Curriculum:
Providing Culturally Competent Care for Transgender Asian/Pacific Islanders who are HIV-Positive

Introduction

Welcome to the National Multicultural Center's curriculum on "Providing Culturally Competent Care for Transgender Asian/pacific Islanders who are HIV- Positive ," one of a series of curricula covering a wide range of topics concerning the provision of culturally competent HIV-related healthcare services to individuals belonging to diverse ethnic, racial, and cultural groups.

Although the total number of Asian/Pacific Islanders diagnosed with HIV/AIDS is a relatively small percentage of all the diagnoses reported to the Centers for Disease Control and Prevention (CDC), the Asian/Pacific Islanders are the fastest-growing racial/ethnic group in the United States. The CDC does not compile surveillance data on the numbers of HIV/AIDS diagnoses among transgender persons, although a number of studies have indicated that the rates of HIV infection are likely high, due to a variety of behavioral and socio-cultural factors, which will be discussed in the following modules. Clear epidemiologic data on HIV disease among transgender Asian/Pacific Islanders specifically, however, are absent. Because Asian/Pacific Islanders and transgender persons have several serious HIV risk factors in common, the incidence of HIV disease among transgender Asian/Pacific Islanders is likely to be high.

Not only are HIV surveillance data for the specific population of transgender Asian/Pacific Islanders who are HIV- positive not available at this time, but the peer-reviewed literature provides very limited information on this particular category of patients. In fact, this group of HIV-affected persons comprises a distinct subpopulation of both the Asian/Pacific Islander and the transgender populations. The data and discussions offered in this curriculum aim to provide an understanding of the unique set of sociocultural, financial, and health issues faced by this uniquely challenged group of patients.

For the purposes of this curriculum, the following definitions will be used:

- Asian/Pacific Islanders are members of the populations that the US Census Bureau categorizes as Asian and Native Hawaiian/Pacific Islander and include scores of different ethnicities and languages.
- In general, "transgender" serves as an umbrella term that encompasses a range of gender-variant, gender-diverse, or gender-nonconforming individuals whose self-identification or self-expression differs from society's norms of male or female or whose gender identity differs from that with which they were identified at birth.

This curriculum will offer data, other information, and resources designed to increase understanding of the above issues and to support approaches that optimize patient outcomes among practitioners who manage the care of transgender Asian/Pacific Islanders who are HIV- positive. This topic is characterized by complex issues regarding these individuals' risks for HIV transmission, access to care, and adherence to therapy, and although this curriculum is not comprehensive, the list of resources in Module 4 and the references in each module can provide a wealth of additional information.

The 5 modules in this curriculum are:

1. HIV Epidemic Among Transgender Asian/Pacific Islanders and Transgender Persons
2. HIV Transmission and Treatment Risk Factors
3. Cultural Competence Barriers and Challenges
4. Implementing Culturally Competent Care for Transgender Asian/Pacific Islanders
5. Case Studies

Learning Objectives of the Overall Curriculum

- Describe the impact of the HIV epidemic among Asian/Pacific Islanders communities
- Describe the impact of the HIV epidemic among transgender individuals
- List the key risk factors associated with the risk for HIV transmission among Asian/Pacific Islanders
- List the risk factors associated with the incidence of HIV infection among transgender individuals
- Describe the challenges of providing HIV testing and access to and retention in care for transgender Asian/Pacific Islanders
- Identify key elements of culturally competent HIV treatment and prevention approaches for transgender Asian/Pacific Islanders

Module 1—Overview of the HIV Epidemic Among Asian/Pacific Islanders and Transgender Persons

Learning Objectives

- Describe the impact of the HIV epidemic among Asian/Pacific Islanders in the United States
- Describe the impact of the HIV epidemic among transgender individuals

Pretraining Assessment

1. Which of the following represents the percentage of all US HIV diagnoses that was reported among Asian Americans during 2007 to 2010?

A. 45%

B. < 1%

C. 2%

D. 30%

E. None of the above

2. Which of the following represents the rate of new HIV diagnoses per 100,000 population among Asian Americans in 2010?

A. 42

B. 6.4

C. 2.5

D. 9.7

E. None of the above

3. Is the following statement True or False?
The Centers for Disease Control and Prevention began to compile data on the number of transgender Asian/Pacific Islanders in 2010.

A. True

B. False

Introduction

In spite of the fact that Asian/Pacific Islanders represent approximately 1% of US HIV and AIDS diagnoses, the Asian/Pacific Islander population is growing (now approximately 4% according to data from the 2010 US Census), suggesting the possibility of larger numbers of diagnoses in the future. In addition, the numbers of HIV diagnoses among Asian/Pacific Islanders may be larger than reported due to underreporting and misclassification of members of this population.

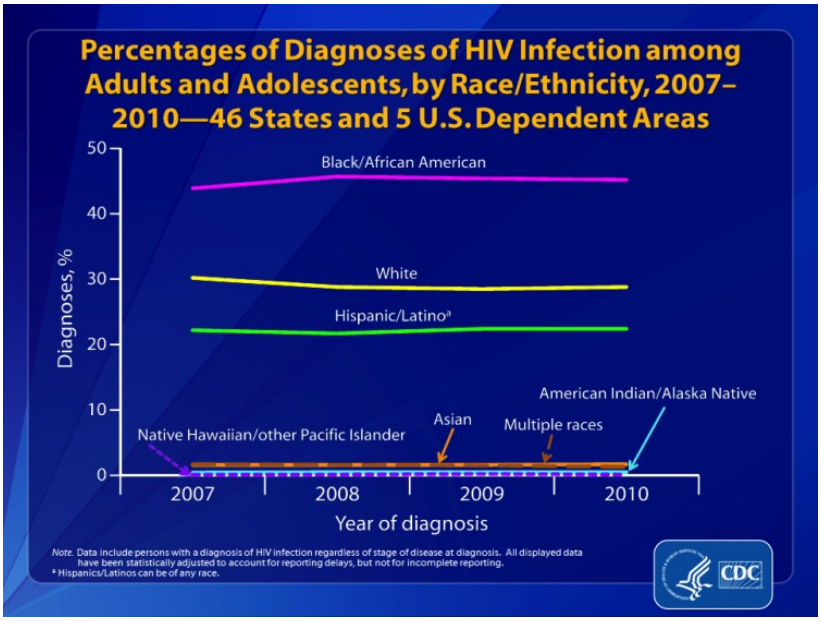
The Centers for Disease Control and Prevention (CDC) has not developed HIV surveillance data concerning transgender Asian/Pacific Islanders who are HIV-positive specifically; such patients comprise a very small and distinct subpopulation. Therefore, this module will focus on the epidemiologic data primarily for Asian/Pacific Islanders, along with data on transgender individuals.

Unless indicated otherwise, the estimated numbers and rates of HIV diagnoses presented in this module are based on data from the 46 states and 5 US dependent areas that have had confidential name-based HIV reporting since at least January 2007; the estimated numbers and rates of AIDS diagnoses are based on data from all 50 states, the District of Columbia, and 6 US dependent areas. Population figures used to calculate those rates use the official postcensus estimates for 2009.[CDC Diagnoses 2010] In addition, these numbers include individuals diagnosed with HIV infection, regardless of disease stage at diagnosis.

HIV Epidemiologic Data for Asian/Pacific Islanders

Diagnoses, 2007 to 2010. Figure 1.0 indicates that, from 2007 through 2010, 2% of reported HIV infections were among Asians and < 1% were among Native Hawaiians/Pacific Islanders—among the lowest percentages of all ethnic groups.

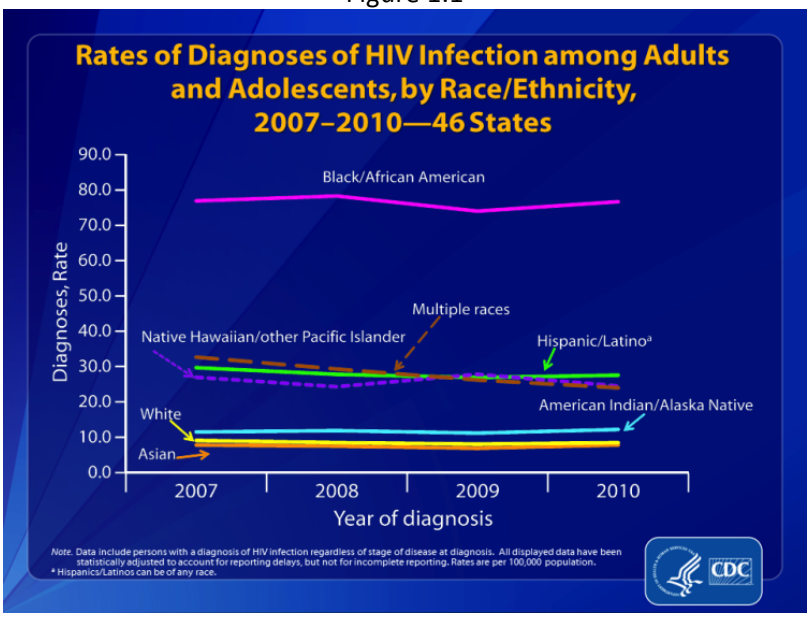
Figure 1.0



Source: CDC 2010

Rates of HIV diagnoses. Figure 1.1 shows the rates of diagnoses of HIV infection by race/ethnicity from 2007 through 2010. Those rates remained stable among Asians and decreased among Native Hawaiians/Pacific Islanders. Changes reported over time are based on an increase or decrease of ≥ 5%.

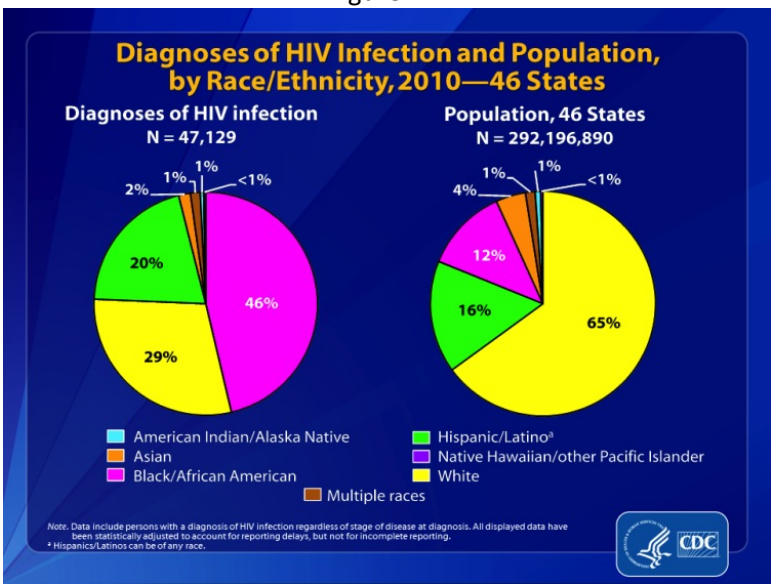
Figure 1.1



Source: CDC 2011

Racial distribution of diagnoses. Figure 1.2, 2 pie charts illustrate respectively, the percentage distribution of HIV diagnoses in 2010 by race/ethnicity and the percentage distribution of the population by race/ethnicity in 2010. Although Asians comprise approximately 4% of the total US population, they represent half (2%) of that proportion among HIV diagnoses in 2010, whereas Native Hawaiians/Pacific Islanders comprise <1% of each group.

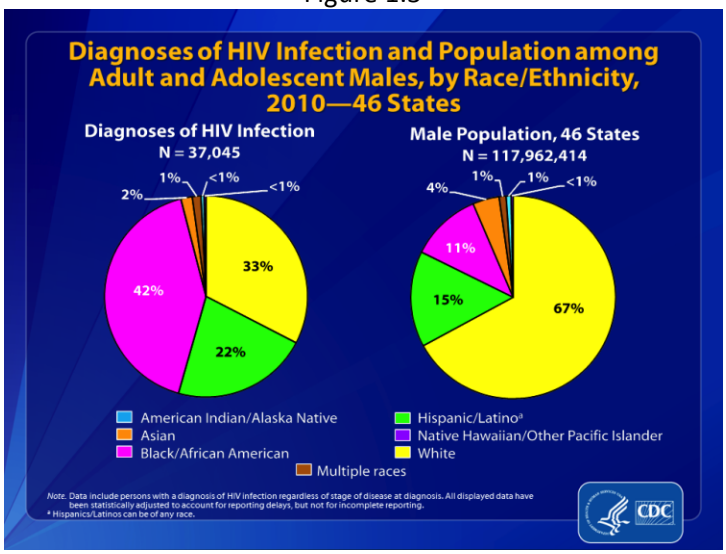
Figure 1.2



Source: CDC 2011

Diagnoses, males. Figure 1.3, the left-hand pie chart below illustrates the percentage distribution of HIV diagnoses in 2010 among adult and adolescent males by race/ethnicity, with the right-hand chart showing the distribution of the overall male population in 2010. Among Asian males, the distribution of HIV diagnoses (2%) was approximately half of their distribution in the overall population, whereas for Native Hawaiian/Pacific Islander males, both figures are 1%.

