were among the fastest growing racial groups in the U.S., increasing by 45.6% and 40.1% (Chart 3). The number of individuals who identified as AA alone or in combination with other races increased by almost half (45.6%) from about 11.9 million in 2000 to about 17.3 million in 2010. NHPI (40.1%) numbers also rose sharply, as a single race and in combination with other races, from slightly under 0.9 million in 2000 to over 1.2 million in 2010.

Table 1: U.S. Populations by Race/Ethnicity (Single-race and in combination with other races) ⁵⁴

Race/Ethnicity	2000 Census		2010 Census	
	Estimated Count	% of U.S. Population	Estimated Count	% of U.S. Population
Asian	11,898,828	4.2%	17,320,856	5.6%
Native Hawaiian/ Pacific Islander	874,414	0.3%	1,225,195	0.4%
White	216,930,975	77.1%	231,040,398	74.8%
Hispanic/Latino	35,305,818	12.5%	50,477,594	16.3%
Black	36,419,434	12.9%	42,020,743	13.6%
American Indian/ Alaska Native	4,119,301	1.5%	5,220,579	1.7%
Total	281,421,906	100.0%	308,745,538	100.0%

Chart 5: Percent Change in the U.S. Population from 2000 to 2010 Census ⁵⁵



⁵⁴ U.S. Census Bureau. 2000 and 2010 Census Data. <http://factfinder2.census.gov/main.html>. Accessed July 10, 2011.

⁵⁵ U.S. Census Bureau. 2010 Census Data. <http://factfinder2.census.gov/main.html>. Accessed July 10, 2011.

ETHNIC DIVERSITY

Almost nine out of every ten AAs (85.1%) came from one of six major ethnic groups: Chinese (22.8%), Asian Indian (19.4%), Filipino (17.4%), Vietnamese (10.6%), Korean (9.7%), and Japanese (5.2%) (See Chart 4). Asian Indians surpassed Filipinos in numbers in the 2010 Census for the first time, reflecting the dramatic increase in immigrants from South Asia over the past decade. Almost two in three NHPs were Native Hawaiian (28.9%), Samoan (20.3%), or Guamanian/Chamorro (16.4%) (See Chart 5).

Chart 6. Percent of Asian Population in the U.S. by Ethnicity⁵

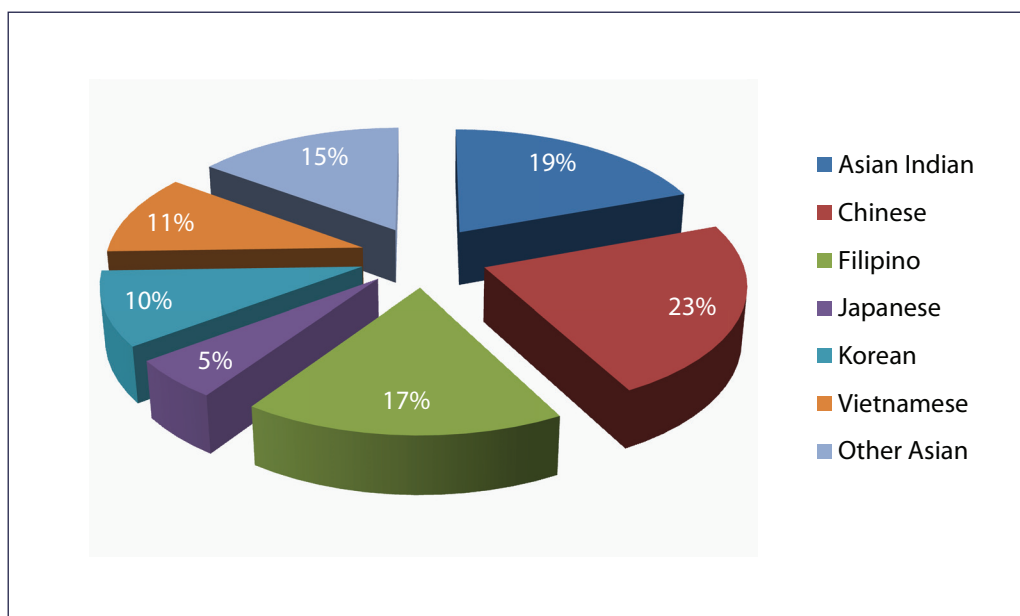
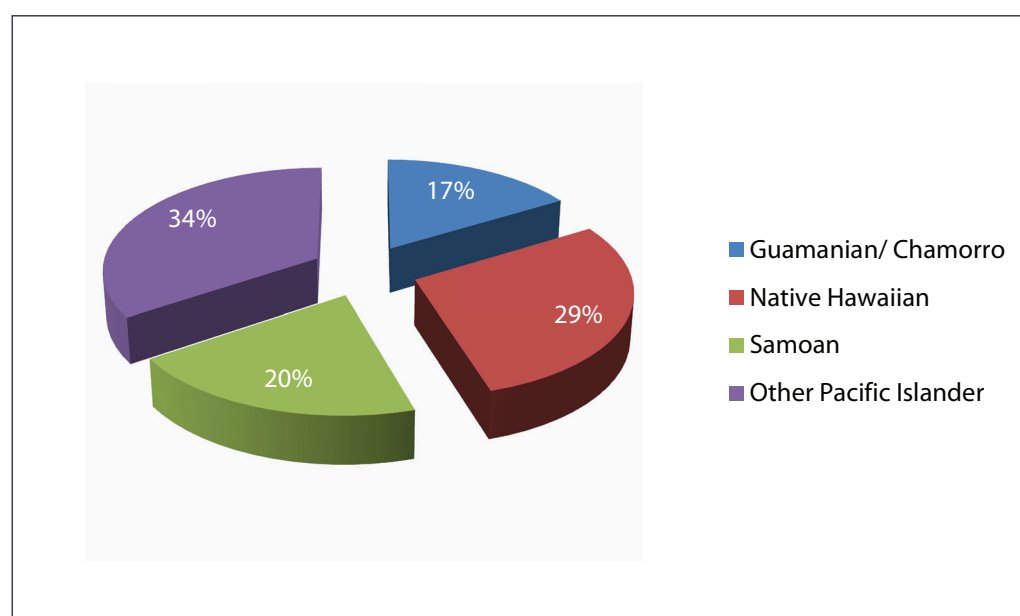


