

National-level Capacity-building Assistance Model to Enhance HIV Prevention for Asian & Pacific Islander Communities

Lina Sheth, Don Operario, Nancy Latham, and Bhupendra Sheoran

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Objectives: Asian & Pacific Islander (A&PI) communities in the United States face increasing risk for HIV, yet have limited access to US culturally competent HIV prevention services. We describe a national HIV prevention capacity-building program for A&PI communities using a multitiered approach addressing systems, institutional, and individual level outcomes. **Methods:** The program developed a national network of A&PI HIV and health-focused institutions, and conducts regional-level replication and dissemination of this model to support four areas of capacity building. This network is led by two national organizations coordinating the planning, implementation, and evaluation of the National Capacity-Building Assistance Program. **Results:** Baseline data are compared with the last 2 years of preliminary data that show increased capacity among community-based organizations and health departments to strengthen culturally competent models of HIV prevention. Systems-level outcomes so far show enhanced leadership skills for HIV-related advocacy efforts, increased ability to leverage the media, and stronger partnerships between peer providers, health departments, and community leaders. **Conclusion:** This program model preliminarily demonstrates that national capacity-building initiatives can foster coalition development, replication of program models, materials sharing, and new leadership that improve HIV-related prevention services for A&PI communities.

KEY WORDS: Asian & Pacific Islander, capacity-building assistance, HIV/AIDS prevention, intervention

Asian & Pacific Islander (A&PI) communities in the United States face a window of opportunity for coordinated public health HIV prevention efforts. Al-

though current HIV prevalence and incidence levels for A&PIs are low compared with other racial and ethnic categories in the United States,¹ studies have documented alarming levels of HIV-related risk behaviors among A&PI subgroups such as men who have sex with men (MSM),² drug users,³ commercial women sex workers,⁴ and transgender women.⁵ Behavioral evidence therefore suggests that HIV prevalence and incidence levels may be on the rise for A&PIs, and preemptive public health responses are necessary to prevent the HIV epidemic from approximating levels seen in other communities of color. This article offers a model for how community-based organizations (CBOs), researchers, and health providers can synergistically combine strengths to build a dynamic infrastructure of culturally competent HIV prevention services for A&PI communities.

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Corresponding author: Lina Sheth, MPH, Asian & Pacific Islander Wellness Center, 730 Polk St, 4th Floor, San Francisco, CA 94109 (e-mail: lina@apiwellness.org).

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Lina Sheth, MPH, is Director of Research and Technical Assistance, Asian & Pacific Islander Wellness Center, San Francisco, California.

Don Operario, PhD, is Professor, Department of Social Policy & Social Work, University of Oxford, Oxford, UK.

Nancy Latham, PhD, is Director of Research and Evaluation, LaFrance Associates, San Francisco, California.

Bhupendra Sheoran, MD, is HIV National Program Manager, Asian & Pacific Islander Wellness Center, San Francisco, California.

● Epidemiology of HIV/AIDS in A&PI Communities

As of December 2004, A&PIs have accounted for less than 1 percent of estimated cumulative AIDS diagnoses in the United States.¹ Although the proportion of A&PI cases remains significantly lower than those for African Americans, Latinos, and whites, diagnosed HIV infections and AIDS incidence for A&PIs, such as Native Americans and Alaska Natives, increased steadily between 1998 and 2004.⁶ Most recently, trend data for HIV/AIDS from 2001 to 2004 revealed that A&PIs had the highest estimated annual percentage change in HIV/AIDS diagnosis rates: 8.1 percent for males and 14.3 percent for females. A&PIs are the only group that show a significant increase in annual percentage change while all other racial and ethnic groups show a decrease.⁷

Behavioral data portray a more disquieting picture of A&PIs and their risk for HIV. Studies of A&PI MSM have shown rates of unprotected anal intercourse resembling levels documented in samples of African American, Latino, and white MSM.² A recent study of young A&PI MSM in San Francisco reported that rates of rectal gonorrhea, syphilis, and unprotected anal intercourse with two or more male partners—each an indicator of HIV vulnerability—have surpassed levels in white MSM.⁸ Research on drug-using A&PI communities has also described high-HIV risk including unsafe sex, sex while under the influence of drugs, and multiple sex partners.^{3,9,10} Asian women who are sex workers in massage parlors have reported engaging in multiple sex acts per day, with frequent condom breakage and forced sex.⁴ A&PI male-to-female transgender individuals, who were born male but identify and express themselves as women, have shown 13 percent HIV prevalence in addition to co-occurring health issues such as frequent drug use, mental health problems, and other sexually transmitted infections.⁵