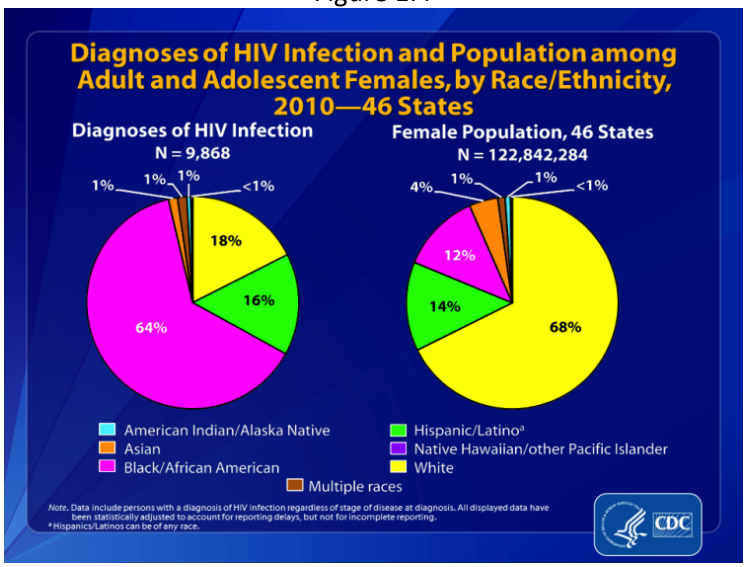
Figure 1.3



Source: CDC 2011

Diagnoses, females. Figure 1.4, the left-hand pie chart below shows the percentage distribution of HIV diagnoses in 2010 among adult and adolescent females by race/ethnicity, with the right-hand chart showing the percentage distribution of the overall female population in 2010. Although Asian females comprise approximately 4% of the total US population, they represent only about one-quarter (1%) of that proportion among HIV diagnoses in 2010, whereas Native Hawaiians/Pacific Islanders comprise <1% of each group.

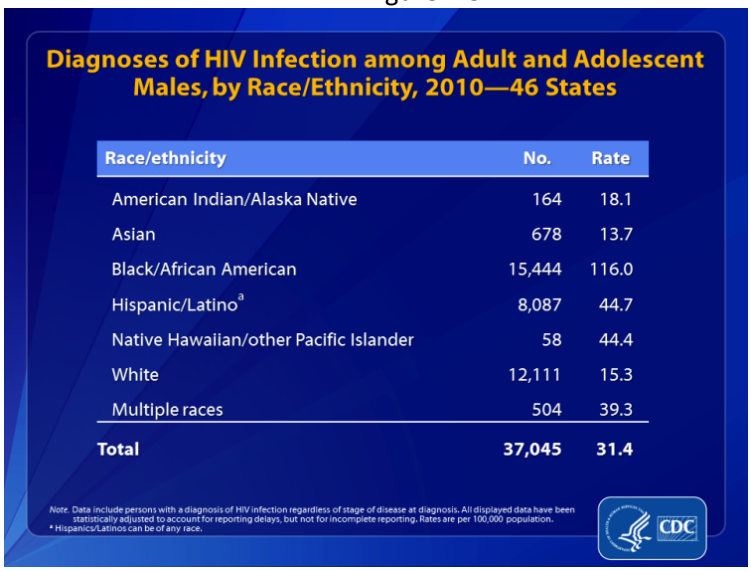
Figure 1.4



Source: CDC 2011

2010 diagnoses, males. Figure 1.5 shows the estimated numbers and rates of HIV diagnoses among adult and adolescent males. In 2010, the rates for Asian males and Native Hawaiian/Pacific Islander males were 13.7 and 44.4 (per 100,000 population), respectively.

Figure 1.5



Diagnoses of HIV Infection among Adult and Adolescent Males, by Race/Ethnicity, 2010—46 States

Race/ethnicity	No.	Rate
American Indian/Alaska Native	164	18.1
Asian	678	13.7
Black/African American	15,444	116.0
Hispanic/Latino[a]	8,087	44.7
Native Hawaiian/other Pacific Islander	58	44.4
White	12,111	15.3
Multiple races	504	39.3
Total	**37,045**	**31.4**

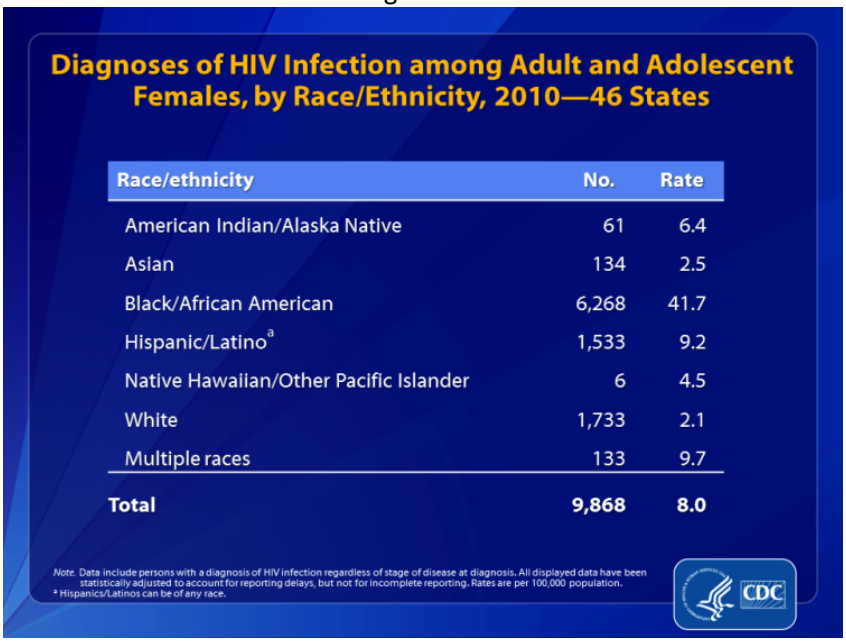
Note. Data include persons with a diagnosis of HIV infection regardless of stage of disease at diagnosis. All displayed data have been statistically adjusted to account for reporting delays, but not for incomplete reporting. Rates are per 100,000 population.
[a] Hispanics/Latinos can be of any race.

CDC

Source: CDC 2011

2010 diagnoses, females. Figure1.6 shows the estimated numbers and rates of HIV diagnoses among adult and adolescent females. In 2010, the rates for Asian females and Native Hawaiian/Pacific Islander females were 2.5 and 4.5 (per 100,000 population), respectively.

Figure 1.6



Diagnoses of HIV Infection among Adult and Adolescent Females, by Race/Ethnicity, 2010—46 States

Race/ethnicity	No.	Rate
American Indian/Alaska Native	61	6.4
Asian	134	2.5
Black/African American	6,268	41.7
Hispanic/Latino[a]	1,533	9.2
Native Hawaiian/Other Pacific Islander	6	4.5
White	1,733	2.1
Multiple races	133	9.7
Total	**9,868**	**8.0**

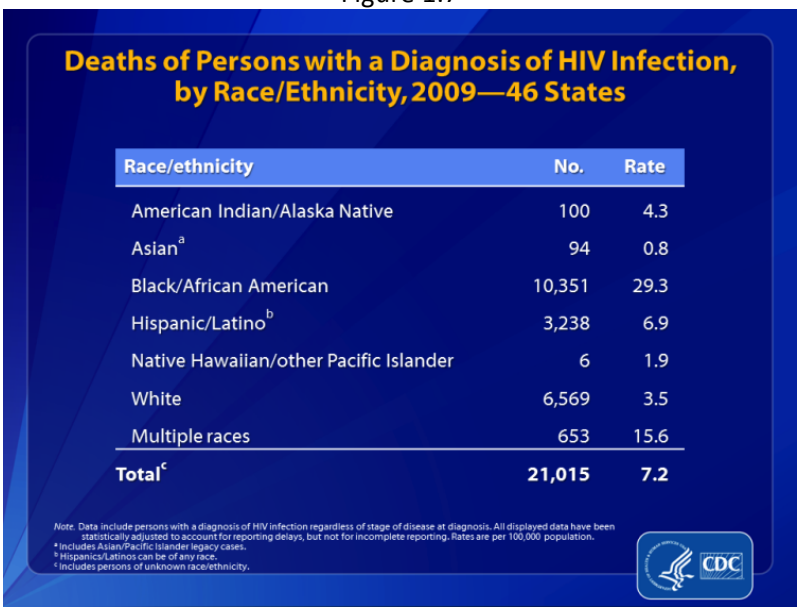
Note. Data include persons with a diagnosis of HIV infection regardless of stage of disease at diagnosis. All displayed data have been statistically adjusted to account for reporting delays, but not for incomplete reporting. Rates are per 100,000 population.
[a] Hispanics/Latinos can be of any race.

CDC

Source: CDC 2011

Mortality, 2009. Figure 1.7 shows the estimated numbers and rates of deaths in 2009 of individuals diagnosed with HIV disease by race/ethnicity. Relatively few deaths occurred among Asian/Pacific Islanders; the mortality rates for Asians and Native Hawaiians/Pacific Islanders were 0.8 and 1.9 per 100,000 population, respectively.

Figure 1.7



Deaths of Persons with a Diagnosis of HIV Infection, by Race/Ethnicity, 2009—46 States

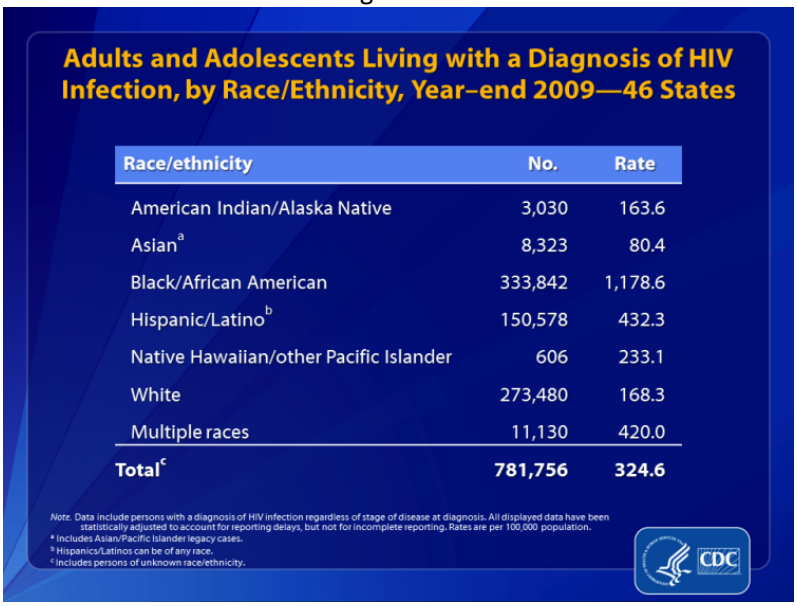
Race/ethnicity	No.	Rate
American Indian/Alaska Native	100	4.3
Asian[a]	94	0.8
Black/African American	10,351	29.3
Hispanic/Latino[b]	3,238	6.9
Native Hawaiian/other Pacific Islander	6	1.9
White	6,569	3.5
Multiple races	653	15.6
Total[c]	**21,015**	**7.2**

Note. Data include persons with a diagnosis of HIV infection regardless of stage of disease at diagnosis. All displayed data have been statistically adjusted to account for reporting delays, but not for incomplete reporting. Rates are per 100,000 population.
[a] Includes Asian/Pacific Islander legacy cases.
[b] Hispanics/Latinos can be of any race.
[c] Includes persons of unknown race/ethnicity.

Source: CDC 2011

Living with HIV, 2009, Figure 1.8. At the end of 2009, an estimated 781,756 adults and adolescents were living with an HIV diagnosis in the 46 states with long-term confidential name-based HIV reporting, with an overall rate of 324.6 per 100,000 population. Although there were relatively few Asian/Pacific Islanders among this total, the rates among Native Hawaiian/Pacific Islanders (233.1) were higher than that of whites; the rate among Asians was 80.4.