Chart 5. Percent of Native Hawaiian and Pacific Islander Population in the U.S. by Ethnicity⁵⁶



⁵⁶ U.S. Census Bureau. 2010 Census Data. <http://factfinder2.census.gov/main.html>. Accessed July 10, 2011.

GEOGRAPHIC DISTRIBUTION

Over half of the Asians living in the U.S. reside in the following five states: California, New York, Texas, New Jersey, and Hawai'i (See Table 2).

Table 2: Top 5 U.S. States with the Estimated Highest Asian Population⁶

State	Asian Population	
	Estimated Count (Alone & In Combination with Other Races)	Percent Distribution of Asian Population in the U.S.
California	5,552,938	32.1%
New York	1,575,954	9.1%
Texas	1,106,069	6.4%
New Jersey	791,234	4.6%
Hawai'i	777,780	4.5%

Similarly, almost two-thirds of the NHPs living in the U.S. reside in the following five states: Hawai'i, California, Washington, Texas, and Utah (See Table 3).

Table 3: Top 5 U.S. States with the Estimated Highest Native Hawaiian and Pacific Islander Population⁵⁷

State	Native Hawaiian and Pacific Islander Population	
	Estimated Count (Alone & In Combination with Other Races)	Percent Distribution of Native Hawaiian and Pacific Islander Population in the U.S.
Hawai'i	352,699	28.8%
California	281,840	23.0%
Washington	65,740	5.4%
Texas	42,991	3.5%
Utah	34,684	2.8%

NATIVITY AND CITIZENSHIP

AAs (59.9%) had the highest proportion of the foreign-born among all racial groups, far higher than the proportion of citizens (12.5%) in the overall U.S. population (Table 4). Among AA ethnic groups, Sri Lankans (76.5%) had the highest proportion of the foreign-born, followed by Malaysians (72.7%) and Bangladeshis (72.6%). Japanese (28.4%) had the lowest proportion of the foreign-born. The vast majority of NHPs (86.4%) were born in the U.S., similar to the U.S. average (87.5%). Virtually all Native Hawaiians (98.5%) were born in the U.S., as well as Guamanians/Chamorros (93.0%) and Samoans (88.4%). As expected, most NHPs (90%) were U.S. citizens, with virtually all Native Hawaiians (99.4%), Guamanians/Chamorros (95.8%), and Samoans (94.0%) having U.S. citizenship.