● Community-based Approaches to HIV Prevention

Communities of color in the United States are underrepresented in HIV prevention research and health promotion campaigns. Indeed, agencies including the Institute of Medicine and US Department of Health and Human Services have called attention to gaps in public health services for racial and ethnic minority communities and urged for increased resources to eliminate racial and ethnic health disparities such as HIV/AIDS.^{11,12} Community-based health initiatives have been effec-

tive mechanisms for bridging gaps in health resources for communities of color. As a result, indigenous community stakeholders have leveled the playing field with scientists and medical professionals to increase access for their communities.¹³

Community-based approaches to HIV prevention for A&PI communities must keep in mind cultural issues that challenge and shape the ways services are conducted as well as those that may create barriers to healthcare access. For example, ethnographic research on Asian women who work in massage parlors in the United States highlighted how culture- and gender-based power inequality, immigration status, low access to socioeconomic resources, and cultural norms contributed to their risk for HIV and sexually transmitted infections (T. Nemoto, PhD, M. Iwamoto, PhD, S. Wong, PhD, M. N. Le, PhD, D. Operario, PhD, unpublished data, 2004). A comprehensive review of behavioral theories guiding HIV prevention work has concluded that cultural bias against A&PIs pervades the research literature in that the dominant models of prevention exclude non-Western processes and experiences that determine manifestations of sexual and general health.¹⁴

CBOs are principal actors in community-based health responses to the HIV epidemic. Health-focused CBOs tend to arise out of social and political movements, such as the women's rights movement and the gay rights movement, and are typically staffed by individuals who represent the communities at risk. Over the past two decades, CBOs throughout the United States have provided crucial HIV services to racial and ethnic minority communities including HIV prevention, testing services, primary care, case management, and support groups for people living with HIV/AIDS, and advocacy for the health needs of vulnerable populations. However, research on HIV-focused CBO programs have identified weaknesses in their service provision, including low utilization and integration of research findings on evidence-based intervention strategies into CBO services.¹⁵⁻¹⁷

Although this highlights areas of improvement for CBOs providing HIV prevention, the development and delivery of HIV prevention and care services—which typically rest in the hands of researchers and medical providers—must be informed by the expertise of CBOs conducting front-line, community-embedded work. Providers can augment their capacity to tailor public health programs to specific, hard-to-reach communities, and CBOs can achieve enhanced capacity to provide evidence-based services within their communities. We have developed and begun to evaluate a model that strengthens the capacity of CBOs and service providers to provide comprehensive state-of-the-art, culturally competent HIV services to A&PI communities.