Figure 1.8



Adults and Adolescents Living with a Diagnosis of HIV Infection, by Race/Ethnicity, Year-end 2009—46 States

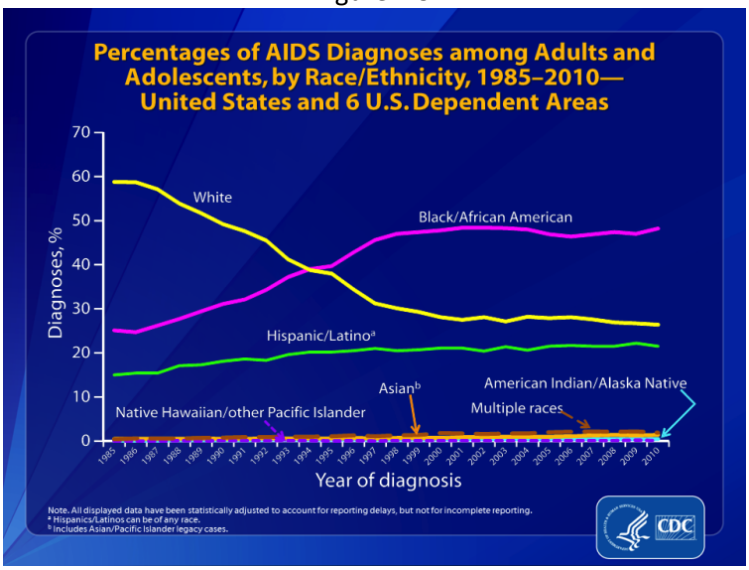
Race/ethnicity	No.	Rate
American Indian/Alaska Native	3,030	163.6
Asian[a]	8,323	80.4
Black/African American	333,842	1,178.6
Hispanic/Latino[b]	150,578	432.3
Native Hawaiian/other Pacific Islander	606	233.1
White	273,480	168.3
Multiple races	11,130	420.0
Total[c]	**781,756**	**324.6**

Note. Data include persons with a diagnosis of HIV infection regardless of stage of disease at diagnosis. All displayed data have been statistically adjusted to account for reporting delays, but not for incomplete reporting. Rates are per 100,000 population.
[a] Includes Asian/Pacific Islander legacy cases.
[b] Hispanics/Latinos can be of any race.
[c] Includes persons of unknown race/ethnicity.

Source: CDC 2011

AIDS diagnoses, 1985 to 2010. Figure 1.9 illustrates, since the beginning of the US HIV epidemic, the percentage distribution of AIDS diagnoses among racial/ethnic groups has changed. The percentage of AIDS diagnoses among adult and adolescent whites has decreased, whereas the percentages among Asians/Pacific Islanders have stayed relatively constant at 0% to 2% of all diagnoses.

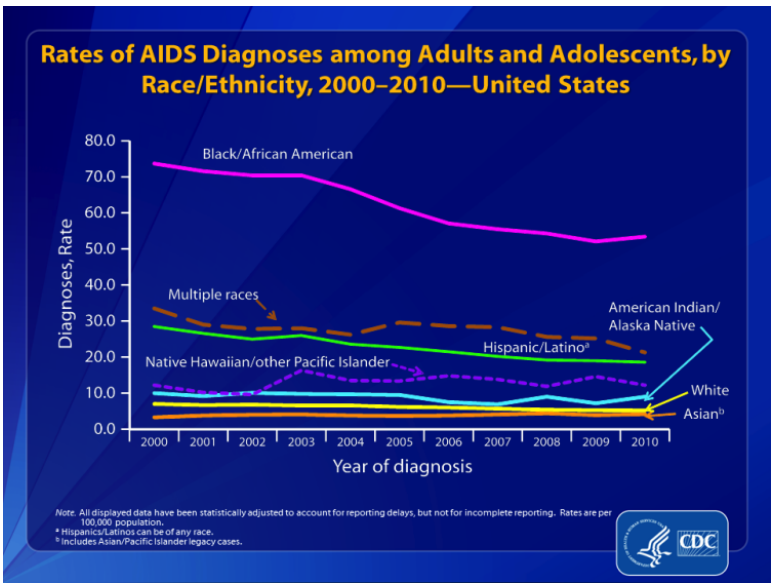
Figure 1.9



Source: CDC 2011

AIDS rates. Figure 2.0 shows the rates (per 100,000 population) of AIDS diagnoses from 2000 through 2010 by race/ethnicity. During that time, the rate among Native Hawaiians/Pacific Islanders remained stable, at 12.2, whereas among Asians the rate increased from 3.3 in 2000 to 4.2 in 2010.

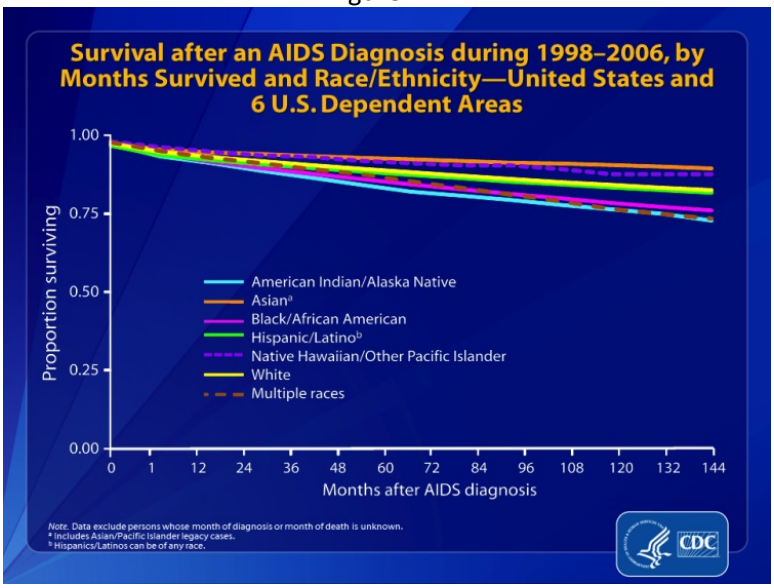
Figure 2.0



Source: CDC 2011

AIDS survival. Figure 2.1 shows the proportion of persons, by race/ethnicity, surviving after a diagnosis of AIDS during 1998 to 2006 in 12-month increments in the United States and 6 dependent areas. Survival was greatest among Asians. The data for Native Hawaiians/Pacific Islanders, however, should be regarded cautiously, as their total numbers are small.

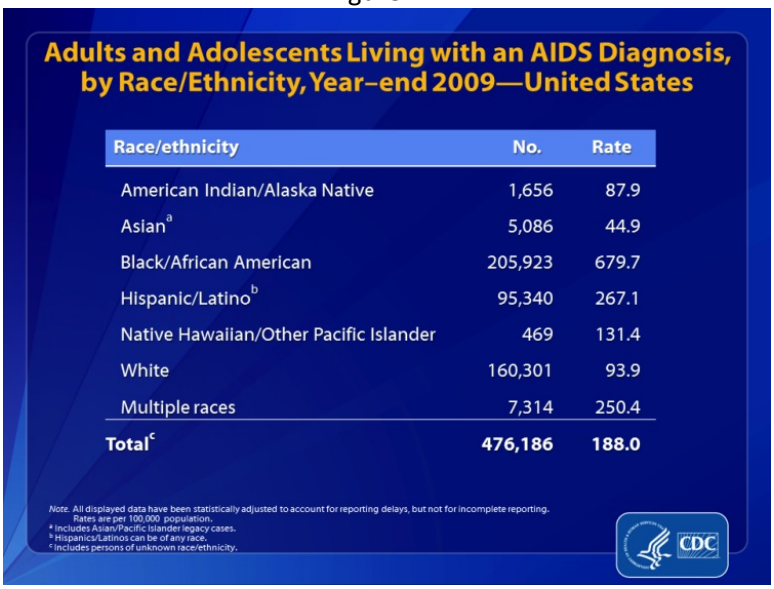
Figure 2.1



Source: CDC (date of data source is needed)

Living with AIDS, 2009, Figure 2.2. At the end of 2009, an estimated 476,186 US adults and adolescents were living with an AIDS diagnosis, for an overall rate of 188 per 100,000 population. The rates among Asians and Native Hawaiians/Pacific Islanders, however, were 44.9 and 131.4, respectively.

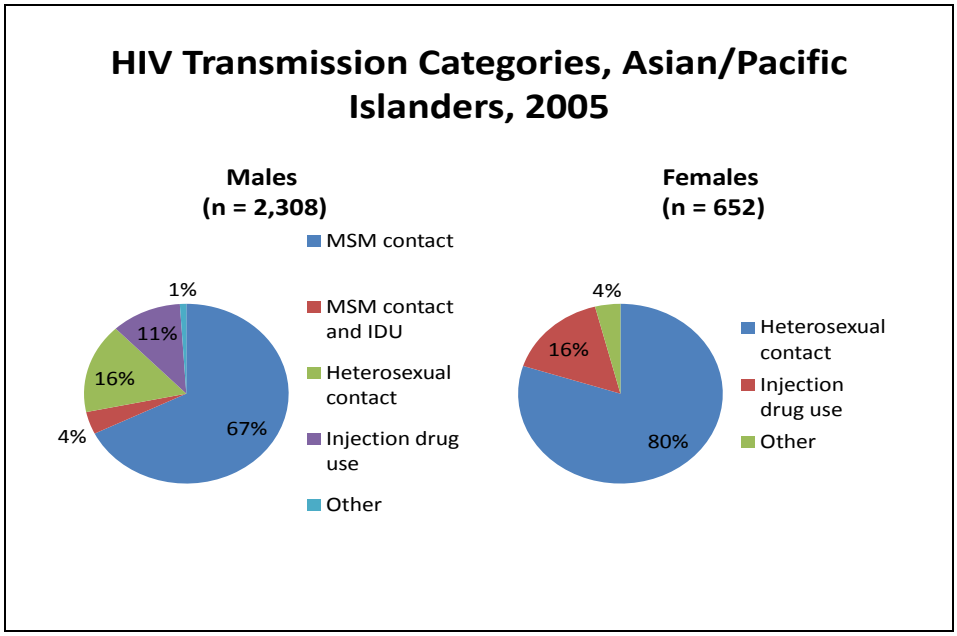
Figure 2.2



Source: CDC 2010

HIV transmission categories. Figure 2.3 shows, among Asian/Pacific Islander males, male-to-male sexual contact (MSM) and/or MSM plus injection drug use (IDU) is the most common mode of HIV transmission, followed by IDU alone. Among Asian/Pacific Islander females, however, the majority of HIV transmissions occur via heterosexual contact, followed by IDU.[CDC Asians and Pacific Islanders 2009]

Figure 2.3



Overview of the HIV Epidemic Among the Transgender Community

Precise data regarding the number of persons in the US population who identify as transgender are not available, although there have been some efforts to estimate the numbers. In part, this is due to the somewhat fluid definitions of the meaning of "transgender." Similarly, the data concerning the size of the transgender Asian/Pacific Islander population are far from precise. Moreover, the CDC has not compiled information specifically on the numbers of transgender individuals who have been diagnosed with HIV or AIDS, much less on the transgender populations within racial/ethnic groups.

Nevertheless, the findings of some studies offer at least a glimpse of the extent of the HIV epidemic's impact among transgender persons. In an analysis of data from the 2006-2008 National Survey of Family Growth, the 2009 California Health Interview Survey, and federal data such as the US Census and the American Community Survey, Gates has suggested that there are nearly 700,000 transgender individuals in the United States, or approximately 0.3% of the adult population, adding that a majority of individuals who identify as transgender have taken some steps to transition from one gender to another.[Gates How many? 2008]

In the absence of CDC HIV surveillance data for the transgender population, data compiled by local health departments and researchers studying transgender people indicate that HIV infection rates are high:[CDC Transgender 2011]

- In 2009, out of 2.6 million HIV testing events, approximately 4,100 were conducted for someone who identified as transgender, with 2.6% of the tests in transgender persons revealing previously undiagnosed HIV infections vs 0.9% of males who were tested and 0.3% of females. The highest percentages of newly identified HIV infections among transgender persons were among African Americans (4.4%) and Latinos (2.5%).
- In New York City, from 2005 to 2009, there were 206 new diagnoses of HIV infection among transgender persons, 95% of whom were transgender women (male-to-female, or MtF). Newly HIV-diagnosed transgender persons were more likely to be in their teens or twenties than were non-transgender persons. Among newly HIV-diagnosed individuals, 50% of transgender women had documentation in their medical records of substance use, commercial sex work, homelessness, incarceration and/or sexual abuse, vs 31% of those who were not transgender.
- Findings from a meta-analysis of 29 published studies showed that 27.7% of transgender women tested HIV-positive (4 studies), but when testing was not part of the study, only 11.8% of transgender women self-reported being HIV-positive (18 studies). In one study, 73% of the transgender women who tested HIV-positive were unaware of their status.[Herbst 2008]

HIV Epidemic Among Transgender Asian/Pacific Islanders

Neither the CDC nor any other groups have compiled surveillance data on the numbers and rates of HIV infections specifically among transgender Asian/Pacific Islanders. For that reason, there are no epidemiologic data that can provide a clear picture of the size of the affected population or of their access to HIV testing and medical care. Nevertheless, in light of the significant risks for HIV transmission and linkage to care among transgender populations and of the healthcare challenges and growing population of Asian/Pacific Islanders, the risks for HIV transmission, the presence of unidentified HIV infections, and inadequate access to care among transgender Asian/Pacific Islanders may be significant. Therefore, healthcare providers who manage members of this group should become knowledgeable in and apply all of the appropriate cultural competence approaches to understand these patients' backgrounds and healthcare needs. (For a detailed discussion of this topic, please review the curriculum, "Understanding and Implementing the CLAS Standards.")