⁵⁷ U.S. Census Bureau. 2010 Census Data. <http://factfinder2.census.gov/main.html>. Accessed July 10, 2011.

Table 4: Estimated Percentage of Language Spoken at Home of U.S. Population 5 Years Old and Over

Race/Ethnicity	Native	Foreign-Born	Foreign-Born	
			Naturalized	Not U.S. Citizen
Asian	40.1%	59.9%	31.9%	68.1%
Asian Indian	30.2%	69.8%	56.7%	43.3%
Bangladeshi	27.4%	72.6%	46.9%	53.1%
Cambodian	48.0%	55.9%	50.1%	49.9%
Chinese, except Taiwanese	38.9%	61.1%	63.4%	36.6%
Filipino	46.7%	53.3%	59.9%	40.1%
Hmong	56.3%	43.7%	63.5%	36.5%
Indonesian	34.5%	65.6%	56.8%	43.2%
Japanese	71.6%	28.4%	34.9%	65.1%
Korean	35.4%	64.6%	32.7%	67.3%
Laotian	45.1%	54.9%	54.3%	45.7%
Malaysian	27.3%	72.7%	61.9%	38.1%
Pakistani	34.9%	65.1%	27.0%	73.0%
Sri Lankan	23.5%	76.5%	57.2%	42.8%
Taiwanese	32.0%	68.0%	43.1%	56.9%
Thai	40.5%	59.5%	66.9%	33.1%
Vietnamese	36.1%	63.9%	49.4%	50.6%
Other Asian	23.6%	76.4%	73.0%	27.0%
Native Hawaiian/Pacific Islander	86.4%	13.6%	23.1%	76.9%
Fijian	33.8%	66.2%	48.5%	51.5%
Guamanian/Chamorro	93.0%	7.0%	40.2%	59.8%
Native Hawaiian	98.5%	1.5%	57.5%	42.5%
Samoan	88.4%	11.6%	48.4%	51.6%
Tongan	63.6%	36.4%	56.6%	43.4%
Other Pacific Islander	71.3%	28.7%	48.0%	52.0%
White	93.1%	8.0%	38.7%	61.3%
Hispanic/Latino	61.8%	38.2%	57.2%	42.8%
Black	92.0%	8.0%	41.5%	58.5%
American Indian/Alaska Native	95.0%	5.0%	28.5%	71.5%
Total	87.5%	12.5%	42.9%	57.1%

Source: 2007-2009 American Community Survey 3-Year Estimates

LANGUAGE USE AND ENGLISH PROFICIENCY

Most AAs (70.5%) spoke a language other than English at home, a rate that is higher compared to all other races except Hispanics/Latinos (76.8%) (See Table 5). In each Asian ethnic group (except for Japanese), the majority spoke a language other than English at home. Many AAs had limited English proficiency (LEP), defined by the U.S. Census as “speaking English less than very well.” Among those who spoke languages other than English at home, AAs (32.4%) had four times as many LEP people compared to the U.S. overall population (8.6%). Vietnamese (50.5%) had the highest proportion of adults with LEP, followed by Bangladeshis (46.1%), Cambodians (43.4%), Hmong (42.9%), and Taiwanese (42.5%).

Table 5: Estimated Percentage of Language Spoken at Home of U.S. Population 5 Years Old and Over