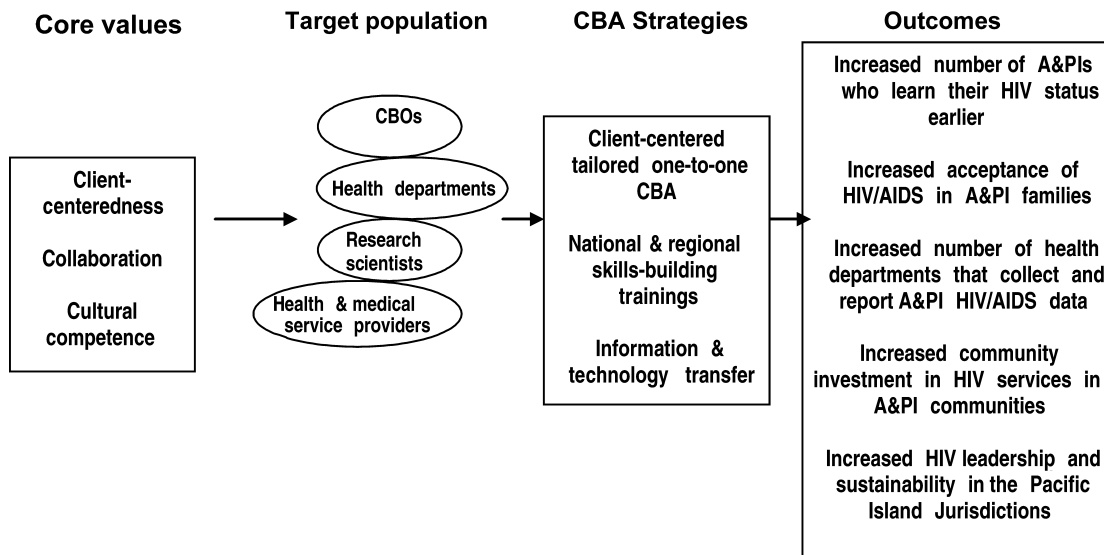


FIGURE 1. Model of the Asian & Pacific Islander HIV National Capacity-Building Assistance Program.

● **A Model for HIV Prevention Capacity Building for A&PI Communities**

Founded in 1987 as an all-volunteer, community-based response to the AIDS crisis in communities of color, Asian & Pacific Islander Wellness Center (A&PI Wellness Center) is the oldest and largest nonprofit organization in North America focusing on sexual health and HIV in A&PI communities. With a staff fluent in 20 languages and three sites in the San Francisco Bay Area, A&PI Wellness Center provides services at the local, state, and national levels, and collaborates with grassroots activists throughout the Asia Pacific Region. In 1993, A&PI Wellness Center developed a national HIV capacity-building assistance (CBA) program to improve the HIV prevention program capacity of A&PIs of other CBOs, health departments, service providers, researchers, and other community stakeholders across the United States and its six affiliated Pacific Island Jurisdictions. Founded in 1986, the Asian and Pacific Islander American Health Forum (APIAHF) is a national CBO that promotes policy, program, and research efforts to improve health and well-being of A&PIs and has focused health programs in HIV, chronic diseases, and domestic violence. The APIAHF has also offered HIV CBA to improve HIV prevention program capacity of A&PIs across the United States and Pacific Island Jurisdictions for more than 10 years. CBA as defined by the Centers for Disease Control and Prevention within a HIV prevention context is “a planned, structured process by which individuals, organizations and communities develop skills and abilities to enhance and sustain HIV prevention efforts. The goal of capacity building is to foster self-sufficiency and the self-sustaining ability

to improve HIV prevention processes, programs and interventions.”¹⁸ CBA for A&PI HIV CBOs has become particularly urgent given recent initiatives by the Centers for Disease Control and Prevention requiring CBO funding recipients to base their services on evidence-based research, none of which have been developed for A&PIs, Native Americans and Alaska Natives.

National CBA model

A&PI Wellness Center together with APIAHF has a longstanding coordinated partnership spanning over a decade in delivering HIV CBA to CBOs, health departments, researchers, health providers, and community stakeholders across the United States and in the Pacific. The two agencies embarked on a nationally coordinated model of CBA funded by the Centers for Disease Control and Prevention that emphasizes a multi-tiered approach addressing systems, institutional, and individual level outcomes. The partnership concurrently re-engaged a national partnership of A&PI HIV and health-focused institutions that extends regional-level replication and dissemination of this model to support four areas of capacity building. A&PI Wellness Center and APIAHF work on four focal areas of CBA and collaborate with the same regional partners in most regions of the United States to support local replication. A&PI Wellness Center focuses on (a) strengthening program intervention design for A&PIs at the CBO and health department level and (b) increasing access to and utilization of HIV services of A&PIs on the community level through the Banyan Tree Project, whereas APIAHF focuses on (a) infrastructure development of CBOs serving A&PIs and (b) leadership development

of A&PI Community Planning Group members and health departments through the Fostering Advocacy & Community Empowerment Project.

Our regional partners are located in areas of the country where the highest population and HIV incidence among A&PIs in the nation exist, and are responsible for delivering CBA in their regions and include Life Foundation (Hawaii & the Pacific Island Jurisdictions); Asian Pacific Islander AIDS Intervention Team (West Coast); Asian Health Coalition of Illinois (midwest); Asian & Pacific Islander Coalition on HIV/AIDS (northeast), and Massachusetts Asian & Pacific Islanders for Health (northeast). A&PI Wellness Center and APIAHF meet monthly, whereas the national network meets biannually to ensure close coordination of program goals and outcomes, program monitoring, evaluation, and quality assurance. LaFrance Associates supports external evaluation to assess success of outcomes and goals of the National CBA Program.