Summary

The CDC has not compiled HIV surveillance data specifically regarding transgender Asian/Pacific Islanders who are HIV- positive (ie, individuals whom the US Census classifies as Asians and Native Hawaiian/Pacific Islanders), who represent a quite small, distinct subpopulation among Asian/Pacific Islanders. During the period 2007 to 2010, < 1% to 2% of HIV diagnoses were among Asian/Pacific Islanders, and in 2010, the rates of new infections among Asians and Native Hawaiian/Pacific Islanders were 13.7 and 44.4 per 100,000 population, respectively. Relatively few deaths occurred among Asian/Pacific Islanders.

Among Asian/Pacific Islanders males, MSM and/or MSM plus IDU is the most common mode of HIV transmission, followed by IDU alone. Among Asian/Pacific Islanders females, the majority of HIV transmissions occur through heterosexual contact.

Precise data regarding the number of persons in the US population who identify as transgender are not available, although one analysis found that approximately 0.3% of the population self-identified as transgender. Likewise, no data specifically on the numbers of HIV-positive transgender individuals of any racial/ethnic group are available. However, a range of studies has indicated that a variety of factors are associated with elevated risk of HIV transmission and inadequate access to care among transgender persons. The significant HIV risks and treatment challenges found in both Asian/Pacific Islander and transgender communities would suggest that the HIV epidemic has likely affected transgender Asian/Pacific Islanders disproportionately.

References

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Centers for Disease Control and Prevention. HIV/AIDS among Asians and Pacific Islanders (fact sheet). Available at: www.cdc.gov/hiv/resources/factsheets/API.htm. Accessed November 28, 2012.

Gates G. How many people are lesbian, gay, bisexual, and transgender? Available at: http://williamsinstitute.law.ucla.edu/research/census-lgbt-demographics-studies/how-many-people-are-lesbian-gay-bisexual-and-transgender/. Accessed October 8, 2012.

Centers for Disease Control and Prevention. HIV infection among transgender people (fact sheet). Available at: www.cdc.gov/hiv/transgender/index.htm. Accessed October 2, 2012.

Herbst JH, Jacobs ED, Finlayson TJ, et al. Estimating HIV prevalence and risk behaviors of transgender persons in the United States: a systematic review. AIDS Behav. 2008;12:1-17.

Assessment Questions

1. Which of the following represents the percentage of all US HIV diagnoses that was reported among Asian Americans during 2007 to 2010?

A. 45%

B. < 1%

C. 2%

D. 30%

E. None of the above

2. Which of the following represents the rate of new HIV diagnoses per 100,000 population among Asian Americans in 2010?

A. 42

B. 6.4

C. 2.5

D. 14

E. None of the above

3. Is the following statement True or False?
The Centers for Disease Control and Prevention began to compile data on the number of transgender Asian/Pacific Islanders in 2010.

A. True

B. False

Module 2—HIV Transmission and Treatment Risk Factors

Learning Objectives

- List the key risk factors associated with the risk for HIV transmission among Asian/Pacific Islanders
- List the risk factors associated with the incidence of HIV infection among transgender individuals

Pretraining Assessment

1. Which of the following is (are) risk factors for HIV infection among Asian/Pacific Islanders?

A. Relatively low rates of HIV testing

B. Methamphetamine use

C. High rates of sexually transmitted infections

D. All of the above

E. A and B only

2. Which of the following is (are) risk factors for HIV infection among transgender individuals?

A. Participation in commercial sexual activity

B. Alienation from family and community members

C. High rates of substance use

D. High levels of financial difficulties

E. All of the above

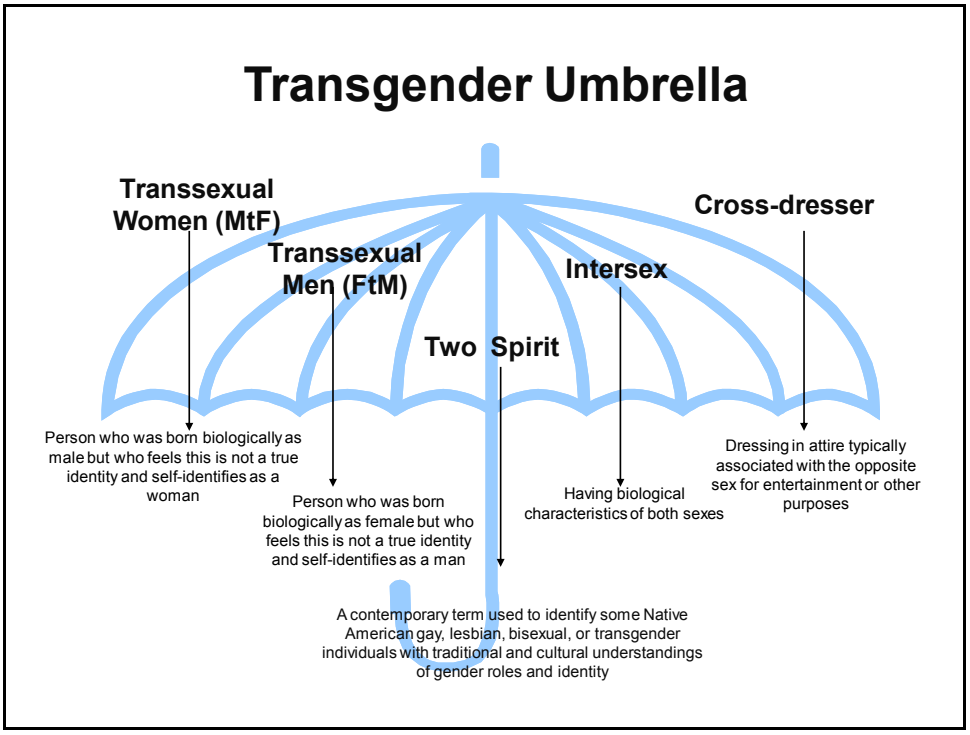
F. A and C only

Introduction

Increasingly, the term "transgender" has come to be regarded as an umbrella term (Figure 2.4) encompassing a range of gender-variant, gender-diverse, or gender-nonconforming individuals whose self-identification or self-expression falls outside societal norms regarding what is male or female or whose gender identity differs from that with which they were identified at birth. "Gender identity" refers to a person's basic sense of self, of identifying as male, female, or some other gender (e.g., transgender, bigender, or intersex). Transgender individuals include people who self-identify as gender-variant; as male-to-female (MtF), ie, transgender women; as female-to-male (FtM), ie transgender men; or simply as female or male.

Gender identity, gender expression, and sexual orientation are distinct concepts, none of which is necessarily linked to one's genital anatomy.[CDC HIV Transgender 2011] Transgender people include but are not limited to transsexuals, genderqueer, third gender, and two-spirit individuals. In short, "transgender" encompasses individuals whose primary commonality is that they transgress conventional gender norms.

Figure 2.4



Source: Jacobs 1997

In many traditional Asian/Pacific Islander cultures, individuals who would be identified in contemporary culture as lesbian, gay, bisexual, transgender, or intersexual fulfilled a variety of social, cultural, and spiritual roles that their societies valued and even revered. These include the *bakla* in Filipino communities, the *shamakhami* and *hijra* in India, the *waria* in Indonesia, the *paksu mudang* in Korea, and the *mahu* in Hawaii. However, the arrival of Western colonialism and Christian missionaries meant

that many of these traditional roles were suppressed and the individuals identified with those roles became stigmatized and marginalized.[Park, Issues]

Because the literature on HIV risk and treatment management specifically for transgender Asian/Pacific Islanders is so limited, this module will discuss these issues separately, first for Asian/Pacific Islanders and then for transgender individuals.

Factors Associated with Increased Risk for HIV Infection Among Asian/Pacific Islanders

Although the proportion of HIV and AIDS diagnoses among Asian/Pacific Islander adults and adolescents remains small vs those in other racial/ethnic groups, studies have indicated that risk behavior levels among this demographic are not significantly lower than in other racial/ethnic populations.[Hou 1997;Peterson 2001] However, these risk levels tend to vary significantly across different areas of the United States and across different ethnicities among the broader Asian/Pacific Islander community.

Sexual Risk Factors

Among Asian/Pacific Islander MSM, social discrimination and lack of family, peer, and community support for sexual and racial diversity can have a negative impact on an individuals' self-esteem, which can be associated with increased risk for HIV infection, including substance use and unsafe sexual behaviors.[Wilson 2004] A large majority of Asian/Pacific Islanders who are HIV- positive are men who have sex with men (MSM), and researchers have reported rising levels of risky behaviors among Asian/Pacific Islander MSM in certain areas of the country. For example, the San Francisco Bay Area is one region where these issues have received particular focus.[Raymond 2007]

In a study of 503 San Francisco Asian/Pacific Islander MSM 18 to 29 years of age, the overall HIV prevalence was nearly 3%, although that varied significantly according to ethnicity, ranging from 0% among Vietnamese MSM to 13.6% among Thai MSM. Of the 503 men in the study, 48% reported having had unprotected anal intercourse during the previous 6 months.[Choi 2002] McFarland and colleagues also found that the rates of unprotected anal intercourse and sexually transmitted infections among young San Francisco Asian/Pacific Islander MSM during 1999 to 2002 were higher than the rates for white MSM.[McFarland 2004] Choi and colleagues found that 57% of gay male Asian/Pacific Islanders in San Francisco used alcohol before engaging in anal intercourse, with approximately 24% reporting unprotected anal intercourse but 85% believing that they were unlikely to contract HIV.[Choi 2005]

Among Asian/Pacific Islander women, high-risk heterosexual contact is the primary mode of HIV transmission, according to the CDC.[CDC Surveillance 2005] Asian/Pacific Islander women reported that cultural taboos against discussing sexual topics and power differentials between genders presented challenges in persuading sexual partners to use condoms. Other risks among women include domestic violence, lack of knowledge about HIV, and lack of culturally and linguistically appropriate HIV prevention programs and materials.[Jemmott 1999]

Substance Use

A study by Nemoto and colleagues found that use of methamphetamines and other drugs was an important factor associated with unprotected anal intercourse among Asian/Pacific Islander MSM. In a survey of Filipino American methamphetamine users in the San Francisco Bay Area, the investigators

reported that methamphetamine use was strongly associated with HIV risk factors such as infrequent condom use, commercial sex activity, and low HIV testing rates.[Nemoto 2002] Choi and colleagues further reported that > 50% of young Asian/Pacific Islander MSM used "party drugs," including MDMA (3,4- methylenedioxymethamphetamine, or "ecstasy"), inhaled nitrates, hallucinogens, crack, and amphetamines and that use of such substances was associated with unprotected anal intercourse.[Choi, Party Drugs—2002] A range of other studies has found that use of such substances is strongly associated with increased risk of engaging in sexual activity that presents risks for HIV transmission.

Low HIV Testing Rates

HIV testing rates are lower among Asian/Pacific Islanders, despite the presence of the types of risk factors for HIV infection discussed here. Data from an HIV testing survey conducted in Seattle indicated that 90% of the Asian/Pacific Islanders surveyed perceived themselves at some risk for HIV infection, but only 47% had been tested during the preceding year.[Kahle 2005] The CDC's Behavioral Risk Factor Surveillance System also found that Asian/Pacific Islanders are significantly less likely than members of other races/ethnicities to report ever having been tested for HIV infection.[Zaidi 2005]

A serious implication of low HIV testing rates is that many Asian/Pacific Islanders who are HIV- positive are diagnosed late in the course of disease. In 2004, 44% of Asian/Pacific Islanders received an AIDS diagnosis within 1 year after being diagnosed with HIV infection. Comparable rates of late HIV diagnosis in other population groups include: 37% of whites, 40% of African Americans, 41% of American Indian/Alaska Natives, and 43% of Latinos.[CDC Surveillance 2005] Increasing the numbers of Asian/Pacific islanders who are tested for HIV infection will result in improved clinical outcomes for individuals, lower risk of further transmission, and reduced community viral load.