Race/Ethnicity	Speak English Only	Speak Other Language at Home	Speak Other Language at Home	
			Speak English "Very Well"	Speak English Less Than "Very Well"
Asian	29.5%	70.5%	67.6%	32.4%
Asian Indian	23.0%	77.0%	78.1%	21.9%
Bangladeshi	8.5%	91.5%	53.9%	46.1%
Cambodian	19.4%	80.6%	56.6%	43.4%
Chinese, except Taiwanese	24.9%	75.1%	58.5%	41.5%
Filipino	43.1%	56.9%	81.5%	18.5%
Hmong	8.7%	91.3%	57.1%	42.9%
Indonesian	32.6%	67.4%	70.1%	29.9%
Japanese	63.9%	36.1%	82.1%	17.9%
Korean	28.8%	71.2%	58.7%	41.3%
Laotian	18.9%	81.1%	59.9%	40.1%
Malaysian	34.8%	65.2%	76.9%	23.1%
Pakistani	14.3%	85.7%	72.4%	27.6%
Sri Lankan	28.1%	71.9%	78.3%	21.7%
Taiwanese	18.2%	81.8%	57.5%	42.5%
Thai	34.0%	66.0%	63.8%	36.2%
Vietnamese	15.8%	84.2%	49.5%	50.5%
Other Asian	19.2%	80.8%	53.2%	46.8%
Native Hawaiian/Pacific Islander	71.4%	28.6%	91.6%	8.4%
Fijian	22.7%	77.3%	79.6%	20.4%
Guamanian/Chamorro	71.9%	28.1%	92.5%	7.5%
Native Hawaiian	89.8%	10.2%	98.2%	1.8%
Samoan	55.2%	44.8%	87.9%	12.1%
Tongan	38.7%	61.3%	81.8%	18.2%
Other Pacific Islander	63.5%	36.5%	87.5%	12.5%
White	85.9%	14.1%	94.2%	5.8%
Hispanic/Latino	23.2%	76.8%	62.4%	37.6%
Black	91.9%	8.1%	97.2%	2.8%
American Indian/Alaska Native	79.8%	20.2%	93.8%	6.2%
Total	80.2%	19.8%	91.4%	8.6%

Source: 2007-2009 American Community Survey 3-Year Estimates

SOCIOECONOMIC STATUS

When data for socioeconomic status is aggregated for AA and NHPI communities, it initially appears as if Asians have higher levels of educational attainment. When data is disaggregated by ethnic subgroup, however the bimodal distribution of educational levels among AA and NHPI groups becomes more apparent (see Table 6).

Table 6: Estimated Percentage of Educational Attainment of Population 25 Years and Over in the U.S.

Race/Ethnicity	Speak English Only	Speak Other Language at Home	Speak Other Language at Home	
			Speak English "Very Well"	Speak English Less Than "Very Well"
Asian	29.5%	70.5%	67.6%	32.4%
Asian Indian	23.0%	77.0%	78.1%	21.9%
Bangladeshi	8.5%	91.5%	53.9%	46.1%
Cambodian	19.4%	80.6%	56.6%	43.4%
Chinese, except Taiwanese	24.9%	75.1%	58.5%	41.5%
Filipino	43.1%	56.9%	81.5%	18.5%
Hmong	8.7%	91.3%	57.1%	42.9%
Indonesian	32.6%	67.4%	70.1%	29.9%
Japanese	63.9%	36.1%	82.1%	17.9%
Korean	28.8%	71.2%	58.7%	41.3%
Laotian	18.9%	81.1%	59.9%	40.1%
Malaysian	34.8%	65.2%	76.9%	23.1%
Pakistani	14.3%	85.7%	72.4%	27.6%
Sri Lankan	28.1%	71.9%	78.3%	21.7%
Taiwanese	18.2%	81.8%	57.5%	42.5%
Thai	34.0%	66.0%	63.8%	36.2%
Vietnamese	15.8%	84.2%	49.5%	50.5%
Other Asian	19.2%	80.8%	53.2%	46.8%
Native Hawaiian/Pacific Islander	71.4%	28.6%	91.6%	8.4%
Fijian	22.7%	77.3%	79.6%	20.4%
Guamanian/Chamorro	71.9%	28.1%	92.5%	7.5%
Native Hawaiian	89.8%	10.2%	98.2%	1.8%
Samoan	55.2%	44.8%	87.9%	12.1%
Tongan	38.7%	61.3%	81.8%	18.2%
Other Pacific Islander	63.5%	36.5%	87.5%	12.5%
White	85.9%	14.1%	94.2%	5.8%
Hispanic/Latino	23.2%	76.8%	62.4%	37.6%
Black	91.9%	8.1%	97.2%	2.8%
American Indian/Alaska Native	79.8%	20.2%	93.8%	6.2%
Total	80.2%	19.8%	91.4%	8.6%

Source: 2007-2009 American Community Survey 3-Year Estimates

Overall, AA ethnic groups tended to have higher annual incomes than the general U.S. population (Table 7). The ethnic groups with the highest median household and family, as well as per capita incomes, were Asian Indian, Taiwanese, Filipino, Sri Lankan, Japanese, Chinese, and Malaysian. Among AA groups, Bangladeshi, Hmong, and Cambodian had median family, median household, and per capita incomes lower than those for the U.S. population.