National CBA Program outcome goals

The National CBA Program aims to achieve five key outcomes leading to increased A&PI leadership around HIV issues and increased cultural and technical competency of HIV/AIDS services for A&PIs. Five key outcomes include (1) increased number of A&PIs who learn their HIV-positive status earlier and get enrolled in HIV care services; (2) increased acceptance of HIV/AIDS in A&PI families and communities; (3) increased number of health departments that collect and report A&PI HIV/AIDS data; (4) increased community investment in HIV services and organizations in A&PI communities; and (5) increased HIV capacity, leadership, and sustainability in the Pacific Island Jurisdictions.

National CBA Program guiding values

National CBA Program is based upon a set of core values. First is *client centeredness*—supporting “clients” (other CBOs, health departments, researchers, media, and health and medical service providers) in whatever stage of professional development they are in, and facilitating growth, adaptation, and development toward their goals. Second is *collaboration*—building and enhancing relationships between all necessary constituents to ensure maximum impact of HIV prevention, care, and treatment. Third is *cultural competence*—ensuring that provisions of services are sensitive, appropriate, and flexible to meet the community’s needs. Additional values to support service delivery are being further articulated.

National CBA Program strategies

The program engages in three major CBA strategies to achieve the five key outcomes: client-centered one-on-one CBA, national and regional skills-building training, and culturally competent information and technology transfer. Since inception of the National CBA Program, we have provided CBA to more than 55 CBOs with HIV-related services in their local A&PI communities, consulted with 18 health departments or Ministries of Health in the United States and Pacific Island Jurisdictions, and provided ongoing culturally competent technology transfer such as program replication toolkits, fact sheets, newsletters, articles, research, and best practice guides to service providers.

Client-centered individualized CBA

This activity takes the form of one-on-one, individualized and culturally tailored technical consultation, coaching, training, and referrals to CBOs and health departments. Past experience had revealed that many CBOs and service providers encountered difficulty identifying and articulating their needs about how to build capacity because they operate under immediate pressures to provide direct services. CBA, therefore, takes a client-centered, tailored approach in which both the client and CBA provider work closely together to (a) assess and diagnose needs, (b) prioritize needs, (c) determine organizational readiness to address the needs, (d) develop an action plan, (e) assess appropriate internal and external resources including regional consultants, (f) review and evaluate progress toward the action plan periodically, and (g) develop a new CBA or discharge plan.

National and regional skills-building trainings

Regional and national technical skills-building trainings to support program outcomes are an effective strategy and are critical because the limited number of HIV programs for A&PIs across the United States and in the Pacific often operate in isolation of one another. Trainings help to bring similar or complementary interest groups together in a cross-learning environment, and, based on our experience, provide an opportunity for the participants to increase peer support beyond the training and to reflect on and assess their situation and request more individualized CBA.

Culturally competent information and technology transfer

Agencies heading CBA initiatives serve a critical function as depositories and clearinghouses of materials on their communities, and hold expertise communicating and transferring this information to other stakeholders.

To this end, the National CBA Program prepared and disseminated over 25 HIV-related educational materials, curricula, fact sheets, and best practices program models on topics including *Testing Options for U (TOFU)—A Multilingual Approach to Counseling: Testing and Referral in A&PI Communities Toolkit*; *Banyan Tree Project Communications Toolkit—How to Develop a Media and Social Marketing Strategy to Curb HIV Stigma & Discrimination in A&PI Communities*; *Supervisor Manual for New Managers*; and *HIV/AIDS Community Networks Toolkit—How to Build Effective Coalitions and Networks*. Other materials are also disseminated through annual newsletters, Web site, and e-mail list-serves, and at regional, national, and international trainings and conferences.

● Evaluation

A baseline evaluation was conducted in 2004 to assess the effectiveness of the National CBA Program. Evidence of effectiveness was classified into (a) first-order effects, reflected through direct impact on the CBA clients, and (b) system-level effects, reflected through impact at the community and policy levels. Another purpose of the evaluation was to identify successes and challenges of the National CBA Program model itself. These baseline data collected 2 years ago helped align the prospective methods for the National CBA Program model across all four focus areas.