A study by Do and colleagues showing an increase in testing (from 63% to 71%) between 1999 and 2002 reported that being tested recently was associated most significantly and consistently with awareness of testing sites to which respondents felt comfortable going.[Do 2006] This finding underlines the importance of developing and providing healthcare services that are culturally and linguistically appropriate to members of diverse Asian/Pacific Islander communities.

A study of HIV testing patterns among MSM found that, out of 99 Asian/Pacific Islander MSM participants who had not been tested for HIV in the preceding 12 months, the most commonly reported reasons for not being tested were:[CDC, Epidemiologic Profile 2010]

- Belief that they were at low risk for HIV infection (74.7%)
- Fear of learning that they were HIV-positive (32.3%)
- Concern that someone would discover the test results (24.2%)
- Not having time to get tested (18.2%)

Cultural and Socioeconomic Diversity Among Ethnicities

Language issues. Asian/Pacific Islanders include a wide diversity of nationalities—Chinese, Filipinos, Koreans, Hawaiians, Indians, Japanese, Thais, Vietnamese, and others—as well as more than 100 languages and dialects. These nationalities differ in their languages, cultures, and histories. Many US Asian/Pacific Islanders are foreign-born and therefore may face cultural and language barriers to receiving public health messages. For example, many health surveys are administered only in English or

possibly Spanish, which may lead to miscommunication or failure to reach Asian/Pacific Islanders who do not speak either English or Spanish.[CDC Asians and Pacific Islanders 2007]

Asian/Pacific Islander individuals and families can be found at both ends of the spectrum of socioeconomic and health issues. For example, although more than 1 million Asian Americans live at or below the federal poverty level ($20,650 for a family of 4 living in the 48 contiguous states or District of Columbia), Asian American women have the longest life expectancy of any racial or ethnic group. Tailoring prevention interventions to meet the needs of this culturally and socioeconomically diverse population remains challenging.[CDC Asians and Pacific Islanders 2007] This can include lack of HIV testing, prevention, and care information in appropriate Asian/Pacific Islander languages, thereby presenting risks for failure to access HIV testing and treatment.

Factors Associated with Increased Risk for HIV Infection Among Transgender Persons

Transgender individuals, including those who are also Asian/Pacific Islander, experience many circumstances that are associated with increased risk for HIV infection:[CDC HIV Transgender 2011

- Low self-esteem
- Difficult economic status
- Substance use
- Lack of social support

Self-esteem and Social Support Issues

Transgender individuals often feel that they lack appropriate social support, due, e.g., to rejection by peers and family members and to lack of relationships with the gay, lesbian, and bisexual communities. Bockting and colleagues found that transgender persons reported the lowest levels of support from their families, compared with men who have sex with men (MSM) and with women who have sex with both men and women.[Bockting 2005] Alienation from family and peers may increase an individual's sense of psychological and social vulnerability—which, in turn, may increase their risk for HIV infection.[Nemoto 2005] For example, condoms may be perceived as undermining intimacy with primary partners, and sex with casual partners and a willingness to engage in unprotected receptive anal intercourse (URAI) may provide a sense of gender validation and of attractiveness that transgender individuals may not find from friends, family, and members of their larger communities.[Nemoto 2004]

Mental health concerns. Studies have found that transgender individuals are > 1.5 times as likely as nontransgender men to experience depression and nearly twice as likely as nontransgender men or women to have considered or attempted suicide.[Nemoto 2005, Bockting 2005] In addition, a meta-analysis of risk behaviors among transgender individuals reported that 35% of MtFs had experienced anxiety and that 44% had experienced depression.[Herbst 2008]

Economic Status

Lack of economic opportunities among transgender persons can occur because of individual or institutional discrimination, stigma, and lower education levels. Studies have identified the following economic difficulties in this population:

- More than one-third of MtFs have experienced job discrimination.[Bockting 2008]
- More than one-fifth of MtFs reported income below the federal poverty level.[Bockting 2005]
- Nearly two-thirds of 16-to-25-year-old MtFs were unemployed.[Garofalo 2006]

Economic difficulties such as these may lead some MtFs to engage in commercial sexual activity to earn money. Herbst and colleagues found that 42% of MtFs reported that they had participated in commercial sex work[Herbst 2008], and Garofalo and colleagues reported in another study that 59% of transgender youth had done so.[Garofalo 2006] The findings of a study by Operario and colleagues underlined the great HIV risk involved in this activity—transgender sex workers were found to have rates of HIV infection as much as 4 times higher than those of female sex workers.[Operario 2008]

HIV risk among MtFs is not limited to exposure through sex work—sexual practices and partnership arrangements also play a role. Concurrent sex partners and URAI—the sexual activity having the highest risk for HIV transmission—are common among MtFs. A study by Herbst and colleagues found that more than one-third of MtFs reported having multiple sex partners and nearly half reported engaging in URAI during casual sexual activity.[Herbst 2008]

Substance Use

Nemoto and colleagues reported that, among a group of San Francisco MtFs of color, URAI with either primary or casual sex partners was associated with drug use before sexual activity.[Nemoto 2004] Many of these individuals begin to use alcohol and a number of different drugs as a means of coping with discrimination, stigma, and the difficulties involved in the sex-work environment. For example, another San Francisco study found that the majority of transgender participants had a history of using noninjected drugs, including marijuana (90%), cocaine (66%), and methamphetamine (57%). In addition, 34% had a history of injecting drugs; nearly half of these had shared syringes—an activity having very high risk for HIV transmission.[Nemoto 2005]

HIV Risk Profile Among Transgender Asian/Pacific Islanders

Although a significant number of studies have evaluated the lives and HIV risk factors among either Asian/Pacific Islanders or transgender persons, one study, by Operario and colleagues, focused specifically on the much narrower population of transgender Asian/Pacific Islanders.[Operario 2005] These researchers examined the prevalence and correlates of HIV-related sexual risk and substance use behaviors among 110 transgender Asian/Pacific Islander male-to-female (MTF) individuals in San Francisco. They found that 13% of the participants reported that they were HIV-positive. Key findings regarding risky behaviors among this population during the past 30 days included:

- 20% engaged in URAI with any male partner.
- Almost 50% participated in sexual activity while under the influence of substances.
- 50% used illicit drugs.

Using multivariate analyses, Operario and colleagues further found that:

- URAI was associated with commercial sex work and previous attempted suicide.
- Participating in sexual activity while under the influence of substances was associated with commercial sex work.
- Illicit drug use was also associated with commercial sex work.

Based on the findings of this study, the researchers concluded that Asian/Pacific Islander MtFs as a group—though few in number—are at particularly high risk for acquiring HIV infection.

Summary

Currently, "transgender" encompasses a range of gender-variant, gender-diverse, or gender-nonconforming individuals—whether they are Asian/Pacific Islander or another race/ethnicity—whose gender self-identification does not conform to societal norms regarding what is male or female. Among young Asian/Pacific Islanders, use of methamphetamine and a variety of other illicit drugs is associated with high rates of engaging in unprotected receptive anal intercourse, which is associated with a significantly greater risk of acquiring HIV infection. In addition, Asian/Pacific Islanders have among the lowest rates of being tested for HIV infection, compared with other racial/ethnic populations. Finally, language barriers and confidentiality concerns may prevent some individuals from accessing HIV testing and care.

Many similar risk factors for HIV infection also confront transgender individuals, including:

- Poverty, job discrimination, and unemployment
- High rates of the use of substances associated with unsafe sexual practices

Financial difficulties are associated with disproportionate rates of participation in commercial sex work among Asian/Pacific Islander transgender persons, often involving risky sexual practices. In addition, many transgender individuals feel that they do not have adequate social support, often because of rejection or discrimination by community and family members. This can result in behaviors associated with risk for HIV infection and lack of access to healthcare services for those who are HIV-positive.

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Assessment Questions

1. Which of the following is (are) risk factors for HIV infection among Asian/Pacific Islanders?

A. Relatively low rates of HIV testing

B. Methamphetamine use

C. High rates of sexually transmitted infections

D. All of the above

E. A and B only

2. Which of the following is (are) risk factors for HIV infection among transgender individuals?

A. Participation in commercial sexual activity

B. Alienation from family and community members

C. High rates of substance use

D. High levels of financial difficulties

E. All of the above

F. A and C only

Module 3—Cultural Competence Barriers and Challenges

Learning Objective

- Describe the challenges of providing HIV testing and access to and retention in care for transgender Asian/Pacific Islanders

Pretraining Assessment

1. Which of the following is (are) among the challenges in providing culturally competent care for Asian/Pacific Islander patients?

A. Lack of English language proficiency

B. Low rates of HIV testing

C. Disrespect for authority figures

D. All of the above

E. A and B only

2. Is the following statement True or False?
Almost all transgender individuals self-identify as female.

A. True

B. False

Introduction

Although precise data on the numbers of transgender Asian/Pacific Islanders who are HIV- positive are not currently available, some of the risks and challenges involved in diagnosing and managing this population overlap between those found in Asian/Pacific Islanders who are HIV-positive. These overlaps include financial difficulties, discrimination and social marginalization, high rates of comorbid conditions, and disproportionate rates of substance use—each of which contributes to increased risk of HIV transmission and challenges to management of HIV-positive individuals. Therefore, a convergence of all these factors can develop, leaving the specific population of transgender Asian/Pacific Islanders vulnerable to acquiring HIV infection and experiencing less than optimal treatment outcomes.

Challenges in the Management of Asian/Pacific Islanders Patients

Demographic Challenges

Although the total number of Asian/Pacific Islanders who are HIV- positive has been relatively small vs other racial/ethnic groups, demographic trends suggest that the total number and the rate of HIV infection in this population have the potential to increase significantly. According to the US Census Bureau, between 2000 and 2010, the US Asian population grew faster than any other racial group.[Census Asian population 2010] Between 2007 and 2008, the US Asian population grew by 2.7% and the Native Hawaiian/Pacific Islander population grew by 2.4%, the second-fastest growth rate after the Asian population. The Census Bureau has also projected that from 2008 to 2050 the Asian population will increase by 162% and the Native Hawaiian/Pacific Islander population by 134%—compared with a projected 44% increase in the population as a whole during that time.[Census Facts 2010]

Many Americans tend to regard Asians as a "model" minority—educated, professional, relatively affluent, and healthy. However, some aspects of Asian/Pacific Islanders' cultures and lifestyles can present barriers and challenges to accessing appropriate healthcare services and achieving optimal treatment outcomes.

Cultural Beliefs and Practices

Family Dynamics

In some Asian cultures, decision making is a family matter, with the family functioning as collective decision maker and the individual's autonomy having a lower priority. This may take the form of the family feeling obliged to protect a patient from undue stress or worry. For example, the family of a patient with a serious illness may wish to conceal the diagnosis from the patient or to make collective treatment decisions for her/him.

Qi

In Chinese culture and medical practices, qi is considered to be the circulating life energy that creates the balance of negative and positive forces in the body that is believed to be essential for good health. Some practitioners and adherents consider blood to be a nonrenewable vital energy of the qi and the

body. In some cases, this may mean that a patient does not want to have lab tests done that involve drawing blood; some may even request a transfusion in the hope of improving the qi.

Self-Control

Some patients may believe that an individual should maintain the inner strength to tolerate crisis and pain, denying that they are experiencing pain even when it is excruciating or attributing physical discomfort to mental problems.

Respect for Authority, Knowledge, and Harmony

The tendency to defer to authority figures who are considered more knowledgeable, may contribute to becoming less involved in one's own treatment planning. Disagreement with an authority figure may cause him/her to lose face.

Broad Conception of Communication

Asian cultures may be more likely to think of communication as involving more than just language; culture, gesture, and posture are all important aspects of effective communication. For example, a patient who appears to be in pain may deny its presence and decline medication.