All NHPI ethnic groups had lower per capita incomes than the national average. Fijians and Native Hawaiians had higher median household, median family, and per capita incomes than the other NHPI ethnic groups. Tongans and Samoans constituted lower-income groups, both of which had median household, median family, and per capita incomes much lower than the overall U.S. population's.

Table 7: Estimated Income in the Past 12 Months in the U.S.

Race/Ethnicity	Median Family Income	Median Household Income	Per Capita Income
Asian	\$76,565	\$68,549	\$28,342
Asian Indian	\$96,872	\$86,660	\$36,533
Bangladeshi	\$45,849	\$45,953	\$16,784
Cambodian	\$49,439	\$50,669	\$15,940
Chinese, except Taiwanese	\$80,369	\$68,420	\$30,061
Filipino	\$84,003	\$76,455	\$25,799
Hmong	\$47,339	\$47,038	\$10,949
Indonesian	\$69,577	\$60,906	\$25,729
Japanese	\$85,368	\$65,767	\$31,831
Korean	\$64,768	\$53,934	\$26,118
Laotian	\$56,296	\$55,119	\$16,585
Malaysian	\$82,777	\$63,269	\$33,264
Pakistani	\$67,379	\$62,744	\$24,663
Sri Lankan	\$83,638	\$73,927	\$32,480
Taiwanese	\$96,007	\$77,596	\$38,312
Thai	\$64,077	\$55,210	\$21,708
Vietnamese	\$59,456	\$54,799	\$21,542
Other Asian	\$55,609	\$51,514	\$20,114
Native Hawaiian/Pacific Islander	\$63,251	\$57,664	\$19,020
Fijian	\$69,757	\$65,766	\$21,456
Guamanian/Chamorro	\$63,146	\$57,900	\$20,054
Native Hawaiian	\$69,784	\$60,950	\$20,954
Samoan	\$55,701	\$53,329	\$15,567
Tongan	\$50,482	\$50,204	\$11,907
Other Pacific Islander	\$63,439	\$54,803	\$19,478
White	\$66,590	\$54,277	\$29,418
Hispanic/Latino	\$42,388	\$40,920	\$15,506
Black	\$40,861	\$34,585	\$17,549
American Indian/ Alaska Native	\$45,666	\$38,515	\$17,933
Total	\$62,367	\$51,369	\$27,100

Source: 2007-2009 American Community Survey 3-Year Estimates

Among AA groups, the proportions of families and children who lived below the federal poverty line were higher for Hmong families (24.5%) and children (32.4%), followed by Bangladeshi (17.8% and 26.0%, respectively), and Cambodians (17.4% and 23.1%, respectively). Similarly, among NHPI groups, the proportions of families and children who lived below the federal poverty line were higher for Tongans (18.4% and 21.9%, respectively), followed by Samoans (13.6% and 16.7%, respectively), and Native Hawaiians (9.4% and 14.8%, respectively) (see Table 8).

Table 8. Estimated Percentages of Poverty in the U.S.

Race/Ethnicity	Families	Persons Under 18 Years
Asian	8.2%	11.0%
Asian Indian	5.2%	7.6%
Bangladeshi	17.8%	26.0%
Cambodian	17.4%	23.1%
Chinese, except Taiwanese	9.4%	9.9%
Filipino	4.6%	6.6%
Hmong	24.5%	32.4%
Indonesian	8.2%	11.1%
Japanese	4.5%	7.1%
Korean	11.2%	11.4%
Laotian	10.5%	14.3%
Malaysian	4.7%	9.0%
Pakistani	12.3%	18.5%
Sri Lankan	5.1%	8.2%
Taiwanese	7.5%	6.7%
Thai	9.6%	15.2%
Vietnamese	12.1%	15.4%
Other Asian	16.9%	27.5%
Native Hawaiian/Pacific Islander	11.5%	16.4%
Fijian	5.3%	8.5%
Guamanian/Chamorro	9.6%	15.2%
Native Hawaiian	11.5%	16.4%
Samoan	13.6%	16.7%
Tongan	18.4%	21.9%
Other Pacific Islander	14.5%	15.8%
White	7.6%	14.8%
Hispanic/Latino	19.6%	29.1%
Black	21.6%	34.0%
American Indian/ Alaska Native	18.4%	28.6%
Total	9.9%	18.9%

Source: 2007-2009 American Community Survey 3-Year Estimates

HEALTH INSURANCE COVERAGE

AAs (71.7%) tended to have higher private insurance coverage rates compared to the U.S. population's (67.4%) (See Table 9). The ethnic groups with the lowest rates of private insurance coverage were Cambodian (52.1%), Hmong (46.0%), and Bangladeshi (44.2%). Lack of insurance rates was the highest for Bangladeshis (22.5%) and Cambodians (21.3%), along with Koreans (22.3%) and Pakistanis (22.9%).