Methodology

The National CBA Program is evaluated using both quantitative and qualitative methodology. *Clients* are defined as CBOs and health departments, or other parties who sought and utilized CBA program services. Qualitative evaluation uses traditional research techniques and analytical approach that involves an iterative process of identifying and organizing emerging themes within the data, creating new questions around that theme, and returning to the data for further answers and insights.¹⁹ The baseline assessment also includes an evaluation of the National CBA Program Network functioning. On the basis of gathered data, a quantitative methodology is coordinated between the two lead agencies and the same methods and tools are used across the program. For all tools, interview protocols are developed utilizing program logic models and dialogue between external evaluators, lead partners, and the regional partners. General interview questions are determined and linked to the logic model outcomes and overall program outcomes and are categorized within CBA's focus areas: (1) infrastructure development, (2) program development, (3) increasing access and utilization of HIV services (The Banyan Tree Project), and

(4) community planning leadership development. Interview protocols include a postevent survey and a follow-up 6-month "post event" survey. The survey tools are distributed onsite by the CBA provider or to the participant through the Web tool Survey Monkey. Client satisfaction to services is integrated into the tools to ensure timeliness, work plan satisfaction and completion, and overall client satisfaction to CBA services. A plan to integrate qualitative evaluation data at 2.5- and 4.5-year cycles will be developed, with the external evaluator to complement the impacts of National CBA Program delivery and its effects on outcomes. To assess National CBA Program Network functioning as part of the effectiveness of the National CBA Program, quantitative and qualitative evaluation methods are also incorporated into the overall evaluation plan.

Baseline Assessment 2004

Baseline qualitative evaluation was conducted to assess National CBA Program delivery in 2004, and allowed the program to better understand our program configuration, goals, and outcomes toward which we sought to focus the National CBA Program. Results from this evaluation showed first-order effects referring to CBA-related changes that occurred at the client level, and revealed that CBA was shown to enhance clients' organizational management and long-term planning skills. Issues of fiscal consciousness and fundraising emerged as the most important areas. Respondents described benefiting from the sessions covering financial management and fundraising and becoming more aware of federal and state funding opportunities, strategies for securing service and research grants, and techniques for obtaining private funds through donations and event fundraising. One respondent stated, "Because of the CBA, [my organization knew to apply] ... for a Title 3 grant from HRSA."

At the level of program development and delivery, several improvements associated with participating in CBA were noted. One of the most commonly mentioned effects was increased access to best practices for HIV prevention interventions for A&PI populations. Such access is important to high program functioning, as certain funding initiatives require that new programs be built from evidence-based models. CBA also helped clients access and adapt existing HIV educational materials that had been developed by other organizations or providers. Respondents stated that CBA workshops on evidence-based models, counseling and testing, and informational materials improved both their ability to provide services and their opportunities for obtaining funding:

One of the most effective aspects of the CBA is the sharing of information. It helps a lot with not having to

reinvent the wheel because if you find something that is working for another community, you can try it with your community. It is critical and beneficial to see what others are doing.

Another way that CBA enhanced service delivery was through increasing access to research and data on HIV prevention. This information is often difficult to acquire and typically resides outside the expertise of community health providers, so CBA was able to provide a vital service:

HIV/AIDS in the A&PI community is not seen as an issue [in this geographic region] so the CBA was addressing the basics. That includes providing of information: statistical data, surveys, research, ideas on what types of things we could do to begin the dialogues.

System-level effects refer to changes that extend beyond the client level to influence the community of A&PI organizations or the policy environment in which the organizations function. Respondents described a number of improvements associated with participation in CBA including improved professional networks, community mobilization, and leadership development.

Professional networks emerged in both formal and informal ways. CBA providers formally created networks by convening community agencies, researchers, and health providers in regional meetings, large conferences, and workshops, and through e-mail list-serves. Informal networks were also generated through interaction among professional entities with similar goals and methods. Once parties were networked, their ability to share information and mobilize resources increased. One important outcome to note was that new or poorly funded service programs were able to gain mentorship and professional resources from older and more well-established programs. Participants described some of the networking activities that developed through this process, as well as the changes resulting from these networks:

We know who the expert is in what area. Because we know who specializes in what, and who we want to call when it comes to specific issues and needs, we can get reliable information fairly easily.