Language/Communication Issues

To provide a context for the potential communications challenges faced by many Asian/Pacific Islander patients—the 2010 US Census found that, after Spanish, Chinese was the most widely-spoken non-English language, with Tagalog, Vietnamese, and Korean each spoken at home by > 1 million people.[Census Facts 2010] The inability to understand or speak English proficiently can pose a serious barrier both to understanding HIV testing, prevention, and care messages and to communicating effectively with healthcare providers. According to a CDC study:[CDC Epidemiologic profile 2010]

- 77% of Asians ≥ 5 years of age speak a language other than English at home, and more than one-third speak English "not very well."
- 43% of Native Hawaiian/Pacific Islanders ≥ 5 years of age speak a language other than English at home and > 10% of them speak English "not very well."

Stigma and Discrimination

Stigma surrounding HIV disease is pervasive in Asian/Pacific Islander communities, causing people to avoid discussions of sex, drug use, and HIV infection as much as possible. This silence can contribute to fears and misconceptions about HIV transmission, and many Asian/Pacific Islanders feel that an HIV-positive test result will bring shame and disgrace on the individual, as well as on his/her family and community.

In a study of HIV disease among undocumented Asian/Pacific Islander immigrants, Kang and colleagues found that many considered HIV to be a "demon plague" that is associated with unacceptable behaviors, such as MSM, drug use, or patronizing commercial sex workers.[Kang 2003] A survey of attitudes regarding migrant workers in China reported that almost two-thirds of respondents thought HIV-positive individuals should be marginalized, forced out of their villages, not treated as friends, or deprived of educational or employment opportunities.[Liu 2005] A 2004 street-intercept survey of the San Francisco Chinese community performed by the Asian & Pacific Islander Wellness Center found that:

- 47.5% of interviewees agreed that people who are HIV-positive should not be allowed to work in public schools
- 60.5% agreed they should not be allowed to handle food in restaurants
- 61.4% agreed they should not be allowed to work with patients in hospitals

Beyond the effects on individuals' mental and physical health, HIV stigma and discrimination can have public health implications—concern about encountering discrimination may cause some people to avoid or delay testing, thereby increasing the risk of ongoing transmission.[Heijnders 2006]

Provider-Related Challenges

Economic Challenges

As mentioned in Module 2, Asian/Pacific Islanders can be found at both ends of the range of US incomes. Based on 2009 inflation-adjusted dollars and a US median household income of $50,000 and per capita income of $26,000:[CDC Epidemiologic profile 2010]

- Median household income among Asians was $68,900, and per capita income was $30,000, and 9% of Asian families had incomes below the federal poverty threshold.
- Median household income among Native Hawaiian/Pacific Islanders was approximately $53,500, per capita income was $20,000, and 12% of Native Hawaiian/Pacific Islander families had incomes below the federal poverty threshold.

In 2009, approximately 17% of Asian/Pacific Islanders had no health insurance coverage. However, coverage rates can vary across ethnicities, with Koreans and Vietnamese less likely to have health insurance than Japanese, Filipinos, or Chinese.[Hughes. Quality 2002] Foreign-born Asian/Pacific Islanders are also twice as likely as those born in the United States to be without health insurance coverage.[Families USA 2006

Inadequate HIV Testing

HIV testing rates are lower among Asian/Pacific Islanders, despite the presence of the types of risk factors for HIV infection discussed here. Data from an HIV testing survey conducted in Seattle indicated that 90% of the Asian/Pacific Islanders surveyed perceived themselves at some risk for HIV infection, but only 47% had been tested during the preceding year.[Kahle 2005] The CDC's Behavioral Risk Factor Surveillance System also found that Asian/Pacific Islanders are significantly less likely than members of other races/ethnicities to report ever having been tested for HIV infection.[Zaidi 2005]

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- Fear of learning that they were HIV-positive (32.3%)
- Concern that someone would discover the test results (24.2%)
- Not having time to get tested (18.2%)

Challenges in the Management of Transgender Individuals

Many cultural, socioeconomic, and health factors contribute to the challenges of providing appropriate HIV prevention and treatment services to transgender individuals, and many of these overlap with the challenges facing Asian/Pacific Islanders.

Identification of transgender persons

Determining who is or is not transgender can be a challenge, both because many people define the word differently and because some individuals do not self-identify as transgender. Because many MtF individuals self-identify as female, their information and experiences may not be captured in transgender data. Many individuals also may not wish to identify as transgender because of the potential for stigma and discrimination—including, for example, the diagnosis of "gender identity disorder" that is required to obtain sex reassignment surgery or hormone therapy.[SF AIDS Foundation. Transgender 2009]

Practitioners should not make assumptions about sexual orientation and behavior based on gender identity alone. Considerable diversity in sexual orientation and behavior occurs among transgender people, with some identifying both as transgender and as gay, bisexual, or lesbian. The US Institute of Medicine has recommended that behavioral and surveillance data for transgender individuals should be collected and analyzed separately, rather than grouped with MSM data.

Discrimination and stigma

Many transgender individuals encounter various forms of discrimination and social stigma, which can hinder their access to education, employment, and housing opportunities. One study reported that transgender individuals were more likely than MSM or heterosexual women to live in transient housing and to have lower education levels. Discrimination may lead some transgender individuals to pursue high-risk activities, such as commercial sex work, to meet basic survival needs. Another high-risk activity associated with discrimination is participation in unprotected receptive anal intercourse, which some transgender persons may agree to because of fear of sex partner rejection or need to affirm their gender identity. Discrimination and stigma may contribute to the high rates of depression, emotional

distress, loneliness, and social isolation—sometimes resulting in suicidal thoughts and suicide attempts among transgender individuals.[CDC Transgender 2011]

Practitioners' insensitivity and lack of knowledge

Healthcare providers may mean well, but lack of knowledge, experience, and skills regarding many aspects of transgender identity, sexual behaviors, and health needs can inhibit transgender persons who are HIV-positive from seeking appropriate healthcare services. Studies have shown that similar proportions of transgender women who are HIV-positive (ie, MtFs) and other HIV-positive individuals have health insurance coverage, but that transgender patients were less likely to receive HAART.[CDC Transgender 2011]

In addition, health insurance policies typically do not offer coverage that is specific to transgender individuals' needs—e.g., medically unsupervised injections of silicone and hormones—leaving many at risk for less than adequate medical care, including HIV prevention, and treatment.[Bockting 2008]

Summary

Some of the risks and challenges involved in diagnosing and managing transgender Asian/Pacific Islanders who are HIV- positive represent a convergence of similar factors found among both Asian/Pacific Islanders who are HIV-positive and transgender individuals who are HIV- positive:

- Financial problems
- Discrimination and stigma
- Presence of comorbidities
- Increased rates of substance use

This convergence means that the very specialized population of transgender Asian/Pacific Islanders who are HIV- positive experiences an exceptional number of risk factors for acquiring HIV infection and experiencing poor treatment outcomes.

Because no specific demographic data on the precise size of this population are available, practitioners who manage transgender Asian/Pacific Islanders who are HIV- positive will need to depend on a combination of knowledge of the 2 groups whose characteristics converge in this population. Providing HIV prevention, testing, and care for these patients will involve awareness of the complex factors many Asian/Pacific Islanders must navigate to achieve financial stability and effective healthcare services—e.g., discrimination, language skills, immigration status, and hurdles of family and community support. And transgender Asian/Pacific Islanders who are HIV- positive must often do so while confronting discrimination and social alienation and healthcare practitioners who are not knowledgeable about transgender patients' specialized medical needs.

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Assessment Questions

1. Which of the following is (are) among the challenges in providing culturally competent care for Asian/Pacific Islander patients?

A. Lack of English language proficiency

B. Low rates of HIV testing

C. Disrespect for authority figures

D. All of the above

E. A and B only

2. Is the following statement True or False?
Almost all transgender individuals self-identify as female.

A. True

B. False

Module 4—Implementing Culturally Competent Care for Transgender Asian/Pacific Islanders

Learning Objective

- Identify key elements of culturally competent HIV treatment and prevention approaches for transgender Asian/Pacific Islanders

Pretraining Assessment

1. A productive cultural competence framework in managing diverse patient populations includes which of the following elements?

A. Discussing what HIV means to the patient

B. Asking the patient about his or her preferences regarding healthcare

C. Inquiring about sources of stress in the patient's life

D. All of the above

E. A and B only

2. Studies have demonstrated that which of the following factors is (are) associated with greater risk of poor adherence to HAART?

A. Active substance use

B. Depression

C. Race or ethnicity

D. All of the above

E. A and B only

3. Which of the following is (are) important components of culturally competent treatment in managing Asian/Pacific Islanders who are HIV- positive?

A. Collaboration between ethnically specific agencies and mainstream healthcare and related institutions

B. Presence of a staff member who is fluent in Spanish

C. Understanding the diversity of Asian/Pacific Islander ethnicities and languages

D. All of the above

E. A and C only

4. Is the following statement True or False?
Even many bilingual Asian/Pacific Islanders are more comfortable when language and culture advocacy services are available.

A. True

B. False

5. Which of the following is (are) important components of culturally competent treatment in managing transgender patients who are HIV- positive?

A. Providing the full range of safer sex recommendations

B. Determining by what name the patient wants to be addressed

C. Prescribing hormone therapy for all patients who request it

D. Assessment by a mental healthcare professional

E. A, B, and D only

F. All of the above

Introduction

As the modules on epidemiology, risk factors, and prevention and treatment challenges in this curriculum discussed, the precise makeup and size of the population of transgender Asian/Pacific Islander who are HIV- positive is uncertain. This is due primarily to 2 factors:

- The relatively small number (compared to other racial/ethnic groups) of Asian/Pacific Islanders who are -positive
- The somewhat fluid definition of "transgender," which may include individuals who self-identify as members of a different gender from their birth gender, those who have undergone sex reassignment treatments, those who are earlier stages of transitioning, and others

Moreover, there is no set of HIV treatment guidelines devoted specifically to transgender Asian/Pacific Islanders, and virtually no peer-reviewed publications on that subject could be found. For these reasons, practitioners who manage the care of patients who self-identify as transgender Asian/Pacific Islanders need to be knowledgeable in the culturally appropriate treatment of both Asian/Pacific Islanders and transgender persons—and be prepared to use both sets of skills at the same time for these patients. This module will discuss the needs of each group separately, while pointing out where the needs of both groups may intersect.

Elements of a Cultural Competence Framework

One widely published HIV clinician has proposed that clinicians who treat patients from a variety of racial/ethnic and cultural backgrounds use "a cultural competence framework" so as to provide care that is appropriate for each patient's particular needs.[Stone 2004, Carrillo 1999] This framework, outlined below, offers the advantage of not requiring a clinician to know all of the specific beliefs and practices associated with each different group. Rather, it utilizes a structured provider-patient dialogue that allows the patient to introduce issues that are important to her or him, whether involving culture, lifestyle, religion, sexual behavior, or other factors. This type of adaptable, interactive framework can be particularly useful during clinical encounters with patients having complex backgrounds that have been shaped by discrimination, social marginalization, language hurdles, and mental health challenges. The preceding modules in this curriculum have shown that these circumstances are common among transgender Asian/Pacific Islanders who are HIV- positive.

The steps involved in this cultural competence framework are:

- Identify the patient's core cultural issues—by asking about values and preferences regarding healthcare, while watching for any spoken or nonverbal hints about these preferences.
- Explore what HIV means to the patient by asking what the patient believes might have caused it and how it affects his or her life. This can elicit information about how the patient regards his own culture's values. Such a conversation can allow the provider to assess the extent to which an Asian/Pacific Islander patient is acculturated to mainstream American society; this can be particularly relevant to immigrant patients.
- Inquire about the patient's social situation:
    - To what extent does the patient feel in control of her/his life—e.g., are there financial or other material constraints?
    - Has the patient experienced any change in environment, such as immigration?

    - What is the patient's preferred language and what is her or his literacy level, in either English or the preferred language?
    - What kind of support systems does the patient have, including factors such as sources of stress, living situation, religious affiliation, family, and friends?
- Negotiate with the patient to develop a treatment plan that is agreeable to both patient and practitioner.

This framework allows a practitioner to learn the key issues that are important to the patient—e.g., the extent to which he or she adheres to the traditional values of his culture or is more acculturated to mainstream US society—and to incorporate those issues into a treatment plan. In addition, practitioners who are managing diverse groups of patients need to take additional measures to optimize patient outcomes, as discussed in the following sections.