NHPIs as an aggregated racial group had a lower private insurance rate (66.3%) but higher public insurance rate (28.4%) than Asians and the overall U.S. population. The lack of insurance rate for NHPIs (13.1%) was lower than for Asians (14.1%) and the U.S. population (15.1%). Samoans (60.3%) who had the lowest private insurance rate had the highest lack of insurance rate (16.5%) among the NHPI groups, despite its high public insurance rate (29.6%).

Table 9. Estimated Percentages of Health Insurance Coverage in the U.S. *

Race/Ethnicity	Private	Public	None
Asian	71.7%	19.4%	14.1%
Asian Indian	79.0%	12.8%	11.8%
Bangladeshi	44.2%	37.3%	22.5%
Cambodian	52.1%	29.7%	21.3%
Chinese, except Taiwanese	72.2%	20.5%	12.3%
Filipino	78.3%	18.1%	10.6%
Hmong	46.0%	43.2%	15.9%
Indonesian	71.8%	17.5%	15.0%
Japanese	84.5%	20.6%	7.9%
Korean	65.7%	16.1%	22.3%
Laotian	58.6%	25.7%	18.5%
Pakistani	55.8%	23.5%	22.9%
Taiwanese	79.6%	11.0%	13.8%
Thai	69.8%	15.3%	19.3%
Vietnamese	59.0%	25.4%	18.7%
Other Asian	49.3%	28.3%	24.6%
Native Hawaiian/ Pacific Islander	66.3%	28.4%	13.5%
Guamanian/Chamorro	72.4%	21.8%	13.1%
Native Hawaiian	70.1%	30.0%	10.2%
Samoan	60.3%	29.6%	16.5%
White	71.8%	27.4%	13.3%
Hispanic/Latino	42.6%	30.0%	31.0%
Black	52.2%	37.8%	17.8%
American Indian/Alaska Na- tive	48.5%	35.4%	24.1%
Total	67.4%	28.5%	15.1%

Source: 2007-2009 American Community Survey 3-Year Estimates

*Note: Data for Malaysian, Sri Lankan, Fijian, Tongan, and Other Pacific Islander was unavailable.

ACKNOWLEDGEMENTS

Ed Tepporn at the Asian & Pacific Islander American Health Forum, consultants Karin Bosh, Haftan Eckholdt, and Suki Ports served as primary authors for this document.

APIAHF's Research, Evaluation, and Data team authored the original document from which the AA and NHPI Demographic and Socioeconomic Data section is drawn.

APIAHF would like to thank the members of the advisory committee who helped to shape and inform the development of this document, including:

- Amy Lansky, PhD, MPH, Centers for Disease Control and Prevention
- Maria Courogen, MPH, Washington State Department of Health
- Natalie Cramer, MSSW, National Alliance of State and Territorial AIDS Directors
- Nevin Krishna, MS, MPH, Centers for Disease Control and Prevention
- Nighat Quadri, MS, MPH, Hawaii Department of Health
- William Adih, MD, DrPH, MPH, Centers for Disease Control and Prevention

APIAHF would also like to acknowledge all of the individuals who provided their valuable insight and experiences via the over 20 key informant interviews that informed the development of the case studies and "bright ideas" snapshots.

APIAHF applauds the profiled jurisdictions for their past efforts and encourages them to sustain and/or enhance these efforts to provide policymakers, planners, and prevention staff with valuable AA and NHPI HIV/AIDS data to inform their respective efforts. APIAHF also hopes that other jurisdictions and agencies are inspired to adopt and adapt these practices for their own data collection, reporting, and dissemination efforts.

The Department of Health and Human Services' Office of HIV/AIDS and Infectious Disease Policy funded the development and production of this document. Technical assistance for the project and review of the report provided by CDC staff was informal. Neither HHS nor CDC has formally reviewed this document or checked the data for accuracy. The contents of this document represent the work and the views of the authors only.



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