Another outcome of CBA was the provision of training to allow individuals to become effective voices for the interests of A&PI communities. Speaking on this topic, respondents described receiving skills and motivation to become community advocates, typically as members of local planning groups for HIV prevention and care. Respondents described their acquired leadership skills as an important marker of success in the creation of optimal policy changes for A&PI communities:

Because I spoke up to the [State] Department of Health, they now have disaggregated A&PI data in [the State]. Our community planning group is now responsive to

A&PIs because we collected HIV data and showed a huge increase in numbers when immigrants and refugees were included on the list.

Baseline data show that the National CBA Program model builds on this infrastructure of knowledge, confidence, and experience to continue strengthening HIV programming in A&PI communities.

Preliminary data results across four focus areas of the National CBA Program

Individual CBA requests

One hundred eighty-two individual CBA requests from 55 CBOs and 18 health departments show generalized results thus far, and that there is a positive effect on leadership, management, and program delivery skills of recipients, including increased confidence and skills in leadership, decision making in overall general management of their agencies, and adapting science-based interventions for their targeted communities. For the individual CBA requests, suggestions for improvement in this area included expanding the consultant pool to ensure the highest level of competence and more local consultants from which to choose.

Individualized CBA requests included fundraising, strategic planning, executive coaching, program planning, service integration, cultural adaptation of evidence-based interventions, media campaign implementation, media strategy, cultural competency, data review, and planning.

Skills-building trainings

Preliminary quantitative data collected to date reported in this result section only encompass information gathered from trainings. Twenty-eight skills-building trainings have been conducted over the past 2 years with more than 550 participants trained across the four focus areas. Some of the training topics include Executive Coaching; Media & Public Relations; Fundraising; Change Management; Adapting & Tailoring DEBIs—Sharing Best Practices; CTR in the Pacific Island Jurisdictions; HIV & Cultural Competency; HIV & Stigma; Social Marketing Campaigns—The Banyan Tree Project; Fostering Advocacy & Community Empowerment; and Leadership in Advocacy. Many of these skills-building trainings are held across the United States and the Pacific Island Jurisdictions, including New York City; San Francisco; Los Angeles; Washington, DC; Boston; Chicago; Honolulu; and Guam, to increase regional participation in the trainings. Postsurvey data collected immediately after a skills-building training across the four focus areas, in general, show the trainings are relevant and useful for participants in concurrence with the baseline

assessment data. Preliminary 6-month posttraining data reveal trainings still remain relevant, and in some cases, have actively led to requests for individualized CBA on the topic area.

The Banyan Tree Project

The Banyan Tree Project is a social marketing campaign aimed at fighting HIV-related stigma and discrimination. Baseline data collected to determine the direction of the campaign point to deep feelings of shame, fear, and isolation within the A&PI communities around HIV/AIDS. Process data revealed that one of the Banyan Tree Project's key components, the First National Asian & Pacific Islander HIV/AIDS Awareness Day on May 19, 2005, served as a "lightning rod" for concurrent commemorative events in nine US cities. This inaugural year's activities garnered the support of A&PI celebrities Olympic gold medallist Greg Louganis and actor Russell Wong, in addition to the endorsement of elected officials from leadership in the US Congress to diverse community leaders. More than 200 media features were documented on television, radio, print, and Web media outlets. Two, 30-second public service announcements highlighting the role of A&PI families addressing HIV-related stigma were developed, produced, and placed "pro bono" in seven major US media markets, with local and national television coverage to 80 million households. Outcome evaluation on HIV-related stigma reduction and increased access to HIV services for A&PIs is still too preliminary to share.

National CBA Program Network functioning

The National CBA Program partnership uses a dashboard survey to assess the functioning of the collaborative as a whole. The dashboard looks at partnership functioning on clarity of roles and responsibilities across the general network and between the leads and regional partners, collaboration, communication, and trust. The data collected over four periods in the current formation indicate that the national network has gone through a "forming, storming, norming, and performing" cycle, common to many group formations. Today, the partnership is between "norming and performing," based on the data scoring.