Improving Communication in the Clinic

Several studies have identified inadequate or ineffective communication as a key component of non-white patients' dissatisfaction with the healthcare services that they receive. The amount of time spent with a practitioner can be a valuable predictor of patient satisfaction[Warde 2001], and transgender Asian/Pacific Islanders who are HIV- positive may require more time than members of other groups to understand the available HIV treatment options and to make appropriate decisions regarding them. To the extent possible, clinicians should try to spend more time with these patients, particularly focusing on listening to them. Clinicians can enhance patients' comprehension by assessing their understanding in a sensitive, non-condescending manner—e.g., by asking, "Does that make sense to you?" or asking the patient to repeat back the treatment plan that has been agreed upon. Providing written materials in the patient's preferred language and at an appropriate literacy level can further enhance comprehension. (This holds particular importance for Asian/Pacific Islander patients—as a group, some 100 languages are spoken by its members. Depending on the geographic location of a practice, locating translators or interpreters proficient in a specific patient's language may present a significant challenge. Some of the organizations found in the resources list at the end of this module may be able to provide advice.) In addition, other clinical staff—such as nurses, physician assistants, case managers, or peer counselors—can be assigned to spend more time with the patient and answer additional questions.

Importance of Staff Diversity

According to an analysis from the HIV Cost and Services Utilization Study (HCSUS), racial concordance between HIV-positive patients and their providers is associated with decreased disparities in time to starting HAART for minority patients.[Stone 2004] Such findings confirm the important potential benefit of diversifying the staff who are involved in providing care. Although recruiting HIV-specializing physicians can be quite challenging, adding other patient-facing staff who are members of one of the many Asian/Pacific Islander cultures can increase patients' comfort level. Such staff may include front-desk staff, medical assistants, case managers, social workers, and others. Furthermore, both current and new staff members at all levels should receive regular cultural competence education and training. (Please review the curriculum "Understanding and Implementing the CLAS Standards" [] for a more thorough discussion of the types of training that are available and who should participate in them.)

Optimizing HIV Care and HAART

Since the early years of the HIV epidemic, disparities in care, including in receipt of antiretroviral therapy, have been reported among patients belonging to racial/ethnic minorities. For example, nonwhite patients often experience a longer average delay after being diagnosed with HIV infection before they access HIV care, and, once linked to care, they are less likely to receive HAART than white patients.[Stone 2004, Cunningham 2006, Dennis 2011]

Practitioners who manage transgender Asian/Pacific Islanders should become familiar with this pattern of disparities and should establish clinical strategies to optimize the probability that HAART will be recommended to these patients and that they will in fact take their medications. Such strategies include working to build trust in the patient-provider relationship, ensuring that the patient participates in decisions about his or her own care, and providing enough time and information—from other clinical staff members if there is not adequate physician time to do so—for the patient to make an informed decision and understand the importance of taking the medications as directed.[Stone Perspectives 2004] Moreover, practitioners should develop approaches to manage comorbidities (such as hepatitis B or hepatitis C coinfection, substance use disorders, or certain cancers that are more common among Asian/Pacific Islanders) and patients' concerns about antiretroviral adverse effects or other medication-related toxicities. This can help to minimize the risks of non-adherence and to optimize the likelihood of attaining full virologic suppression.

Enhancing Adherence to HAART

Researchers and clinicians have known for many years that patient adherence to HAART is critical to achieving full virologic suppression and good immune reconstitution. Once this became well established, interest began to grow in whether certain factors could be associated with predicting adherence and, therefore, whether certain patients might be at greater risk for non-adherence and treatment failure. As far back as 2001, investigators found that a patient's demographic characteristics generally cannot be used to predict adherence to HAART—when other key predictors of non-adherence are considered.[Stone 2001, Battaglioli-DeNero 2007] Studies of HAART adherence have demonstrated that only a limited number of patient factors can reliably be associated with inadequate adherence:[Malcolm 2003, Alfonso 2006, Malta 2008, Cohn 2011]

- Depression
- Active alcohol abuse
- Active injection drug use (former users seem to have adherence rates similar to patients with no substance use history)
- Low health literacy

Depression, substance use. Depression is common in persons who are HIV-positive , as is alcohol and substance abuse; some patients experience both types of concerns.[Angelino 2001, Angelino 2008, Tegger 2008, Starace 2002] Furthermore, in nonwhite patients, depression may be more difficult to diagnose. For these reasons, practitioners who manage HIV-infected patients should perform routine screening for depression in all patients before initiating HAART. Likewise, all patients—not just those who likely became HIV-positive via injection drug use—should be screened for potential substance abuse issues. (For more detailed discussion of this subject, please review the curriculum, "Culturally Competent Care for Substance Users Diagnosed with HIV Disease.")[Before prescribing HAART for

patients in whom depression, substance or alcohol use issues, or some combination of these is identified, clinicians should develop a management plan. The risk of poor adherence is greater if these issues remain unaddressed. HIV practitioners should make an effort to collaborate with patients' mental healthcare or drug treatment providers to optimize both HIV treatment and mental health and substance use outcomes.[Stone 2004] As discussed in Module 2, studies have shown that, among some populations of Asian/Pacific Islanders, methamphetamine use—which is strongly associated with risky sexual behaviors—is a growing problem. Practitioners who manage these patients should be particularly alert to indications that their patients may use methamphetamines.

Health literacy. Clinicians should endeavor to assess patients' health literacy levels and to correct any misconceptions.[Corbie-Smith 2002, Kumar 2009, Armstrong 2007, Zekeri 2009] Although a patient's racial/ethnic background has generally not been found to be predictive of adherence, some highly charged emotional factors may disproportionately affect nonwhite patients' willingness and ability to adhere to HAART. These include misunderstanding and distrust of traditional healthcare practices and concerns about potential harm associated with medications that some may regard as toxic, experimental, or ineffective.[Corbie-Smith 2002, Kumar 2009, Armstrong 2007, Stone 2004, Cunningham 2006] Support groups, peer educators, and treatment buddies are some of the strategies that clinical staff can use to help patients develop more positive attitudes about their treatment.

Importance of trust. Cultivating a trusting clinician-patient relationship before beginning HAART can enhance adherence. Several important studies of adherence have shown that the quality of the patient-provider relationship may be one of the most important predictors of adherence, particularly for nonwhite patients.[Stone 2004, Simoni 2008] Communication can be critically important in cultivating trust for some groups of Asian/Pacific Islander patients. This is due to not only potential language issues but also to some Asian patients' tendency to defer to authority figures such as physicians. This may require practitioners to be especially aware that patients both understand and agree with recommended treatments. Logistical supports—such as directly observed therapy—can significantly enhance patients' adherence to HAART if a practitioner observes indications that a patient may be at risk for poor adherence.[Moitra 2011, Mitty 2002, Goggin 2007]

Improving Use of HIV Testing and Access to Care

Within a cultural competence framework for managing HIV-positive patients like the one by Stone outlined above, there are several broad strategic approaches that are key to achieving an overall enhanced level of appropriate care for transgender Asian/Pacific Islanders who are HIV- positive.

Increasing the numbers of transgender Asian/Pacific Islanders who are aware of their HIV status represents a critical first step; as the preceding module discussed, this population has one of the lowest rates of HIV testing vs other racial/ethnic groups. Studies have shown that individuals who know that they are HIV-positive typically reduce risky sexual behaviors, thereby contributing to reductions of ongoing HIV transmission and community viral load.[Colfax 2002] In addition,persons who are HIV-positive who are not aware of their status are the primary cause of new HIV infections.[Marks 2006] Efforts to expand the number of transgender Asian/Pacific Islanders who are aware of their HIV status will require that both these patients and the healthcare providers who work with them become knowledgeable about the Centers for Disease Control and Prevention's current guidelines for HIV testing.[Branson 2006] (For more detailed discussion of testing issues, please review the curriculum, "Promoting HIV Testing in Diverse Populations.")[]

Similarly, healthcare providers and facilities need to develop and implement approaches that take into account the risks and challenges discussed in Modules 2 and 3 of this curriculum so as to link transgender Asian/Pacific Islanders who are HIV-positive to HIV care—and to ensure that they are retained in care.

Cultural Competence and the Asian/Pacific Islanders Community

Although the cultural competence framework outlined above can be employed for patients having a wide variety of ethnic, language, and cultural backgrounds, the exceptional ethnic and linguistic diversity of Asian/Pacific Islander communities presents cultural competence challenges that should be tailored to each patient's background and experiences. A Commonwealth Fund study underlined the importance of developing cultural competence approaches that address the specific needs of Asian patients' ethnic and language backgrounds. The study found that Asian American patients were less likely than white patients to report being very satisfied with their overall care (42% vs 64%) and less likely to trust in their physicians (55% vs 71%). Moreover, Asian Americans were more likely than whites to indicate that their physicians did not understand their background and values (61.7% vs 49.6%), and fewer than half (47.1%) felt that their providers listened to everything that they wanted to say, vs nearly 70% of white patients.[Hughes Quality]

Bridges Project

Although the need for culturally competent healthcare services tailored to Asian/Pacific Islanders has become clear, very few studies have evaluated the program details and outcomes of efforts that specifically targeted Asian/Pacific Islanders who are HIV- positive. Perhaps the best known of these is the Bridges Project in New York City, which focused on patients at the Asian and Pacific Islander Coalition on HIV/AIDS (APICHA), a community-based AIDS service organization. Chin and colleagues evaluated the key features of the cultural competence approach developed by the Bridges Project and offered their recommendations for features that are critical to serving Asian/Pacific Islanders who are HIV-positive.[Chin 2006]

A particular focus of the Bridges Project was patients who had the greatest need for cultural competent care—ie, those with limited English proficiency, for whom overcoming barriers to HIV medical and related services presented a serious challenge. Lack of competent care of such patients can result in poor symptom recognition, failure to provide appropriate treatment, and low utilization of available services.

A succinct description of the elements of the Bridges approach is the provision of: interpretation services, client escorts, cultural competency training for healthcare providers, and linkage to programs that address other patient factors that inhibit access to appropriate services. The interpretation, client escort, and case management services were all performed by bilingual, part-time peer workers and full-time case managers who were employees of APICHA.

Service Barriers

The key barriers to obtain services (in order of frequency) that clients reported were:

- Staff does not speak client's language
- Client not sure where to go
- Costs too much
- Other
- Afraid of what provider might say
- Staff not competent
- Unsure HIV status would be kept confidential
- Afraid providers would not understand client's problem
- Staff not good at listening
- Fear of revealing status to family members
- Staff not polite
- Lack of child care
- Lack of transportation

Project Overview

On entering Bridges, a client was assigned a bilingual case manager and, if needed, a bilingual peer advocate, who escorted clients to appointments and provided interpretation and advocacy services. For example, after a bilingual case manager made a medical referral and scheduled an appointment the bilingual peer advocate would arrange to accompany the client to facilitate participation in treatment. The program had an on-call corps of 12 to 15 trained peer advocates who had the combined ability to speak 12 different Asian/Pacific Islander languages and dialects. The Bridges Project enrolled 58 clients—83% male, 15% female, 1 MtF transgender—having a mean age of 38 years.

The direct healthcare services that clients received at APICHA were integrated with other services funded by different sources, including:

- Legal aid organizations
- Housing placement services
- Ambulatory care services
- Acupuncture clinic
- Asian food and nutrition program
- Social events to address other support needs

Follow-up analyses showed that there were dramatic improvements in service utilization and reduction in the number of barriers reported in accessing services, and the differences between undocumented Asian-language clients and documented English language clients all but disappeared.

Language Services Critical

The investigators concluded that the types of language services provided by Bridges were a critical component of the program's success, even for bilingual participants. When patients presented with acute HIV infection, their ability to understand medical and treatment terminology in English is diminished, and the cultural associations of mental health, substance abuse, and HIV-risk behaviors are more easily grasped in their native languages.

Many Asian/Pacific Islander patients may have limited understanding of issues related to HIV disease progression and treatment, regardless of their language skills. Even when patients and providers speak the same language, lack of familiarity with diagnostic and treatment terminology can interfere with communication. Bilingual case managers and peer advocates can play a critical role in helping patients understand the significance of markers like CD4+ cell count and viral load and the importance of treatment adherence. Bridges Project clients valued the importance of having providers who understand their cultural norms of interaction and communication. Comfort levels were enhanced by interacting with others from their home countries and by being able to share histories and experiences as a means of mutual support, in addition to having a common language.

Testimonials

The researchers cited the experiences of several patients as examples of how critical the availability of providing language services and cultural advocacy are to patients' comfort level in accessing services.

- A 45-year old Japanese man who had lived in the United States for 12 years explained the benefits of interpretation services during his hospitalization for acute HIV infection, even though he could speak English: "You know when you are really sick lying in the bed in a hospital and the doctor comes up and says something with all these difficult terms and everything, it doesn't register in your brain. I had a hard time in the hospital. And when I was freshly out of the hospital, I really appreciated everything explained in my own language."

- A 37-year-old Burmese man who had lived in the United States for 7 years described the comfort of shared culture as being like visiting his mother's house: "To see the other friends who are sick like me, other Asian friends. Sometimes they have the meeting and eat dinner together. I feel like I go visit my mother's house. I could feel it. I could relax, sit down, drink a cup of coffee and open the refrigerator."

- A 36-year-old Chinese man attested to the comfort of being able to openly share experiences with other Asian/Pacific Islanders without fear of being ostracized: "I met many people who are from my hometown. Once we met, we all know what was going on. Then, we become friends over same illness. Because we are all the same, then we also can understand each other, it's particularly comfortable because we don't have secret between us. It's like having mutual sympathy. We all respect each other."

Organizational Commitment

Chin and colleagues explained that the commitment to providing culturally competent healthcare services to Asian/Pacific Islanders requires organization-wide commitment beyond the patient-provider interaction. That commitment needs to include overall practices such as hiring, scheduling, and design of the physical space. They also stressed that ethnically targeted agencies such as APICHA—whose leadership, staff, and clientele are mostly Asian/Pacific Islander—typically have limited capacities to provide a full range of services, although they can effectively reduce barriers and improve service utilization. Ethnically specific agencies and more mainstream institutions need to collaborate to ensure that Asian/Pacific Islanders who are HIV- positive simultaneously receive the strong support of shared culture and language as well as access to the full range of services available in the larger healthcare and social services system.

Cultural Competence for the Transgender Community

In providing culturally competent care for transgender Asian/Pacific Islanders who are HIV-positive , practitioners also must be knowledgeable about the unique medical and other needs of transgender persons, as well as those of Asian/Pacific Islanders who are HIV-positive. The section that follows will provide a concise review of the elements of culturally competent care of transgender individuals who are HIV-positive.

Many transgender individuals do not access the appropriate healthcare services that are needed to maintain health and to prevent and manage HIV infection. Moreover, they bring to any clinical encounter a set of unique physical and psychosocial healthcare needs. By developing culturally sensitive and appropriate practices, healthcare providers can reduce the barriers to care and help transgender patients achieve optimal health outcomes. Below are some of the core components of creating a practice environment that is transgender-friendly.[Williamson 2010]

Patient Health History

Intake forms should include "transgender" and "other" in addition to "male" and "female." Intake forms and all patient-facing staff should use gender-appropriate language as initial indicators of the healthcare practice's sensitivity to the special needs of transgender patients. For example, an individual who was assigned a male name at birth may now choose to be called by a female name. Some basic questions can help further clarify this issue:

- Do you self-identify primarily as male or female?
- How long ago did you realize that your body and your self-identification did not match?
- Have you ever received hormones?
- Have you used needles to inject hormones, silicone, narcotics, or other drugs?

Sexual health. Practitioners should ask about sexual behaviors, such as the use of condoms and preferred sexual partners (male, female, or both), because transgender persons may self-identify as gay, heterosexual, or bisexual. Since behavior, rather than gender or orientation, is the key factor in the risk for HIV transmission, practitioners should inquire whether a patient has participated in unprotected receptive intercourse with biological males. By obtaining an accurate sexual health history, a provider can offer safer sex recommendations that are culturally appropriate and useful to each individual patient.

Mental health. Practitioners should determine whether transgender patients have seen a mental healthcare professional, especially regarding gender issues. Transgender individuals often experience feelings of depression, frustration, social isolation, and anxiety as they develop their sense of self-identification. Mental healthcare professionals can provide clinicians with an assessment of whether a transgender patient is suitable for hormone therapy, if the patient is considering that approach. If a mental healthcare provider has diagnosed a patient with a serious coexisting mental disorder, a clinician may decide against prescribing hormone therapy at that time.

Physical examination. Many transgender persons might not have had a complete physical examination for a long time, due to reluctance to discuss their gender identity or to concerns that a practitioner would be unqualified, uncomfortable, or judgmental. After taking other measures to reassure the

patient, the clinician should ask transgender patients when they last had a complete physical, which should include the chest and genital areas. Use of neutral terms such as these is preferable to terms like breast or testicular exam, which may cause discomfort to some transgender patients whose feelings about their anatomical incongruity are still ambivalent. Clinicians' findings from a physical exam can vary widely, depending on whether a patient has received hormone or cosmetic surgical treatments. In addition, some MtFs may dress in women's clothes, yet have entirely male anatomy.

Safer Sex Education

Because transgender patients may engage in a variety of sexual behaviors, practitioners should be prepared to provide patients with the full range of recommendations regarding safer sex practices, so that patients are not put into the position of have to reveal their own personal sexual practices, which some may not feel comfortable enough to discuss. Practitioners should encourage the use of condoms, latex gloves, and other barriers for all types of penetrative oral, vaginal, and anal sexual activities. The overall goal of safer sex practices should be to decrease the risk of all sexually transmitted infections.

Hormone Therapy

Managing hormone therapy in transgender patients who are HIV-positive can present challenges, due to the potential for interactions between the hormones and antiretroviral agents. Hormonal agents often used among transgender patients include testosterone, estradiol, and oral contraceptives. In addition to or instead of hormones prescribed by a clinician, some transgender patients may obtain these agents illegally and self-administer them. Co-administration of antiretroviral agents and hormones in transgender women (MtFs) has not been studied extensively, and clinicians should review the most up-to-date HIV treatment guidelines from the US Department of Health and Human Services (www.aidsinfo.nih.gov/guidelines) when considering such co-administration.

In Short

Provision of culturally competent healthcare for transgender patients who are HIV-positive requires that practitioners present a transgender-friendly clinical environment and that clinicians be knowledgeable about the physical effects of treatments such as hormone therapy and genital-conforming surgery—as well as the potential implications for selection of antiretroviral agents and treatments for any comorbidities. Critical elements to providing such an environment include:

- Staff commitment to eliminating institutional barriers to care
- Collecting appropriate history for each transgender patient
- Presenting treatment information in a way that involves transgender patients in all aspects of decision making about their healthcare

Selected Resources

Asian/Pacific Islander Resources

AIDS Services in Asian Communities (ASIAC). Philadelphia organization providing HIV prevention, education and outreach, testing and counseling, and case management services. www.asiac.org/.

APICHA Community Health Center. Provides HIV-related services, education, and research to Asian and Pacific Islander communities in New York City. www.apicha.org/.

Asian & Pacific Islander Wellness Center. San Francisco–based organization providing education and support for Asian and Pacific Islander communities, including those living with or at-risk for HIV infection. www.apiwellness.org/home.html.

Asian Pacific AIDS Intervention Team (APAIT). Southern California–based organization providing HIV prevention and education, case management and therapy, substance abuse programs. www.apaitonline.org/.

Asian Health Services. Oakland, California–based agency providing HIV treatment program, counseling, and testing. www.asianhealthservices.org.

National Minority AIDS Coalition (NMAC). Washington, DC–based organization dedicated to developing leadership within communities of color to address the challenge of HIV/AIDS.

Life Foundation. Hawaii agency providing case management, HIV education, sterile needle exchange, peer support and outreach, and treatment education. http://lifefoundationorg.ipage.com/.

Transgender Resources

Asian and Pacific Islander Wellness Center. HIV-specific programs and services for Asian/Pacific Islander transgender people. Located in San Francisco. www.apiwellness.org/transgen.html.

Callen-Lorde Community Health Center. This New York City–based organization has developed a set of protocols for hormone treatment of transgender individuals. To request a copy of the protocols, please visit: www.callen-lorde.org.

Center of Excellence for Transgender HIV Prevention. This organization's mission is to increase access to comprehensive, effective, and affirming healthcare services for transgender and gender-variant communities. www.transhealth.ucsf.edu.

National Center for Transgender Equality. This organization is dedicated to advancing the equality of transgender people through advocacy, collaboration, and empowerment by monitoring federal activity and communicating information about it to members around the country, providing congressional education, and maintaining a center of expertise on transgender issues. www.nctequality.org.

Positive Health Project. This agency provides HIV prevention and care services to marginalized populations who are at very high risk of HIV infection and transmission. http://positivehealthproject.org/.

Transgender Awareness Training and Advocacy. Website of Samuel Lurie, who provides healthcare trainings regarding transgender people to a variety of organizations. www.tgtrain.org/.

Transgender Care. This is a Tampa, Florida, group that compiles a range of information and articles on transgender health issues. www.transgendercare.com.

World Professional Association for Transgender Health (WPATH). WPATH is an international, multidisciplinary professional association whose mission is to promote evidence-based care, education, research, advocacy, public policy, and respect in transgender health. www.wpath.org.

Summary

In managing the care of transgender Asian/Pacific Islanders who are HIV-positive, practitioners should understand the key risk factors for HIV transmission and inadequate access to care and the complex set of challenges related to this group's social, cultural, psychological, and health circumstances. This understanding of transgender Asian/Pacific Islanders' beliefs, attitudes, and behaviors can be practically applied through a "cultural competence framework," a process that allows a practitioner to become familiar with the issues that are important to the patient and to incorporate them into treatment plans. Effective communication is key to patients' satisfaction with their healthcare encounters. Practitioners should take appropriate measures to ensure that patients understand and agree with recommended treatment plans. Adherence to HAART is critical to optimal clinical outcomes, and studies have shown that patients' race/ethnicity are not associated with their ability to achieve optimal adherence. Factors associated with greater risk of poor adherence include: depression, active alcohol or substance abuse, and low health literacy. Although specific data and practice guidelines for transgender Asian/Pacific Islanders are unavailable at this time, a wide range of resources is available to assist practitioners in understanding HIV-related behaviors, risks, and clinical management among both Asian/Pacific Islanders and transgender individuals.

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Assessment Questions

1. A productive cultural competence framework in managing diverse patient populations includes which of the following elements?

A. Discussing what HIV means to the patient

B. Asking the patient about his or her preferences regarding healthcare

C. Inquiring about sources of stress in the patient's life

D. All of the above

E. A and B only

2. Studies have demonstrated that which of the following factors is (are) associated with greater risk of poor adherence to HAART?

A. Active substance use

B. Depression

C. Race or ethnicity

D. All of the above

E. A and B only

3. Which of the following is (are) important components of culturally competent treatment in managing Asian/Pacific Islanders who are HIV-positive?

A. Collaboration between ethnically specific agencies and mainstream healthcare and related institutions

B. Presence of a staff member who is fluent in Spanish

C. Understanding the diversity of Asian/Pacific Islander ethnicities and languages

D. All of the above

E. A and C only

4. Is the following statement True or False?

Even many bilingual Asian/Pacific Islanders are more comfortable when language and culture advocacy services are available.

A. True

B. False

5. Which of the following is (are) important components of culturally competent treatment in managing transgender patients who are HIV-positive?

A. Providing the full range of safer sex recommendations

B. Determining by what name the patient wants to be addressed

C. Prescribing hormone therapy for all patients who request it

D. Assessment by a mental healthcare professional

E. A, B, and D only

F. All of the above

Module 1—Case Study

41: Case Study Adapted from Addressing HIV Care and Transgender Communities

Angela is a 22 year old Chinese transgender male to female person. She seems nervous and does not make eye contact. English is not her first language. She is currently going through estrogen hormone therapy. She has a history of depression and drug use. Angela was referred by a local CBO to your clinic to obtain an annual physical examination.

Discussion Questions

1. Estrogen Hormone Therapy
   - Where does she receive therapy? Is she using clean needles?
   - Are there side effects?
   - How does she pay for it? Is she employed?
2. Assess Social Support
   - Does she have family? Do they support her gender identity/transition? If not, how does this affect her?
   - Where does she get social support from?
   - Where does she live?
3. Assess Depression
   - Is she under treatment?
   - Is she on medication (s) for her depression?

4. Assess Capacity to Understand her Current Medical Condition

   -Does she need a medical interpreter due to her limited English speaking skills?
   -What is her literacy level?
   -Does she understand fully her medical condition?

5. Assess Drug Use
   a. Is she currently using substances? If so, what kind? Assess for HIV/Hepatitis C risk if needles are involved
6. Assess Sexual History and Risk
   a. Has she been tested for HIV/STDs?
   b. If involved in commercial sex work, ask about use of condoms

AIDS Education and Training Center – National Multicultural Center (AETC-NMC)
1840 7th Street NW, 2nd Floor
Washington, DC 20001
202-865-8146 (Office)
202-667-1382 (Fax)
Goulda Downer, Ph.D., RD, LN, CNS
Principal Investigator/Project Director (AETC-NMC)
www.aetcnmc.org
HRSA Grant Number: U2THA19645