● Discussion

CBA programs can provide a vital service to underrepresented racial and ethnic minority communities that experience high, unmet demands for HIV prevention and care. A&PI communities in the United States represent one such community, as their risk for

HIV infection and need for prevention and care appear to be on the rise, yet few culturally competent public health initiatives have been organized. Grassroots efforts by CBOs such as A&PI Wellness Center, APIAHF, and their regional partners have resulted in a National CBA Program that has been associated with improvements in clients' organizational functioning, provision of culturally competent HIV prevention and care services, professional networks, access to relevant information, leadership training, and opportunities to change health-related policies to benefit A&PI communities.

The National CBA Program described here is facilitated by the strong relationships between parties involved in the delivery of the CBA program services, including national agencies, regional partners, client organizations, health departments, researchers, and funding program officers. Ultimately, the goal of the National CBA Program is to build national, regional, and local community infrastructures for improving culturally competent and high-quality access to HIV prevention and care services for A&PIs. Infrastructures can be viewed as a network of relationships between and within parties (agencies, providers, researchers, funding agents). The core values guiding this CBA program—being client-centered, collaborative, and culturally competent—enhanced the ability of parties to communicate, share resources, train one another, and learn from one another. For disadvantaged groups such as racial and ethnic minority communities or socially stigmatized populations, these relationships might be complicated because of competition over scarce funding opportunities for health services as well as other sociopolitical deficits (limited access to political power and poor economic viability). CBA programs that work with such groups to improve HIV prevention programs must, therefore, keep these realities in mind when defining their core values and developing their program models.

In this process of implementing the National CBA Program model, some challenges to developing and sustaining the national CBA network of relationships were encountered. One specific procedural challenge stemmed from conflicting distributions of authority among members of the CBA network. Community-based work often implies highly democratic, nonhierarchical relationships among collaborators. In practice, truly nonhierarchical relationships are difficult to achieve. To achieve adequate network alignment, it may be important for CBA programs to include both hierarchical and democratic elements such that organizational roles are clear, responsibilities are assigned, and flow of communication proceeds across all directions of the hierarchy. A challenge for conducting future CBA with underrepresented communities of color

is to identify ways in which partnerships can effectively deal with issues of authority, mitigate negative effects associated with uneven concentrations of informational and decision-making power, and improve accountability for all members of the partnership.

Another general CBA challenge, specifically related to HIV prevention in communities of color, is the task of defining core competencies and standardized CBA protocols. In the National CBA Program described here, the program model outlined the core values, target populations, strategies, and outcomes; however, the exact competencies expected of individual CBA staff providers were not specified beforehand. These competencies were developed in the first year of the project to ensure clearer understanding of the skills that CBA providers must possess. Related to this, the National CBA Program has standardized CBA protocols so that clients can receive consistent quality in services regardless of their location, size, and preexisting services.

It is important to note the several limitations to the evaluation findings reported here. The sample of respondents might not have been representative of the general client base. The qualitative techniques employed cannot be used to infer statistical or direct associations for the baseline assessment. Response biases might have inhibited respondents' comments, particularly criticisms or complaints of the program. Much of the recent data for the program are extrapolated from quantitative survey tools with some open comment boxes. This coming year, qualitative data will be collected to complement the results collected thus far and increase the holistic potential of National CBA Program delivery to assess the overall impacts toward program outcomes and goals. On the basis of the overall picture, the survey tools would be modified slightly to ensure all evaluation data also collect impacts across each core focus area to understand the cross-impacts across all four areas.

Keeping in mind the procedural and evaluation limitations, the CBA experience described here can offer important implications for other attempts at national CBA-coordinated HIV prevention initiatives. First, CBA can be an effective means for bringing together geographically or programmatically diverse parties that share an interest in HIV and related health issues in specific communities of color. Second, a clear definition of CBA core values, target populations, strategies, and outcomes can facilitate the implementation and delivery of services in a focused and more cost-effective method. Third, specific activities can be effective at developing community-based public health infrastructures, such as building regional networks and organizations, disseminating evidence-based intervention models and other information throughout these bodies, and strengthening leadership in regions that

will impact the national picture. Finally, evaluation and documentation of CBA experiences are centralized and may improve future attempts to build linkages between CBOs, federal and state health departments, health providers, and researchers, who collectively can improve HIV prevention and care services for underserved racial and ethnic minority communities.

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